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FAST FACTS About the GYNECOLOGIC EXAM
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FAST FACTS About the GYNECOLOGIC EXAM

A Professional Guide for NPs, PAs, and Midwives

Second Edition

R. Mimi Secor, DNP, FNP-BC, FAANP
Heidi Collins Fantasia, PhD, RN, WHNP-BC

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Contributor

Teri Bunker, DNP, FNP
Family Nurse Practitioner
Bridge City Family Medical Clinic
Portland, Oregon
This new edition 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 explained 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.

Joellen W. Hawkins, PhD, RN, WHNP-BC

Professor Emeritus, William F. Connell School of Nursing, Boston College

Chestnut Hill, Massachusetts
Preface

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

Fast Facts About the Gynecologic Exam represents the coauthors’ more than four decades of combined clinical experience in women’s health and teaching NPs 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 the instructors/preceptors who are assisting them.

Each chapter in this book contains 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 have 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 Papanicolau 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 new edition will be a welcome resource, especially for students and their instructors.

R. Mimi Secor
Heidi Collins Fantasia
Acknowledgments

Thanks to my coauthor, Dr. Heidi Fantasia, who is a great writer and with whom it was a pleasure to work on this second edition. I am indebted to the patients I have encountered over the years. They are a source of inspiration as I continually learn so much from them. Thank you to the friends, students, and nurse practitioner colleagues for their insight, inspiration, support, and friendship. Special thanks to Dr. Joellen Hawkins, for being a dear friend and a career-long mentor, and to Teri Bunker, for writing our new chapter on care of the transgender patient. 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 Secor

Thank you to Mimi Secor for the wonderful opportunity to contribute to this project. I am forever grateful to my patients, colleagues, and coworkers, 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 mother, Gretchen Collins, my husband, John, and my children, Andrew, Amelia, and Evan.

Heidi Collins Fantasia

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Fast Facts About the Gynecologic Exam:
A Professional Guide for NPs, PAs* and Midwives
Second Edition
The bimanual exam allows the clinician to assess the vagina, cervix, uterus, and ovaries. It should be performed in a gentle but thorough manner, first palpating the vagina, then the uterus, ovaries, and, if indicated, the rectovaginal structures, and rectum last.

In this chapter, you will learn how to:

- Perform the bimanual examination for palpating the uterus and ovaries
- Perform a rectovaginal exam

The traditional approach is to perform the speculum exam prior to conducting the bimanual exam. However, some clinicians recommend conducting the bimanual exam prior to the speculum exam. Advantages to this sequence include less discomfort with the speculum exam, an opportunity to locate the cervix prior to speculum insertion, and less need for lubrication with the speculum exam.
THE BIMANUAL EXAM

The bimanual exam is conducted while standing at the foot of the examination table with the woman’s buttocks at the end of the table. Place one gloved hand on the lower abdomen just above the mid-suprapubic area and, using a small amount of lubricant, insert one, or preferably two, gloved finger(s) into the vagina. Using lubricant reduces discomfort and facilitates the exam. Begin the bimanual exam by thoroughly palpating the vagina and cervix, noting areas of tenderness or masses.

To palpate the uterus, gently apply suprapubic pressure while positioning fingertips under the cervix and gently lifting up. Assess the uterus for position (angle), size, shape, contour, mobility, and tenderness. Note any abnormal findings such as tenderness (suggesting pelvic inflammatory disease [PID]), masses (suggesting fibroids), and lack of mobility (possible endometriosis).

The position of the uterus within the pelvis varies (see Figure 5.1). An anteverted uterus is angled toward the abdomen, whereas a retroverted uterus is angled toward the tailbone and rectum. Bimanual palpation of the anteverted uterus is shown in Figure 5.2.

A normal uterus is approximately the size of a lemon or small pear, but can range somewhat in size. The uterus is normally smooth, semifirm, nontender, and mobile. If the uterus is tender, rule out PID. If the uterus is diffusely enlarged, rule out pregnancy and consider additional diagnostic testing based on the history, exam, and differential
diagnosis. If the uterus is irregular and unusually firm, suspect fibroids and confirm with transvaginal ultrasound and/or hysteroscopy (Figure 5.3).

The uterus is not always easy to palpate, especially if the woman is obese, anxious, physically disabled, or elderly. Examining these special populations is discussed in Chapter 10.
Figure 5.3  Appearance of uterine fibroids. Source: Carcio and Secor (2010).

Fast Facts in a Nutshell

If the uterus is not palpable suprapubically, it may be retroverted, or “tipped” back toward the woman’s tailbone. In this case, the uterus may be palpable only by rectovaginal exam (Figure 5.4).

Figure 5.4  Bimanual palpation of the retroverted uterus. Source: Carcio and Secor (2010).
THE ADNEXAL EXAM

Perform the adnexal exam next. During this part of the exam, the clinician will examine the ovaries, which are located lateral to the fundus of the uterus and are about the size of almonds. Assess the ovaries for size (enlarged), shape (masses), and tenderness.

To examine the ovaries (Figure 5.5):

- Move abdominal hand to either the right or left lateral lower abdomen area, just lateral to the fundus of the uterus
- Position the fingers of the vaginal hand in the vaginal fornix of the adnexal side being examined
- Apply pressure similar to that used to palpate the uterus
- Repeat this same technique on the opposite side to examine the second ovary

Ovaries normally are almond sized, nontender, and semifirm (Table 5.1); however, it is not uncommon for them not to be palpable. Endometriosis may cause the ovaries to be located behind the uterus.
Table 5.1

Assessment Findings of the Uterus and Adnexae: Normal and Abnormal

<table>
<thead>
<tr>
<th>Findings of area assessed</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uterus</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Size</td>
<td>approximate size of a lemon</td>
<td>Enlargement: may indicate pregnancy or other mass</td>
</tr>
<tr>
<td></td>
<td>Normally smooth, semifirm, nontender, and mobile</td>
<td>Tender: possible pelvic inflammatory disease (PID) or endometriosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Irregular: may suggest fibroids</td>
</tr>
<tr>
<td>Position</td>
<td>Most often anteverted, anteflexed (angled toward the abdomen)</td>
<td>Retroverted, retroflexed (angled toward the tailbone) uterus may be difficult to palpate bimanually; a rectovaginal exam may be required; may be the result of endometriosis</td>
</tr>
<tr>
<td></td>
<td>Freely movable</td>
<td></td>
</tr>
<tr>
<td><strong>Adnexae</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ovaries</td>
<td>Size: almond size</td>
<td>Enlargement: may be due to cystic enlargement, polycystic ovarian syndrome (PCOS), or tubal pregnancy; palpation will convey sense of “fullness”; may be tender; further testing is required to distinguish</td>
</tr>
<tr>
<td></td>
<td>Nontender, semifirm, and mobile</td>
<td>Endometriosis: may push ovaries to relocate behind the uterus, this position is called holding hands</td>
</tr>
<tr>
<td>Postmenopausal—usually not palpable</td>
<td></td>
<td>If palpable, consider abnormal and investigate</td>
</tr>
<tr>
<td>Fallopian tubes</td>
<td>Normal: about 5 inches in length, rubbery, half the diameter of a pencil, not palpable, and nontender</td>
<td>If palpable, consider salpingitis or an ectopic pregnancy; in rare cases, may be associated with fallopian tube cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If palpable and feel like fibrous bands, consider previous salpingitis or endometriosis</td>
</tr>
</tbody>
</table>

*Source: Adapted from Carcio and Secor (2010); Rhoads (2006).*

(referred to as *holding hands*), so they will not be palpable. Cystic enlargement of the ovaries will feel like fullness in the affected adnexal area and may be tender or nontender. A tubal pregnancy is indistinguishable clinically from an ovarian cyst, so additional testing is
urgently needed to determine the underlying etiology. This may include pelvic ultrasound, pregnancy testing, complete blood count (CBC) with differential, CA125, and a sedimentation rate. A history of unprotected intercourse and late menses increases the risk of pregnancy and the clinician’s index of suspicion.

The ovaries may be palpable without conducting a rectovaginal exam, but when they are not palpable on the vaginal bimanual exam, the rectovaginal bimanual exam may be particularly helpful (see Chapter 6).

The fallopian tubes, considered part of the adnexae (Exhibit 5.1), are not typically palpable because of their small size. They are approximately 5 inches in length, about half the diameter of a pencil, and rubbery. If palpable, consider the possibility of salpingitis or endometriosis.

References


Exhibit 5.1

Sample Documentation of the Vulvar, Speculum, and Bimanual Portions of the Gynecologic Exam

External genitalia: Normal distribution of pubic hair and normal anatomy; no masses, lesions, abnormal discharge, or tenderness

Vagina: Pink; rugat ed without bulging or lesions; scant opaque white discharge without odor; good muscle tone; vaginal pH 4.0 (normal), amine/KOH (potassium hydroxide) test negative, vaginal microscopy negative for clue cells, trichomons, yeast forms, or white blood cells (WBCs)

Cervix: Pink, smooth, no lesions, or mucopus; nontender, no cervical motion tenderness (CMT)

Uterus: Anteverted, normal size, shape, contour (NSSC), mobile, nontender, without palpable masses

Adnexae: Ovaries palpated, normal size, nontender, and no masses palpated

Rectovaginal: No lesions, masses, or fissures; nontender, small amount of brown soft stool present, guaiac test negative

Many women are anxious during gynecologic exams, but some women are extremely anxious. Sometimes a cause for the anxiety cannot be determined, but extreme anxiety can also be associated with specific events, such as a history of physical or sexual abuse. Vaginismus, or abnormal involuntary spasms of the vagina, can be a result of sexual abuse or trauma and causes increased pain and inability to tolerate a gynecologic exam. During the interviewing process, a thorough psychological, social, family, and sexual history should be obtained, noting evidence of or past history of anxiety, sexual abuse, violence, family trauma, negative gynecologic experiences, and other factors that might indicate the woman may have difficulty with gynecologic exams.

In this chapter, you will learn how to:

- Recognize behaviors that signal extreme anxiety and apply strategies to help the woman work through the pelvic exam
- Approach a pelvic exam with a woman who has a history of physical and/or sexual abuse
ANXIETY

A severely anxious woman can be very challenging to examine and make completing a pelvic exam difficult. If the woman has previously had a gynecologic exam, she should be asked about prior experiences and any difficulties she had. Women who are having their first exam should be told exactly what to expect. They may benefit from seeing the speculum, and some women may want to hold it and try opening and closing it.

Women who are extremely anxious should be talked through the entire exam so they know exactly what is happening and in what order the exam will proceed. Women should know they can ask the clinician to stop the exam at any time and that the clinician will honor the request. Proceed with the exam slowly and gently, communicating in a relaxed and unhurried manner. If the woman is known to the practice and previous exams have been difficult, allow extra time and adjust the schedule to accommodate a longer time slot for this appointment.

Encourage relaxation techniques, including deep breathing, meditation, and imagery. The woman may benefit from the presence of a support person of her choice, and, if possible, should be allowed to have this person present with her for the exam. If speculum insertion is difficult, consider asking her to bear down and breathe deeply. It may take multiple attempts to insert the speculum and complete the exam over multiple visits and sometimes many months. Palpating the cervix in advance of the speculum exam may help both the woman and the clinician. Conducting the exam patiently and allowing the woman to control the pace and content of the exam is critical to decreasing anxiety. A woman who senses that the clinician is frustrated and attempting to hurry will probably not be able to relax.

Consider short-acting antianxiety medications in a single dose with no refills if the woman has a support person who is able to drive her home after the exam. The decision to prescribe antianxiety medications should be based on her clinical history, current medications, and preferences. Practitioners should always prescribe the lowest dose possible and inform the woman that the goal is to lessen anxiety, not to eliminate it entirely. Caution should be used in women with a history of substance abuse or avoided completely if there are concerns about sobriety and/or relapse. All antianxiety medications have side effects.
of drowsiness and dizziness and women should be informed of this. See Table 8.1 for common antianxiety medications and available doses. It is often helpful to have women take the prescribed dose 30 minutes prior to the exam.

<table>
<thead>
<tr>
<th>Medication (generic and brand names)</th>
<th>Single dose (mg) prior to exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam (Ativan)</td>
<td>0.5, 1, or 2</td>
</tr>
<tr>
<td>Alprazolam (Xanax)</td>
<td>0.25, 0.5, 1, or 2</td>
</tr>
<tr>
<td>Clonazepam (Klonopin)</td>
<td>0.5, 1, or 2</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>2, 5, or 10</td>
</tr>
</tbody>
</table>

*These medications should be used with caution, especially with women who have a history of addiction, who are taking other central nervous system (CNS) depressants, or have a current or previous history of mental health issues.

Fast Facts in a Nutshell

**Documentation**

- Physiologic signs of anxiety should be documented. Examples:
  - Tachycardic, HR 94.
  - Patient diaphoretic, tense, and guarding.
- The extent to which the exam can be completed is documented. Examples:
  - Exam performed; bimanual limited by patient anxiety, unable to accurately assess uterus and ovaries.
  - Unable to insert speculum or perform bimanual exam due to anxiety and/or pain when exam attempted.

**Communication**

Women with extreme anxiety are often upset over the difficulties with the exam and apologetic that the process takes longer than usual or is incomplete. Clinicians should remain patient, calm, and understanding, as their anxiety or frustration will only increase the woman’s anxiety. Each aspect of the exam should be done slowly, at a pace that...
is set by the woman. It is important for the clinician to communicate what is happening during each step. This will allow the woman to decide whether she is able to continue. At the completion of the exam, the woman should be informed of all findings and whether any follow-up is needed.

**Follow-Up**

If the exam can be completed and is normal, then follow-up is not necessary. If anxiety prevents all or part of the exam, then a plan should be made for repeating the exam at a different time. If this is necessary, strategies can be implemented to address the woman's anxiety and therefore increase the likelihood the next exam will be successful. If anxiety is extreme, referral to a therapist may help the woman work through underlying issues related to the gynecologic exam. Bringing a friend and implementing meditation, biofeedback, and other relaxation techniques can also be very effective in reducing anxiety. If anxiety is not specific to the gynecologic exam and is part of an overall anxiety disorder, referral to a mental health provider should be considered to have mental health issues evaluated and treated.

**Fast Facts in a Nutshell**

- Encourage use of a mirror and the woman’s involvement during the exam process.
- Proceed with the exam slowly and thoroughly, and explain the exam simply (especially in advance) to decrease anxiety.
- Encourage relaxation techniques and deep breathing.
- Consider short-acting antianxiety medications in a single dose if appropriate for the woman and situation.

**PHYSICAL AND SEXUAL VIOLENCE**

Performing a pelvic exam on a woman with a history of physical/sexual abuse can be especially challenging. It is extremely important not to revictimize the woman during the exam. Exposure and touching the pelvic area and positioning for the exam often bring up memories of the abuse. Many women who have experienced sexual abuse
or assault do not disclose this to their health care providers. Researchers who conducted the National Intimate Partner and Sexual Violence Survey reported that approximately one third of women in the United States have experienced intimate partner violence (IPV) at some point in their lifetime and nearly half have experienced sexual violence (Black et al., 2011).

Victims of sexual violence may demonstrate certain behaviors that suggest a history of abuse. During an examination, the woman may be reluctant to undress and allow the clinician access to her pelvic and genital area. Women who have been victims of sexual violence may also move away as the clinician attempts to insert the speculum or may close her legs tightly. Arching her back off the exam table and having a rigidly tense posture are also actions that are common for violence victims as are crying, shaking, hiding under the drape sheet, or complete disassociation and separation from the exam.

For women with a known history of sexual abuse or violence, having control over the flow and timing of the exam is crucial. The visit often takes much longer, and an exam may be impossible or require multiple visits to complete. Violence victims need to feel secure, and therefore the process from introduction and first visit to the completion of a full exam can take many visits or even years as the woman learns to trust the provider and feel safe. Women who have experienced any form of sexual violence should always be greeted and interviewed while fully clothed.

Before beginning any part of the exam, let the woman know exactly what to expect. Some women feel more comfortable if they have a support person with them and the clinician should always try to accommodate this request. Being completely undressed is often difficult for women who have experienced sexual violence. Allowing a woman who has experienced sexual violence to keep on some clothing, such as her shirt, may increase her comfort.

There are other important steps the clinician can take when performing a gynecologic exam on a woman who has been a victim of sexual violence. Letting the woman set the pace of the exam and have control over certain actions can enhance empowerment and increase the chance of a nontraumatic exam. Women may wish to use a mirror and insert the speculum themselves. The speculum should be warm, the smallest size possible, and inserted slowly. Lubricant should be used to decrease discomfort. Consider alternate positions, such
as semireclining without using the stirrups. Assess her anxiety and level of tolerance for the exam multiple times. Let her know that the examination will stop at any point if she is having difficulty completing the exam.

If it is impossible to complete the exam, she may require a step-by-step desensitization process. Over the course of multiple appointments, she can become more familiar with the environment and exam process. At this point, the clinician might consider co-managing care with a counselor who has expertise in working with women who have been affected by sexual violence.

When caring for a woman who has experienced a recent sexual assault or sexual trauma, the genital area should be examined carefully. According to Brown and Muscari (2010), many health care providers use the TEARS pneumonic to describe the different types of genital injuries. Becoming familiar with this pneumonic will assist the clinician in identifying the constellation of injuries that are often experienced by victims of sexual assault:

T = tears, any break in tissue integrity
E = ecchymosis, any discoloration of skin or mucous membranes; also called *bruising*
A = abrasion, skin excoriations caused by the removal of the most superficial layer of skin
R = redness, erythematous skin that is abnormally inflamed because of irritation
S = swelling, edematous, or transient engorgement of tissues

Brown and Muscari also report the “common genital injuries in elder victims of sexual assault are lacerations, abrasions, and bruises” (2010, p. 185).

Sommers (2007) identifies the most common locations for injury as:

- Posterior fourchette
- Labia minora
- Hymen
- Fossa navicularis

However, not all women who report an incident of sexual assault will present with obvious signs of trauma to the genital area. The exam
should proceed objectively without any judgment or bias from the clinician.

**Fast Facts in a Nutshell**

**Documentation**
- With a remote history of sexual assault, documentation includes the woman’s emotional response to the exam. Examples:
  - Mild anxiety verbalized but able to tolerate exam without incident.
  - Unable to complete exam due to anxiety and emotional distress.

**Communication**

The timing of sexual violence will often guide the discussion before and after the exam. Screening all women for a current and past history of physical and sexual violence is essential and supported by major organizations such as the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), the Institute of Medicine (IOM), and the American Academy of Pediatrics (AAP). Simple screening questions, such as “Have you ever been forced to have sex when you didn’t want to?” will help assist with disclosure and focus of the exam and follow-up. If the physical or sexual violence has occurred in the past and the woman is stable and out of immediate danger, then the conversation will focus on the woman’s feelings toward the exam, any previous difficulties she has encountered, and what can be done to increase her comfort with the present exam. If the physical or sexual violence was recent or ongoing and the woman has not received evaluation and health care since the most recent incident, the conversation will be very different. If sexual violence has occurred during the past 5 to 7 days, the woman should be informed about the collection of forensic evidence (see Follow-Up section). If it has been more than 5 to 7 days since the sexual violence, the practitioner should ask about the woman’s immediate concerns, such as pregnancy or sexually transmitted infections (STIs).
INTIMATE PARTNER VIOLENCE

Caring for a woman who has experienced physical, psychological, or emotional violence from a current or former intimate partner is similar to the care of women who are victims of sexual violence because often the two forms of violence occur simultaneously. One in three women or approximately 33% of women have experienced physical violence by an intimate partner (Black et al., 2011). Women are often reluctant to disclose IPV and it may take multiple visits before an atmosphere of trust exists and a woman feels comfortable disclosing the violence to a health care provider. Women who have been victims of IPV often have the same difficulties with a pelvic exam as do women who have been victims of sexual abuse. Techniques, such as approaching the exam slowly and allowing the woman to control what happens with her body, will be just as important for women with a history of IPV as for women with a history of sexual violence.

Communication

Nonjudgmental and consistent screening for IPV is the first step to increasing the chances that a woman will disclose a history of violence. Although rates of reporting are low, women are more likely to disclose if asked about violence directly. This can be accomplished through standardized screening questions such as: “Have you ever been abused or felt unsafe in relationship (physical/sexual/emotional threats or violence)?” and “Are you currently afraid of anyone?” These types of screening questions should be incorporated into the standardized patient history and intake forms and reviewed with women at each visit. They can also be grouped with questions about sexual violence so that the most sensitive questions are asked together. Making violence screening a standard protocol ensures that all women, regardless of age, sexual orientation, gender identification, marital status, race, ethnicity, relationship status, and other sociodemographic factors, are screened equally and without bias. It is important to frame questions about physical and sexual violence in a nonjudgmental way and to let women know that questions of this type are asked of everyone so that individual women do not feel threatened or singled out for what has happened to them.
Follow-Up

A woman’s ability to tolerate gynecologic exams after a history of physical or sexual violence will vary widely. Some women may experience only mild anxiety, whereas others will exhibit symptoms of severe distress. Follow-up plans will be based on her symptoms and feelings about the exam. For those with acute distress that prevents completion of a pelvic exam, follow-up and comanagement with a therapist or counselor are often helpful. If the abuse or assault was recent and the clinician is the first provider whom the woman has encountered, he or she should provide information about rape crisis centers and options regarding reporting to law enforcement. If assaulted within the past 5 to 7 days, the woman should be informed that forensic evidence can be collected, although the exact time frame for collection can range from 3 to 7 days and varies from state to state. This is best done by a provider who has specialized experience and training in sexual assault exams and may require the woman to visit a hospital emergency department that is designated as a site that can provide forensic evidence collection. The clinician should be aware of what services are available in his or her practice area if referrals are needed. Additional follow-up for repeat STI or pregnancy testing can also be scheduled based on the timing of the sexual violence.

For women who disclose an experience of ongoing physical violence in a current relationship, the clinician must do a lethality assessment and start a discussion about whether she has the ability to leave the relationship. Many barriers to leaving an abusive relationship exist for women who are experiencing IPV, including social isolation, financial control, and lack of resources for housing, child care, transportation, and legal assistance. Women who are not documented face additional barriers that coexist with their immigration status, including fear of incarceration, deportation, and loss of parental rights. Providers can assist women in starting a safety plan that includes the resources they will need to leave the relationship. It may take women an extended period of time to leave a violent relationship. Clinicians should always have an updated list of local resources, including law enforcement, as well as legal, counseling, and shelter services. If women are unable to immediately terminate a violent relationship, then reassessing safety, plans, and available resources at each visit is essential.
Human trafficking can be viewed as a subset of sexual violence and abuse. Commercial sexual exploitation is the most common reason for human trafficking, and adolescents and young women are most at risk. Because of the secretive nature of trafficking, it is difficult to accurately determine the scope of the problem, but it is estimated that more than 14,000 young women and girls are trafficked in the United States each year.

It is very hard to determine whether a woman is being trafficked, as often there are no definitive signs and the woman will appear outwardly to be well assimilated into the community. A woman who is being trafficked is under the control of a pimp who is the gatekeeper to her health care access. Therefore, these women often do not receive routine care. Instead, they present for episodic office visits when there is a problem or concern that is usually related to a gynecologic issue.

The signs of trafficking can be vague and, if they appear individually, may not be enough to raise concern. As with all cases of violence, the woman's stated history of the illness or injury may not match with the exam findings, or there may be inconsistencies in her account of the problem. A male partner’s refusal to leave the woman alone in the exam room or a partner who appears impatient about the length of the office visit may also be indications of control and abuse. Other possible signs of human trafficking include multiple pregnancies and pregnancy terminations, STIs, inconsistent and episodic health care, and overt signs of trauma such as bruising, burns, cuts, and a history of bone fractures. Table 8.2 includes a list of possible signs of human trafficking.
Table 8.2

<table>
<thead>
<tr>
<th>Possible Warning Signs of Human Trafficking</th>
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<tbody>
<tr>
<td>■ Homelessness, frequent address changes, inconsistent health care</td>
</tr>
<tr>
<td>■ Presence of an older boyfriend or age disparity in an intimate or sexual relationship</td>
</tr>
<tr>
<td>■ Signs of violence and/or psychological trauma (including mental illness and suicide attempts)</td>
</tr>
<tr>
<td>■ History of criminal behavior or involvement with youth services</td>
</tr>
<tr>
<td>■ Travel with an older male who is not a guardian</td>
</tr>
<tr>
<td>■ History of family violence</td>
</tr>
<tr>
<td>■ Younger than age 18 and involved in or history of prior prostitution</td>
</tr>
<tr>
<td>■ Chronic runaway (adolescents)</td>
</tr>
<tr>
<td>■ Unique tattoos (used to mark victim as property of pimp)</td>
</tr>
<tr>
<td>■ STIs, pregnancy, history of pregnancy terminations</td>
</tr>
<tr>
<td>■ Substance use/abuse</td>
</tr>
<tr>
<td>■ Access to material things that the woman/adolescent cannot afford</td>
</tr>
<tr>
<td>■ History of rape or child sexual abuse</td>
</tr>
<tr>
<td>■ Not attending school, frequent absences, or academic failures (adolescents)</td>
</tr>
</tbody>
</table>

STIs, sexually transmitted infections.

Source: Adapted from U.S. Department of Health and Human Services (2009).

Fast Facts in a Nutshell

Documentation

Because there are usually no definitive signs of human trafficking, documentation needs to accurately describe both the woman’s history and physical exam findings. Examples:

■ Recently relocated to area, states unemployed, last gyn exam >2 years ago.
■ Complaining of pelvic pain, vaginal discharge × 3 weeks.
■ 4-cm yellow bruise on inner aspect of left thigh; pt does not recall injury.
Communication

It is important to establish an open and safe dialogue in all cases of suspected trafficking. Women who are trafficked often fear retaliation from a pimp if the lifestyle is discovered, and they are never sure whom they can trust. Therefore, they are reluctant to disclose a history of abuse. Pimps may threaten with physical harm, deportation if in the country illegally, or harm to family members if the woman divulges the trafficking. Questions for the woman should start with a general health history that includes social aspects, such as work, school, housing, and finances/health insurance. More specific inquiries include questions related to physical and sexual health and safety. Examples of more direct questions are: “Have you been physically or emotionally hurt or threatened by anyone, including a sex partner?” “Have you ever been forced to have sex when you didn’t want to?” “Have you ever exchanged sex for drugs, money, food, or a place to live?” and “Have you ever been threatened with harm if you did not perform sexual acts in exchange for money?”

Follow-Up

Scheduling exam follow-ups can also be challenging. Pimps are typically reluctant to bring these women in for even one visit and can become suspicious if it is recommended that the woman be seen again. If a follow-up exam is scheduled, it is not uncommon for the woman to miss the visit and have contact information that is not valid. These women are moved around frequently and often do not stay in one area long enough to establish consistent health care, although they may come back to the practice after a long absence.

All health care providers should be aware of local recourses in their practice area for women who are victims or suspected victims of abuse. As with IPV, those who traffic women use multiple control tactics, including financial control, social isolation, physical control/abuse, and psychological abuse. Leaving a pimp is dangerous and complicated; often these women have no money or personal possessions other than what they are wearing. If the woman is a minor, laws regarding statutory rape and mandatory reporting vary from state to state. All health care providers need to have a list of shelters, abuse hotlines, community advocates, and local law enforcement agencies that can be provided to women.
Fast Facts in a Nutshell

- Sexual trafficking is the most common form of human trafficking.
- Signs of human trafficking are often vague and difficult to determine.
- Gynecologic complaints are common among women who are trafficked.

References


