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Approach to the Patient

Patients approach a doctor in the hope of a cure for their ills. Diagnosis is the first stage of the process, and is both a science and an art. The science is the reasoning which promotes the correct conclusions based on the facts assimilated from a good history and clinical examination, including the assessment of both positive and negative findings. The art is the skilful collection of these facts, and is learned and mastered only with much practice. All diagnoses are based on the three firm foundations of history, physical signs and the results of necessary investigations. The first two of these will be considered in more detail.

THE HISTORY

History taking is of paramount importance. The ability to obtain a good history is partly based on instruction, partly initiative and partly acquired by experience.

It is essential to hear the woman's story in order to learn the exact nature of her complaints. Each individual symptom should be dealt with in detail; the date and mode of onset, subsequent progression, exacerbating and relieving factors, previous treatment, etc. The symptom of pain must always be carefully considered and its site, nature, severity, duration, frequency, periodicity, radiation and relation to menses, micturition, defaecation and fetal movements, should all be recorded. She should not be allowed to leapfrog from one symptom to another before a complete account of each individual symptom has been rendered. Leading questions should be kept to a minimum, but may be necessary to elucidate the full story in a logical pattern. Direct questions may yield important information quickly, but should not suggest an answer. Once the voluntary history is complete, direct questioning is used for the assessment of the remaining systems and the student should be familiar with the essential questions for each system.

Having dealt with the general aspects of history taking which are applicable to any specialty, the woman with gynaecological symptoms will now be specifically considered.

History of the Gynaecological Patient

Many women of differing age, social class and culture find it difficult to discuss gynaecological and sexual matters. The doctor must adopt a tactful, understanding and unhurried approach to gain the full confidence of the patient. It is often best to obtain general information first such as age, marital status, number of children, obstetric, family and social history, to allow the woman time to settle. She should then be encouraged to tell the story in her own words with gentle guidance to encourage the taciturn and direct the garrulous. As with all clinical documentation, the details should be recorded in a clear, precise and legible manner.

Presenting complaint(s)

Often there are two or more symptoms and these should be enumerated to allow the doctor a clear picture in his/her mind of the facts which must subsequently be recorded in more detail. It is useful to note how long the symptoms have been present and record them in the woman's own words: (1) heavy periods for

6 months; (2) vaginal discharge for 3 years; (3) heavy feeling down below for 5 years. It is often of value to note which symptom is the most troublesome.

History of presenting complaints. Each symptom enumerated above should now be dealt with in detail and interrelated to each other and/or bodily functions where appropriate, e.g. pelvic pain and menstruation; uterovaginal prolapse and urinary symptoms. The features of any pain should be recorded as previously outlined.

Remaining gynaecological history

The following points should also be elicited as they will cast further light on the presenting symptoms or will bring out other possible problems:

1. Date of onset of last menstrual period, if not already noted.
2. Duration of menstruation.
3. Amount of blood loss — this may be recorded in terms of heavy, average or light, or by the amount of protection required.
4. The presence or absence of clots in the menstrual loss.
5. Length and regularity of menstrual cycle.
6. Age of menarche.
7. Age of menopause.
8. Dysmenorrhoea (pelvic pain associated with menstruation) — premenstrual, menstrual or both; site of the discomfort; severity; radiation; associated nausea; previous treatment.
9. Breast discomfort associated with menstruation.
10. Intermenstrual bleeding.
11. Postcoital bleeding.
12. Dyspareunia (pain on intercourse) — superficial (i.e. discomfort at the introitus or vaginal walls) or deep (i.e. pelvic pain experienced on full penetration of the penis).
13. Vaginal discharge — timing in relation to menstrual cycle; duration; character; amount; odour; irritation.
14. Pruritus — vulvul irritation or itch.
15. Climacteric symptoms — hot flushes; dry vagina; irritability; insomnia; etc.
16. Contraception.
17. Urinary symptoms — frequency; dysuria; incontinence — stress or urge; nocturia; haematuria.
18. Bowel function — frequency; consistency and colour of stool; straining, pain on defaecation; blood or mucus per rectum.

PHYSICAL EXAMINATION

The thought of a physical examination is likely to cause anxiety due to embarrassment and the fear of discomfort or pain. This is especially true for pelvic examination which is always performed last. The obstetrician/gynaecologist should approach the examination of the woman in a reassuring and gentle manner, remembering that she is not simply a carrier of pelvic organs but an entire human entity. An assessment of her general physical condition is required to provide valuable information as a background to her local pelvic condition. It is often of value to explain what is being done at each stage of the examination and to give a warning of anything which might be unexpected, such as pressure of the examining hand on the abdomen, the temperature of the bell of the stethoscope, vaginal speculum, etc.

An attendant nurse is essential during the examination. She can reassure the woman and, by allaying her fears, help her to relax. The nurse can also verify the correctness of the examination should the need ever arise in a medico-legal inquiry.

Ideally, the woman should be shown into an examination room. If this is not possible, she is left with the nurse to prepare for examination, which includes removal of all her clothes, although for antenatal appointments, this in unnecessary. A gown allowing easy access for examination should be available or she should be placed supine on a couch with two sheets

covering her, one across the upper half of her body and the other across the lower half. This allows exposure of the part of the body to be examined, yet maintains a degree of modesty.

The order of examination will vary from one doctor to another, and the student should decide for him/herself which system to adopt and adhere to it thereafter. An orderly, logical approach will avoid missing important signs. On the other hand, the methods for elucidating clinical signs have stood the test of time and the student should be attentive in learning the correct methods from his/her seniors. Inspection, touching, palpation and hearing are the cornerstones of physical examination. Leonardo's motto was *Sapere vedere* — learn to see things. As the woman walks into the examination room, an impression of height, weight, gait and body posture (kyphosis, lordosis) can be gained.

Examination of Head and Neck

The woman's facies, e.g. pallid, florid, cyanotic, is noted and the mucous membranes checked for the presence of anaemia. The eyes are observed for any suggestion of exophthalmos and any change in colour of the sclera. Any loss of normal texture, brittleness or excessive dryness of the hair should also be recorded. Lymphadenopathy is always important and the glands of the supraclavicular region, anterior and posterior triangles of the neck are examined. The thyroid gland is gently examined for asymmetry, enlargement or other irregularities, remembering that a slight, diffuse enlargement may occur in pregnancy. The tongue, tonsils and teeth require inspection, the latter being particularly important in pregnancy as any caries present will almost certainly worsen as pregnancy advances.

Examination of the Breasts

Breast examination is important in both obstetric and gynaecological examinations and should never be omitted. The breasts are first inspected with the patient sitting upright, her arms by her side. Their size, shape and position of the nipples are compared. Prominent veins, retracted nipples, discharge from the nipples and prominent Montgomery's tubercles in the primary areola are noted. The woman is then asked to raise her arms above her head and the features outlined above are again checked. Any indentation or bulge in the contour of the breast or retraction of a nipple may indicate underlying pathology. The axillae are next examined, but this is only satisfactorily achieved if the pectoral muscles are relaxed. The woman should rest her forearm on the examiner's arm while the axilla is carefully palpated. She is then placed supine and the breast gently palpated with the flat portion of the fingers. This should be done systematically, starting with the upper inner quadrant and finishing with the upper outer quadrant. Finally, the nipple should be palpated and gently squeezed to release any secretion which might be present.

Examination of the Abdomen

In order to examine the abdomen properly, both the woman and the examiner must adopt the correct position. The former should be placed supine, as flat as is tolerable, with her arms at her sides. The examiner should be seated or on one knee, so that even pressure may be applied with the flat of the hand. The abdomen should be examined in sequence and is best divided into nine imaginary portions (Fig. 1.1). The sequence for the examination is inspection, palpation, percussion and auscultation.

Inspection allows assessment of the condition of the abdominal wall, and size and contour of the abdomen. Previous surgical wounds are noted as are any motile phenomena, such as movement with respiration, visible peristalsis or pulsation.

Palpation is performed gently, noting the presence of superficial or deep tenderness and any rigidity of the abdominal wall. If pain is a presenting symptom, palpation should commence in the diagonally opposite region, so that the area of pain is palpated last. The viscera should be checked for enlargement of

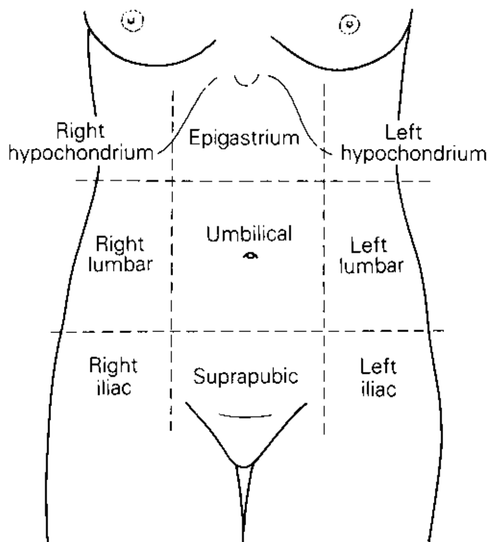

Fig. 1.1 *The regions of the abdomen.*

liver, spleen and kidneys, and abnormal masses are noted, specifically those arising from the pelvic viscera — bladder, uterus, ovaries. Site, size, shape, contour, consistency and mobility are recorded. Hernial orifices should be checked routinely.

Percussion may add confirmatory information in the case of enlarged viscera and tumours and is the only technique in most patients for establishing the presence of ascites.

Auscultation is used to confirm the presence and nature of bowel sounds.

It should be emphasised that abdominal examination is an essential part of the gynaecological examination and should never be omitted. Occasionally, a tumour arising from a pelvic viscus is only palpable per abdomen and it is not unknown for uterovaginal prolapse to be caused by the raised intra-abdominal pressure of ascites or an ovarian cyst.

The foregoing is of necessity a superficial and incomplete account of the general medical examination of a patient. However, the obstetrician/gynaecologist must be capable of performing such an examination correctly. Coexisting conditions will affect his/her patient throughout pregnancy or influence the anaesthetic and postoperative risks of the woman requiring surgery for a gynaecological complaint. No one can be an expert at everything, but a proper examination allows for appropriate referral for advice. Examination of the respiratory, cardiovascular and nervous systems have been omitted and reference should be made to a textbook of medicine. The importance of neurological examination must never be forgotten. The woman presenting to the gynaecological clinic with urinary incontinence and is found to have saddle anaesthesia is most unlikely to have a gynaecological cause for her complaint.

The Pelvic Examination

As previously mentioned, the pelvic examination must be approached by the examiner in a reassuring and gentle manner in order to allow the woman to relax as much as possible. Adequate palpation of the pelvic viscera is extremely difficult, if not impossible, when the abdominal and pelvic musculature is contracted.

There are several positions which can be employed for the pelvic examination and each has its adherents for many and differing reasons. Only the two most commonly used will be described here.

The full dorsal position. This is the most commonly used position. The woman is placed supine with the hips flexed and abducted as fully as possible, the knees flexed and the ankles or soles of feet in apposition. The woman will feel much less exposed if the lower abdomen and upper thighs are covered with a sheet. This is the best position for inspection of the vulva, visualisation of the cervix with a bivalve speculum and for bimanual palpation of the uterus, fallopian tubes and ovaries. It is of less value than the lateral position for inspection of the vagina and assessing uterovaginal prolapse.

Modified Sim's or left lateral position. The woman is placed on her left side and near the edge of the examining couch. The left leg is kept straight, extended at the knee, while the right hip and knee are fully flexed so that the leg is over the abdomen. It is valuable if

the nurse can help support the right leg at the knee and also gently retract the right buttock upwards. The anus, perineum and posterior vulva can be inspected and, using a Sim's speculum, the vagina is easily visualised. This is the best position for assessing uterovaginal prolapse. Bimanual examination is possible, but not as satisfactory as with the woman in the dorsal position.

Inspection of vulva and perineum

Adequate lighting must be available for this part of the examination. Points to note are local hair growth; the state of the skin — erythema, excoriation, rashes; ulceration; tumours; development of external genitalia — hypotrophic or hypertrophic labia, clitoral hypertrophy; presence of excessive vaginal discharge; presence of haemorrhoids; and any previous vaginal delivery. The woman is asked to strain down to detect any evidence of uterovaginal prolapse.

Speculum examination

Speculum examination is required to allow inspection of the vaginal tissues and cervix, and to assess any degree of uterovaginal prolapse. The woman should be told what is happening at each stage of the examination. The index finger and thumb of the left hand are used to gently separate the labia minora to expose the vestibule. The speculum, which should be at body temperature and slightly lubricated, is gently inserted in an oblique position and in a cephalad and posterior direction with a gentle rotating action to bring it to lie in the transverse axis of the vagina. A speculum should not be inserted with its blade(s) in the axis of the vulval cleft as pressure on the urethra and clitoral region is painful. The blades of a bivalve speculum should only be opened when the instrument is fully inserted. The woman can be told as the examiner gently opens the blades of the speculum that she might experience a little pressure. The cervix is usually easily visualised. If a cervical smear is required, it should be taken at this stage. Opinions differ as to whether the speculum should be lubricated when a smear is required, but it is our opinion that a little lubrication never causes problems in obtaining an adequate cervical sample and enhances patient comfort and continuing co-operation.

The cervix is inspected for size, colour, contour, evidence of previous damage, eversion, infection, polyps and discharge form the canal. The finding of an irregular, injected, granular-looking cervix requires further diagnosis by cytology and possibly colposcopy.

The speculum is then withdrawn slowly and the vaginal walls inspected as they come into view. Colour, erythema, petechiae, ulcerations and adherent discharge are noted. If the woman has been examined in the dorsal position, an impression of the degree of any uterovaginal prolapse may be formed if she is asked to bear down as the speculum is removed. If prolapse is present, the woman may then be examined in the modified Sim's position using a Sim's speculum and the degree of prolapse assessed more accurately.

If vaginal infection is suspected, swabs for culture are obtained from the posterior vaginal fornix and the endocervical canal during the speculum examination. A urethral swab is also sometimes of value and should be taken once the speculum has been removed.

Bimanual vaginal examination

It should be stressed that this part of the examination requires two hands, each assuming equal importance. Most gynaecologists use their right hand for the vaginal examination and the left as the abdominal counterpart. After the labia minora have been parted using the left hand, one finger of the lubricated right hand is introduced, passing upwards and backwards. As previously mentioned, pressure on the posterior vaginal wall and rectum is much less uncomfortable than pressure on the urethra and anterior vagina wall. Once the woman has started to relax the muscles around

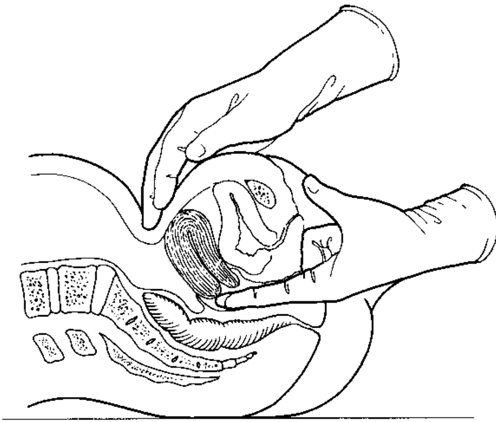

Fig. 1.2 *Bimanual examination, step 1. Two fingers are gently inserted into the vagina. The consistency and symmetry of the cervix are noted. The uterus is then elevated towards the abdominal wall to enable the size of the uterus to be ascertained. (Modified from A.S. Duncan, 1955. In* British Gynaecological Practice, *1st edn., A. Bourne, ed. Philadelphia: Davis.)*

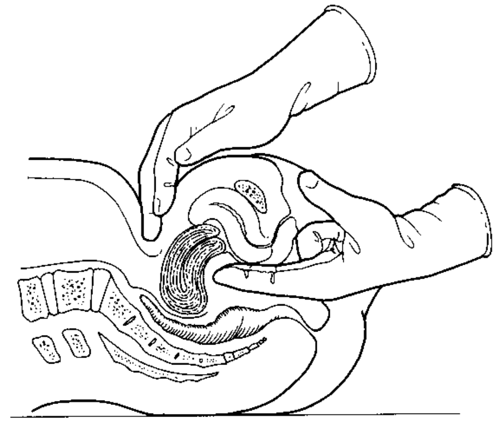

Fig. 1.4 *Bimanual examination, step 3. If the tips of the vaginal and abdominal fingers meet when performing step 2, it can be concluded that the uterus is retroverted or, less commonly, axial. The vaginal fingers are then moved to the posterior fornix. Contour, symmetry, consistency and mobility of the corpus uteri are assessed.*

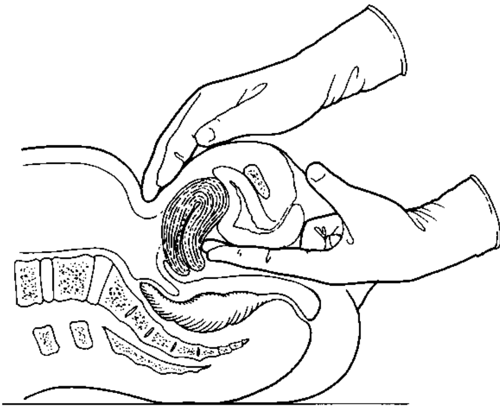

Fig. 1.3 *Bimanual examination, step 2. The vaginal fingers are moved into the anterior fornix and the body of the uterus is palpated. Size, contour, consistency and mobility are noted.*

the vagina, and it is clear that vaginal capacity is adequate, a second finger may be gently introduced. Slight pressure exerted by the abdominal hand brings the pelvic viscera into easier reach of the vaginal fingers.

The cervix is palpated for size, consistency, contour, lateral lacerations and mobility. It should be moved in both anteroposterior and lateral directions to ascertain that such movement causes no discomfort (Fig. 1.2). If there is sharp pelvic pain related to cervical movement, this is called excitation pain.

The uterus must then be palpated between the hand on the abdomen and the fingers in the vagina. The vaginal fingers should move the cervix backwards to rotate the fundus of the uterus downwards and forwards. The abdominal hand is placed just below the umbilicus and gradually moved lower until the fundus is caught against the fingers in the anterior fornix (Fig. 1.3). If the uterus remains impalpable, then it is in a retroverted position and may be felt by the vaginal fingers when placed in the posterior fornix (Fig. 1.4). The uterine size, shape, contour, regularity, consistency and mobility are noted, along with any tenderness.

The abdominal hand is now moved to the left iliac fossa and the vaginal fingers to the left lateral fornix (Fig. 1.5). This allows palpation of the left adnexa. Features such as thickening, tenderness, ovarian outline, mobility, and the presence of a mass should be noted. The procedure is then repeated on the right side. It should be noted that normal fallopian tubes are rarely, if ever, palpable and often normal ovaries are not felt.

Bimanual examination should impose no significant discomfort. If a painful lesion is

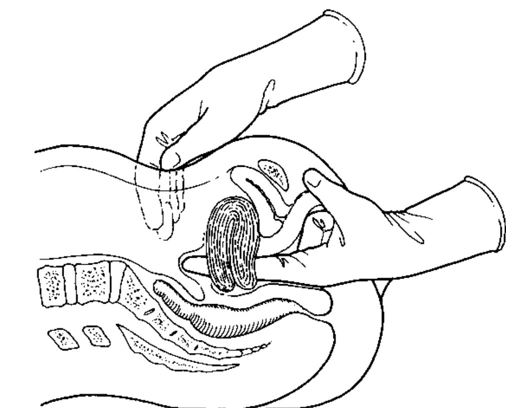

Fig. 1.5 *Bimanual examination, step 4. The vaginal fingers are moved to one of the lateral fornices and the abdominal fingers are moved towards the ipsilateral iliac fossa. The two are then approximated as closely as possible and the intervening tube and ovary palpated.*

encountered, extreme gentleness is required and the woman must never feel that she has been needlessly hurt by the examination.

Rectal examination

Rectal examination may replace vaginal examination in children or in adults who are *virgo intacta*. It can prove a useful adjunct to vaginal examination especially in the assessment of the uterosacral ligaments, pouch of Douglas and outer portions of the broad ligaments. Occasionally, a combined rectovaginal examination, with the index finger in the vagina and the middle finger in the rectum, is of value for assessing lesions of the rectovaginal septum or bowel.

COMMUNICATION

When the examination is complete, the woman dresses and there should then follow an explanation, in terms that can be understood, of the findings, the diagnosis and its implications and any investigations or treatment that are required. It is well known that much of what a doctor tells a patient is immediately forgotten and some points may require reiteration. She should then be encouraged to ask questions and these should be answered patiently, honestly and clearly. There will be times when the news is not good and such situations will be briefly considered further with both patient and doctor in mind.

The Approach to Difficult Situations

Situations arise in every practitioner's lifetime when events will be difficult for both doctor and patient to discuss. Obstetric and gynaecological practice is no exception. What should be done when an ultrasound examination reveals an abnormal fetus? How should we deal with the parents whose baby has died in the first few days of life or has survived with a congenital anomaly or has suffered cerebral damage? Should we tell the truth to the woman with gynaecological malignancy? Views on these subjects vary greatly among all those concerned with patient care and among patients themselves. Only a brief consideration is possible here, but may provide an introduction for further thought.

The ability of the doctor to provide comfort while imparting bad news will, to a large extent, depend on the doctor's own reactions and feelings. The art of communication with the dying patient remains a difficult and uncertain area, often inducing insecurity and anxiety, and may lead to doing nothing in such a situation. Such feelings may be enhanced by a fear of being blamed by the patient as the cause of her illness, rather than acceptance as the healer, soother or comforter. A patient's reaction to bad news if often difficult to predict, and the need for knowledge of how to deal with the consequences of the news we break to an individual enshrines a universal criterion of all medical practice. Fear of expressing emotion may also prove restricting, as all our clinical training is directed to encourage a calm approach, even in emergencies, and stifle any emotional response invoked by the situation or the individual patient. It is necessary to learn to show sincere sympathy. Junior doctors commonly express the fear of incomplete knowledge, and not knowing all the answers is a real handicap when facing

difficult situations. All confidence can be totally undermined. While ignorance should not be condoned, it is worth remembering that often the patient realises that the answers to his/her questions are unknown, or even does not want the answers, but simply needs someone to listen. The skill of talking to patients about difficult matters is an acquired talent. Those who do it often and do it well, should be encouraged to teach the rest of us. Guidance as to how to relate to parents suffering bereavement due to loss of pregnancy or a child is given in Chapter 16.

The aim in all these situations is broadly to provide the best possible degree of health for the woman in mind and body. This requires patience and commitment by all those involved and perhaps reflects the vocational element of 'medical' practice.

FURTHER READING

Jenkins D. (1986). *Listening to the Gynaecological Patient's Problems*. London: Springer-Verlag.

Buckman R. (1992). *How to Break Bad News: A Guide for Health-Care Professionals*. London: Papermac.