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CHAPTER 1

Well Woman Care

Serving as both specialist and primary care provider, gynecologists provide patient screening, emphasize ideal health behaviors, and coordinate appropriate consultation for care beyond their scope of practice. Various organizations provide regularly updated preventive care recommendations. Guidelines commonly accessed are those from the American College of Obstetricians and Gynecologists (ACOG), Centers for Disease Control and Prevention (CDC), U.S. Preventive Services Task Force (USPSTF), and American Cancer Society.

MEDICAL HISTORY

During a comprehensive well woman visit, patients are first queried regarding new or ongoing illness. To assist with evaluation, complete medical, social, surgical, and family histories are obtained. Specific gynecologic topics usually cover current and prior contraceptives; results from prior sexually transmitted disease (STD) testing, cervical cancer screening, or other gynecologic tests; sexual history, described in Chapter 3 (p. 63); and menstrual history, outlined in Chapter 8 (p. 182). Obstetric questions chronicle circumstances around deliveries, losses, or complications. Screening for intimate partner violence (p. 24) or depression is also completed (p. 19). Discussion might also assess the patient's support system and any cultural or spiritual beliefs that might affect her general health care. Last, a review of systems, whether performed by the clinician or office staff, can add clarity to new patient problems.

PHYSICAL EXAMINATION

Breast Examination

Many women present to their gynecologist with complaints specific to the breast or pelvis. Accordingly, these are often areas of increased focus, and their evaluation is described here.

Self breast examination (SBE) is an examination performed by the patient herself to detect abnormalities. In contrast, clinical breast examination (CBE) is completed by a health care professional and may identify a small portion of breast malignancies not detected with mammography. In addition, CBE may identify cancer in young women, who are not typical candidates for mammography (McDonald, 2004). Overall, however, studies show that SBE and CBE raise diagnostic testing rates for ultimately benign breast disease and are ineffective in lowering breast cancer mortality rates (Kösters, 2008; Thomas, 2002). Accordingly, several organizations have removed SBE and CBE from their recommended screening practices (Oeffinger, 2015; Siu, 2016). However, the American College of Obstetricians and Gynecologists (2017b) encourages breast self-awareness, which focuses on breast appearance and architecture and may include SBE. It also recommends that women receive a CBE every 1 to 3 years between ages 20 and 39. At age 40, CBE is completed annually. Specific mammography guidelines are listed in Chapter 13 (p. 293).

During CBE, the breasts are initially viewed as a woman sits on the table's edge with hands placed at her hips and with pectoralis muscles flexed. Alone, this position enhances asymmetry. Additional arm positions, such as placing arms above the head, do not add vital information. Breast skin is inspected for breast erythema; retraction; scaling, especially over the nipple; and edema, which is termed peau d'orange change. The breast and axilla are also observed for contour symmetry.

Following inspection, axillary, supraclavicular, and infraclavicular lymph nodes are palpated most easily with a woman seated and her arm supported by the examiner (Fig. 1-1). The axilla is bounded by the pectoralis major muscle ventrally and the latissimus dorsi muscle dorsally. Lymph nodes are detected as the examiner's hand glides from high to low in the axilla and momentarily compresses nodes against the lateral chest wall. In a thin patient, one or more normal, mobile lymph nodes less

FIGURE 1-1 One method of axillary lymph node palpation. Finger tips extend to the axillary apex and compress tissue against the chest wall in the rolling fashion shown in Figure 1-2. The patient's arm is supported by the examiner.

than 1 cm in diameter may commonly be appreciated. The first lymph node to become involved with breast cancer metastasis (the sentinel node) is nearly always located just behind the midportion of the pectoralis major muscle belly.

Breast palpation is completed with a woman supine and with one hand above her head to stretch breast tissue across the chest wall. Examination includes breast tissue bounded by the clavicle, sternal border, inframammary crease, and midaxillary line. Breast palpation within this pentagonal area is approached in a linear fashion. Technique uses the finger pads in a continuous rolling, gliding, circular motion (Fig. 1-2). At each palpation point, tissue is assessed both superficially and deeply.

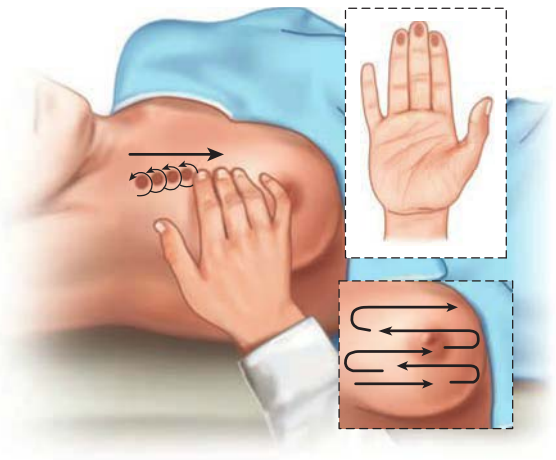

FIGURE 1-2 Recommended patient positioning and palpation technique. One inset shows the path of palpation. The other illustrates use of finger pads and a circular rolling motion to palpate the entire breast.

During CBE, intentional attempts at nipple discharge expression are not required unless a *spontaneous* discharge has been described by the patient.

If abnormal breast findings are noted, they are described by their location in the right or left breast, clock position, distance from the areola, and size. Evaluation and treatment of breast and nipple diseases are described in Chapter 13 (p. 280).

During examination, patients are educated that new axillary or breast masses, noncyclic breast pain, spontaneous nipple discharge, new nipple inversion, and breast skin changes such as dimpling, scaling, ulceration, edema, or erythema should prompt evaluation. This constitutes breast self-awareness. Patients who desire to perform SBE are counseled on its benefits, limitations, and potential harms and instructed to complete SBE the week after menses.

Pelvic Examination

Pelvic examination is typically performed with a patient supine, legs in dorsal lithotomy position, and feet resting in stirrups. The head of the bed is elevated 30 degrees to relax abdominal wall muscles for bimanual examination. A woman is assured that she may stop or pause the examination at any time. Moreover, each part of the evaluation is announced or described before its performance. Recommended STD screening is discussed prior to examination, and necessary samplers are assembled (Table 1-1).

Inguinal Lymph Nodes and Perineal Inspection

Pelvic cancers and infections may drain to the inguinal lymph nodes, and these are palpated during examination. Following this, a methodical inspection of the perineum extends from the mons pubis ventrally, to the labiocrural folds laterally, and to the anus. Notably, infections and neoplasms that involve the vulva can also involve perianal skin. Some clinicians additionally palpate for Bartholin and paraurethral gland pathology. However, in most cases, patient symptoms and asymmetry in these areas will dictate the need for this specific evaluation.

Speculum Examination

Both metal and plastic specula are available for this examination, each in various sizes to accommodate vaginal length and laxity. The plastic speculum may be equipped with a small light that provides illumination, whereas metal specula require an external light source. Preference between these two types is provider dependent.

The vagina and cervix are typically viewed after placement of either a Graves or Pederson speculum (Fig. 1-3). Prior to insertion, a speculum may be warmed with running water or by warming lights built into some examination tables. In addition, lubrication may add comfort to insertion. Gel lubricants do not raise unsatisfactory Pap smear cytology rates or decrease *Chlamydia trachomatis* detection rates compared with water (Griffith, 2005). If gel lubrication is used, a dime-sized aliquot is applied sparingly to the outer surface of the speculum blades.

Immediately before insertion, the labia minora are gently separated, and the urethra is identified. Because of urethral sensitivity, the speculum is inserted well below the meatus. Alternatively, prior to speculum placement, an index finger may be placed in the vagina, and pressure exerted against the

TABLE 1-1. Sexually Transmitted Disease Screening Guidelines for Nonpregnant, Sexually Active Asymptomatic Women

Infectious Agent	Screening Recommendations	Risk Factors
C trachomatis + *N gonorrhoeae*	All ≤24 yr; those older with risks Timing: annually or if new or persistent factors since last negative result	New or multiple partners; partner with STD or multiple partners; inconsistent condom use; sex work; current or prior STD
T pallidum	Those with risks	Sex work; incarceration; HIV; high local prevalence
HIV virus	All aged 13–64 yrs: one time[a] Those with risks: periodically	Multiple partners; injection drug use; sex work; concurrent STD; MSM; at-risk partners; initial TB diagnosis
HCV	All aged 18–79 yrs: one time Those with risk factors: periodically	Injection/intranasal drug use; dialysis; infected mother; blood products before 1992; unregulated tattoo; high-risk sexual behavior
HBV	Those with risk factors	HIV; injection drug use; affected family or partner; multiple partners; high-prevalence country of origin[b]
HSV	No routine screening	

[a]Centers for Disease Control and Prevention (2015) and American College of Obstetricians and Gynecologists (2017d) recommend one-time screening between ages 13 and 64 years. The U.S. Preventive Services Task Force uses a 15–65 yr age range.
[b]Regions of the world with high or intermediate prevalence of include much of Eastern Europe, Asia, Africa, the Middle East, and the Pacific Islands.
C trachomatis = *Chlamydia trachomatis*; HBV = hepatitis B virus; HCV = hepatitis C virus; HIV = human immunodeficiency virus; HSV = herpes simplex virus; MSM = men having sex with men; *N gonorrhoeae* = *Neisseria gonorrhoeae*; STD = sexually transmitted disease; TB = tuberculosis; *T pallidum* = *Treponema pallidum*.
Compiled from those above and Centers for Disease Control and Prevention, 2015; LeFevre, 2014a,b; Moyer, 2013a,b; U.S. Preventive Services Task Force, 2016c,d, 2019.

posterior wall. A woman is then encouraged to relax this wall to improve comfort with speculum insertion. This practice may prove especially helpful for women undergoing their first examination and for those with infrequent coitus, dyspareunia, or heightened anxiety.

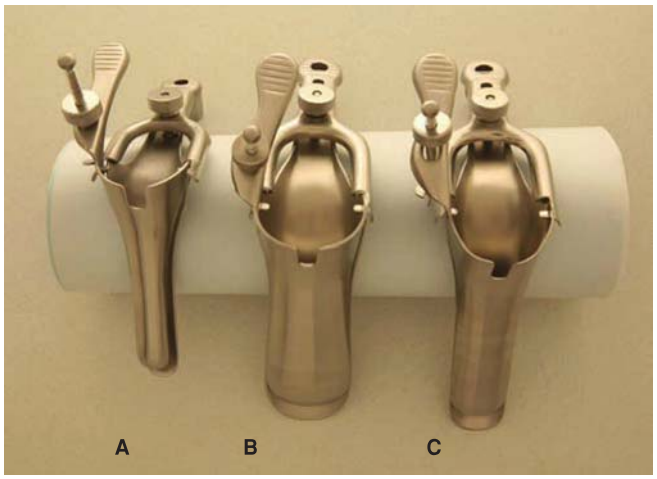

FIGURE 1-3 Vaginal specula. **A.** Pediatric Pederson speculum. This may be selected for child, adolescent, or virginal adult examination. **B.** Graves speculum. This may be selected for examination of parous women with relaxed or collapsing vaginal walls. **C.** Pederson speculum. This may be selected for sexually active women with adequate vaginal wall tone. (Reproduced with permission from US Surgitech, Inc.)

With speculum insertion, the vagina commonly contracts, and a woman may note pressure or discomfort. A pause at this point typically is followed by vaginal muscle relaxation. As the speculum bill is completely inserted, it is angled approximately 30 degrees downward to reach the cervix. Commonly, the uterus is anteverted, and the ectocervix lies against the posterior vaginal wall.

As the speculum is opened, the ectocervix can be identified. Vaginal walls and cervix are inspected for masses, ulceration, or unusual discharge. As outlined in Chapter 29 (p. 630), cervical cancer screening is often completed. Additional swabs for STD screening, culture, or microscopic evaluation can be collected as needed.

Bimanual Examination

Most often, the bimanual examination is performed after the speculum evaluation. Some clinicians prefer to complete the bimanual portion first to better identify cervical location prior to speculum insertion. Either process is appropriate. Uterine and adnexal size, mobility, and tenderness can be assessed during this examination. For women with prior hysterectomy and adnexectomy, bimanual examination is still valuable and can be used to exclude other pelvic pathology.

To begin, a gloved index and middle finger are inserted together into the vagina until the cervix is reached. To ease insertion, a water-based lubricant can be initially applied to these gloved fingers. Once the cervix is reached, uterine orientation can be quickly assessed by sweeping the index finger inward along the

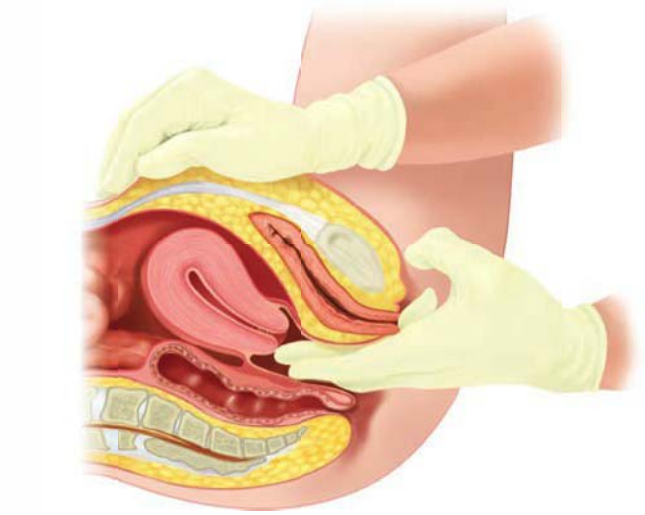

FIGURE 1-4 Bimanual examination. Fingers beneath the cervix lift the uterus toward the anterior abdominal wall. A hand placed on the abdomen detects upward pressure from the uterine fundus. Examination allows assessment of uterine size, mobility, and tenderness.

anterior surface of the cervix. In those with an anteverted position, the uterine isthmus is noted to sweep upward, whereas in those with a retroverted position, a soft bladder is palpated. However, in those with a retroverted uterus, if a finger is swept along the cervix's posterior aspect, the isthmus is felt to sweep downward. With a retroverted uterus, this same finger is continued posteriorly to the fundus and then side-to-side to assess uterine size and tenderness.

To determine the size of an anteverted uterus, fingers are placed beneath the cervix, and upward pressure tilts the fundus toward the anterior abdominal wall. A clinician's opposite hand is placed against the abdominal wall to locate the upward fundal pressure (Fig. 1-4).

To assess adnexa, the clinician uses two vaginal fingers to lift the adnexa from the posterior cul-de-sac or from the ovarian fossa toward the anterior abdominal wall. The adnexum is trapped between these vaginal fingers and the clinician's other hand, which is exerting downward pressure against the lower abdomen. For those with a normal-sized uterus, this abdominal hand is typically best placed just above the inguinal ligament.

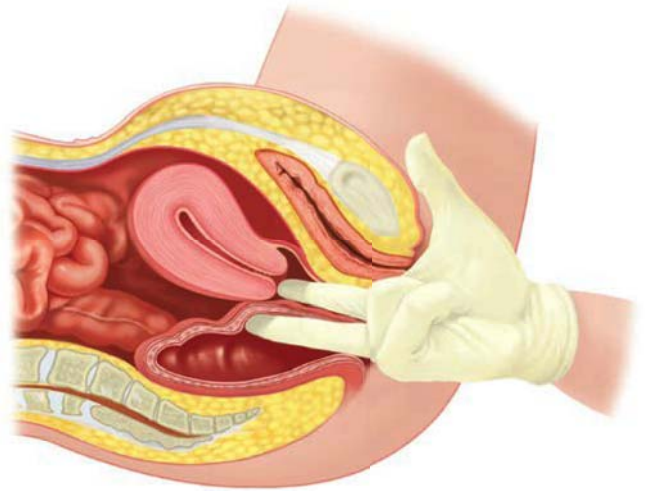

FIGURE 1-5 Rectovaginal examination.

Rectovaginal Examination

The decision to perform rectovaginal evaluation varies among providers. Some prefer to complete this evaluation on all adults, whereas others elect to perform rectovaginal examination for those with specific indications. These may include pelvic pain, an identified pelvic mass, rectal symptoms, or risks for colon cancer.

Gloves are changed between bimanual and rectovaginal examinations to avoid contamination of the rectum with potential vaginal pathogens. Initially, an index finger is placed into the vagina and a middle finger into the rectum (Fig. 1-5). These fingers are swept against one another in a scissoring fashion to assess the rectovaginal septum for scarring or peritoneal studding. The index finger is removed, and the middle finger completes a circular sweep of the rectal vault to exclude masses. If immediate diagnostic fecal occult blood testing is indicated, it may be performed with a sample from this portion of the examination. As noted later, this single fecal occult blood testing does not constitute adequate colorectal cancer screening.

Examination Interval

An initial reproductive health visit is recommended between ages 13 and 15 years (American College of Obstetricians and Gynecologists, 2016b). This visit initiates discussion between an adolescent and health care provider on issues of puberty, menstruation, contraception, and STD protection. Although not mandated, a pelvic examination may be necessary if gynecologic symptoms are described.

For women older than 21, the American College of Obstetricians and Gynecologists (2016c) recommends annual well woman visits for examination, screening, counseling, and immunizations based on age and risk factors. In many cases, physical examination includes a pelvic examination to assess specific symptoms or to complete cervical cancer or STD screening. However, outside these indications, the American College of Physicians, the American Academy of Family Physicians (2017), and USPSTF (2017) recommend against screening pelvic examination for asymptomatic, nonpregnant, adult women. They cite potential harms that include discomfort, anxiety, and overtreatment (Qaseem, 2014). In contrast, potential benefits are early detection of dermatologic changes or of vulvar or vaginal cancer. Thus, the American College of Obstetricians and Gynecologists (2018b) recommends a patient-provider discussion of the benefits and risks of pelvic examination in the asymptomatic, nonpregnant, adult woman who does not require genital screening.

Care of the Transgender Patient

"Transgender" refers to individuals whose gender identity, expression, and behavior differ from those typically associated with their gender assigned at birth (World Professional