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Female genitourinary exam

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Page last updated - 05/04/2024 The pelvic exam is a vital part of every woman's preventative care and is also important towards making a number of diagnoses when presenting with abdominal or pelvic complaints. Here we cover each aspect of the pelvic exam and demonstrate both in text and in our video how this done. The main equipment you will use is the speculum so it's important for you to understand the most commonly used types. These include the: Pederson's speculum Graves' speculum (or Duckbill speculum) - a little wider (often used for procedure) Note: These are cold! Important to keep in warmer temperatures or run under warm water prior to use. Speculums come in various sizes, including smaller, pediatric sizes. 1. Examine the vulvar region looking for erythema or other rashes 2. Place lubricant on both index finder of non-dominant hand and warmed speculum 3. Insert index finger into base of vagina 4. Touch speculum onto patient's thigh to see if temperature appropriate then insert speculum at slight angle into vagina above finger and rotate to level position as it's inserted Important: Insert speculum all the way BEFORE opening 5. Open speculum and adjust until the cervix is in sight and lock open 6. If planned, conduct pap smear and STD testing Note: a little bleeding (especially if patient nulliparous) after a pap smear is expected. If bleeding profuse of cervix is erythematous and/or purulent discharge present, suspect cervicitis (gonorrhea, chlamydia). Lichen Sclerosis – itching without any discharge, all age groups Vaginal Discharge --> This case shows yeast vulvovaginitis – common cause of vaginal itching and/or discharge, common in hospitalized patients, especially if getting antibiotics. Also note, bacterial vaginosis is another common cause of discharge and often we need a microscope to differentiate between the two. Trichomonas infection causing a "Strawberry cervix" Click this link to jump to the bimanual exam section of the video. Insert index finger and possibly additional finger (with lubricant) in vaginal canal with non-dominant hand free to palpate the abdomen. o Look for: Cervical motion tenderness – could suggest cervicitis or pelvic inflammatory disease Position of uterus (image in folder) – helpful to know if you may not be able to palpate uterus if axial or retroflexed Adnexal size and tenderness – looking for any adnexal masses. Obesity may create a challenge to appreciating the adnexa. The post-menopause ovary can often be too small to palpate. Click here to jump to the rectovaginal exam section of the video. The purpose of the exam is to: Appreciate a retroflexed uterus and adnexal masses Look for presence of hemorrhoids, polyps/growths and assess the tone of the rectal sphincter Place lubricant on index and middle finger of dominant hand then insert index finger into vaginal canal Insert middle finger into rectum, asking patient to bare down and insert fingers as far possible Appreciate Retroflexed uterus Nodularity along ureteral sacral ligament and cul-de-sac behind uterus – suggesting endometriosis To find ureteral sacral ligament, pull the cervix anterior with index finger to stretch and palpate for the ligament with finger inserted into rectum Adnexa – looking for masses and tenderness Rectal or anal masses/polyps o Hospitalized patients – Given a proper exam table with leg rests is often not available, if possible delay this exam until patient can be seen in clinic. However if speculum exam is needed immediately, one method is to place an inverted bedpan under the patient's buttocks to raise pelvis. If yeast vulvovaginitis is suspected, you or patient can obtain a swab and look under microscope or send to lab. o Patient's first exam or elderly patients – May require more discussion and education prior to the exam o Patients with history of trauma – ensure patient knows they have control and can stop the exam at anytime The gynecologic examination is a critical component of comprehensive women's healthcare. The pelvic exam traditionally includes a careful inspection of the external genitalia and a speculum and bimanual exam to assess the internal genitalia. Under some circumstances, a rectovaginal examination may also be appropriate to better characterize the posterior pelvis. The gynecologic pelvic examination serves as a critical diagnostic tool, enabling healthcare providers to assess and diagnose a wide spectrum of gynecological conditions, including abnormal bleeding or discharge, pelvic pain, sexually transmitted infections (STIs), benign or malignant tumors, cysts, and anatomic abnormalities. Additionally, the exam is an important component of routine obstetric evaluations.An appropriate exam can help identify abnormalities, assess patients before performing procedures (eg, intrauterine device insertion), monitor women during their reproductive years, and ultimately improve outcomes. This activity describes the indications, contraindications, and techniques for performing a gynecologic pelvic exam and highlights the role of the interprofessional team in caring for patients undergoing this assessment. Objectives: Apply current knowledge of female genital and pelvic anatomy, physiology, and pathology to perform thorough pelvic examinations, ensuring comprehensive patient care.Implement a patient-centered approach during gynecologic pelvic examinations, using evidence-based protocols to facilitate early detection and intervention. Select appropriate medical instruments and techniques for correctly performing a gynecologic pelvic examination.Collaborate with an interprofessional team to improve the comfort and utility of a gynecologic pelvic examination. Access free multiple choice questions on this topic. The gynecologic examination is a critical component of comprehensive women's healthcare. The pelvic exam traditionally includes a careful inspection of the external genitalia and a speculum and bimanual exam to assess the internal genitalia. Under some circumstances, a rectovaginal examination may also be appropriate to better characterize the posterior pelvis. The gynecologic examination is a critical diagnostic tool, enabling healthcare providers to assess and diagnose a broad spectrum of gynecological conditions, such as abnormal bleeding or discharge, pelvic pain, sexually transmitted infections (STIs), benign or malignant tumors, cysts, and anatomical abnormalities. Additionally, the exam can be part of obstetric and routine screening evaluations. An appropriate exam can help identify abnormalities, assess patients before performing procedures (eg, intrauterine device [IUD] insertion), and monitor women during their reproductive years.[1]The gynecologic pelvic examination can pose several challenges for healthcare professionals. First, these are sensitive exams, often used to assess very private concerns that can cause patients to feel vulnerable, embarrassed, and/or physically uncomfortable. For this reason, excellent communication with the patient is essential, and the healthcare professional must be able to effectively explain the procedure and obtain informed consent while respecting a patient's concerns. Additionally, due to the sensitive nature of the procedure, it can be harder to practice and gain competence in this crucial skill. External Genitalia Collectively, the external female genitalia is referred to as the vulva and includes the mons pubis, labia majora and minora, clitoris, vulvar vestibule, vestibular bulbs, Skene's and Bartholin glands, vaginal introitus, urethral meatus, and perineum.[2][3][4] The mons pubis is a rounded area of fatty tissue overlying the pubic symphysis. Inferior to the mons pubis are the labia majora, paired structures containing skin and adipose tissue. Both the mons pubis and lateral surfaces of the labia majora naturally grow pubic hair, though the medial surface of the labia majora is typically hairless. On each side of the body, medial to the labia majora, is the thinner, hairless labia minora, which can vary widely in size. The almond-shaped space between the labia minora is known as the vestibule. The urethral meatus can be found just anterior to the vaginal orifice within the vestibule and typically takes the shape of a sagittal cleft. The perineum is the area located posterior to the labia majora extending to the anus. The clitoris is visible as a small projection of erectile tissue located in the midline at the anterior aspect of the labia, inferior to the mons pubis. Typically, there is a flap of skin that overlies the clitoris that arises from the anterior confluence of the labia minora and is known as the clitoral hood or prepuce. The small visible portion of the clitoris is known as the glans. The internal portion of the clitoris forms a "Y"-shaped structure, consisting of the body, which passes internally in the midline inferior to the pubic symphysis, and a pair of crura, which anchor the clitoris laterally to the inferior edges of the pubic arch.[5][6]Deep to the labia majora are 2 elongated masses of erectile tissue known as the vestibular bulbs. The vestibular bulbs originate at the midline anteriorly and extend posteriorly to wrap around the lateral aspects of the vaginal orifice. On each side of the vagina, posterior to the vestibular bulbs (at the 4 o'clock and 8 o'clock positions when a patient is in the lithotomy position), are the greater vestibular glands, also known as the Bartholin glands, which secrete fluid that keeps the vagina moist and provides additional lubrication during intercourse. Under normal circumstances, these glands are each approximately the size of a pea and neither visible nor palpable. However, if the glands are occluded, they can become enlarged and infected, which is exquisitely painful. The paraurethral glands, also known as Skene glands, are located on both sides of the urinary meatus within the vestibule and are homologous to the male prostate. Internal Genitalia The internal female genitalia includes the vagina, cervix, uterus, fallopian tubes, and ovaries. The bladder, rectovaginal septum, and pelvic floor musculature can also be assessed on an internal pelvic exam.The vagina is a muscular, elastic canal, typically 8 to 10 cm in length, that extends from the vulva to the protrusion of the cervix. The vaginal mucosa is folded into thick ridges called vaginal rugae, which create friction during intercourse to stimulate the penis. The vagina is acidic under normal circumstances, with a pH of approximately 3.5 to 4.0, due to bacteria converting glycogen in the epithelial cells to lactic acid.The hymen is a thin membrane of tissue that partially covers the vaginal orifice near the distal end of the vagina at birth. There are many variations to the shape of the hymen, and it may be difficult to identify after hymenal rupture, which can occur during the first act of intercourse, masturbation, tampon use, pelvic examination, injury, or even physical exercise.The cervix is the distalmost portion of the uterus. It is a thick fibromuscular, canulated organ that connects the uterine cavity to the vaginal canal. The cervix is visible on a speculum exam protruding into the proximal end of the vagina, known as the fornix. The distal end of the cervical canal is the external os, and the proximal end is the internal os. In obstetrics, "cervical dilation" refers to dilation of the internal os.The uterus is a triangle-shaped thick muscular organ within the pelvis that opens into the vagina through the cervix at its lower end. The broad superior curvature of the uterus is the fundus, and the uterus typically averages about 7 cm in length from the cervix to the fundus in a nongravid individual. The uterine wall is made up of thick layers of smooth muscle, and the uterine cavity is lined with mucosa, known as the endometrium. The uterus can be examined on bimanual palpation to assess its size, shape, position, and mobility.The uterine cavity opens into 2 fallopian tubes superolaterally (1 on each side). These tubes are approximately 10 cm long and connect the uterine cavity with the ovaries; however, they are typically not palpable on examination unless they contain a mass (see Image. Uterine Tubal Anatomy and Ligaments). The ovaries are almond-shaped glands located lateral to the uterus within the pelvic cavity and about 2 to 3 cm in size, though they are typically much smaller in postmenopausal patients. Examinations to Assess Gynecologic Symptoms A pelvic examination is used to assess the external and internal female genital structures. The urethra, bladder, perineum, anus, and/or rectum are also frequently evaluated at the same time.[7] A pelvic examination is warranted to assess patients with relevant symptoms or concerns as follows:Abnormal bleeding, including menstrual abnormalities and postcoital and postmenopausal bleedingPelvic pain, such as dysmenorrhea, dyspareunia, or dyschezia Abnormal vaginal dischargeItchingMassesVisible lesions or ulcersInfertilityTrauma Retained foreign bodies [8]Concerns regarding abnormal anatomy or developmentNeurological conditionsIncontinenceProlapse or other pelvic floor disorders [9]Unexplained new gastrointestinal symptoms (eg, difficulty eating, early satiety, abdominal pain, bloating, etc) [7][10]Additionally, during pregnancy, a pelvic exam is warranted to assess patients with bleeding, cramping, contractions, and loss of amniotic fluid and to monitor patients during the intrapartum period. Routine Screening Examinations The gynecologic pelvic examination has traditionally been a part of routine screening assessments in asymptomatic, nonpregnant women to screen for gynecologic cancers and infections. However, more recent data has questioned the utility of these exams as cancer screening guidelines have changed and newer, less invasive STI tests have been developed.[11] Specifically, the limited data that exists suggests that screening asymptomatic individuals does not improve outcomes for benign gynecologic conditions, such as genital herpes or bacterial vaginosis, and noncervical gynecologic malignancies, including ovarian cancer.[7][11][12][13] This is potentially due to poor diagnostic accuracy for detecting ovarian cancer or benign conditions in asymptomatic patients.[1][13]Due to the limited evidence of benefit, guidelines vary somewhat regarding screening pelvic exams. The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians discuss the risks and benefits of a screening gynecologic exam with their asymptomatic patients and decide together whether or not to perform the exam.[11] On the other hand, the American College of Physicians (ACP) recommends against screening exams in asymptomatic women, and the US Preventative Services Task Force 2017 guideline states that there is insufficient evidence to assess the balance of benefits versus harms.[1][12][14]Reasons to consider performing a screening pelvic exam include the possible early detection of a treatable vulvar or vaginal cancer before the appearance of symptoms, identifying abnormal anatomy or foreign bodies, and providing an opportunity for patients to ask questions about their reproductive health they would not have otherwise mentioned. The exam also allows the clinician a chance to ask about potential findings that the patient may not have realized were abnormal (eg, pigmented vulvar lesions and abnormal vaginal discharge).[7][11] Although the exam can be uncomfortable, 1 study found that 82% of respondents felt that the examination provided reassurance about their health.[15] There is low-quality evidence to suggest the gynecologic pelvic exam may cause potential harm, including pain or discomfort, anxiety, fear, and embarrassment, especially if the patient has a history of sexual violence.[1] It should be noted that a gynecologic exam is not required before prescribing hormonal contraception to healthy asymptomatic individuals.[7][16]The only absolute contraindication is a lack of consent for the procedure.[17]The pelvic examination is typically performed on a flat surface or examining table, preferably 1 with foot supports or stirrups.[18][17] A drape or absorbent pad is typically placed beneath the patient's buttocks, and the patient should be covered with a drape from the waist down to preserve modesty. Exam gloves, a speculum, a light source, and water-soluble lubricant are needed to complete the internal portion of the exam. Supplies for obtaining cultures or other diagnostic tests should be readily available if abnormal findings (eg, purulent discharge) are encountered.Specula come in various sizes and styles; however, the Pedersen and Graves specula are the 2 most commonly used. The Graves speculum is designed to be self-retaining once inserted into the vagina. It is wider than the Pederson speculum and is generally reserved for parous women. The Pederson speculum is narrower and often the most comfortable for women, though these specula are not self-retaining and must be held in place throughout the exam. Pediatric specula, which are much shorter and narrower than specula designed for adolescents and adults, are also available.Metal specula are not disposable and require sterilization between each use, while plastic specula are single-use disposable items. Many plastic specula are designed to be used with a fiberoptic light source that improves visibility; however, metal specula require an adjustable lamp. Simple room lighting will not be adequate for the examination.It is best to perform a gynecologic exam in the presence of a chaperone for both the patient's and provider's security, although there is little evidence suggesting that the presence of a chaperone reduces litigation.[19][18] Typically, a medical assistant or nurse functions as a chaperone while assisting the clinician in performing the examination. Informed Consent Informed consent should be obtained before starting the examination. The provider should discuss the indications for the exam with the patient and describe all components of the exam that are to be performed.[18][17] Patient Positioning The patient should be undressed from the waist down and covered with a sheet to maintain modesty. The patient should be uncovered for the shortest duration possible and only during the exam. She should remain draped until properly positioned.Gynecologic exams are best performed with patients in the dorsal lithotomy position using foot supports (see Image. Lithotomy Position for Urologic and Gynecologic Procedures). The patient should be instructed to position herself with her buttocks extending slightly past the edge of the table so that the vaginal orifice is in line with or just past the edge of the table. This positioning is required because the table itself will obstruct the insertion of the speculum into the vagina. If a table with foot supports is unavailable, space for the speculum can be created by placing the patient's hips on top of a padded, upside-down bedpan. Her legs may be flexed at the hips and knees, or she may be placed in a frog-leg position with the soles of her feet together. If a speculum exam is not planned (eg, evaluation of external genitalia in a pediatric or postpartum patient), the frog-leg position is also appropriate.The gynecologic exam typically includes an inspection of the external genitalia, a speculum exam to inspect the vagina and cervix, and a bimanual exam to assess the uterus and adnexa by palpation. In some situations, a rectovaginal exam may also be appropriate; however, this step is often omitted. Inspection of External Genitalia The exam should start with a visual evaluation of the external genitalia. Inform the patient the exam is beginning and inspect the mons pubis, labia, clitoris, and perineum. The clinician should note the basic development of vulvar anatomy, symmetry, hair distribution, and any swelling, bruising, erythema, rashes, lesions, nodules, masses, or discharge. Palpation can further characterize visual abnormalities and provide information about a mass or nodule's tenderness, size, mobility, and construct.[18][17] Masses can be palpated by placing the thumb on the labia with the index finger in the vaginal introitus, capturing the mass between the digits. The labia should then be gently separated, allowing for better inspection of the labia minora, as well as the vestibule, vaginal introitus, and urethral meatus. Prolapse can be assessed by asking the patient to bear down and observing the movement of the internal vaginal walls and uterus. A complete examination of pelvic organ prolapse (known as the POP-Q exam) is beyond the scope of this review. Speculum Examination The speculum exam typically follows an inspection of the external genitalia. First, the blades of the speculum should be lubricated. The speculum is held in the palm of 1 hand, with the blades extending between the index and middle fingers, which keeps them closed. The examiner then spreads the labia slightly with the other hand and then enlarges the introitus slightly by applying gentle downward pressure at the lower margin of the vagina.When inserting the speculum, the blades should be rotated about 45 ° off the midline (ie, so that the top of the speculum is at about the 2 or 10 o'clock position) and directed posteriorly toward the sacrum. Once the speculum has entered the vagina, the examiner's hand is removed from the vagina. The speculum is then rotated to an upright position (ie, so the top of the speculum is at the 12 o'clock position) and inserted to its full length. During insertion, gentle downward pressure is applied with the speculum itself, which helps reduce discomfort from the speculum sliding against the sensitive urethra anteriorly. The clinician should take care to ensure no pubic hair or tissue is caught within the speculum during insertion.With proper insertion technique, the inferior blade of the speculum should be placed in the posterior fornix of the vagina. The speculum is then opened carefully until it cups the cervix. The cervix will appear as a smooth, firm, bulge of tissue compared to the surrounding rugated vaginal mucosa. If the cervix is difficult to identify, the speculum should be withdrawn slightly, repositioned, and reopened. If the uterus is anteverted, the cervix is directed toward the posterior vaginal fornix, while a retroverted uterus will result in a more anterior position of the cervix. If the cervix is difficult to find visually, a bimanual exam can help ascertain its location.Once the cervix is identified, characteristics of the cervix should be noted, including its position, size, color, and the presence of any lesions, ulcers, discharge, or blood. Any necessary samples are taken at this time. Purulent discharge suggests an infection, and samples should be collected for testing. Masses concerning for malignancy should be further evaluated with colposcopy and biopsied. If the patient is pregnant, the clinician should also note whether the external os appears open or closed and whether any protruding tissue is visible. Any foreign bodies should be noted and removed.To remove the speculum, the clinician releases the blades while starting to slowly withdraw the speculum to avoid pinching the cervix and vaginal walls. The speculum should be withdrawn in a slightly open position to allow the clinician to examine the vaginal wall for any irregularities, including inflammation, discharge, ulcers, or masses. The speculum should be closed as it is withdrawn from the vaginal introitus. Bimanual Examination Lubrication is applied to the index and middle fingers of the examiner's dominant hand, which are then gently inserted into the vagina. Similar to the insertion of the speculum, pressure should be directed posteriorly. The thumb should be abducted, and care should be taken to avoid pressing the thumb directly into the urethral meatus or clitoris; the fourth and fifth fingers are flexed into the examiner's palm. The nondominant hand is placed on the lower abdomen in the suprapubic region.With the internal hand, the cervix is located and moved slightly, allowing the examiner to assess its position, consistency, mobility, cervical motion tenderness, and any lesions or nodularity. If the patient has an IUD in place, the presence of palpable strings should also be noted. It may be necessary to push down and inferiorly with the nondominant hand on the abdomen to push the cervix closer to the internal fingers.Next, the internal fingers should move beneath the cervix and elevate the uterus while the abdominal hand presses down and inward, allowing the uterus to be grasped between the examiner's 2 hands. This allows the examiner to assess the uterus's size, shape, mobility, and tenderness, which may suggest a diagnosis. For example, an enlarged uterus with irregular fundal contours suggests uterine leiomyomas, whereas tenderness is more consistent with inflammation (eg, from endometriosis, pelvic inflammatory disease [PID]). Poor mobility suggests pelvic adhesive disease, which can be seen with endometriosis, a prior history of PID, and gynecologic malignancies. If the uterus is retroverted, it may be better assessed with a rectovaginal exam.Finally, the adnexa should be palpated by moving the pelvic hand to the anterior lateral fornix and the abdominal hand to the corresponding lower abdominal quadrant. The abdominal hand should press in and downward, attempting to sweep the adnexal structures into the pelvic hand. The adnexa's size, shape, mobility, and tenderness should be identified, and that process should be repeated on the opposite side. Note that the ovaries are often difficult to palpate in women who are obese, postmenopausal, or tense. After palpating the adnexa, the internal fingers are gently withdrawn. Rectovaginal Examination A rectovaginal examination may be necessary to examine the rectovaginal septum, uterosacral ligaments, posterior cul-de-sac, adnexa, or a retroverted uterus. Since this step is often omitted, the plan to insert a rectal finger should be explicitly discussed with the patient before this step is performed. The presence of hemorrhoids, polyps, and abnormal lesions should be noted. The lubricated third digit is slowly inserted into the rectum while the patient bears down to allow for relaxation of the sphincter, minimizing discomfort. At the same time, the index finger is inserted into the vagina, and both fingers are used to feel the rectovaginal septum and internal organs in the posterior pelvis. Downward pressure from an abdominal hand can help move the pelvic structures closer to the internal fingers.Although uncommon, complications can occur during a gynecologic exam.In women with atrophic vaginitis, the speculum exam may be very painful and may cause mucosal tearing; liberal lubrication and a narrow speculum are recommended for these patients. Additionally, a pelvic exam may exacerbate symptoms in patients with chronic pelvic pain.In patients with a history of sexual trauma, a pelvic examination may trigger anxiety or posttraumatic stress disorder. Excellent communication and obtaining consent before and during each part of the exam can help alleviate anxiety in some patients. Mental health counseling, anxiolytics, and various modifications to the exam can also be offered, such as self-insertion of the speculum, offering the option of a female-only clinical team, or having a friend or family member in the room for support. It should be stressed that the examiner can stop the exam at any time the patient requests.[18]The gynecologic exam allows clinicians to assess vulvar, vaginal, uterine, adnexal, and pelvic pathology. The exam is a critical component of the evaluation for numerous obstetric and gynecologic complaints, including abnormal bleeding, discharge, pain, masses, lesions, incontinence, prolapse, and more.[17] Many specimens can be collected for diagnostic or screening tests, including STI testing, cervical cancer screening, microscopic evaluation of discharge, and biopsies.The gynecologic examination must be performed with a patient-centered approach, including good comprehensive clinical skills and proper technique to avoid iatrogenic effects, such as pain, traumatization, and anxiety. Communication skills are vital for explaining procedures and addressing patient concerns. Physicians, physician assistants, and nurse practitioners should be familiar with exam techniques, and nurses and medical technicians should be comfortable providing support to both the physician and patient and serving as a patient advocate during the exam.[17] Review QuestionsLithotomy position for urologic and gynecologic procedures Image courtesy S Bhimji MD Uterine Tubal Anatomy and Ligaments. Shown in this illustration are anatomical structures surrounding the uterus and fallopian or uterine tubes, including the mesosalpinx, mesovarium, ovarian artery, ovarian vein, suspensory ligament, uterine tube, ovary, (more...)1.Qaseem A, Humphrey LL, Harris R, Starkey M, Denberg TD., Clinical Guidelines Committee of the American College of Physicians. Screening pelvic examination in adult women: a clinical practice guideline from the American College of Physicians. Ann Intern Med. 2014 Jul 01;161(1):67-72. [PubMed: 24979451]2.Pauls RN. 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Chaperones for rectal and genital examinations in the emergency department: what do patients and physicians want? South Med J. 2008 Jan;101(1):24-8. [PubMed: 18176287] Disclosure: Agnieszka Bialy declares no relevant financial relationships with ineligible companies. Disclosure: Laveena Kondagari declares no relevant financial relationships with ineligible companies. Disclosure: Anton Wray declares no relevant financial relationships with ineligible companies. All patients presenting with genitourinary symptoms require a focused history and thorough examination. The availability of genitourinary imaging should not replace the clinical skills which lead to a possible diagnosis and list of differential diagnoses. It is these that point the clinician towards appropriately focused tests delivered with appropriate urgency.Symptoms must be assessed in the context of the patient's medical, surgical and gynaecological background, obstetric history, family history, sexual history and risk factors both general and specific.Remember also that symptoms apparently localised to the genitourinary system may occasionally be referred from elsewhere - eg, urinary symptoms may be caused by metabolic, neurological or psychological problems. Moreover, symptoms which appear initially to relate to other systems may be produced by genitourinary pathology (eg, lower back pain in upper urinary tract infection, or iliac fossa pain in ectopic pregnancy.The following account lists important elements of the history and examination, and provides some diagnostic pointers. The article refers mainly to adult women. However, paediatric genitourinary history and examination are also referred to and important aspects particular to children are outlined.The separate Genitourinary History and Examination (Male) article covers detail specific to male patients.Female genitourinary historyA clear and focused history is essential. Patients may feel awkward or even reluctant to give a full account of some aspects of the history, and may need prompting with specific questions. It is the skill of the clinician to obtain the relevant history. The history-taking should be conducted with sensitivity, but details should be pursued according to the importance and relevance to the presenting problem.Be sensitive but unembarrassed. A statement such as 'I am sorry to ask you such an embarrassing question' may make the patient feel worse, as it suggests that the doctor may also be embarrassed. Try instead to signpost - explain that you need to ask some questions which may feel personal in order to try to get to the bottom of the problem.If necessary explain why you are asking the question: for example, if asking about positional pain during intercourse, explain that this can give you an idea of which internal structures or organs are producing the pain.History of presenting complaintAll history-taking starts with an exploration of the problem, initially allowing the patient to talk freely, with open questions and a facilitative form of questioning. Phrases such as 'Tell me more' and 'What did you think it was?" may help clarify the patient's ideas and concerns.Be sure that before moving on to the specific history items below you have discovered the following.The presenting complaintPainPain: onset, nature, time course, radiation, exacerbating or relieving factors.These points can be remembered with the mnemonic 'SOCRATES': [Site] [Onset] [Character] [Radiation] [Associated symptoms][Time] [Exacerbating/relieving] [Severity].Onset - establish how, when and where.Ask whether the patient has had any previous investigation or treatment.Discuss relationship to menses (eg, dysmenorrhoea, Mittelschmerz).Discuss relationship to intercourse (see 'Dyspareunia', below).Determine the effect of the pain on life and work.Discuss the patient's ideas, concerns and expectations.DyspareuniaDetermine whether this is superficial (eg, vaginismus, episiotomy scar) or deep (uterine, cervical or adnexal).Note whether there is radiation.Ask whether it is preventing penetration or full intercourse.Ask whether libido and foreplay are adequate.Discuss positional factors. Pain relating to deep penetration may come from the ovaries.Ask whether there is dryness/atrophy.Note whether there is any rash.Ask whether it is intermittent/recurrent or always present.Establish the degree of distress.Note whether there is evidence of mood disorder.Discuss relationship to menses. Note whether the patient is postmenopausal.Urinary symptomsIf pain is a urinary symptom, discuss relationship to micturition.Establish whether there is urethral discharge.Discuss frequency of micturition (day and night).Establish urgency.Urge incontinence - note whether this leads to partial or total voiding.Stress incontinence - note what provokes this and whether it leads to partial or total voiding.Discuss whether there is restriction on normal activities and plans.Ask whether symptoms are intermittent/recurrent or always present.Vaginal dischargeEstablish the colour of vaginal discharge and whether or not it is bloodstained.NB: physiological discharge is usually scanty, mucoid and pale/colourless; it should not be offensive. Therefore, discuss with the patient:Discharge odour.Consistency of discharge.Whether there is associated itch, burn or fever.Discuss use of gels, douches, vaginal deodorants or perfumed bath additives.Ask whether there is associated localised tenderness (eg, Bartholinitis).Abnormal vaginal bleedingNote whether the patient has clotting and/or flooding.Establish whether there is intermenstrual or postcoital bleeding.Establish periodicity.Discuss relationship to menses and relationship to coitus.Ask whether there is possibility of pregnancy.Having obtained all relevant information regarding the presenting complaint, ask the patient about their:Ideas about the problem.Concerns or anxieties regarding the cause.Expectations from the consultation.Then move systematically through the history covering the areas below, and focusing on those that are relevant to the case.Menstrual historyAge at menarche: Average age in the UK is approximately 12 years. There is some variation according to ethnicity.Body weight is a factor (average weight at onset 48 kg).If there is concern about abnormal puberty (precocious puberty, delayed puberty) ask about onset of other secondary sexual characteristics and thelarche (onset of breast development).Ask whether the patient is sexually active and, if so, when last active. Ask about contraceptive method and whether they are trying for a baby.In primary amenorrhoea: Look for presence of secondary sexual characteristics.Consider imperforate hymen (very rare).Look for features suggesting genetic abnormality - eg, Turner syndrome.Look for features of hyperandrogenism.Consider relevant causes of secondary amenorrhoea: The pattern of the menstrual cycle. Record: First day of last normal menstrual period.Days of blood loss.Length of cycle.Whether blood loss was heavy: number of tampons and/or pads, whether clots were present.What form of contraception is used.Any discharge other than the menses.The normal menstrual cycle: Range is 21 to 35 days and average is 28.Most healthy, fertile women have regular cycles with 1 or 2 days of variation.Blood loss is 50-200 mls and averages 70 mls.Guide to loss is use of pads and tampons.Passage of large clots suggests excessive bleeding.Abnormal patterns of bleeding: Psychosexual historyThis needs to be conducted sensitively. It requires experience, knowledge and good clinical judgement to recognise and define underlying psychosexual problems and differentiate them from other causes of symptoms (dyspareunia, low abdominal or pelvic pain, for example). A history should include enquiry about:Relationship details, including issues of sexuality.Intercourse and sexual practices.Libido.Orgasm.Association of other symptoms.If it seems relevant/there are cues, ask about previous negative sexual experiencesObstetric historyAsk whether the patient has ever been pregnant.Record completed and unsuccessful pregnancies.Take details of gestation at time of any miscarriages or terminations.Note complications of pregnancy, particularly gestational diabetes, hypertension, HELLP syndrome - a condition related to pre-eclampsia and characterised by:H aemolysis.EL (elevated liver) enzymes.LP (low platelet) count.Ask about features of labour which might encourage weakness of the pelvic floor, resulting in stress incontinence): Note length of labour and whether there was any prolonged pushing.Note size of babies - a larger baby, particularly if there was shoulder dystocia - may increase the chances of later stress incontinence.Ask whether any methods of assisted delivery were required (forceps, caesarean section).Ask whether there was postpartum haemorrhage.Note complications in the puerperium - eg, depression.Other symptomsLoin pain; urinary calculi can cause ureteric obstruction and lead to severe loin pain which radiates to the symphysis pubis and groin. The sudden onset of pain in renal colic or acute urinary retention contrasts with the gradual build-up of pain from a renal tumour or the slow development of urinary symptoms from outflow obstruction. Ask about associated features such as pain, haematuria or incontinence.Urinary incontinence; may be stress incontinence, detrusor instability, detrusor underactivity or urethral obstruction.Urethral discharge may occur as a result of a sexually transmitted disease.Systemic symptoms of acute kidney injury or chronic kidney disease - eg, anorexia, vomiting, fatigue, pruritus and peripheral oedema.Some patients have no symptoms but abnormalities are discovered on measuring blood pressure or abnormalities on routine urinalysis, renal function or serum biochemistry.Occupational historyExposure to chemical carcinogens such as 2-naphthylamine or benzidine in the chemical or rubber industries (these may induce bladder cancer many years later).Foreign travelTravel to Egypt or Africa may result in exposure to schistosomiasis.Dehydration during time in a hot climate may lead to development of kidney stones.Family historyAny family history of chronic kidney or polycystic kidney diseasePast medical historyNeurological diseases may cause abnormal bladder function - eg, Parkinson's disease, multiple sclerosis or cerebrovascular disease.Any previous kidney disease, hypertension, diabetes, gout or back injury may be relevant. Abdominal or pelvic surgery can cause denervation injury to the bladder.Previous surgery - eg, for urinary incontinence.Ureteric injury may occur following abdominal or gynaecological operations.Medication historyA full current and past medication history is important.Past history of prolonged analgesic use may be a cause of chronic kidney disease.Dosages of some drugs may need to be adjusted or stopped in chronic kidney disease.Preparation for the examinationEquipment should have been prepared beforehand.Taking the history can help establish rapport and help patients prepare for the intrusive examination which may follow.Most patients will be prepared for an examination if their symptoms suggest that such examination is likely to be required.Nevertheless, time should be taken to explain any examination: you need to explain exactly what you are about to do, and why.Make sure that you have clear consent to proceed.Patients should be warned about discomfort or pain when and if this is likely.Advise patients that if at any point during the examination they are uncomfortable or would like you to stop then they need to indicate this and you will stop at once.Ensure comfort and privacy are maintained with basic facilities for undressing.Offer chaperones, preferably nurses, who are qualified to assist and reassure the patient. Ideally the chaperone should speak the patient's language, as this avoids misunderstanding. Failing this, consider offering a translator outside or inside the curtain as the patient wishes, in addition to the nurse chaperone. If none is available offer to postpone the examination unless you feel it is clinically ur