Chapter 2

Clinical Approach to the Patient

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As is the case in most areas of medicine, a careful history and physical examination should form the basis for patient evaluation and clinical management in obstetrics and gynecology. This chapter outlines the essential details of the clinical approach to, and evaluation of, the obstetric and gynecologic patient. Pediatric and adolescent patients, the geriatric patient, and women with disabilities all have unique gynecologic and reproductive needs, and this chapter concludes with information about their evaluation and management.

Obstetric and Gynecologic Evaluation

In few areas of medicine is it necessary to be more sensitive to the emotional and psychological needs of the patient than in obstetrics and gynecology. By their very nature, the history and physical examination may cause embarrassment to some patients. The members of the medical care team are individually and collectively responsible for ensuring that each patient’s privacy and modesty are respected while providing the highest level of medical care. Box 2-1 lists the appropriate steps for the clinical approach to the patient.

Although a casual and familiar approach may be acceptable to many younger patients, it may offend others and be quite inappropriate for many older patients. Different circumstances with the same patient may dictate different levels of formality. Entrance to the patient’s room should be announced by a knock and spoken identification. A personal introduction with the stated reason for the visit should occur before any questions are asked or an examination is begun. The placement of the examination table should always be in a position that maximizes privacy for the patient as other health-care professionals enter the room. Finally, any appropriate cultural beliefs and preferences for care and treatment should be recognized and respected.

Obstetric History

A complete history must be recorded at the time of the prepregnancy evaluation or at the initial antenatal visit. Several detailed standardized forms are available, but this should not negate the need for a detailed chronologic history taken personally by the physician who will be caring for the patient throughout her pregnancy. While taking the history, major opportunities will usually arise to provide counseling and explanations that serve to establish rapport and a supportive patient–physician encounter.

PREVIOUS PREGNANCIES

Each prior pregnancy should be reviewed in chronologic order and the following information recorded:

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<th>BOX 2-1</th>
<th>Approach to the Patient</th>
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The doctor should always:

- Knock before entering the patient’s room.
- Identify himself or herself.
- Meet the patient initially when she is fully dressed, if possible.
- Address the patient courteously and respectfully.
- Respect the patient’s privacy and modesty during the interview and examination.
- Ensure cleanliness, good grooming, and good manners in all patient encounters.
- Beware that a casual and familiar approach is not acceptable to all patients; it is generally best to avoid addressing an adult patient by her first name.
- Maintain the privacy of the patient’s medical information and records.
- Be mindful and respectful of any cultural preferences.
1. **Date of delivery** (or pregnancy termination)
2. **Location of delivery** (or pregnancy termination)
3. **Duration of gestation** (recorded in weeks). When correlated with birth weight, this information allows an assessment of fetal growth patterns. The gestational age of any spontaneous abortion is of importance in any subsequent pregnancy.
4. **Type of delivery** (or method of terminating pregnancy). This information is important for planning the method of delivery in the present pregnancy. A difficult forceps delivery or a cesarean section may require a personal review of the labor and delivery records.
5. **Duration of labor** (recorded in hours). This may alert the physician to the possibility of an unusually long or short labor.
6. **Type of anesthesia**. Any complications of anesthesia should be noted.
7. **Maternal complications**. Urinary tract infections, vaginal bleeding, hypertension, and postpartum complications may be repetitive; such knowledge is helpful in anticipating and preventing problems with the present pregnancy.
8. **Newborn weight** (in grams or pounds and ounces). This information may give indications of gestational diabetes, fetal growth problems, shoulder dystocia, or cephalopelvic disproportion.
9. **Newborn gender**. This may provide insight into patient and family expectations and may indicate certain genetic risk factors.
10. **Fetal and neonatal complications**. Certain questions should be asked to elicit any problems and to determine the need to obtain further information. Inquiry should be made as to whether the baby had any problems after it was born, whether the baby breathed and cried right away, and whether the baby left the hospital with his mother.

**MENSTRUAL HISTORY**

A good menstrual history is essential because it is the determinant for establishing the expected date of confinement (EDC). A modification of Nægå's rule for establishing the EDC is to add 9 months and 7 days to the first day of the last normal menstrual period (LMP). For example:

- **LMP**: July 20, 2008
- **EDC**: April 27, 2009

This calculation assumes a normal 28-day cycle, and adjustments must be made for longer or shorter cycles. Any bleeding or spotting since the last normal menstrual period should be reviewed in detail and taken into account when calculating an EDC.

**CONTRACEPTIVE HISTORY**

This information is important for risk assessment. Oral contraceptives taken during early pregnancy have been associated with birth defects, and retained intrauterine devices (IUDs) can cause early pregnancy loss, infection, and premature delivery.

**MEDICAL HISTORY**

The importance of a good medical history cannot be overemphasized. In addition to common disorders, such as diabetes mellitus, hypertension, and renal disease, which are known to affect pregnancy outcome, all serious medical conditions should be recorded.

**SURGICAL HISTORY**

Each surgical procedure should be recorded chronologically, including date, hospital, surgeon, and complications. Trauma must also be listed (e.g., a fractured pelvis may result in diminished pelvic capacity).

**SOCIAL HISTORY**

Habits such as smoking, alcohol use, and other substance abuse are important factors that must be recorded and managed appropriately. The patient’s contact or exposure to domesticated animals, particularly cats (which carry a risk for toxoplasmosis), is important.

The patient’s type of work and lifestyle may affect the pregnancy. Exposure to solvents (carbon tetrachloride) or insulators (polychlorobromine compounds) in the workplace may lead to teratogenesis or hepatic toxicity.

**Obstetric Physical Examination**

**GENERAL PHYSICAL EXAMINATION**

This procedure must be systematic and thorough and performed as early as possible in the prenatal period. A complete physical examination provides an opportunity to detect previously unrecognized abnormalities. Normal baseline levels must also be established, particularly those of weight, blood pressure, funduscopic (retina) appearance, and cardiac status.

**PELVIC EXAMINATION**

The initial pelvic examination should be done early in the prenatal period and should include the following: (1) inspection of the external genitalia, vagina, and cervix; (2) collection of cytologic specimens from the ectocervix and superficial endocervical canal; and (3) palpation of the cervix, uterus, and adnexa. The initial estimate of gestational age by uterine size becomes less accurate as pregnancy progresses. Rectal and rectovaginal examinations are also important aspects of this initial pelvic evaluation.

**CLINICAL PELVIMETRY**

This assessment is carried out following the bimanual pelvic examination and before the rectal examination. It is important that clinical pelvimetry be carried out systematically. The details of clinical pelvimetry are described in Chapter 8.
Diagnosis of Pregnancy

The diagnosis of pregnancy and its location, based on physical signs and examination alone, may be quite challenging during the early weeks of amenorrhea. Urine pregnancy tests done in the office are reliable a few days after the first missed period, and office ultrasonography is used increasingly as a routine.

SYMPTOMS OF PREGNANCY

The most common symptoms in the early months of pregnancy are amenorrhea, urinary frequency, breast engorgement, nausea, tiredness, and easy fatigability. Amenorrhea in a previously normally menstruating, sexually active woman should be considered to be caused by pregnancy until proved otherwise. Urinary frequency is most likely caused by the pressure of the enlarged uterus on the bladder.

SIGNS OF PREGNANCY

The signs of pregnancy may be divided into presumptive, probable, and positive.

Presumptive Signs

The presumptive signs are primarily those associated with skin and mucous membrane changes. Discoloration and cyanosis of the vulva, vagina, and cervix are related to the generalized engorgement of the pelvic organs and are, therefore, nonspecific. The dark discoloration of the vulva and vaginal walls is known as Chadwick’s sign. Pigmentation of the skin and abdominal striae are nonspecific and unreliable signs. The most common sites for pigmentation are the midline of the lower abdomen (linea nigra), over the bridge of the nose, and under the eyes. The latter is called chloasma or the mask of pregnancy. Chloasma is also an occasional side effect of oral contraceptives.

Probable Signs

The probable signs of pregnancy are those mainly related to the detectable physical changes in the uterus. During early pregnancy, the uterus changes in size, shape, and consistency. Early uterine enlargement tends to be in the anteroposterior diameter so that the uterus becomes globular. In addition, because of asymmetric implantation of the ovum, one cornua of the uterus may enlarge slightly (Piskacek’s sign). Uterine consistency becomes softer, and it may be possible to palpate or to compress the connection between the cervix and fundus. This change is referred to as Hegar’s sign. The cervix also begins to soften early in pregnancy.

Positive Signs

The positive signs of pregnancy include the detection of a fetal heartbeat and the recognition of fetal movements. Modern Doppler techniques for detecting the fetal heartbeat may be successful as early as 9 weeks of gestation and are nearly always positive by 12 weeks. Fetal heart tones can usually be detected with a stethoscope between 16 and 20 weeks. The multiparous woman generally recognizes fetal movements between 15 and 17 weeks, whereas the primigravida usually does not recognize fetal movements until 18 to 20 weeks.

LABORATORY TESTS FOR PREGNANCY

Pregnancy Tests

Tests to detect pregnancy have revolutionized early diagnosis. Although they are considered a probable sign of pregnancy, the accuracy of these tests is very good. All commonly used methods depend on the detection of human chorionic gonadotropin (hCG) or its β subunit in urine or serum. Depending on the specific sensitivity of the test, pregnancy may be suspected even before a missed menstrual period.

Diagnostic Ultrasonography

The imaging technique of ultrasonography has made a significant contribution to the diagnosis and evaluation of pregnancy. Using real-time ultrasonography, an intratonic gestational sac can be identified at 5 menstrual weeks (21st postovulatory day), and a fetal image can be detected by 6 to 7 weeks. A beating heart is noted at 8 weeks or even sooner with the latest equipment. Radiographic imaging, usually avoided in early pregnancy, depends on detection of the fetal skeleton, which is usually not seen until 16 weeks.

Gynecologic History

A full history is equally as important in evaluating the gynecologic patient as in evaluating a patient in general medicine or surgery. The history-taking must be systematic to avoid omissions, and it should be conducted with sensitivity and without haste.

PRESENT ILLNESS

The patient is asked to state her main complaint and to relate her present illness, sequentially, in her own words. Pertinent negative information should be recorded, and as much as possible, questions should be reserved until after the patient has described the course of her illness. Generally, the history provides substantial clues to the diagnosis, so it is important to evaluate fully the more common symptoms encountered in gynecologic patients.

Abnormal Vaginal Bleeding

Vaginal bleeding before the age of 9 years and after the age of 52 years is cause for concern and requires investigation. These are the limits of normal menstruation, and although the occasional woman may menstruate
regularly and normally up to the age of 57 or 58 years, it is important to ensure that she is not bleeding from uterine cancer or from exogenous estrogens. Prolongation of menses beyond 7 days or bleeding between menses, except for a brief *kleine regnen* at ovulation, may connote abnormal ovarian function, uterine myomas, or endometriosis.

**Abdominal Pain**

Many gynecologic problems are associated with abdominal pain. The common gynecologic causes of acute lower abdominal pain are salpingo-oophoritis with peritoneal inflammation, torsion and infarction of an ovarian cyst, endometriosis, or rupture of an ectopic pregnancy. Patterns of pain radiation should be recorded and may provide an important diagnostic clue. Chronic lower abdominal pain is generally associated with endometriosis, chronic pelvic inflammatory disease, or large pelvic tumors. It may also be the first symptom of ovarian cancer.

**Amenorrhea**

The most common causes of amenorrhea are pregnancy and the normal menopause. It is abnormal for a young woman to reach the age of 16 years without menstruating (primary amenorrhea). Pregnancy should be suspected in a woman between 15 and 45 years of age who fails to menstruate within 35 days from the first day of her last menstruation. In a patient with amenorrhea who is not pregnant, inquiry should be made about menopausal or climacteric symptoms such as hot flashes, vaginal dryness, or mild depression.

**Other Symptoms**

Other pertinent symptoms of concern include dysmenorrhea, premenstrual tension, fluid retention, leukorrhea, constipation, dyschezia, dyspareunia, and abdominal distention. Lower back and sacral pain may indicate uterine prolapse, enterocele, or rectocele.

**MENSTRUAL HISTORY**

The menstrual history should include the age at menarche (average is 12 to 13 years), interval between periods (21 to 35 days with a median of 28 days), duration of menses (average is 5 days), and character of the flow (scant, normal, heavy, usually without clots). Any intermenstrual bleeding (metrorrhagia) should be noted. The date of onset of the LMP and the date of the previous menstrual period should be recorded. Inquiry should be made regarding menstrual cramps (dysmenorrhea); if present, the age at onset, severity, and character of the cramps should be recorded, together with an estimate of the disability incurred. Midcycle pain (*mittelschmerz*) and a midcycle increase in vaginal secretions are indicative of ovulatory cycles.

**CONTRACEPTIVE HISTORY**

The type and duration of each contraceptive method must be recorded, along with any attendant complications. These may include amenorrhea or thromboembolic disease with oral contraceptives; dysmenorrhea, heavy bleeding (menorrhagia), or pelvic infection with the intrauterine device; or contraceptive failure with the diaphragm, contraceptive sponge, or contraceptive cream.

**OBSTETRIC HISTORY**

Each pregnancy and delivery and any associated complications should be listed sequentially with relevant details and dates.

**SEXUAL HISTORY**

The health of, and current relationship with, the husband or partner(s) may provide insight into the present complaints. Inquiry should be made regarding any pain (dyspareunia), bleeding, or dysuria associated with sexual intercourse. Sexual satisfaction should be discussed tactfully.

**PAST HISTORY**

As in the obstetric history, any significant past medical or surgical history should be recorded, as should the patient’s family history. A list of current medications is important.

**SYSTEMIC REVIEW**

A review of all other organ systems should be undertaken. Habits (tobacco, alcohol, other substance abuse), medications, usual weight with recent changes, and loss of height (osteoporosis) are important parts of the systemic review.

**Gynecologic Physical Examination**

**GENERAL PHYSICAL EXAMINATION**

A complete physical examination should be performed on each new patient and repeated at least annually. The initial examination should include the patient’s height, weight, and arm span (in adolescent patients or those with endocrine problems) and should be carried out with the patient completely disrobed but suitably draped. The examination should be systematic and should include the following points.

**Vital Signs**

Temperature, pulse rate, respiratory rate, and blood pressure should be recorded.

**General Appearance**

The patient’s body build, posture, state of nutrition, demeanor, and state of well-being should be recorded.
Head and Neck
Evidence of supraclavicular lymphadenopathy, oral lesions, webbing of the neck, or goiter may be pertinent to the gynecologic assessment.

Breasts
The breast examination is particularly important in gynecologic patients (see Chapters 29 and 31).

Heart and Lungs
Examination of the heart and lungs is of importance, particularly in a patient who requires surgery. The presence of a pleural effusion may be indicative of a disseminated malignancy, particularly ovarian cancer.

Abdomen
Examination of the abdomen is critical in the evaluation of the gynecologic patient. The contour, whether flat, scaphoid, or protuberant, should be noted. The latter appearance may suggest ascites. The presence and distribution of hair, especially in the area of the escutcheon, should be recorded, as should the presence of striae or operative scars.

Abdominal tenderness must be determined by placing one hand flat against the abdomen in the nonpainful areas initially, then gently and gradually exerting pressure with the fingers of the other hand (Figure 2-1). Rebound tenderness (a sign of peritoneal irritation), muscle guarding, and abdominal rigidity should be gently elicited, again first in the nontender areas. A “doughy” abdomen, in which the guarding increases gradually as the pressure of palpation is increased, is often seen with a hemoperitoneum.

It is important to palpate any abdominal mass. The size should be specifically noted. Other characteristics may be even more important, however, in suggesting the diagnosis, such as whether the mass is cystic or solid, smooth or nodular, and fixed or mobile, and whether it is associated with ascites. In determining the reason for abdominal distention (tumor, ascites, or distended bowel), it is important to percuss carefully the areas of tympany (gaseous distention) and dullness. A large tumor is generally dull on top with loops of bowel displaced to the flanks. Dullness that shifts as the patient turns onto his side (shifting dullness) is suggestive of ascites.

Back
Abnormal curvature of the vertebral column (dorsal kyphosis or scoliosis) is an important observation in evaluating osteoporosis in a postmenopausal woman. Costovertebral angle tenderness suggests pyelonephritis, whereas psoas muscle spasm may occur with gynecologic infections or acute appendicitis.

PELVIC EXAMINATION
The pelvic examination must be conducted systematically and with careful sensitivity. The procedure should be performed with smooth and gentle movements and accompanied by reasonable explanations.

Vulva
The character and distribution of hair, the degree of development or atrophy of the labia, and the character of the hymen (imperforate or cribriform) and introitus (virginal, nulliparous, or multiparous) should be noted. Any clitorimegaly should be noted, as should the presence of cysts, tumors, or inflammation of Bartholin’s gland. The urethra and Skene’s glands should be inspected for any purulent exudates. The labia should be inspected for any inflammatory, dystrophic, or neoplastic lesions. Perineal relaxation and scarring should be noted because they may cause dyspareunia and defects in rectal sphincter tone. The urethra should be “milked” for any inflammatory exudates, which if found should be cultured for pathologic organisms.

Speculum Examination
The vagina and cervix should be inspected with an appropriately sized bivalve speculum (Figure 2-2), which should be warmed and lubricated with warm water only, so as not to interfere with the examination.
of cervical cytology or any vaginal exudate. After gently spreading the labia to expose the introitus, the speculum should be inserted with the blades entering the introitus transversely, then directed posteriorly in the axis of the vagina with pressure exerted against the relatively insensitive perineum to avoid contacting the sensitive urethra. As the anterior blade reaches the cervix, the speculum is opened to bring the cervix into view. As the vaginal epithelium is inspected, it is important to rotate the speculum through 90 degrees, so that lesions on the anterior or posterior walls of the vagina ordinarily covered by the blades of the speculum are not overlooked. Vaginal wall relaxation should be evaluated using either a Sims’ speculum or the posterior blade of a bivalve speculum. The patient is asked to bear down (Valsalva’s maneuver) or to cough to demonstrate any stress incontinence. If the patient’s complaint involves urinary stress or urgency, this portion of the examination should be carried out before the bladder is emptied.

The cervix should be inspected to determine its size, shape, and color. The nulliparous patient generally has a conical, unscarred cervix with a circular, centrally placed os; the multiparous cervix is generally bulbous, and the

os has a transverse configuration (Figure 2-3). Any purulent cervical discharge should be cultured. Plugged, distended cervical glands (nabothian follicles) may be seen on the ectocervix. In premenopausal women, the squamocolumnar junction of the cervix is usually visible around the cervical os, particularly in patients of low parity. Postmenopausally, the junction is invariably retracted within the endocervical canal. A cervical cytologic smear (Papanicolaou, or Pap, smear) should be taken before the speculum is withdrawn. The exocervix is gently scraped with a wooden spatula, and the endocervical tissue is gently sampled with a Cytobrush.

Bimanual Examination

The bimanual pelvic examination provides information about the uterus and adnexa (fallopian tubes and ovaries). During this portion of the examination, the urinary bladder should be empty; if it is not, the internal genitalia will be difficult to delineate, and the procedure is more apt to be uncomfortable for the patient. The labia are separated, and the gloved, lubricated index finger is inserted into the vagina, avoiding the sensitive urethral meatus. Pressure is exerted posteriorly against the perineum and puborectalis muscle, which causes the introitus to gape somewhat, thereby usually allowing the middle finger to be inserted as well. Intromission of the two fingers into the depth of the vagina may be facilitated by having the patient bear down slightly.

The cervix is palpated for consistency, contour, size, and tenderness to motion. If the vaginal fornices are absent, as may occur in postmenopausal women, it is not possible to appreciate the size of the cervix on bimanual examination. This can be determined only on rectovaginal or rectal examination.

The uterus is evaluated by placing the abdominal hand flat on the abdomen with the fingers pressing
gently just above the symphysis pubis. With the vaginal fingers supinated in either the anterior or the posterior vaginal fornix, the uterine corpus is pressed gently against the abdominal hand (Figure 2-4). As the uterus is felt between the examining fingers of both hands, the size, configuration, consistency, and mobility of the organ are appreciated. If the muscles of the abdominal wall are not compliant or if the uterus is retroverted, the outline, consistency, and mobility must be determined by ballottement with the vaginal fingers in the fornices; in these circumstances, however, it is impossible to discern uterine size accurately.

By shifting the abdominal hand to either side of the midline and gently elevating the lateral fornix up to the abdominal hand, it may be possible to outline a right adnexal mass (Figure 2-5). The left adnexa are best appreciated with the fingers of the left hand in the vagina (Figure 2-6). The examiner should stand sideways, facing the patient’s left, with the left hip maintaining pressure against the left elbow, thereby providing better tactile sensation because of the relaxed musculature in the forearm and examining hand. The pouch of Douglas is also carefully assessed for nodularity or tenderness, as may occur with endometriosis, pelvic inflammatory disease, or metastatic carcinoma.
It is usually impossible to feel the normal tube, and conditions must be optimal to appreciate the normal ovary. The normal ovary has the size and consistency of a shelled oyster and may be felt with the vaginal fingers as they are passed across the undersurface of the abdominal hand. The ovaries are very tender to compression, and the patient is uncomfortably aware of any ovarian compression or movement during the examination.

It may be impossible to differentiate between an ovarian and tubal mass, and even a lateral uterine mass. Generally, left adnexal masses are more difficult to evaluate than those on the right because of the position of the sigmoid colon on the left side of the pelvis. An ultrasonic examination should be helpful for delineating these features.

**RECTAL EXAMINATION**

The anus should be inspected for lesions, hemorrhoids, or inflammation. Rectal sphincter tone should be recorded and any mucosal lesions noted. A guaiac test should be performed to determine the presence of occult blood.

A rectovaginal examination is helpful in evaluating masses in the cul-de-sac, the rectovaginal septum, or adnexa. It is essential in evaluating the parametrium in patients with cervical cancer. Rectal examination may also be essential in differentiating between a rectocele and an enterocele (Figure 2-7).

**LABORATORY EVALUATION**

Appropriate laboratory tests normally include a urinalysis, complete blood count, erythrocyte sedimentation rate, and blood chemistry analyses. Special tests, such as tumor marker and hormone assays, are performed when indicated.

**ASSESSMENT**

A reasonable differential diagnosis should be possible with the information gleaned from the history, physical examination, and laboratory tests. The plan of management should aim toward a chemical or histologic confirmation of the presumptive diagnosis, and the appropriate therapeutic options, along with the rationale for each option, should be recorded.

**Patients with Special Needs**

**THE PEDIATRIC AND ADOLESCENT PATIENT**

Girls experience fewer gynecologic problems than do adult women, but their concerns need to be met effectively and skillfully in a way that will allay anxiety and create a positive attitude toward their gynecologic health. Unique complaints fall generally into a handful of categories: congenital anomalies, genital injuries, inflammation of the nonestrogenized genital tract, pubertal problems, and psychosexual concerns. Genital ambiguity, trauma, and vaginal bleeding in the prepubertal child are covered briefly in this chapter.

**GENITAL AMBIGUITY**

Dealing with genital ambiguity in the newborn requires a coordinated and timely response. The family’s psychological well-being must be addressed because they must feel confident in the gender identity of their child. Ambiguity can result from masculinization of a female child due to exogenous hormone ingestion or maternal or fetal overproduction of androgen. It may also result from incomplete virilization of a male infant, hormonal insensitivity, gonadal dysgenesis, or chromosomal anomalies (see Chapters 31 and 32).

When assessing an infant with ambiguous genitals, fluid and electrolyte balance should be monitored and blood drawn for 17-hydroxyprogesterone and cortisol to rule out 21-hydroxylase deficiency. Life-threatening illness may be missed in children with the salt-losing form of congenital adrenal hyperplasia (see Chapter 32).

**TRAUMA**

Straddle injuries are the most common cause of trauma to the genitalia of a young girl, and the injuries have a seasonal peak when bicycles come out in the spring. Most of these injuries are to the labia. Penetrating vaginal injuries can cause major intraabdominal damage with minimal external findings. Sexual assault
must always be considered. After a life-threatening condition is ruled out, an ice pack, chilled bag of intravenous solution, or cool compress may be applied to the injured area and the child allowed to rest quietly for 20 minutes before being assessed further. Extensive injuries usually require examination under anesthesia and surgical repair.

In any case of trauma concurrent damage to the rectum or urinary tract should be considered. If there is any reason to suspect sexual or physical abuse, the child protection authorities must be notified, and the examination should include the collection of medico-legal evidence.

VAGINAL BLEEDING IN THE PREPUBERTAL CHILD

Vaginal bleeding is a frequent and distressing complaint in childhood. Although it will most often be of benign cause, more serious pathologic processes must always be ruled out. Vaginal bleeding in the newborn is most often physiologic as a result of maternal estrogen withdrawal. In such cases, there should be supportive evidence of a hormonal effect, such as the presence of breast tissue and pale, engorged vaginal epithelium. Bleeding disorders are uncommon in this age group but should be considered. Vitamin K is routinely given to the newborn, but some patients may refuse the medication.

Precocious puberty (see Chapter 31) may present with vaginal bleeding, although most commonly other evidence of maturation will have preceded the bleeding and will be evident on examination. At the very least, a pale, estrogenized vaginal epithelium will be seen, and cytologic analysis of the vagina will confirm the hormonal effect. Transient precocious puberty may occur in response to a functional ovarian cyst, and vaginal bleeding may be triggered by the spontaneous resolution of the cyst. Exogenous hormonal exposure should be considered because children have been known to ingest birth control pills. Ovarian tumors resulting in pseudoprecocious puberty should be ruled out.

Vulvovaginitis is common but is a diagnosis of exclusion. When bleeding is present, it is necessary to assess the vagina and to rule out a foreign body or vaginal tumor.

Vaginal tumors are the most serious possibility to be considered. Sarcoma botryoides classically presents with vaginal bleeding and grape-like vesicles. Fortunately, this is a rare tumor.
The gynecologic assessment of the elderly woman may present a special challenge. Many older patients tend to underreport their symptoms, possibly because of a belief that any new physical problems are due to the normal aging process. Also, a fear of loss of their independence may contribute to this denial, and this may lead to a delay of diagnosis and perhaps a worse prognosis. In addition to the routine gynecologic history and physical examination, these patients should be evaluated for any sensory impairment (such as visual or hearing loss), any impaired mobility, malnutrition, urinary incontinence, or confusion, which may be due to polypharmacy. Appropriate referral, when improvement can be reasonably expected, should be considered for these problems once identified.

Gynecologic conditions such as atrophic vaginitis, uterine and vaginal prolapse, and genital tract malignancies are among the more common problems encountered in the geriatric patient.

Patients with Disabilities

Women with developmental or acquired disabilities should receive the same high-quality obstetric and gynecologic care as anyone else, with a goal of sustaining their best level of functioning. Assisting families of mentally or physically disabled individuals with obstetric or gynecologic problems or attending to them in special institutions can be quite challenging. The woman with a disability is a person with special and unique needs, and communicating to her a sense of caring and respect is paramount.

Suggested Reading


