Evidence Based Advanced Pelvic Exam
Disclosures

Jacki Witt
- Watson Pharmaceuticals – Honorarium – Advisory Board
- Agile Pharmaceuticals – Honorarium – Advisory
- Afaxus Pharmaceuticals – Honorarium – Advisory Committee
- Bayer Pharmaceuticals – Honorarium – Advisory Board

Caroline Hewitt
- Prior to February 5, 2014 disclosures: Watson Pharmaceuticals – Honorarium- Advisory Board
- After February 5, 2014: Nothing to disclose
Objectives

- Identify the indications for a pelvic examination
- Describe at least two techniques for performing pelvic examination with an obese patient
- Describe at least two techniques for performing pelvic examination with a patient who has signs/symptoms of decreased estrogen stimulation to vaginal tissues
- Describe at least two techniques for performing pelvic examination with a developmentally/cognitively disabled person
Describe at least two techniques for performing pelvic examination with a patient who has experienced sexual assault/abuse

Practice at least two new pelvic examination techniques with a standardized patient

Select appropriate screening and diagnostic testing for women with specific pelvic organ symptoms
Performing Pelvic Exams

- WHO
- WHAT
- WHEN
- WHERE
- HOW
- WHY
- Lithotomy common in US
- Some patients find it disempowering, abusive & humiliating

Haar, et al 1997

- Patient’s have described metal stirrups as ‘cold’ & ‘hard’; say their use is impersonal, sterile or degrading

Olson 1981
Positioning

- 197 adult women having routine cervical cytology
- Patients reported less discomfort and feelings of vulnerability if:
  - Semi-reclining vs. supine
  - No stirrup method used
  - No significant differences in quality of cyto specimen (but study not powered to definitively look at this outcome)

- Routine in UK, Australia, N. Zealand

Speculae

- No real industry standard for size or type
- Pedersen medium is generally 2.5 cm (1 in) wide and 10 cms (4 in) long
- Pediatric speculae are shorter and confer an advantage only if the cervix is < 8 cms (3 in) from the introitus
- Pedersen extra narrow is 1.5 cm (3/4 in) wide and 11.5 cms (4 ¼ in) long and is useful for women with postmenopausal atrophy

Speculae

- Longest speculum is the Graves supersize XL with an 18 cm (7 inch) bill appropriate for women with long vaginal vault where cervix is barely reachable by examining fingers.
Metal or Plastic?

- **PLASTIC**: direct lamp connection, transparency facilitates visualization, audible and sensible clicks distressing and considered not ‘green’
Metal or Plastic?

- **METAL**: can be too hot or too cold, are considered ‘green’ and come in more sizes and varieties than plastic

- **CONCLUSIONS**:
  - Choice primarily related to provider familiarity and opinion
  - No studies comparing patient comfort
  - No analysis comparing landfill impact of plastic vs resources required to sterilize and reuse metal
To lube or not to lube

- 4 RCTs
- RCT X 2 comparing water-soluble gel to water alone with conventional cytology
- No difference in rate of unsatisfactory cytology in any of the studies
- No difference in rate of unsatisfactory cytology or in Chlamydia detection rate in one study

Griffith et al, Contraception, 2005; Amies et al, Obstet Gynecol, 2002
The elusive cervix

- If you can’t find it, perform bimanual
- If deep in vault and barely reachable, need extra long speculum
- Significant uterine flexion will cause cervix to be anterior
  - Close partially ➔ retract slightly ➔ redirect anteriorly
- Extreme retroversion of uterus will cause cervix to be lodged behind symphysis pubis
  - Exert more pressure on posterior fornix to manipulate it into view

Bates et al 2011
Cervical Specimen Collection
Sampling the cervix

Recommendations from manufacturers:

- **Broom**
  - Rotate in one direction for 5 rotations (do not reverse directions)

- **Spatula and cytobrush**
  - Rotate spatula 360 degrees
  - Rotate brush 180 degrees in one direction (more than 180 degrees may cause bleeding and does not improve adequacy)
10,241 Paps using ThinPrep over 1 year
Spatula + cytobrush
AND
Broom + cytobrush

Statistical significance over broom alone in Pap adequacy (endocervical component)

Selvaggi et al 2000
281 HIV positive & 68 HIV negative women
Abnormal anal cytology diagnosed in 26% of HIV+ & 8% of HIV- women
Increased risk of anal disease as viral load increased & CD4 decreased
History of anal intercourse & abnormal cervical cytology were statistically significantly associated with abnormal anal cytology

Holly, et al 2001
Anal sampling

- Dacron cotton swab on plastic stick
  - Avoid using a cotton swab on a wooden stick, because these often break and will splinter
Swab is rotated and slowly withdrawn from the anal canal

- Make sure to sample the transition zone during removal, as this area, which separates the columnar epithelium of the rectum from the keratinizing anal squamous mucosa, is the site where most anal intraepithelial neoplasms arise
Anal sampling

- In women, the dorsal lithotomy position may be used
- A moistened dacron swab is inserted 5 to 6 cm without direct visualization
- Firm lateral pressure is applied to the swab handle
Anal sampling

- Liquid cytology preferred
  - Eliminates artifact with drying and reduces amount of fecal material and bacteria that can obscure cellular detail

Beam and Chhieng, 2010
Bimanual Exam
Ovary Norms

- Normal ovaries can range from 2-4 cm depending on time in cycle.

- During ovulation the ovary may be as large as 4 cm; bring patient back in 2 weeks to recheck if concerned or perform pelvic US.
Limitations of the bimanual exam


- 84 women undergoing pelvic surgery
- With patient consent, examined under anesthesia by attending, resident and medical student
- Pelvic exam accurate compared to surgery:
  - 70.2% Attending
  - 64% Residents
  - 57.3% Students
Limitations of the bimanual exam
Padilla, Radosevich and Milad

- Sensitivity to detect adnexal masses much lower than sensitivity to assess uterine size/contour.
- Obesity reduced detection of adnexal masses
- Conclusions:
  - Bimanual exam appears to be a limited screening test for upper genital tract abnormalities (even under the best possible circumstances – anesthesia)
  - Uterine assessment appears to be more accurate than adnexal assessment
Limitations of the bimanual exam

Ueland FR; et al. The accuracy of examination under anesthesia and transvaginal sonography in evaluating ovarian size. Gynecol Oncol. 2005 Nov;99(2):400-3

• Ovaries can be difficult to palpate
• Ovaries detected in bimanual exam performed by Ob/Gyn under anesthesia:
  • 30% in women ≥ 55 years old
  • 51% in women < 55 years old
  • 9% in women > 200 lbs
Limitations of bimanual exam

- Poor evidence for distinguishing benign from malignant adnexal masses:
  - Pooled sensitivity: 45%
  - Pooled specificity: 90%

Myers, et al 2006
Palpation of Ovaries: Position

- If right handed, right index and middle fingers are in vagina-place right foot up on step of exam table, your knee is flexed

- Keep right elbow into your body

- Push forward with your body, not with arm muscles.
Palpation of Ovaries: Posture & Position

- Move your fingers to side of cervix and lift fingers high on vaginal roof to form a flat landing pad for the ovary.

- Pivot your entire body toward the ovary you are palpating.

- Your body, fingers, arm should be in direct alignment with the patient’s ovary.
Palpation of Ovaries: Tips

- DROP wrist down, keep fingers flat and raised
- Abdominal fingers sweep ovaries down from iliac crest toward your internal fingers
- Internal fingers: feel ovary slide between fingers, assess size (compare with fingers’ width), nodular?, smooth?, tender?
More finesse needed

- First exam
- Trauma survivor
- Vaginismus and vulvodynia
- Postmenopausal atrophy
- Post-radiation stricture
- Women with disabilities
- Redundant vaginal walls
- Morbid obesity
- Female circumcision
Things to consider......

PSYCHOLOGICAL
- Education
- Consent
- Support
  - Chaperone?
  - Advocate?
- Empowerment

TECHNICAL
- Exam table
- Positioning
- Speculum choice
- Lubrication
- Topical anesthetic
- Finding the os
First Pelvic Exams

What has she heard?
Previous experiences with providers?
What does she expect?
She has CONTROL (mirror, asking permission for next step of exam)
An exam done WITH her...not to her
Show her PICTURES
Sensitivity with Obese Women

- Obese women may avoid exams due to embarrassment or fear of clinician reactions or admonitions about their weight

- A sensitive approach is essential
Physical Exam of the Obese Woman

- Will the table support her? Is table wide enough? Have assistant stand to side of table to stabilize and reassure her.

- The vulva may be hidden by the panniculus and a longer speculum is often necessary.
Physical Exam of the Obese Woman

- There is a higher risk of diabetes; check for fungal infections and intertrigo

- Check skin folds carefully; she may not be able to inspect herself as well as you can
Physical Exam of the Obese Woman

- Speculum exam: vaginal walls may have more relaxation and decrease visibility
  - Use Grave’s vs Pederson speculum; may need more length
  - Use condom or finger cut off latex glove to hold vaginal walls back
Physical Exam of the Obese Woman

- Use an instrument: ring forceps (closed) or tongue blade to gently push vaginal walls to the side to improve visibility
- Use larger/longer speculum as comfort dictates
Physical Exam of the Obese Woman

- The cervix may be difficult to visualize or palpate...have her pull her knees up ("cannon ball")
- She pulls her knees back and exposes the vaginal opening
- ...curled up in this position may give better speculum visualization of the cervix
Physical Exam of the Obese Woman

- Have her hips over the edge of the exam table. This drops her pelvis and cervix forward and makes visualization easier.
Consider “upside down”
Visualizing or Palpating the Cervix in Very Obese Women (Sharon Schnare’s method)

- Place woman on covered floor in knee-chest position; kneeling behind her, insert two fingers into her vagina, the cervix will be easier to locate.

- For cytology: place brush between your 2 fingers, insert into the vagina, feel for cervix and obtain the Pap.
Physical Exam of the Obese Woman

- The bimanual exam is more challenging and it may be difficult to impossible to palpate the uterus or ovaries.

- Place the abdominal hand UNDER the panniculus to decrease amount of adipose tissue between the examiner’s hand and the uterus.

- Pelvic sonogram indicated if symptoms
Pelvic Exam with Older Women

- May take longer
- Positioning more challenging
- Smaller speculum necessary
- Topical analgesic use
- Pain control, pain vs pressure
- Hypnotherapy
Pre-Exam Vaginal Estrogen

• An option in women with postmenopausal vaginal atrophy

• How much?
  • – ½ gram QHS x 2 weeks

• Reduces reactive cellular changes

• Not studied for ability to reduce pelvix exam discomfort, but shown to improve symptoms and findings of atrophic vaginitis

Cervix & vagina of the older (or post-menopausal) woman

- Cervix small, os closed, short cervical neck; neck may be flat against vaginal wall
- ▼ rugae, pale, thin, bleeds easily from ▼ estrogen
- Vaginal pH high >5.0 from fewer lactobacilli (▼ estrogen levels)
- Polyps common
Insertion of speculum in older women

- Viscous lidocaine 2%, before exam
- 2-3 weeks of estrogen cream before exam
- Use smallest speculum
- Separate labia to see introitus, insert gently & do not twist or turn
Pap Smear in Older Women

- Stenotic os more common - to find, use OsFinder, cytobrush or lacrimal probes (ENT tools)

- SCJ is high within the canal-use cytobrush or broom to obtain adequate Pap
Often small, narrow, atrophic

Assess vaginal tone: anterior – cystocele and posterior- rectocele

Have her grip your fingers- assess pelvic musculature strength
By 2 years post menopause most ovaries not palpable

If palpable consider further evaluation

Ultrasound if unsure
Pelvic Examination with Women with Developmental Delays

- What is her mental, social, physical age? Treat her at her age of development

- Previous experiences with exams?

- Caretakers, history of physical, sexual trauma?

- Women with developmental delays are at VERY high risk of abuse
Facts about women with disabilities

- National Study of Women with Physical Disabilities found that 94% of respondents were sexually active with sexually transmitted infection rates the same as women without disabilities

Nosek et al, 2001
In some women with certain types of brain damage, temperature control may be unstable.

Keep her warm, inspect ALL areas thoroughly, she may not be aware of injuries.

? abuse, self mutilation
The woman guides the exam—ask how she prefers to be examined; what positions work best, what suggestions does she have for you?

Ask, ask, ask
Examination Techniques and Positions with Disabled Clients

From
Table Manners: A Guide to the Pelvic Examination for Disabled Women and Health Care Providers By Ferreyra and Hughes
Planned Parenthood 1991
blind patient
deaf patient
diamond-shaped position
knee-chest position
M-shaped position
OB-stirrups position
V-shaped position
Screening pelvic exam started as a
- Method to obtain cervical specimen for CT/GC
- Screen for cervical cancer with cytology
- Screen for ovarian cancer with bimanual exam
- Performed *annually* because of "yearly Pap smear" strategy until 2003
<table>
<thead>
<tr>
<th>Screen for</th>
<th>Preferred test</th>
</tr>
</thead>
<tbody>
<tr>
<td>GC, Ct</td>
<td>NAAT: vaginal swab or urine sample</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>Not recommended until 21 years old</td>
</tr>
<tr>
<td></td>
<td>Cytology every 3-5 yrs afterward</td>
</tr>
<tr>
<td></td>
<td>None, if total hysterectomy for benign disease</td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td>USPSTF rec. against bimanual exam</td>
</tr>
<tr>
<td>Vulvar lesions</td>
<td>Unnecessary if asymptomatic</td>
</tr>
<tr>
<td>Vaginal infxn</td>
<td>Unnecessary if asymptomatic</td>
</tr>
<tr>
<td>Myomas</td>
<td>Unnecessary if asymptomatic</td>
</tr>
</tbody>
</table>
Pelvic Exam at the Well-Woman Visit

ACOG Committee Opinion 524; August 2012

- Women younger than 21 years
  - Pelvic exam only when indicated by medical history
  - Screen for GC, chlamydia with vaginal swab or urine

- Women aged 21 years or older
  - “ACOG recommends an annual pelvic examination”
    - No evidence supports or refutes routine exam if low risk
  - If asymptomatic, pelvic exam should be a “shared decision”
    - Individual risk factors, patient expectations, and medico-legal concerns may influence these decisions
  - If TAH-BSO, decision “left to the patient” if asymptomatic
### Screening Pelvic Examination

Qaseem, et al ACP Clinical Guideline 2014

- ACP recommends against performing screening pelvic examination in asymptomatic, nonpregnant, adult women

| High-Value Care | No evidence that routine pelvic examination in asymptomatic, nonpregnant, adult women provides any benefit. …we conclude that performing pelvic examination exposes women to unnecessary and avoidable harms with no benefit. … these examinations add unnecessary costs to the health care system. ….costs may be compounded by expenses incurred by additional follow-up tests, including follow-up tests as a result of false-positive screening results, increased medical visits, and costs of keeping or obtaining health insurance. |
“I find the pelvic exam to be indispensable in the assessment of the vulva, vagina, pelvic floor, and sexual function—and it yields information I often cannot obtain in any other way.”

For example, some vulvar lesions produce no symptoms but still pose a risk of cancer or represent a developing problem such as lichen sclerosis, but I cannot identify them unless I see them. The physical examination of tissue also prompts me to ask focused questions, frequently about things the patient is too embarrassed to bring up herself. For example, I may examine a woman and find a cystocele or urethrocele. If she hasn’t mentioned leaking urine or other difficulties, the discovery prompts me to ask more specifically about these symptoms. When I do, I often uncover a significant source of distress that, for whatever reason, the patient did not report herself. Other examples: On occasion, during the pelvic examination, I discover vaginismus. That finding prompts me to ask about painful sex. And sometimes a perimenopausal woman has dry vaginal tissue that is not bothersome...yet. By identifying this condition early, I can suggest interventions that prevent the dryness from becoming bothersome.
## Summary of Cervical Cancer Guidelines

<table>
<thead>
<tr>
<th></th>
<th>Under 21 years old</th>
<th>21-29 years old</th>
<th>30-65 Years old</th>
<th>&gt;65 years old</th>
<th>Hyst, benign</th>
</tr>
</thead>
<tbody>
<tr>
<td>USPSTF 2012</td>
<td>[D]</td>
<td>Every 3 y</td>
<td>Co-test: Q5</td>
<td>None*</td>
<td>[D]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cytology: Q3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triple A 2012</td>
<td>None</td>
<td>Every 3 y</td>
<td>Co-test: Q5</td>
<td>None*</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cytology: Q3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACOG 2012</td>
<td>“Avoid”</td>
<td>Every 3 y</td>
<td>Co-test: Q5</td>
<td>None*</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cytology: Q3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hrHPV test</td>
<td>Never</td>
<td>Reflex only</td>
<td>Co-test or reflex</td>
<td>None</td>
<td>None</td>
</tr>
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</table>

* If adequate prior screening with negative results

Co-test: cervical cytology plus hrHPV test
Cytology: cervical cytology (Pap smear) alone
<table>
<thead>
<tr>
<th>Examination</th>
<th>Needed for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>OC, patch, ring</td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>None</td>
</tr>
<tr>
<td>Weight (BMI) (weight [kg]/ height [m]²)</td>
<td>Hormonal methods</td>
</tr>
<tr>
<td>Bimanual examination, cervical inspection</td>
<td>IUC, cap, diaphragm</td>
</tr>
<tr>
<td>Glucose, Lipids</td>
<td>None</td>
</tr>
<tr>
<td>Liver enzymes</td>
<td>None</td>
</tr>
<tr>
<td>Thrombogenic mutations</td>
<td>None</td>
</tr>
<tr>
<td>Cervical cytology (Papanicolaou smear)</td>
<td>None</td>
</tr>
<tr>
<td>STD screening with laboratory tests</td>
<td>None</td>
</tr>
<tr>
<td>HIV screening with laboratory tests</td>
<td>None</td>
</tr>
</tbody>
</table>
Indications for pelvic exam include:

- Vulvar or vaginal complaints
- Pelvic or abdominal pain in a woman
- Exposure to STI?
- Pregnancy? (known or proven)*
- Health maintenance (to perform cytology and HPV testing)
Indications for pelvic exam


- 193 females 13 – 23 years old
- Twenty patients (10.4%) were dx’d with PID
  - Lower abdominal pain reported by 90% of those dx’d with PID
  - Lower abdominal pain reported by 56% of those not dx’d with PID
  - Lower abdominal pain and/or dyspareunia
    - 100% sensitivity - 40% specificity
    - Positive predictive value 17% - Negative predictive value 100%
Indications for pelvic exam

Geisler (2007) Pelvic exam findings and chlamydia trachomatis infection in asymptomatic young women screened with a NAAT

- Retrospective analysis of 577 asymptomatic women age 17 – 25 years old
- NAAT positive in 68 women (11.8%)
- Most common physical exam findings
  - 5.9% vaginal discharge
  - 3.6% cervical ectopy
  - 2.3% friability/easily induced bleeding
  - 1.4% cervical motion tenderness
  - 0.7% adnexal tenderness
Abnormal pelvic exam findings were infrequent (<6%) in asymptomatic young women having NAAT for chlamydia.

Concerns have been voiced by some that not doing a pelvic exam may miss significant morbidity and can’t be justified.

Results of this study would refute that concern.
Conclusions:

- Symptomatic women should have pelvic exams
- Finding MPC in young asymptomatic women was infrequent (9/68 or <15%)
- Mandatory pelvic exams in asymptomatic women is often seen as a barrier to screening
- Findings should increase confidence of clinicians that significant clinical disease is NOT being missed by not performing pelvic examinations
Physicians Reporting Routine Use of Pelvic Examinations for Selected Purposes, by Specialty (DocStyles Survey, 2009)

Table. Physicians Reporting Routine Use of Pelvic Examinations for Selected Purposes, by Specialty (DocStyles Survey, 2009)

<table>
<thead>
<tr>
<th>Reported Use</th>
<th>Physicians, No. (%)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FP/GPs (n=609)</td>
<td>Internists (n=391)</td>
</tr>
<tr>
<td>As part of a “well-woman exam”</td>
<td>545 (89.5)</td>
<td>211 (54.0)</td>
</tr>
<tr>
<td>To screen for ovarian cancer</td>
<td>336 (55.2)</td>
<td>116 (29.7)</td>
</tr>
<tr>
<td>To screen for other gynecologic cancers</td>
<td>414 (68.0)</td>
<td>161 (41.2)</td>
</tr>
<tr>
<td>To screen for STIs</td>
<td>444 (72.9)</td>
<td>152 (38.9)</td>
</tr>
<tr>
<td>As a requirement for hormonal contraception</td>
<td>412 (67.7)</td>
<td>157 (40.2)</td>
</tr>
</tbody>
</table>

Abbreviations: FP/GPs, family/general practitioners; OB/GYNs, obstetrician/gynecologists; STIs, sexually transmitted infections.

a Pearson χ² asymmetrical 2-sided tests were used to compare percentages across specialties. “Routine use” is defined as performing pelvic examinations for each stated purpose “always” or “most of the time.”

About

Choosing Wisely® aims to promote conversations between physicians and patients by helping patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

In response to this challenge, national organizations representing medical specialists have been asked to “choose wisely” by identifying five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. The resulting lists of “Five Things Physicians and Patients Should Question” will spark discussion about the need—or lack thereof—
Don’t perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.

Most observed abnormalities in adolescents regress spontaneously, therefore Pap smears for this age group can lead to unnecessary anxiety, additional testing and cost. Pap smears are not helpful in women after hysterectomy (for non-cancer disease) and there is little evidence for improved outcomes.

Don’t screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer.

There is adequate evidence that screening women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk provides little to no benefit.

Don’t screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology.

There is adequate evidence that the harms of HPV testing, alone or in combination with cytology, in women younger than 30 years of age are moderate. The harms include more frequent testing and invasive diagnostic procedures such as colposcopy and cervical biopsy. Abnormal screening test results are also associated with psychological harms, anxiety and distress.
Choosing Wisely

An initiative of the ABIM Foundation

The American College of Obstetricians and Gynecologists

Five Things Physicians and Patients Should Question

3. Don’t perform routine annual cervical cytology screening (Pap tests) in women 30–65 years of age.

In average risk women, annual cervical cytology screening has been shown to offer no advantage over screening performed at 3-year intervals. However, a well-woman visit should occur annually for patients with their health care practitioner to discuss concerns and problems, and have appropriate screening with consideration of a pelvic examination.

4. Don’t treat patients who have mild dysplasia of less than two years in duration.

Mild dysplasia (Cervical Intraepithelial Neoplasia [CIN 1]) is associated with the presence of the human papillomavirus (HPV), which does not require treatment in average risk women. Most women with CIN 1 on biopsy have a transient HPV infection that will usually clear in less than 12 months and, therefore, does not require treatment.

5. Don’t screen for ovarian cancer in asymptomatic women at average risk.

In population studies, there is only fair evidence that screening of asymptomatic women with serum CA-125 level and/or transvaginal ultrasound can detect ovarian cancer at an earlier stage than it can be detected in the absence of screening. Because of the low prevalence of ovarian cancer and the invasive nature of the interventions required after a positive screening test, the potential harms of screening outweigh the potential benefits.
BENEFITS

- Patient comfort
- Technical assistance
- Legal protection

NO UNIVERSAL GUIDELINES

- AAFP no guidelines
- ACOG addresses, but does not mandate
## Chaperone – patient preference

<table>
<thead>
<tr>
<th></th>
<th>Female Examiner</th>
<th>Male Examiner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefer Chaperone</td>
<td>11%</td>
<td>62%</td>
</tr>
<tr>
<td>Object to Chaperone</td>
<td>34%</td>
<td>9%</td>
</tr>
<tr>
<td>No preference</td>
<td>55%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Study of 1,000 women in Scottish family planning clinic

Women < 25 and/or nulligravid more likely to dislike exam, but didn’t change preference for chaperone

Fiddes, P, 2003
Chaperone – Provider Utilization

- AAFP survey, n=5,000, 71% response rate
- 75% use routinely
- Male (84%) > Female (31%) providers
- More frequent use among providers who:
  - Are younger
  - Do fewer exams
  - Practice in South

Rockwell et al. Ann Fam Med 2003
Conventional Wisdom - Chaperones

- Inform patients of availability
- Male providers – recommended
- Female providers – ascertain preference
What happened to pubic hair?
Is it bad?

- NO, we clearly accept shaving underarms (a very delicate area) and the vulva is really not that different...so why does it bother us?

- Research data does not link vulvar shaving to serious health sequelae.
2008 national and international literature review from 1976-2008 showed no associations between pubic shaving and infection.

Cochrane review 2006: no difference in infection rates between shaved & unshaved genitals


11 RCT’s related to clipping, depilatory vs shaving
Reasons for hair removal

- For some women they feel more sensation when shaved or “feel cleaner”
- May feel pubic hair is “ugly”
- Alterations in genitals: “He wants me to shave to look like a porn star.”
- Sex partner may prefer cunnilingus without pubic hair
- Shaving the vulva may make the vulva appear prepubescent (is this ok?)
La Naissance de Venus, 1862. Eugene Emmanuel Amaury Duval. France

L'Origine du monde, 1866. Gustave Courbet. France
Women’s Body Hair Removal

- 235 Australian undergraduate women
- 96% regularly removed leg and underarm hair, most frequently by shaving
  - Femininity and attractiveness were motivators
Women’s Body Hair Removal

- 60% removed at least some pubic hair
- 48% removed all or most of it
  - Motivators: self-enhancement and sexual attractiveness
  - Predictors: having a partner, reading fashion magazines and watching ‘Sex and the City’ and ‘Big Brother’

Authors concluded that the removal of pubic hair furthers the belief that women’s bodies are unacceptable the way they are. Tiggeman & Hodgson, 2008
Use a disposable razor only once in the pubic area
Exfoliate before and use a moisturizing shaving cream or hair conditioner – never use drying bar soap
Triple antibiotic cream (avoid vagina); apply scant amount a couple of minutes after shaving
Exfoliate daily starting 24 hours after
Tips for treating:

- Don’t shave for five to seven days (if impossible, shave in direction of hair growth)
- Moisturize! (no bar soap, try aloe vera gel)
- Avoid tight underwear and pants
- Abstain for at least 24 hours
- Black tea [brew, refrigerate and apply to area with cotton ball – soothing]
Ovarian Cancer Screening

- Options for screening
  - (Bimanual) Pelvic examination
  - Transvaginal pelvic ultrasound (TVS)
  - Serum Tumor Marker: CA-125

- Not recommended for low risk asymptomatic women
  - Low sensitivity, specificity for early disease
  - Low prevalence of disease
  - High cost of evaluation
Ovarian Cancer Screening

USPSTF (2012)

- Screening asymptomatic women with ultrasound, tumor markers, or exam is not recommended [D]
- Insufficient evidence to recommend for or against in asymptomatic women at increased risk [I]
Randomized trial of 78,216 women 55-74
Annual screening with CA-125 for 6 years + TVUS for 4 years (n=39,105) versus usual care (n=39,111)
10 US screening centers
Followed a median of 12 years
Bimanual examination originally part of the screening procedures but was discontinued

JAMA. 2011;305(22):2295-2303
Ovarian Cancers: PLCO Cancer Screening RCT

Cumulative cases:
- Intervention group
- Usual care group

Cumulative deaths:

JAMA. 2011;305(22):2295-2303
Surgical and path report needed?
Bilateral oophorectomy?
Taking exogenous hormones (estrogen, testosterone)?
If hysterectomy for cancer-continue cytology from cervical/vaginal cuff and closely inspect vulva and vagina
Lower rates of cervical cancer screening

- Negative experiences with the healthcare system & misinformation about disease risk & preventive healthcare needs of lesbians contribute to underuse of medical services in general & cervical cancer screening in particular
Avoidance of Health Care

- Discrimination, prejudice, rejection
- Lack of health insurance
  - No ‘domestic partner’ benefits
- Concern over documented sexual orientation
  - Employer, loved ones, other medical providers
- Low perceived risk of acquiring STDs
- Lesbian women >30% decreased odds of having routine exams
- Bisexual women >2.5% times the odds of not seeking medical care due to cost

Blosnich, et al, 2014
Pelvic Exam for WSW

- STI’s known to be transmitted female to female
  - Herpes
  - HPV
  - Trichomoniasis

- Bacterial vaginosis transmitted between women

Mayer, et al 2008
Bacterial Vaginosis


- **Prevalence of BV high in lesbian population**
  - 25 – 52 % vs 14 % in heterosexual population

- **Groups did not differ significantly in report of receptive oral sex** (which has been proposed as a risk for BV among lesbians)

- **Lesbians in monogamous relationships usually have concordant vaginal secretions**
  - Reflects sexual transmission of BV between lesbians

- **BV is significantly associated with sexual contact with new and multiple male & female partners**
Pelvic Exam with Women Who Have Been Sexually Traumatized
67 female veterans were assessed for history of sexual violence (SV), post-traumatic stress disorder (PTSD) and distress and pain with pelvic examination

- Distress highest for women with h/o SV plus PTSD
- Next highest for women with h/o SV only
- Lowest for women with h/o neither
- Higher pain ratings for women with h/o SV compared to those without SV
- PTSD was not linked with more pain than was accounted for by SV

Weitlauf, et al 2008
Considerations

- All women can refuse an exam
- Will this exam add to her trauma?
- How does she want you to do her exam?
- What will she allow, or not allow?
Considerations

- ?Provide exam over several visits
- Give her control...lift the back of the table so she can see you
- **ASK** permission to examine
- “Is it ok if we get started now?” “Could you lift the sheet so that I can start the exam?”
Considerations

- Careful with words...rapists may say “stay still, don’t move, relax” etc.
- Have her assist you during the exam...hand you cotton swabs, etc.
- Use mirror to guide her through the exam
- The more empowered she is with her knowledge about her body the more control she takes back
Female Genital Cutting/Mutilation/Circumcision

- Myths, religious and cultural beliefs
- Africa and Middle East
- WHO categorizes 1 - 4
1: Clitoridectomy (removal of clitoral hood or clitoris)

2: Excision (removal of clitoral hood or clitoris plus some or all of labia minora)

3: Infibulation (removal of all external female genitalia, leaving a small opening for blood and urine)

4: Unclassified (cutting, burning, piercing, scraping)
Goals for Health Care Providers

- Recognize the type of circumcision
- Ensure cultural competency
- Provide appropriate clinical care
  - Long-term complications
    - Urinary complications (frequent infection)
    - Scarring
    - Pain
    - Infection
    - Infertility
Meatal obstruction and urethral strictures

- Signs/symptoms
  - Straining to urinate
  - Urinary retention
  - Slow urinary stream

- Treatment/referral
  - Cystoscopy, urethral dilation or urethroplasty
Chronic urinary tract infections

Treatment/referral

- Suppressive antibiotic treatment
- Deinfibulation (repair/revision of scar)
Scarring

- Partial labial fusion
- Complete labial fusion
- Large sebaceous cysts (0.5 to 12 cm)
  - Can obstruct introitus
  - Can become very painful
    - Abscesses or large cysts require surgical excision and deinfibulation
Obstructed vaginal environment encourages candida and bacteria growth

- 25% of infibulated women have recurrent yeast infections
- Avoid vaginal administration of antifungal
- Oral administration preferred

Severe dysmenorrhea and menorrhagia secondary to obstructed outflow documented as high as 65% of women

Nour, 2004
That's all Folks!
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