FAST FACTS ABOUT
THE GYNECOLOGIC EXAM
FOR NURSE PRACTITIONERS
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Conducting the GYN Exam
in a Nutshell

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Foreword

This is an extraordinarily down to earth and useful guide for both novice clinicians and experienced clinicians who are presented with challenging patient situations. The format facilitates both a rapid review immediately prior to stepping into the examination room, as well as a more leisurely study in anticipation of a new clinical challenge or a prospective roster of patients.

The authors have both synthesized and explicated the most important aspects of preparation for, and conduction of, a gynecologic examination under what are sometimes less than ideal circumstances. Their writing is succinct, clear, and easy to read and meets their goal of providing guidance for novice clinicians, as well as providing a quick review for experienced clinicians about to examine patients with unusual or unfamiliar characteristics.

Most of all, this book is a gold mine for clinicians committed to delivering the best possible care to women who present with a wide range of characteristics and challenges. Equally so, it should become a must-have book for novice clinicians as they struggle to make it through their first solo gynecologic examination, and move on to mastering the art of caregiving.
as well as the science of providing the best possible individualized care for each woman across the life span.

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Many advanced practice clinicians (NPs, PAs, CNMs) lack confidence in their women’s health skills and may be particularly apprehensive and unsure of their gynecologic exam skills. We’ve written this book because there is a great need for more practical information about how to improve the advanced practice clinician’s gynecologic exam skills.

*Fast Facts About the Gynecologic Exam for Nurse Practitioners* represents the coauthors’ more than four decades of combined clinical experience in women’s health and teaching nurse practitioners and other advanced practice clinicians how to perform gynecologic examinations.

This practical guide is designed in an “easy-to-follow” format well suited for the busy clinician looking to refine his or her skills, or for students just learning how to perform a gynecologic exam and their instructors/preceptors who are assisting them.

This book is divided into chapters that each contain key learning objectives and content related to the specific aspect of the gynecologic exam being discussed.

We have included detailed suggestions, approaches, and step-by-step sequences on how to perform the various aspects of the gynecologic exam. Tapping into our vast combined clinical experiences, we’ve included many practical suggestions both in the body of the text and in the “Fast Facts in a Nutshell” sections of each chapter. These special “Fast Facts”
sections contain clinical pearls intended to help clinicians improve their skills so they can conduct a better exam. There are also helpful figures to illustrate information and procedures being discussed.

The text and appendices provide valuable guidelines and documents, including suggestions and strategies for various gynecologic exam challenges and dealing with special populations, a vaginal microscopy flow sheet and summary of how to perform this test and document your results, the new cervical cancer screening guidelines, how to perform an anal Pap smear, and patient education guidelines for vulvovaginal self-care.

This book will help advanced practice clinicians develop and refine their gynecologic examination skills so they can perform a more accurate, patient-centered exam with confidence. This will be a welcome resource, especially for students and their instructors.
Acknowledgments

Thanks to my coauthor, Dr. Heidi Fantasia, who is a great writer and with whom it was a pleasure to work on this project. I am indebted to my patients I’ve encountered over the years. They are a source of inspiration as I continually learn so much from them. Thank you to my friends, students, and nurse practitioner colleagues for their insight, inspiration, support, and friendship. Special thanks to Dr. Joellen Hawkins and Carine Luxama, NP, for help in editing the manuscript, especially during the final weeks. Finally, thanks to my family, including my husband Mike, daughter Katherine, and mother Irene Clarke, for their unconditional love and for sharing me with my work.

R. “Mimi” Clarke Secor

Thank you to Mimi Secor for the wonderful opportunity to contribute to this project. I am forever grateful to my patients, colleagues, and co-workers, who have provided valuable stories, shared life experiences, and taught me to challenge myself and never stop learning. I would especially like to acknowledge Dr. Joellen Hawkins for being a lifelong mentor and friend. I appreciate the unconditional love, support, and strength from my family, including my husband John and my children Andrew, Amelia, and Evan.

Heidi Collins Fantasia

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Introduction to the Gynecologic Exam

Conducting a gynecologic exam requires many clinical skills. These include competence in establishing and building emotional rapport with patients; knowing how and what questions to ask to elicit an appropriate gynecologic history; conducting a systematic, thorough, accurate pelvic exam in a confident, reassuring manner; and documenting medical records appropriately. Frequently, this involves the use of electronic medical records, including transmitting prescriptions electronically.
Conducting the Interview and Taking a Gynecologic and Sexual History

INTRODUCTION

The gynecologic exam visit involves many competencies, skills, and steps, including taking a gynecologic history, conducting a gynecologic exam, excellent communication and clinical skills, and the ability to formulate a management plan to address preventive goals and health issues pertinent to the individual patient. This process is complex and individualized to each patient and situation. Knowledge, practice, and experience are required to develop basic competency and, with time, expert skills.

In this chapter you will learn how to:

1. Develop skills and strategies for creating a therapeutic environment for conducting a gynecologic exam.
2. Obtain key elements of a gynecologic history.
3. Take a gynecologic history, including how to ask questions particularly related to taking a sexual history.

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CREATING A THERAPEUTIC ENVIRONMENT

The environment that welcomes the patient into the office setting establishes the stage for a therapeutic environment. There are many elements to take into consideration when designing and furnishing a waiting room or area. For example, introducing “comfort” measures into the waiting area communicates that the patient is expected and welcomed. These measures can include comfortable chairs, current magazines, pleasant art on the walls, and access to a water cooler with disposable cups, which can each contribute to increasing the patient’s feeling of being welcomed and comfortable upon arrival. Be sure to train the reception personnel to be pleasant, call the patient by name, provide easy instructions for completing needed paperwork, and offer directions to the bathroom, all of which can contribute to a more relaxed patient.

PREAPPOINTMENT INSTRUCTIONS

Before the appointment, the patient should be advised to avoid intravaginal medications, douching, and intercourse within 24 hours of her visit. This improves diagnostic accuracy by minimizing disruptions in the vaginal ecosystem potentially caused by these factors.

ESTABLISHING RAPPORT

It is important to establish and maintain effective rapport with patients and to incorporate various approaches to facilitate this process. This begins by introducing yourself to each patient by your full name and clearly stating your professional title, nurse practitioner.

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Other strategies to help establish rapport include the following:

**Professional Image**

Dress professionally and wear a nametag in a visible location on your lab coat, scrubs, or clothing. Your nametag should be clearly visible. Some clinicians opt not to wear a lab coat; if you choose to wear street clothes, these should be appropriate to your setting, community, and patient population; always clean and wrinkle free; and communicate a professional image.

**The Initial Conversation**

Help the patient feel comfortable by asking about her occupation and family and how her day is going. At first glance this may seem like small talk, but it provides both the patient and the clinician with useful information and helps transition into the reason for the patient’s visit. This initial conversation helps establish rapport, breaks the ice, and sets the tone for the visit and relationship.

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*FAST FACTS in a NUTSHELL*

Always shake the patient’s hand (perhaps not during “flu season”). This establishes physical contact, respect, friendliness, and equality. This is the first opportunity for body contact (a gradual approach is good) and is an important component of the gynecologic examination.
Communicate About the Role of the Nurse Practitioner

Ask if the woman has seen a nurse practitioner before; this can create an opportunity to educate the patient about nurse practitioners, including discussion about your particular specialty, position in the practice, experience, and expertise. You might want to discuss how patients can address you, for example, Mrs. Secor or Ms. Secor or by first name, Mimi. You can also ask the patient, particularly if she is older than you, how she would like to be addressed, by first name or by marital status and last name.

Use Humor

Use appropriate humor to help the patient relax. For example, saying something like, “Men don’t know what courage is; it’s making a gyn exam appointment and keeping it!” This helps create a moment of levity and bonding. Do, however, avoid inappropriate humor.

INTRODUCTION TO DOCUMENTING THE GYNECOLOGIC EXAM

The Electronic Medical Record (EMR)

Advantages of using an EMR includes enhanced accuracy of documentation and greater opportunity for patients to participate in and negotiate the specific data that are recorded (medicolegal implications). Also, when the clinician becomes proficient, EMR use can actually improve efficiency.

When using EMRs during the interview, position the computer to facilitate optimal eye contact with the patient.
and to promote ergonomic comfort for both the patient and clinician. Inform the patient that it may be necessary to periodically interrupt the conversation to accurately record findings during the visit. This requires a certain level of proficiency; otherwise, the patient may feel that the clinician is not fully listening to her. Predesigned EMR templates facilitate communications, provide a systematic structure for the work-up, ensure inclusion of the key elements of the assessment, and potentially save time.

Examples of documenting a gynecologic exam visit are provided in sections throughout the next few chapters, as the gynecologic exam is described.

**FAST FACTS in a NUTSHELL**

Documenting as you progress through the patient visit increases accuracy of data reporting and improves proficiency of EMR use.

**INTRODUCTION TO CONDUCTING THE MEDICAL INTERVIEW**

Conduct the initial interview in a private location, with the patient fully clothed, and with both you and the patient sitting in relatively close proximity. Inform the patient that the conversation and care are confidential per the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and that questions you ask are for the purpose of helping to provide the highest quality individualized care, including diagnosis and management of the patient’s problems. Note the general appearance of the patient as you conduct the interview and prepare to examine the patient.

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Obtain the General Medical History

Elicit a general medical history, being careful to include the following elements:

- Current medical history, including review of systems (ROS)
- Past medical and surgical history
- Family history
- Allergies to medications
- Medications, including nonprescription and over-the-counter; herbs; homeopathics; and supplements
- Health maintenance, such as last Pap smear, mammogram, colonoscopy, bone density, etc.
- Vaccination status
- Social history
  - Occupation, work, home, family, friend network, spiritual base, leisure activities
  - Smoking, alcohol use, recreational drug use
  - Exercise, sleep, stress, diet, nutritional status
  - Abuse history
  - Safe sex practices
  - Distracted driving, seat belts

Obtain the Gynecologic History

Begin the gynecologic history by asking about related problems and taking a detailed history of these problems. The menstrual history includes the following elements:

- Age of menarche
- Cycle interval (approximately 28 days)
- Duration and amount of flow
- Date (first day) of last menstrual period (LMP)
- Associated menstrual symptoms
  - Recent changes in menses
  - Premenstrual symptoms
• Menorrhagia
• Dysmenorrhea (onset, duration, self-management)
• Late or lighter menses (suspect pregnancy) and associated pregnancy symptoms
• History of unprotected intercourse since LMP (must rule out pregnancy)

**FAST FACTS in a NUTSHELL**

If the patient reports unprotected intercourse, inconsistent use of birth control, or a later, lighter menses, you must rule out pregnancy. This is especially important if the patient is complaining of pregnancy symptoms, such as breast tenderness, urinary frequency, and/or nausea.

Ask the patient about menstrual history since menarche, being careful to obtain details about the occurrence of:

• Amenorrhea
• Oligomenorrhea
• Pregnancy
• Irregular or abnormal vaginal bleeding (ABV); formerly known as dysfunctional uterine bleeding (DUB)
• Spotting

**FAST FACTS in a NUTSHELL**

• A history of irregular menses since menarche, especially if there is significant irregularity (skipping months numerous times over one or more years), should prompt you to consider polycystic ovarian syndrome (PCOS).
• Significant dysmenorrhea and dyspareunia over months and/or years may suggest endometriosis or pelvic inflammatory disease (PID).
Obtain Sexual History

Sexual history is a key component of a gynecologic history. How you ask questions and create an environment conducive to disclosure are both critically important factors in taking a sexual history. As a clinician you must help patients feel comfortable discussing their sexuality. Also, you need to take care in avoiding a heterosexual bias.

- Ask about past and current sexual activity.
- Note age of first intercourse, also referred to as “coitarche.”
- Estimate the total number of sexual partners the patient has been involved with (including genders and percent of condom use). This information helps you as the clinician to evaluate the patient’s risk for cervical cancer and other sexually transmitted infections (STIs).
- If the patient is currently sexually active, ask if her partner is male or female, if she has more than one partner, and if the patient and/or her partners are having sex with men, women, or both.
- Note the duration of the current relationship, along with the date of last intercourse, or sexual relations.
- Ask if the relationship is monogamous; this is critical, as this information helps you to assess STI risk and the need for STI testing.
- Even though the patient may not currently have a sexual partner, she may still be sexually active; ask about utilization of sex toys or other forms of self-stimulation, including masturbation.
- Ask about specific sexual practices, including a history of penile/vaginal intercourse, oral/genital receptive sex, and/or anal receptive intercourse.
- Ask about condom use and estimate the percent of condom use; both are critical to assessing STI and pregnancy risk.
• Elicit and note past or current history of STIs, including both the type and dates of infections, treatment (if known), and any complications or sequelae such as chronic pelvic pain or infertility.
• Ascertain the date when the patient was last tested for STIs, including specific tests and the results. If the patient has current symptoms of a possible STI or vaginitis, elicit a history of present illness, including chief complaint, symptoms, and associated symptoms.

Pap Smear History

Obtain the patient’s Pap smear history, as this is critical when evaluating current and past Pap smear results and is important when determining appropriate frequency of screening intervals.

• Ask for date of most recent Pap smear and the results.
• Obtain patient report of abnormal Pap smears in the past, including the dates, any follow-up such as colposcopy and biopsies, and follow-up Pap results.
• Follow the new cervical cancer screening guidelines that recommend the first Pap smear test be conducted at age 21, every 3 years until age 30, then every 5 years.
• Advise patients that they may consider discontinuing Pap screenings after age 65.

History of Urinary Tract Infections

Elicit a history of urinary tract infections (UTIs), including current symptoms, past infections, total number of infections, history of genitourinary surgery or diagnostic tests such as cystoscopy, or urodynamic testing. Asking about a history of
urinary tract symptoms or infections is an important part of the gynecologic history because these problems may be associated with gynecologic conditions such as vaginitis or STIs such as genital herpes. UTIs may also be caused by or aggravated by intercourse and/or atrophic vaginitis.

**Contraceptive History**

Taking a comprehensive contraceptive history is also a key component of the gynecologic history. Include questions about:

- The patient’s current contraceptive method, if any
- Level of satisfaction with the method
- Compliance with the method
- Side effects experienced
- Elicit patient questions/concerns about current method
- Ask about past methods used and level of satisfaction or problems associated with these methods
- Unplanned pregnancies, complications, side effects, and other patient concerns

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**FAST FACTS in a NUTSHELL**

A personal or family history, especially of cardiovascular problems, stroke, migraines with aura, or coagulopathies, is important to elicit, especially if the patient is considering combination contraceptives.

**ASSESS VITAL SIGNS**

Assess specific vital signs based on the reason for the visit and the nature of the patient complaint and clinical problem. If the patient has presented for a well-woman exam, it is reasonable
and appropriate to assess full vital signs, including blood pressure, heart rate, weight, body mass index, and height. If a patient has presented for a problem such as vaginitis, it may not be necessary or appropriate to assess full vital signs. However, whenever a patient complains of fever, significant abdominal pain, malaise, or urinary tract symptoms, it is appropriate and essential to assess temperature, blood pressure, and heart rate as well. During this part of the patient interview, you will begin to determine exam components to perform based on the patient’s vital signs.

**Patient Weight**

Assess the patient’s weight during a well-woman visit and when indicated based on history. If you note or the patient reports a significant change, assessing weight is even more important. During any visit, patients may ask to have their weight checked regardless of the type of visit, problem based or a periodic well-woman visit.

**Vital Signs**

1. Assess blood pressure when the woman reports any or all of the following symptoms:
   - Significant abdominal pain
   - Abnormal vaginal bleeding
   - Dizziness
   - Weakness

Promptly assess the patient’s blood pressure if you suspect PID, tubal pregnancy, or abnormal vaginal bleeding, or if the patient appears pale, weak, disoriented, diaphoretic, septic, or very ill or in significant pain. Include assessment of heart rate and respiratory rate in each of these clinical situations.
2. Assess heart and respiratory rates:
   • As part of a well-woman exam
   • During problem visits as indicated
   • If the patient appears ill or has constitutional symptoms, or you suspect a significant infection, assessing heart rate is appropriate
   • If the patient reports heart or respiratory problems or complaints

3. Assess the patient’s temperature in any of the following clinical situations:
   • Urinary tract symptoms
   • Abdominal pain, especially lower or flank areas
   • Pain with intercourse
   • Vaginal discharge or vaginitis complaints
   • Abnormal vaginal bleeding, irregular or heavy menses

**FAST FACTS in a NUTSHELL**

Assess the patient’s temperature after the gynecologic exam, especially if you suspect PID even with only mild tenderness on examination of the uterus and/or adnexal area.

Performing additional non–gynecologic examination components is determined by the purpose of visit, patient’s complaints, problems, and findings from other aspects of the physical exam performed thus far.

**TRANSITIONING TO CONDUCTING THE GYNECOLOGIC EXAM**

On completion of the patient interview and obtaining the patient’s gynecologic and sexual history, you’ll begin to transition to the actual gynecologic exam. Ask the patient to empty
her bladder before the examination and collect a urine sample for testing, if indicated. Testing may include a urine dipstick screen, urinalysis, culture, pregnancy test, and STI testing.

In general, conduct the nongynecologic aspects of the physical exam before the gynecologic exam. This helps the patient become comfortable with the clinician. When conducting the physical examination, we recommend a head-to-toe sequence. There may be exceptions in which the clinician and/or the patient prefers to proceed to the gynecologic exam, such as a history of vulvovaginitis, extreme anxiety, sexual abuse, patient requests, or other specific considerations. We will discuss these special situations in more detail in Part II.