The following is a summary of the principles and procedures of the female breast and pelvic exam. Its focus is to place emphasis on building a trusting provider-patient relationship. The guide was written by medical students in collaboration with Dr. Nadine Katz, Director of Undergraduate Medical Education in the Department of Obstetrics & Gynecology and Women’s Health of the Albert Einstein College of Medicine. For complete technique, clinicopathology, and images, please refer to relevant chapters in *Textbook of Physical Diagnosis* by Swartz or *Current Obstetric and Gynecologic Diagnosis and Treatment*, edited by DeCherney and Nathan. For a definitive discussion, see *Obstetrics and Gynecology* by Beckmann *et al.* Bear in mind that many experienced practitioners have some variation in technique that may deviate from this or other instructions.

**Language and Communication**

The complete medical, obstetrical, and gynecological history should be taken while you and the patient are both seated in chairs, facing each other at an equal eye level. When you start to talk to the patient, she should be fully clothed. You should make sure that you not wearing gloves. Minimize the time the patient spends in a gown and on the examination table. Throughout the exam, keep the patient informed of what you are doing. This means telling her what you are going to do before doing it. Since you do not need to wait for a response, this should not lengthen the time of your exam.

If this is the patient’s first visit to the gynecology clinic, the counseling time may need to be longer. You should ask your patients, especially adolescents, if this is the first visit. If so, the use of models may be very helpful. Specifically, show the patient what her anatomy looks like on the inside and outside. Explain where each organ is and what it does. Show her the speculum. Demonstrate its operation and explain which parts will be placed in her vagina. Offer her the speculum for inspection. Explain each component of the examination at this time and answer all of her questions.

This is also an opportunity to educate your patient about HPV, genital warts, and the HPV vaccine.

**Tip:** How to explain anatomy during a patient’s first visit to the gynecologist:
1. The cervix is the bottom of the uterus and is what opens when it is time to have a baby. It becomes “fully dilated” when the baby is delivered.
2. The uterus is where the baby grows.
3. The ovaries make your hormones and make the eggs that can become fertilized to make babies.

**Tip:** As a physical demonstration, considering making a fist with your hand. Equate this circle with the patient’s vagina and with your other hand, show her how the speculum will be placed in a diagonal fashion into the vagina.

**Tip:** Med students are trained to think about disease. In contrast, patients are interested in health. Instead of “this is an important test to check for cancer,” consider “this is an important test to make sure everything is healthy and normal.”

<table>
<thead>
<tr>
<th>Words to Avoid</th>
<th>Words to Use Instead</th>
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<tbody>
<tr>
<td>touch, feel</td>
<td>palpate, examine, check</td>
</tr>
<tr>
<td>check for cancer,</td>
<td>make sure everything</td>
</tr>
<tr>
<td>check for any problems</td>
<td>is healthy, normal</td>
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<tr>
<td>tighten the screw</td>
<td>adjust the speculum</td>
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<tr>
<td>large/small breasts, flat-chested</td>
<td>more/less breast tissue, pendulous</td>
</tr>
<tr>
<td>stirrups</td>
<td>footrests or pedals</td>
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<tr>
<td>spread your legs</td>
<td>relax your legs out to the side</td>
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</table>
The phrases “bearing down” and “clamping down” are a source of confusion for medical students and patients. **Bearing down** is increasing intra-abdominal pressure to expel contents, such as during a bowel movement or delivery of a baby. **Clamping down** is a contraction of the levator ani (“Kegel”) muscles. Kegel exercises are employed to strengthen pelvic muscles to help decrease stress incontinence, loss of urine during increased intra-abdominal pressure (e.g. cough), and to help decrease uterine prolapse.

### The Breast Exam

Let your patient know that the examination will be done in both the seated and “lying down” or supine position on the examination table. Explain to her that she will feel light and deep pressure, but the examination should not cause pain.

Inform the patient that having regular breast and pelvic exams is an important part of maintaining her health. Ask her if she performs self-breast exams and how often. If a patient wishes to learn breast examination techniques, counsel her that if she detects a change or feels an abnormal mass, this may warrant further evaluation. Use this time as an opportunity for teaching or refreshing this skill of breast examination, which should ideally be done 4-5 days after the first day of her period. Consider having the patient demonstrate how she performs a self-breast exam.

**Tip:** Remember that no matter how nervous you may be, your patient is relying on you to take care of her. Take time to make sure she is comfortable. Ask her if she has any questions. Remind her and yourself to breathe and relax.

#### When the Patient is in the Seated Position

1. Inspect for symmetry (patient’s arms at sides).
2. Inspect position of nipples, coloration, and presence of dimpling.
3. Inspect for symmetry (hands on ribs, press to flex pectoral muscles).
4. Consider whether you will be using gloves for the axillary exam. Palpation: place pads of fingers high in the axilla and palpate anterior, medial, posterior, and lateral boundaries of the axilla.

#### When the Patient is in the Supine Position

1. Ask patient to place her arm over her head. Support the scapula with a towel. Explain your preferred exam technique to the patient so that she can follow the steps you perform while doing her monthly self-exams.

   A. Start from the axillary tail of the breast; work in an inwardly spiraling path to palpate all regions of breast tissue under both light and firm pressure. Alternatively, begin at the outer perimeter of the breast and work inward toward the nipple in a straight line, covering the entire breast like the spokes of a wheel.

   B. Palpate the areola around the nipple for masses beneath.

   C. Ask the patient if she can express any discharge from the nipple.

**Tip:** After symmetry is assessed (#3), consider exposing only one breast at a time for palpation. Use an additional gown or sheet as a drape.

**Tip:** When inspecting lateral lymph nodes, palpate all the way to the middle of the humerus.

**Tip:** Don’t forget to inform your patient about the lack of conclusive data about breast exams and reassure her that if she is not comfortable doing self-examination that it is not a problem.

Monthly breast examinations have not been demonstrated to improve morbidity or mortality. These examinations may increase anxiety and increase the number of imaging tests done for concerns about "lumps or bumps" that may actually be normal tissue. Some patients, however, feel empowered by participating in their own care.

**Tip:** Explain that the rationale for the arm position is to evenly spread breast tissue over the chest, improving palpation.

**Tip:** Avoid rubbing the nipple as you palpate breast tissue by constantly adjusting the angle of your wrist as you circle around the breast.
The Pelvic Exam

**Preparation.** The patient should empty her bladder prior to the exam. You have already determined, based on your initial interview, if she has ever had a pelvic exam and speculum examination in the past. Introduce her to everyone in the room (your supervising physician and/or female chaperone) and explain why they are there. **Be sure** to inform her that you will be talking during the exam in order to ensure that she knows what will take place. Offer the patient a hand mirror that she may use during the inspection portion of the exam. Ask if she has any questions and assure her that she may ask questions at any time during the exam. Remind the patient that she may experience discomfort or pressure, but that the exam should not be painful, and to let you know if she experiences pain.

**Position.** Ask the patient to place her heels in the footrests, to relax her legs to the side or to the walls, and bring her hips to the edge of the table. Place your hands against the edge of the table with the palms of your hands facing away from her and instruct her to slide down until she feels the backs of your hands. Next, position the drape so that you have a clear view of the area to be examined. Use a drape on the patient’s lap to minimize exposure. Gauge or ask your patient’s comfort level and desire for participation.

**Inspection.** Allow her to watch, if she chooses, as you point out: labia majora, labia minora, urethra, clitoral hood and clitoris, vagina, and rectum.

Notice the Bartholin’s glands at 4 and 8 o’clock. Tell the patient you are going to place your fingers on them. Use two fingers to express any discharge from the glands.

**Speculum Exam.** Use a speculum lubricated with warm water or lubricant.

1. Inform the patient that you will begin the next part of the exam. Use your non-dominant hand to spread the labia and gently place the bills of the speculum at the vaginal opening. Tell her that she may have a cold and wet sensation from the water or gel lubricant. Also, tell her that she may experience some pressure in the back of the vagina as the speculum is placed.

**Tip:** Hand your patient a sample speculum to examine before beginning the pelvic exam. It may not be obvious to your patient that only the smooth bill (and not the sharp, bulky handle) will be inserted into her vagina.

**Tip:** Whether lubricant affects the quality of cervical cytology is still in question; follow the guidelines of your local clinic.

**Tip:** Take the time to become familiar with the differences in manipulating a metal or a plastic speculum before you begin the examination.

**Tip:** Before inserting the speculum into the vagina, some practitioners separate the labia with thumb and ring finger.
2. Inform the patient that you are going to insert the speculum. Insert the closed bills of the speculum diagonally. As the speculum is inserted, turn the bills horizontally and move the bills of the speculum into the posterior fornix. Note that some cervices are in the anterior position. Do not be frustrated if you cannot find the cervix on your first placement of the speculum. Women who have had prior surgeries or who are obese may have more difficult examinations. It will take time to find the proper positioning. Be patient.

3. Open the speculum bills and locate the cervix. Then, secure the fastening apparatus. Reassure the patient. Tell her she may feel pressure in the vagina and possibly on the bladder.

4. Inspect the cervix for erythema, discoloration, erosion, or masses. Note if there is discharge or bleeding and determine if it is coming from the os. If there is a large amount of discharge, use a large swab to clean the cervix for better visualization. If the discharge has a yellow or green color or has a foul, fishy odor, consider taking a swab for further evaluation.

5. Pap smear and Gonococcus/Chlamydia Trachomatis (GC/CT) screening. During these procedures, some women experience a “pinch” or “pressure” or “cramping.” Try to make your patient aware of this beforehand to ease her level or anxiety. There are a variety of commercially available testing methods for these tests. Before performing the examinations, you should familiarize yourself with kits and sampling devices available at your clinical site by reading package inserts and consulting with your supervisors.

Tip: The anterior surface of the vaginal canal is much more sensitive than its posterior surface. When inserting and removing fingers or instruments, maintain downward pressure parallel to the floor. Be sure the downward pressure is even from the tip of the finger or speculum to the base.

Tip: Throughout the speculum exam, do not rest your thumb on the speculum’s lever. The lever will, by definition, transmit small movements of your thumb into large movements of the bill.

Tip: If you do not locate the cervix initially, you can remove the speculum and palpate the cervix (see below) to get a sense of where it is, and then re-insert the speculum. On re-insertion, try to maneuver the bills of the speculum in the direction you palpated the cervix.

Tip: As liquid-based Pap, HPV DNA testing, and the HPV vaccine are evaluated, guidelines for screening, prevention, and management of cervical cancer may change in the coming years. For reviews on these topics, see:

The Bimanual Exam. This exam is done with two lubricated gloved fingers of your dominant hand inserted into the vagina and the other hand on the lower abdomen.

1. Insert two fingers, face down, into the vagina and above the cervix. They are now in the anterior fornix. Palpate the cervix and check for cervical motion tenderness as you rotate your fingers around it one half turn. Your fingers should now be facing up in the posterior fornix. Cervical motion tenderness or adnexal tenderness require further evaluation.

Tip: Before inserting index and middle finger into the vagina, some practitioners separate the labia with thumb and ring finger.

Tip: When inserting two fingers into the vagina, you may cross one over the other and separate them once inserted in the vagina.
2. Use your two fingers to apply upward pressure on the cervix.

3. With your internal fingers on the cervix, use your non-dominant hand to apply pressure to the abdomen; medially for the body of the uterus and then laterally for each ovary. During this process your goals are to note the position (anterior vs. posterior vs. lateral), flexion (anteverted or retroverted), size of the uterus and of the ovaries, and to elicit adnexal tenderness and fullness. Tenderness or fullness may warrant further evaluation.

4. While withdrawing the examining fingers, ask the patient to bear down for a few seconds. Observe anteriorly for cystocele and posteriorly for rectocele.

**The Rectovaginal Exam** – Remove your glove and use a clean one. This exam is also done with two lubricated fingers inserted internally and your external hand on the lower abdomen. The 3rd digit will be inserted into the rectum, while the index finger will be in the posterior fornix. Inform the patient what will be happening during this part of the examination.

1. Press with the pad of your 3rd finger on the outside of the anus briefly. Ask the patient to bear down and then insert the 3rd finger into the rectum with an anterior arching motion. Simultaneously, the index finger is inserted into the vagina. Let the patient know that although it may feel like she is having a bowel movement, she is not.

2. As in the bimanual exam, using your index finger, press up on the cervix. Again, you will use your non-dominant hand to apply sweeping pressure to the abdomen to facilitate palpation of the uterus and ovaries.

3. Notice the width of the rectovaginal septum between your two inserted fingers.

4. Use the 3rd finger to palpate the posterior wall of the rectum. Assess for masses and growths such as hemorrhoids.

5. If indicated based on age and symptoms, when you withdraw your finger from the rectum, rub your gloved finger on a guaiac card and perform an occult stool test with the developing drops.

**Tip:** Do not be discouraged if you cannot palpate the ovaries; it takes time and practice. Even the most experienced physicians have difficulty palpating ovaries, so do not be discouraged at first. Also in obese patients, examination of the uterus and ovaries may be difficult.

**Tip:** Focus your attention on palpating with the internal examining hand. The outer hand is used to bring the uterus and ovaries into position so that they can be palpated. Do not repetitively “dig” with the outer hand, as this can be uncomfortable for the patient.

**Tip:** Be gentle, but fully insert your fingers. The webbing between your two fingers should meet the perineum.

**Tip:** A retroverted uterus may be more easily palpated on rectovaginal exam.

**Tip:** Pay particular attention to the Cul-de-sac or Pouch of Douglas (rectouterine pouch), as this is a common location of thickening or masses.

**Tip:** As you withdraw your fingers from the vagina and rectum, use the edge of the exam table to conceal the glove from the patient’s line of sight. After the guaiac test, remove the glove by turning it inside out and dispose of it properly.
Inform the patient that the exam is over and that she may get dressed. Offer her assistance to get to a seated position. Remember to lower the table to help prevent the patient from falling. Communicate with her regarding the test results and the next steps in her medical care.

**Tip:** Before you leave, hand the patient paper towels so she can clean the lubricant off of her body. Be sure to allow her to do this in private.

**Tip:** Some patients are more comfortable if you pull out the bottom edge of the exam table first. Once the patient is in a seated position, be sure to push it back in.

1. These authors contributed equally.