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Female gu exam

This article discusses restrictions on using content from this website in third-party applications, including artificial intelligence technologies like large language models and generative AI. It is prohibited to use or upload content accessed through this site into external apps, bots, software, or websites that utilize AI technologies. The article then transitions to discussing the importance of genitourinary, vaginal, and rectal examinations in evaluating female patients. A specific diagnosis is discussed, and after completing an online educational activity, students will be able to describe appropriate draping techniques, outline the proper sequence of the exam, explain basic anatomy, discuss catheterization technique, and target audiences include medical students, residents, physician assistants, nurses, and nurse practitioners. The article goes on to explain the components of the external female genitalia, including the mons pubis, labia majora and minora, clitoris, vestibule, vestibular bulb, and greater vestibular glands. It also discusses the importance of inspecting the mons pubis, labia, and perineum for abnormal skin findings. Allergens, infections, or inflammatory conditions can cause various types of rashes on the skin. Rashes that affect only one area of the body are called localized rashes, while those that occur throughout the body are considered generalized rashes. The skin is the largest organ in the human body, composed of the epidermis and dermis. The epidermis has a high turnover rate, while the dermis contains dense layers of connective tissue. Cysts are fluid-filled sacs lined by an epithelium that can be benign or malignant. Other types of skin lesions include pigmented nevi, warts, ulcers, herpetic lesions, and discoloration. To inspect the vulva, separate the labia majora to examine the labia minora, clitoris, urethral meatus, and vaginal opening. Check for any abnormal findings, such as swelling or lesions. If swelling is noted, check Bartholin glands and inspect the vagina for discharge or tenderness. Common skin lesions of the vulva include epidermoid cysts, which are small, firm, round growths. Cystic fibrosis change nodules in the labia may appear yellow. Dark punctum marks blocking gland openings can be inspected for. Genital warts are a sign of genital HPV infection, described as raised, pearly, flesh-colored lesions that cause itching, pain, or bleeding. Warty growths on the labia and anus are caused by human papillomaviruses. Genital herpes infections are common, characterized by painful vesicles, dysuria, and lymphadenopathy. Lichen sclerosus is a condition with atrophy, inflammation, and pruritus. Pain and itching sensations can be experienced. Atopic dermatitis is marked by inflammation and epithelial thinning. The vagina is the female genital canal, extending from the vulva to the cervix internally. Vulvar squamous intraepithelial lesions can be asymptomatic or scaly. Lichen Planus; requires biopsy Biopsy Removal and pathologic examination of specimens from the living body. Ewing Sarcoma Noninvasive squamous lesion and precursor of squamous cell carcinoma Squamous cell carcinoma Cutaneous squamous cell carcinoma (cSCC) is caused by malignant proliferation of atypical keratinocytes. This condition is the 2nd most common skin malignancy and usually affects sun-exposed areas of fair-skinned patients. The cancer presents as a firm, erythematous, keratotic plaque or papule. Squamous Cell Carcinoma (SCC) of the vulva The vulva is the external genitalia of the female and includes the mons pubis, labia majora, labia minora, clitoris, vestibule, vestibular bulb, and greater vestibular glands. Vagina, Vulva, and Pelvic Floor: Anatomy Syphilitic chancre The primary sore of syphilis, a painless indurated, eroded papule, occurring at the site of entry of the infection. Syphilis Firm, nontender ulcer Secondary syphilis Secondary Syphilis Syphilis (condyloma) Slightly raised, flat, round, or oval papules covered by a gray exudate. Exudates are fluids, cells, or other cellular substances that are slowly discharged from blood vessels usually from inflamed tissues. Pleural Effusion The genitourinary examination is a crucial component of the female patient's evaluation, and this module aims to demonstrate its technique and methodology. The exam involves assessing the reproductive organs and urinary tract, and it is essential for identifying potential health issues. Through this presentation, we will discuss specific diagnosis and provide students with the skills to perform the exam correctly. Upon completion of this activity, learners will be able to: * Describe proper draping technique * Outline the sequence of the exam * Explain the basic anatomy of the genitourinary exam * Discuss catheterization technique Given article text here Feel worse, as it suggests that the doctor may also be embarrassed. Instead, explain that you need to ask some questions that might feel personal to help get to the bottom of the problem. History of Presenting Complaint All history-taking starts with exploring the problem by allowing the patient to talk freely and using open-ended questions. Ask phrases like "Tell me more" and "What did you think it was?" to clarify their ideas and concerns. Before moving on, make sure you've discovered: Presenting Complaint Pain: onset, nature, time course, radiation, exacerbating or relieving factors SOCRATES: [Site] [Onset] [Character] [Radiation] [Associated symptoms] [Time] [Exacerbating/relieving] [Severity] Onset: establish how, when, and where. Ask about previous investigations or treatments. Discuss relationships with menses and intercourse. Determine the effect on life and work. Explore patient's ideas, concerns, and expectations. Dyspareunia Determine if it's superficial (vaginismus, episiotomy scar) or deep (uterine, cervical, adnexal). Note radiation and prevention of penetration or full intercourse. Ask about libido, foreplay, and dryness/atrophy. Discuss positional factors and note any rash. Urinary Symptoms If pain is a urinary symptom, discuss relationship to micturition. Establish if there's urethral discharge. Discuss frequency of micturition (day and night). Establish urgency and urge incontinence (partial or total voiding). Stress incontinence (provocation and partial or total voiding). Vaginal Discharge Establish the color and whether it's bloodstained. Note any odor, consistency, itch, burn, or fever. Discuss use of gels, douches, deodorants, or perfumed bath additives. Ask about localized tenderness (Bartholinitis). Abnormal Vaginal Bleeding Note clotting and/or flooding. Establish intermenstrual or postcoital bleeding. Determine periodicity. Discuss relationship to menses and coitus. Ask about the patient's ideas, concerns, and expectations. The possibility of pregnancy exists. To gather more information about the presenting complaint, ask the patient about their ideas on the issue, concerns or anxieties regarding the cause, and expectations from the consultation. Then, systematically go through the history covering areas such as menstrual history, age at menarche, body weight, and secondary sexual characteristics. For primary amenorrhoea, look for presence of secondary sexual characteristics and consider imperforate hymen, genetic abnormalities, or hyperandrogenism. In terms of secondary amenorrhoea, consider relevant causes such as the pattern of menstrual cycle, including first day of last normal period, days of bleeding, length of cycle, heaviness of blood loss, and type of contraception used. Also, ask about any discharge other than menses and whether the patient has a regular or irregular menstrual cycle. A psychosexual history should be conducted sensitively to recognize underlying problems and differentiate them from other causes. This includes enquiring about relationship details, intercourse practices, libido, orgasm, and association with other symptoms. If relevant, ask about previous negative sexual experiences. An obstetric history should also be taken, including questions about past pregnancies, miscarriages or terminations, complications during pregnancy, and any assisted delivery methods required. Additionally, note the length of labour, prolonged pushing, baby size, postpartum haemorrhage, and any complications in the puerperium, such as depression. Finally, ask about other symptoms like loin pain that may be related to urinary calculi causing ureteric obstruction and leading to severe loin pain. When examining urinary symptoms, pain radiates from the back down to the pubic symphysis and groin. The timing of the pain's onset can help identify its cause - sudden in pain is often associated with renal colic or acute retention, while gradual build-up may indicate a tumour or outflow obstruction. Associated features like haematuria, incontinence, and urethral discharge should be asked about. Urinary incontinence might be stress-related, due to detrusor instability, underactivity, or urethral obstruction. Urethral discharge can occur from sexually transmitted diseases. Systemic symptoms of kidney injury or disease include anorexia, vomiting, fatigue, pruritus, and peripheral oedema. Some patients don't have noticeable symptoms but are found to have abnormalities in blood pressure measurements or routine urinalysis, renal function, or serum biochemistry. Relevant factors to explore include occupational exposure to chemicals like 2-naphthylamine or benzidine, foreign travel, especially to areas where schistosomiasis is prevalent. A patient's family and medical history are also important, including neurological diseases that may affect bladder function, previous kidney disease, hypertension, diabetes, gout, or back injuries. Abdominal or pelvic surgery can cause denervation injury to the bladder. Medication history, especially prolonged analgesic use, should be reviewed for potential causes of chronic kidney disease. Dosages of certain drugs might need adjustment in patients with chronic kidney disease. A full and current medication list is essential. Before the examination, ensure all necessary equipment is prepared and ready. Taking a thorough history helps establish rapport and prepares patients for what's to come. Explain each step clearly, obtain consent, and warn about potential discomfort or pain. Maintain comfort and privacy during the examination by providing basic facilities for undressing. Offer chaperones, preferably nurses who can assist and reassure the patient, ideally speaking their language. If necessary, offer a translator outside or inside the curtain as desired. Encourage patients to empty their bladder beforehand. Genitourinary Examination for Genital Urinary Disease: A Comprehensive Approach Genitourinary disease can manifest in various ways, including hirsutism, acne, anemia, thyroid disease, Cushing's syndrome, and other chronic conditions. A thorough examination of the genitourinary system can help identify these symptoms and detect potential health issues. Abdominal Examination ------------------- The uterus, vagina, and adnexa lie within the pelvis, but a careful abdominal examination may reveal findings relevant to the genitourinary system. The abdomen may be palpable due to: * Abdominal masses arising from the pelvis, such as large ovarian cysts * Palpable bladder in urinary retention * Tender bowel loops suggesting irritable bowel disease or other gut pathology Renal Angle Tenderness --------------------- Renal angle tenderness can be an important cause of pain. This is often detected through percussion. Ascites -------- Ascites, which is the accumulation of fluid in the abdomen, can be detected through percussion and may reveal lateral dullness and a tympanic central abdomen. National Institute for Health and Care Excellence (NICE) Guidelines --- The NICE guidelines recommend that if physical examination identifies ascites and/or a pelvic or abdominal mass, a referral to a gynaecological cancer service should be made using a suspected cancer pathway referral. Additionally, if serum CA125 is 35 IU/ml or greater, an ultrasound scan of the abdomen and pelvis should be arranged. External Genitalia Examination ----------------------------- Preparation for examination involves positioning the patient in a supine position with flexed hips and knees, covering their abdomen with a sheet, and using proper lighting to ensure a clear view of external genitalia. Disposable gloves should be worn during the examination. The examination should include: * Systematically examining the labia majora, labia minora, introitus, urethra, and clitoris * Assessing atrophic changes in menopause and pubertal development in teenagers Further examination may be necessary if the patient has not been sexually active or is using tampons. NB: the hymen is typically perforated even in infants, as many courts of law believe. Rectal examinations are rarely necessary or appropriate and can cause distress in both children and adults. Ultrasound has made such invasive procedures unnecessary. For genital exams, separate the labia and have patients bear down to visualize the vestibule and identify: * Cystocele * Rectocele * Uterine descent or prolapse * Examination of the cervix Use a speculum for vaginal wall and cervical examination. Single-use disposable specula are now standard. Avoid lubricants other than tepid tap water for smears, including forensic examinations. Visualize the lateral position, Sims' speculum, and prolapse. The cervix relates to uterine position (anteverted, axial or retroverted). Cervical os shape indicates parity. Bluish cervix in early pregnancy is Chadwick's sign. Explain the importance of cervical smears and swabs according to local laboratory guidelines. Remove the speculum carefully without discomfort. Internal examination: * Explain bimanual examination for uterus, Fallopian tubes, and ovaries. * Expose introitus, holding labia apart with a gloved hand. * Introduce lubricated fingers to palpate organs, assess size, consistency, and mobility, and identify tenderness. Cervical excitation may occur with infection or inflammation. Discuss findings after patient is dressed and prepared for information. Genitourinary history and examination in children: * Involve parents and conduct sensitive and careful exams. * Genitourinary disease in children is more varied and complex than in adults, requiring an understanding of normal growth and development, particularly pubertal development. Consider child sexual abuse with genitourinary symptoms. Where there's excessive discharge, keep in mind that vaginal foreign bodies in kids might be linked to abuse. During examination, it's vital to understand normal development and handle the child sensitively. Internal organs can now be assessed using ultrasound or other techniques, often making detailed inspection unnecessary. If needed, consult a paediatrician for their expertise. Children may feel more comfortable holding a soft toy during vulval exams. Rectal exams to check genitalia are unacceptable in kids and should be avoided. In cases of vulvo-vaginal discharge, consider factors such as toileting habits, whether they wipe front-to-back, showering or bathing preferences, signs of scratching (potentially due to threadworms), primary skin conditions like psoriasis on the vulva, or candidal skin infections. Be aware that vaginal thrush is rare in pre-pubertal girls, but streptococcus B colonisation might be a more common cause. When assessing discharge, always consider the possibility of sexual abuse, though it's an uncommon cause. With proper explanation and guidance, some children or parents may take a low vaginal or vulval swab with your help.