ACKNOWLEDGEMENTS
This pack has been produced in consultation with Linda Croft (Consultant gynaecologist), Diane Poad (Consultant gynaecologist), Rosemary Reid (Consultant gynaecologist), Annette Finlay (Maori Cultural Development Facilitator), Sue Bagshaw (Senior Lecturer Christchurch School of Medicine).
Contents:

Acknowledgements

Learning objectives

Pre-requisites to learning this skill

Tutorial outline (preparation, procedure, finishing)

Appendix 1 – Anatomy and physiology

Appendix 2 – Potential problems to consider

Source material

Self / peer assessment form

User feedback sheet
GYNAECOLOGICAL EXAMINATION

Learning objectives

Completion of this package will enable learners to:-
1. Demonstrate appropriate examination technique, describing the rationale for each step in the procedure
2. Communicate with patients in a way, which reduces anxiety, provides necessary information, earns their trust and ensures safe practice.
3. Describe the relevant anatomy of the female genitalia.
4. List potential problems which may be encountered
5. Document information relating to the procedure in a way which ensures patient safety and meets quality standards.
6. Be familiar with the cervical screening programme policy and manual

Before learning this skill it is expected that learners will:

- Have up to date knowledge of related anatomy and physiology
- Be familiar with associated organisational documents and policy manuals:
  - Have read through whole package before starting
  - Identify own learning needs relating to this procedure

This pack can be used for:

- Practical group teaching session using simulation models and / or training video
- Individual self-directed learning session, with / without peer support using simulation models and / or training video

Using this pack is intended to help learners to:

- Meet stated objectives
- Meet some / all own learning needs
- Feel prepared for formative / summative assessment requirements

It is recommended that learners:

- Complete self evaluation form and amend on-going professional development action plan – useful for professional portfolio
- Complete user feedback sheet for on-going improvement of Clinical Skills Unit facilities.
TUTORIAL OUTLINE

The following guidance is provided to enable clinicians to perform this skill with confidence and competence, without risk of cross infection or undue discomfort to your patient.

If you are new to this skill, you are encouraged to study the written guidance and practice the skill in the safety of the Clinical Skills Unit, as frequently as you feel necessary before being assessed and ultimately taking responsibility for performing this procedure with patients.

Alternatively, even if you have experience, the opportunity to revise your knowledge and practice the skill in a safe environment will improve your technique, thus increasing your confidence and competence.

Your patients will be thankful that you spent time with this activity.

Gynaecological examination is commonly undertaken for:-

- Screening
- Diagnosis of presenting signs and symptoms
- Monitoring the severity and progression of a documented pathology.

To perform this task in a sensitive and well-organised way, you need to apply your knowledge about

- ✓ anatomy and physiology (Appendix 1)
- ✓ infection risk
- ✓ good communication, including common courtesy
- ✓ culturally appropriate practice
GYNAECOLOGICAL EXAMINATION

PREPARE

a) EQUIPMENT / ENVIRONMENT

Work in a comfortable, private area, with a good light source at hand.

Use anatomical model to explain procedure and findings.

Correct size / type of speculum (Sims, Cuscoes, metal, plastic)

Ensure the speculum is warm (but not too hot), testing on inner thigh.

Water-based lubricant

b) SELF

Think through the whole procedure and consider the potential problems you might encounter (Appendix 2)

Acknowledge, to yourself, any discomfort / embarrassment you feel about the examination procedure, as a sign of your sensitivity to the patient’s needs and proceed as confidently as possible.

Secure attendance of a chaperone / assistant once discussed and agreed upon by patient (Best practice recommends for either male or female practitioners, to protect patient and practitioner).

Wash hands carefully and dry well, prior to following Universal Precautions for infection control, throughout the procedure.

c) PATIENT

Introduce yourself and confirm their identity. (Note - a Māori person may not immediately reveal their name or their situation, without the preliminary formalities having been appropriately completed.)

Explain and discuss the procedure to both reduce patient anxiety, being sensitive to the tapu nature of the genital area (for Maori) and to the wide range of cultural sensitivities for other ethnic groups. Every attempt should be made to recognize and respond to these, remember there is an interpreter service available for an extensive range of languages. Remember you can also seek guidance from the patient or their whanau about whom it is appropriate to have present during the procedure, and also who is appropriate to undertake the procedure. For example, the patient/whanau may not wish to have a male perform the procedure (particularly in some ethnic groups).

Acknowledge, with the patient / whanau, your sensitivity to their potential anxiety / embarrassment relating to the examination. (Aim to achieve a balance between “not enough” and “too much” focus on this)
Allow sufficient time for issues to be set out, explained and talked through sufficiently for a clear decision pathway to emerge. **Ensure understanding so that given consent is thus informed.**

You may also want to give some thought as to how you
- deal with different styles of communication, including silence
- can use family/whanau and kaumatua as part of the healthcare team
- can obtain help to assist with interactions with Maori patients and their whanau and patients from ethnic backgrounds for whom English is a second language if you need it e.g. interpreters, Maori health workers
- reinforce the holistic care perspectives, including all aspects of well being described in the Maori Healthcare document

Ask about any latex allergy.

Check that patient’s bladder is empty before examination.

Be clear about what clothing to take off

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**A Maori Health note**

Maori women are at the centre of their whanau, hapu and iwi, considered Te Whare Tangata, the house of the people. The spiritual link between land and the health and wellbeing of Maori women is reflected in the language used to describe the functional anatomy of Te Whare Tangata. The female genitals are the doorway to Te Whare Tangata and there are deeply felt cultural beliefs relating to the sanctity of Te Whare Tangata with consequences for related clinical practices such as catheterisation. Some Maori may want to say karakia before the procedure. Show through words and actions that you understand Maori concepts of health and well-being eg. Using appropriate greeting processes and not expecting Maori to continually look directly at other people during an interaction or assuming silence means assent. Consider the implications of Cartwright’s (1988) explanation

“…… cultural inhibitions on modesty and what is or isn’t proper exposure is ingrained into most Maori girls at an early age. Exposure of the pubic area is forbidden and proper behaviour and practice during menstruation especially is taught at the onset of menses.”
## GYNAECOLOGICAL EXAMINATION

**PROCEED**

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
<th>Rationale &amp; Remedial Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ask Patient to assume a position of comfort with knees flexed and legs abducted, with a drape covering the genital area from the umbilicus.</td>
<td></td>
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<tr>
<td>2</td>
<td>Wash hands and put on well fitting, non-sterile gloves.</td>
<td>To ensure maximum sensitivity whilst protecting against potential cross infection.</td>
</tr>
<tr>
<td>3</td>
<td>Separate the labia and inspect external genitalia.</td>
<td></td>
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<tr>
<td>4</td>
<td>Assess the support of vaginal walls by asking patient to “cough” or “bear down”, with labia separated by your middle and index fingers.</td>
<td>Bulging can indicate range of prolapses.</td>
</tr>
<tr>
<td>5</td>
<td>Applying downward pressure on lower margin with two fingers to enlarge the introitus, insert a lubricated speculum, at an angle, in a gently downward direction, being careful not to catch pubic hair or pinch labia.</td>
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<tr>
<td></td>
<td>Rotate speculum into horizontal position, maintaining pressure posteriorly and insert to full length. <strong>Stop if causing pain.</strong> <strong>Give patient chance to relax before continuing.</strong> <strong>Change speculum size /type if necessary</strong></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Open the speculum, adjusting the position until it brings the cervix into view. Position the light to see well.</td>
<td>If you have difficulty finding the cervix, withdraw the speculum slightly and re-position on a different angle. If discharge is obstructing the view of the cervix, remove with swab.</td>
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<tr>
<td>10</td>
<td>Inspect the cervix and the os for colour, position, surface characteristics, bleeding or discharge. <strong>(Figure 1 and 2)</strong></td>
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<tr>
<td>11</td>
<td>Secure speculum in open position, by tightening screw.</td>
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</tr>
<tr>
<td>12</td>
<td><strong>Taking cervical smear :</strong> If spatula and brush technique is used two 360</td>
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</tbody>
</table>
degree sweeps with the spatula - spread horizontally on to the top half of the slide, and whilst covering the bottom half spray. Then the brush - just one turn - being careful not to cause bleeding and roll it on to the bottom half of the slide and spray.

With the cervibroom insert into the os and do 360 degree turn 5 times (any less often results in a higher chance of no Cervical Cells) wipe both sides of the broom onto the slide and spray.

| 15 | **Taking cervical smear:**  
|    | Place sample of material evenly, onto slide and “fix” immediately, to avoid air drying. |

| 13 | **Taking endocervical swab:**  
|    | Remove surface discharge with larger swab then insert smaller swab into os. Roll it between index finger and thumb for a full minute.  
|    | If doing STI screen - High Vaginal Swab is not necessary unless there are symptoms or signs of vaginitis. An endocervical swab to remove mucus from the os to check for gonorrhoea is done first. Take the smear using a spatula and cytobrush or a cervibroom on its own then the endocervical swab for chlamydia. This needs to be done by pressing the narrow of the 2 swabs provided in a PCR kit against the canal of the os, and turning vigorously to ensure good collection of endocervical cells. This can cause bleeding if done properly thus doing the smear first is better. |

| 14 | **Taking high vaginal swab:**  
|    | Insert swab into visible discharge and / or vaginal fornices, taking care not to contaminate it on entry of removal. |

| 16 | **Taking endocervical or high vaginal swab:**  
|    | Place sample in transport medium immediately and seal container. |

| 17 | Loosen the speculum screw, whilst maintaining in open position with thumb to avoid pinching cervix. |

| 18 | Withdraw speculum slowly, whilst inspecting the vagina, for colour, discharge, surface characteristics. |

| 19 | Close the speculum carefully as it emerges from the introitus. *To avoid excessive stretching or pinching.* |

| 20 | **Performing a bimanual examination:**  
|    | From a standing position, insert lubricated middle and index fingers (*or only one, if anatomy* ...
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<thead>
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<tbody>
<tr>
<td><strong>21</strong></td>
<td>Palpate the cervix, noting position, shape, consistency, regularity, mobility and tenderness.</td>
</tr>
<tr>
<td><strong>22</strong></td>
<td>Palpate the fornices.</td>
</tr>
<tr>
<td><strong>23</strong></td>
<td>Palpate the uterus by placing other hand on abdomen midway between umbilicus and symphysis pubis. Whilst elevating cervix and uterus with one hand, press abdominal hand in and down, grasping the uterus between. Note size, shape, consistency, mobility, any tenderness or masses.</td>
</tr>
<tr>
<td><strong>25</strong></td>
<td>Palpate each ovary by placing abdominal hand on right lower quadrant with pelvic hand in right lateral fornix. Pressing abdominal hand in and down pushing adnexal structures towards pelvic hand, between your fingers. Note their size, shape, consistency, mobility and tenderness. Repeat other side.</td>
</tr>
<tr>
<td><strong>27</strong></td>
<td>Withdraw fingers, dispose of gloves and offer patient tissue to clear discharge or lubricant.</td>
</tr>
</tbody>
</table>
Table 13.3 Variations in the Cervix

Shapes of the Cervical Os

The normal cervical os may be round, oval, or slitlike. The trauma of one or more vaginal deliveries may tear the cervix, producing lacerations. Illustrated here, from left to right, are an oval os, a slitlike os, and lacerations described as unilateral transverse, bilateral transverse, and stellate.

Variations in the Cervical Surface

Two kinds of epithelium may cover the cervix: (1) shiny pink squamous epithelium, which resembles the vaginal epithelium, and (2) deep red, plump, columnar epithelium, which is continuous with the endocervical lining. These two meet at the squamocolumnar junction. When this junction is at or inside the cervical os, only squamous epithelium is seen. A ring of columnar epithelium is often visible to a varying extent around the os—the result of a normal process that accompanies fetal development, menarche, and the first pregnancy.

By another process termed neoplasia, all or part of this columnar epithelium is transformed into squamous epithelium again. This change may block the secretions of columnar epithelium and thus cause retention cysts (endocervical cysts). These appear as one or more translucent nodules on the cervical surface, and have no pathologic significance.

*Terminology is in flux. Other terms for the columnar epithelium that is visible on the ectocervix are ectropion, ectopy, and eversion.

Table 13.4 Abnormalities of the Cervix

Carcinoma of the Cervix

Carcinoma of the cervix begins in an area of metaplasia. In its earliest stages, it cannot be distinguished from a normal cervix. In a late-stage, an extensive, irregular, cauliflower-like growth may develop. Early frequent intercourse, multiple partners, and infection with human papillomavirus increase the risk for cervical cancer.

Cervical Polyp

A cervical polyp usually arises from the endocervical canal, becoming visible when it protrudes through the cervical os. It is bright red, soft, and rather fragile. When only the tip is seen, it cannot be differentiated clinically from a polyp originating in the endometrium. Polyps are benign but may bleed.

Mucopurulent Cervicitis

Mucopurulent cervicitis produces purulent yellow drainage from the cervical os, usually due to infection from Chlamydia trachomatis, Neisseria gonorrhoeae, or herpes. These infections are sexually transmitted, and may occur without symptoms or signs.

Fetal Exposure to Diethylstilbestrol (DES)*

Daughters of women who took DES during pregnancy are at much higher risk for a number of abnormalities, including (1) columnar epithelium that covers most of all the cervix, (2) vaginal adenosis, i.e., extension of this epithelium to the vaginal wall, and (3) a circular collar or ridge of tissue, of varying shapes, between cervix and vagina. Much less common is an otherwise rare carcinoma of the upper vagina.

*In the United States, exposure to DES diminished in the late 1960s and stopped in 1971 when the drug was banned.
GYNAECOLOGICAL EXAMINATION
FINISH

a) **PATIENT**
   Be clear that you have finished and offer a tissue and a pad if there is any spot bleeding. Check with the patient that they are comfortable and understand your findings

   Some Māori may want to say karakia when the procedure is completed. Be aware that when Māori are embarrassed, shy, feeling powerless, frustrated, under scrutiny or at a disadvantage, they may use or exhibit the description “whakamā”. It is an expression of unhappiness, and requires time and sensitivity to work through what is creating the unhappiness.

b) **EQUIPMENT**
   Rinse or soak speculum immediately to dislodge secretions. Document findings

c) **SELF**
   Wash your hands
   Think about what you learned from the procedure on this occasion
APPENDIX 1
ANATOMY AND PHYSIOLOGY

- Mons pubis
- Prepuse
- Clitoris
- Urethral meatus
- Opening of paraurethral (Skene’s) gland
- Vestibule
- Introtius
- Perineum
- Labium majus
- Labium minus
- Hymen
- Vagina
- Opening of Bartholin’s gland
- Anus
- Location of Bartholin’s glands
APPENDIX 2

POTENTIAL PROBLEMS TO CONSIDER

**Vaginism**
This may be due to previous trauma / abuse

It may be overcome by:
- counselling
- reassurance understanding approach
- One tip is to encourage women to feel in control of the procedure - sometimes it helps to ask permission at each step of the procedure, so that she knows she can stop toe procedure at any time.

**Deep cervix**
It may be overcome by elevating the buttocks with a pillow

**Cervix not visible**
This may be due to fibroids, endometriosis, pelvic mass, poor speculum positioning

It may be overcome by:
- gentle V.E. to locate cervix,
- reinserting speculum,
- repositioning patient (pillow, left lateral)

**Prolapsing vaginal walls**
This may be overcome by:
- left lateral position
- using Sims speculum and sponge forceps
- larger broader Cuscoes speculum

If the vaginal walls are "floppy" - a condom over the speculum with a hole at the end helps to keep the vaginal walls out of the way.
Source material used to develop this pack includes:


Bickley L. Hoekelman 1999 Bates’ guide to history taking and physical examination. Chapter 13. Lippincott
## Self / peer assessment form

### Performance criteria

<table>
<thead>
<tr>
<th>Performance criteria</th>
<th>Done well</th>
<th>Could be better</th>
<th>Not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepares equipment including warming speculum</td>
<td></td>
<td></td>
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<tr>
<td>Prepares self</td>
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<td></td>
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<tr>
<td>Explains procedure to patient</td>
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<tr>
<td>Checks patient’s bladder is empty</td>
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<tr>
<td>Selects appropriate speculum – can explain choice</td>
<td></td>
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<tr>
<td>Washes hands correctly and puts on non-sterile gloves</td>
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<tr>
<td>Ensures patient is in correct position</td>
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<tr>
<td>Presents as confident and un-embarrassed, whilst being clearly sensitive to patient’s potential psychological and physical discomfort</td>
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<tr>
<td>Locates cervix with lubricated finger</td>
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<tr>
<td>Assesses vaginal tone</td>
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<tr>
<td>Inserts, rotates and positions speculum correctly</td>
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<tr>
<td>Opens speculum sufficiently to ensure cervix is well visualised</td>
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<tr>
<td>Takes smear correctly</td>
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</tr>
<tr>
<td>Takes endocervical swab correctly</td>
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<td></td>
<td></td>
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<tr>
<td>Takes high vaginal swab correctly</td>
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<td></td>
<td></td>
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<tr>
<td>Removes speculum gently</td>
<td></td>
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<tr>
<td>Performs bi-manual examination correctly</td>
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<tr>
<td>Describes finding of palpation of uterus, adnexae and ovaries</td>
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<tr>
<td>Assesses pelvic floor muscle tone</td>
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<tr>
<td>Disposes of gloves correctly</td>
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<tr>
<td>Completes documentation</td>
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<tr>
<td>Checks patient is satisfied with procedure</td>
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### ACTION PLAN:

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**User feedback sheet**
*(Please complete and leave in box provided)*

This feedback will be used to improve the environment and learning opportunities in the Clinical Skills Unit. Summarised feedback (maintaining the anonymity of the user) will be available to those monitoring the Clinical Skills Unit facility and specific skills tutors. If you would like us to follow up your comments, please add your contact details.

**Session topic**

**Date**

**Skill(s) taught / practiced**

Please rate your experience as follows:-

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<tbody>
<tr>
<td>1</td>
<td>Unsatisfactory</td>
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<tr>
<td>2</td>
<td>Poor</td>
</tr>
<tr>
<td>3</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>4</td>
<td>Good</td>
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<tr>
<td>5</td>
<td>Exceptional</td>
</tr>
<tr>
<td>N/A</td>
<td>Not applicable</td>
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</table>

Please rate your experience as follows:

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<tbody>
<tr>
<td>1</td>
<td>Prior planning / information</td>
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<td>2</td>
<td>Structure of session</td>
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<tr>
<td>3</td>
<td>Instruction given (rationales explained)</td>
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<tr>
<td>4</td>
<td>Access to simulation model</td>
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<td>5</td>
<td>Opportunity to ask questions</td>
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<tr>
<td>6</td>
<td>Written information provided</td>
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<tr>
<td>7</td>
<td>Physical environment of the unit</td>
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<tr>
<td>8</td>
<td>Time available</td>
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Comments

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Suggestions for improvements

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Professional group / current role

Name / contact details (OPTIONAL)

THANK YOU VERY MUCH FOR CONTRIBUTING TO THE ONGOING DEVELOPMENT OF THE CLINICAL SKILLS UNIT