MODULE: FEMALE GENITALIA, RECTUM

OBJECTIVES:

Upon completion of this module, the student will be able to:

1. Identify normal female anatomical structures.

2. Perform, with assistance, a complete female genito-urinary examination.

3. Perform a complete sexual history in a sensitive fashion.

4. Identify STD and AIDS risk factors.

5. Demonstrate verbal and non-verbal behaviors designed to decrease the anxiety of patients undergoing genito-urinary examination.

6. Recognize the personal biases of a provider which may impact sexual history taking.

REQUIRED READINGS:

1. Bates’ guide to physical examination and history taking, Chapter 13, Female Genitalia.

PRACTICE:

Equipment needed:

<table>
<thead>
<tr>
<th>Vaginal speculum</th>
<th>Tissue</th>
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<tr>
<td>Cotton and Dacron applicators</td>
<td>Culture media</td>
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<tr>
<td>Cervical scrapers (pap stick)</td>
<td>Pillow, Drapes</td>
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<td>Occult Blood Test Kits</td>
<td>Lamp</td>
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<tr>
<td>Glass Slides and cover slips</td>
<td>Gloves</td>
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<tr>
<td>Water soluble lubricant</td>
<td>Fixative spray</td>
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</table>
MODULE: FEMALE GENITALIA/ANUS/RECTUM

STUDY QUESTIONS

1. Define or describe:
   a. adnexae
   b. amenorrhea
   c. Bartholin’s glands
   d. chancre
   e. cystocele
   f. Douglas/cul-de-sac
   g. dysmenorrhea
   h. dyspareunia
   i. endometriosis
   j. escutcheon
   k. fibroid
   l. fornix
   m. fourchette
   n. hemorrhoids
   o. hymen
   p. introitus
   q. leukorrhea
   r. menarche
   s. menorrhagia
   t. metrorrhagia
   u. mittleschmerz
   v. multipara
   w. nullipara
   x. oophoritis
   y. oligomenorrhea
   z. rectocele
   aa. rugae
   bb. salpingitis
   cc. Skene’s glands
   dd. vestibule
   ee. vulva

2. Label the parts of the external and internal female genitalia.

3. List the cardinal symptoms of the female genitourinary system.

4. Describe the technique for checking the Skene’s and Bartholin’s glands.

5. Describe the lymph drainage of the vulva, vagina, and internal organs.

6. Discuss the 5 stages of pubic hair growth (Tanner stages).

7. How do these changes correlate with the growth spurt, breast development, and menarche?

8. Describe the normal changes in the female genitalia which occur with aging.

9. How do you select the correct vaginal speculum for a particular patient?

10. Mrs. S is 7 yrs. post-menopause. On pelvic examination, you feel a palpable R ovary. What is your assessment of this exam?

11. Differentiate a retroflexed vs. a retroverted uterus.

12. What is the rationale for the rectovaginal exam?

13. Chart a normal pelvic exam. using correct terminology.

14. Differentiate external vs. internal hemorrhoids.

15. Chart a normal rectal exam.

ASSESSMENT OF THE ELDERLY CLIENT

Female Genitalia

The female reproductive organs show evidence of the aging process; secondary sex characteristics recede. Pubic hair decreases. Generalized pelvic muscle weakening may cause urinary urgency and frequency. Backache may occur with progressive muscle weakening. The vulva may decrease in size or appear pendulous due to subcutaneous tissue changes. The vagina, as a result of estrogen deficiency, loses its normal rugae, has diminished secretions, thin friable tissue and the vaginal outlet decreases in size. The cervix may be difficult to identify as it regresses in size and becomes flush with the vaginal vault. The ovaries also shrink in size as does the uterus of the post-menopausal woman. Multiple births and subsequent scarring may make the internal exam difficult to perform and/or painful.

Although libido decreases somewhat, sexual functioning should be normal in the aged female. Orgasm is shortened, however.

<table>
<thead>
<tr>
<th>Subjective complaints</th>
<th>Objective findings</th>
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<tbody>
<tr>
<td>decreased pubic hair</td>
<td>decreased pubic hair</td>
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<tr>
<td>backache</td>
<td>vaginal wall shiny, friable, dry and glistening</td>
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<tr>
<td>painful cramps’ after coitus</td>
<td>small vaginal outlet</td>
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<td>discomfort during coitus</td>
<td>cervix not identifiable</td>
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<td></td>
<td>adnexa non-palpable</td>
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<td></td>
<td>uterine outlet difficult to obtain</td>
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<td></td>
<td>vaginal wall muscle weakening</td>
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<td>vaginal mucosa bleeds with exam</td>
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<td>ability to insert only one finger for vaginal/bimanual exam.</td>
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<td></td>
<td>vaginal mucosal scarring</td>
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</tbody>
</table>
MODULE: FEMALE GENITALIA
GYNE HISTORY

Menstrual History--The gyn. history is sensitive and personal information for many women. A non-judgmental approach respecting women's differing values and beliefs (about menses, abortions, sexual relationships, etc.) is essential to assisting the client to feel comfortable with her own individual expression of "womanhood."

A. Description of menstrual pattern (frequently inconsistent)
   1. menarche
   2. regularity, amount/duration of bleeding each menses
   3. length of cycle (number of days between 1st day of one period and 1st day of next)
   4. date of last normal menstrual period (LNMP)
   5. any associated mittlesmertz, metrorrhagia, menorrhagia, irregular bleeding, spotting, post-coital bleeding, dyspareunia.

B. Perimenstrual distress:
   1. symptoms --before and/or during menses:
      emotional changes: increased lability, increased irritability or depression, moodiness, aches or pains; headaches, backache, leg ache, lower abdominal cramps
      edema, abdominal bloating, breast tenderness
   2. treatment, self-care:
      medication--drugs alcohol
      diet, exercise, psychophysiological--meditation, biofeedback
      vitamin therapy
   3. effect on lifestyle--absenteeism

C. If amenorrhea or menopausal:
   1. duration of amenorrhea, related surgery, related lifestyle changes or other events
   2. concurrent symptoms--flushes, fatigue, insomnia, night sweats, increased irritability
   3. postmenopausal bleeding?
      treatment--exogenous hormones, psychophysiological--biofeedback, meditation

D. Vaginal discharge--normal or abnormal
   1. color, consistency, amount odor
   2. concurrent symptoms--burning, itching labia, burning with urination or intercourse

E. Female self-care
   1. feminine hygiene--wiping techniques--douching, frequency and with what
cotton wearable, use of deodorants, sprays, deodorant tampons/pads
use of tampons, encourage use of pads at night (toxic shock syndrome)
Kegals
   2. Pap smears/BSE
      frequency/techniques BSE
      Last PAP

F. Sexually transmitted diseases (STD)
   1. determine diagnosis/treatment/complications for each:
      herpes
      condyloma (warts)
      HPV (human papilloma virus)
      crabs
      trichonomas
      bacterial vaginosis
      gonorrhea
      syphilis
      chlamydia

G. Pelvic pain
   1. onset
   2. duration
   3. character
   4. intensity
   5. location
6. relation to other systems
7. relation to menstrual cycle
8. relation to sexual intercourse and other activity
9. effect on daily living
   treatment, medications, and effects

H. History of any other pelvic problems
   1. tumors, cysts, fibroids
   2. endometriosis
   3. ext. lesions--bumps, boils, ingrown hair follicles, rash
   4. cervical problems--friable ectopy--cautery? cervicitis/chlamydia
      abnormal pap smear--treatment? follow-up?

I. Sexual history
   1. Puberty? what was it like for you--easy? difficult?
   2. Sexual behavior
      a. age at first intercourse/circumstances
      b. comfort with sexuality
      c. sexual preference--men, women, or both
      d. satisfaction with present sexual experience/relationship/frequency of intercourse
      e. masturbation, vibrator, other?
      f. past or present problems/concerns with intercourse
         pain--when? with penetration, deep thrusting, burning afterwards?
         vaginal dryness, decreased lubrication
         lack of responsiveness (ability to perform, enjoy sexual intercourse
         partner involvement/communication
         history of abuse/rape
   3. history or high risk behavior
      a. self or partner with STD (HIV?)
      b. sex with person who used needles to take drugs?
      c. sex with hemophiliac
      d. sex with bisexual man
      e. anal intercourse
      f. sex without condoms
      g. sex with more than one partner in past 5 years
      h. sex with a nonmonogamous partner

J. OB/contraceptive assessment
   1. History--contraceptive and pregnancy information--begin with first coitus and
      move sequentially to present
      A. Pregnancy data
         Gravida____  Para____ abortions (includes miscarriages______
         For each pregnancy
            1. prenatal course/complication
            2. description of labor
            3. date and type of delivery (vaginal/c. section/full-term/preemie
            4. condition, sex, weight of infant
            5. postpartum course
         For each abortion:
            1. when in pregnancy
            2. spontaneous
            3. induced
            4. concerns, feelings
      B. Contraception data--method, rationale for use, duration of use/correct use
         1. difficulties, side effects, problems--method or lifestyle related
         2. reason for stopping
         3. note periods without sexual involvement or sex without protection
      C. For present situation assess
         1. general attitudes/comfort regarding use or non-use of contraception
         2. need for additional information regarding methods
         3. if not sexually active, method planned for emergencies or future feelings
            about body
2. Decision-making about contraceptive methods
   • cost-benefit analysis
   • goals and priorities: absolute prevention of pregnancy
care delay/spacing
   • safety-no side effects
   • preservation of fertility
   • separation of method from coitus/spontaneity
   • hassle associated with any method
   • watch clinician bias

3. Assess “person method fit”
   Given all the above information--is this woman at risk for unplanned/unwanted
   pregnancy? how satisfied is she with present situation? what would she do if she did
   become pregnant now?

4. relevant medical history
   a. for oral contraceptives:
      severe migraine, cerebral arterial insufficiency, cardiovascular
disease, liver disease, diabetes, genital or breast cancer, thrombotic
problems, hypertension, family history of stroke, MI before age 50,
irregular menses/late menarche
   b. for intrauterine device (IUD)
      valvular heart disease

K. Fertility
   1. history of infertility
   2. length of time of intercourse without contraceptives; regularity of intercourse
   3. extent of previous workup: tests, dates, results
   4. past pelvic disease, especially PID, endometriosis
   5. motivation for pregnancy
   6. reactions to infertility--does she still have hope?

L. Other chronic disease or conditions, surgeries, treatments, medication--may have side effects

Relative to gyn history:
narcotics, ETOH, sedatives, tranquilizers, tricyclic antidepressants,
antihypertensives, MAO inhibitors, progesterone, estrogen
PELVIC EXAMINATION GUIDELINES

I. Pelvic Examination Guidelines
   A. Possible reasons for an inadequate assessment
      1. full bladder—uterus often seems to cease to exist in this case
      2. too small speculum—vaginal walls occlude vision
      3. large amount stool in colon
      4. tense abds.--will relax on deep exhalation
      5. obesity
      6. very tight introitus--1 finger exam better than none.
      7. examiner with short fingers--brace the elbow of the examining arm on her/his hip to increase pressure or try reversing hand position--palm down to gain distance
   B. General rules
      1. during pelvic, observations of pt. face & attitudes will help determine pain or tenderness
      2. all motions within pelvis must be accomplished in a slow fashion because of sensitivity area
      3. all movements must be gentle, but firm to accomplish the task
      4. many women will appreciate being offered a mirror in order to observe the ext. exam and view cervix
      5. client will relax more readily if you explain what you are doing. You may find you have to repeatedly remind the client to relax.
      6. remember that this examination involves the use of the concept of spatial relations and it is very important to visualize what you feel with your hands
      7. avoid draping procedures that don’t allow eye contact

II. Counseling/Teaching Considerations
   A. Sexual issues/problems--sex dysfunction, pain or lack of orgasm--most common, uncertainty or difficulties regarding sex preference
   B. Contraception--sexually active minors--unplanned pregnancy
   C. prevention of problems/disease: first intercourse, multiple partners

III. Charting
   A. order of chart note:
      1. Ext genitalia--female vs. male--normal hair distribution
      2. BUS--refers to ext. inspection, Bartholin's Urethra, Skene's glands—note presence or absence of abnormalities
      3. introitus--vag. opening/hymen
      4. vagina--note mucosal color; presence/absence of rugae/normal or abnormal discharge, lesions, support
      5. cervix--note multip/multip os; color; discharge per os/ IUD string, if present laceration, lesions, ectopy
      6. uterus--description often abbr. NSSC: Normal Size, Shape, and Consistency—also position, mobility, tenderness
      7. adnexa—if nonpalpable, state, if palpable & WNL state; if no masses felt, state if abnormal, describe
      8. recto-vaginal (RV) if no new findings, you write RV confirms; masses, hemorrhoids, stool guaiac
   B. Sample charting of pelvic exam
      1. EXT genitalia-nl female
      2. BUS-no discharge or lesions
      3. Vagina-pink, well rugated, min shite discharge, good support
      4. Cx-parous, pink, sl ectopy. Nabothian cyst @ 4 o’clock
      5. Uterus--ant, NSSC, mobile, nontender
      6. Adnexa--both ovaries 2 cm x 2 cm, without masses or tenderness
** Branching Exam Procedure**

<table>
<thead>
<tr>
<th>COMPONENT ACTIVITIES</th>
<th>DONE</th>
<th>NOT DONE</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td><strong>PELVIC EXAMINATION</strong></td>
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<tr>
<td>1. Assemble equipment prior to exam</td>
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<td>2. Position client</td>
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<td>3. Inspect: mons pubis, perineum, labia majora, labia minora, clitoris, urethra, introitus</td>
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<td>4. Milk the Skene’s glands</td>
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<td>5. <strong>Culture discharge, if present</strong></td>
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<td>6. Palpate for Bartholin gland enlargement</td>
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<td>7. Assess support of vaginal outlet</td>
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<td>8. Assess position of cervix (optional)</td>
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<td>9. Insert speculum:</td>
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<td>a. Lock blades with cervix in position</td>
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<td>10. Inspect cervix and os</td>
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<td>11. **Culture any malodorous or colored discharge from os; wet mount-KOH and NS</td>
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<td>12. Obtain and fix pap smear:</td>
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<td>a. s-q junction</td>
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<td>b. Endocervical swab</td>
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<td>13. **Obtain gonorrhea culture and chlamydia specimen</td>
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<td>14. Inspect cervix and vaginal walls as speculum is withdrawn</td>
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<td>15. Perform bimanual exam:</td>
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<tr>
<td>a. Palpate vaginal walls</td>
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<td>b. Palpate cervix and fornices</td>
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<td>c. Palpate uterus</td>
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<tr>
<td>d. Palpate right and left adnexae</td>
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<tr>
<td><strong>ANUS AND RECTUM</strong></td>
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<tr>
<td>1. Inspection</td>
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<tr>
<td>a. Inspect anus</td>
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<td>b. Inspect with straining for varicosities</td>
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<td>2. Palpation</td>
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<td>a. Instruct client to bear down</td>
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<td>b. Insert lubricated, gloved finger into rectum</td>
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<td>c. Evaluate sphincter tone</td>
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<td>d. Palpate: L lateral, posterior, R lateral &amp; anterior areas (may feel cervix through anterior wall)</td>
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<tr>
<td>e. Ask client to strain (bear down), feel deeper</td>
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<td>f. Withdraw finger</td>
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<td>g. Wipe external genitalia/anus</td>
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<td>h. Test fecal material for occult blood</td>
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<td>3. Assist client to sitting position</td>
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