Unit 14. Stree Rugna Parikshana – Gynaecological Examination a. Gynaecological History taking

Unit 14(a): Gynaecological History Taking

1) Purpose and Principles

A good gynaecological history lets you:

- identify the **site and system** involved (uterus, cervix, vagina, vulva, adnexa, urinary tract, pelvic floor);
- map symptoms to **physiology across the life-course** (adolescence, reproductive years, perimenopause, postmenopause);
- generate a **focused differential diagnosis** and decide first-line investigations safely.

Core principles

- **Privacy & dignity:** single patient, door/curtain closed, chaperone available.
- **Consent:** explain scope—history may include sexual, menstrual, obstetric and mental health questions; patient may decline any question.
- **Cultural sensitivity & non-judgement:** neutral language, avoid assumptions about marriage/sexuality.
- **Confidentiality:** reassure; disclose only if safety concerns (self-harm, violence) with patient informed.
- **Trauma-informed:** pace the interview, offer pauses, normalise emotions.

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2) Order of the Gynaecological History

1. **Identification data**
   Name, age, occupation, address, contact, **marital/partner status**, parity, language preference.
2. **Chief complaint(s) with duration**
   Patient's own words (e.g., "heavy periods for 6 months", "white discharge and itching for 3 weeks", "lower abdominal pain").
3. **History of present illness (HOPI)** — structured by symptom:

A) Menstrual history (all menstruating patients)

- **Menarche age**; **cycle length** (first day to first day), **regularity**, **menses duration**, **pad/cloth usage**, passage of **clots**, **dysmenorrhoea** (cramps).
- **LMP** (Last Menstrual Period) and **PMP** if cycles irregular.
- **Intermenstrual bleeding (IMB)**, **postcoital bleeding (PCB)**.
- **Perimenopause/postmenopause:** date of **FMP**; any **postmenopausal bleeding (PMB)**.
- **AUB framework (FIGO PALM-COEIN)** to guide differentials:
  Polyp, **A**denomyosis, **L**eiomyoma, **M**alignancy/Hyperplasia | **C**oagulopathy, **O**vulatory dysfunction, **E**ndometrial, **I**atrogenic, **N**ot yet classified.

  Quantify flow: Number of pads/day; flooding; "soil clothes/bedding?"; **PBAC** (Pictorial Bleeding Assessment Chart) if used in your unit.

B) Vaginal discharge

- **Onset, colour, amount, odour**, **pruritus/burning**, **dyspareunia**, **dysuria**, **post-void irritation**; association with cycle/antibiotics/new partner.
- **Risk factors:** recent **change of partner**, **douching**, **diabetes**, **pregnancy**, **immunosuppression**; prior **STI**.

C) Pelvic pain

Use **SOCRATES/OLDCARTS**: Site, Onset, Character (cramp/dull/sharp), Radiation (back/thigh), **Association** (menses, coitus, micturition), Timing, Exacerbating/relieving factors, Severity (0–10).

- **Primary dysmenorrhoea** (adolescence; prostaglandin-mediated) vs **secondary** (endometriosis, adenomyosis, fibroids, PID).
- **Acute pain** red flags: adnexal torsion, ectopic pregnancy, ruptured cyst, acute PID, UTI/stone.

D) Fertility and reproductive goals

- Desire for pregnancy/spacing/limiting; **duration of infertility** (≥12 months; ≥6 months if ≥35 years); **coital frequency**, prior evaluation and treatments (ovulation induction, IUI, IVF), **semen analysis** status (if known).

E) Sexual history (patient-centred, non-judgemental)

- "Are you sexually active?"; number and gender of partners; **dyspareunia** (superficial/deep), **libido/arousal**, **orgasm**, **vaginismus** symptoms.
- **IPV (intimate partner violence) screening** (where safe): "Do you ever feel unsafe with your partner?"; offer resources if positive.

F) Urinary and pelvic floor symptoms

- **Frequency, urgency, dysuria**, **incontinence** (stress/urge/mixed), **nocturia**, **hematuria**; **prolapse** symptoms—vaginal bulge, heaviness, need to **splint** for voiding/defecation; bowel symptoms (constipation, fecal incontinence).

G) Contraceptive history

- Current and past **method**, compliance, side effects, reasons for switching; **EC (emergency contraception)** use; **LARC** interest (IUCD/implant).

H) Screening and preventive history

- **Cervical screening** (Pap/HPV): last date and result, any colposcopy; **breast screening** (CBE/mammography) and self-awareness; **vaccinations** (HPV, hepatitis B, tetanus).

4. **Obstetric history (G-P-L-A)**

- **Gravida**, **Para** (term + preterm), **Abortions** (spontaneous/induced, gestational age), **Living**; mode of deliveries, **instrumental/LSCS**, **complications** (PPH, PIH, GDM), **neonatal outcomes**; **Rh** status if known.

5. **Past medical history**

- **Endocrine** (thyroid, diabetes), **hypertension**, **tuberculosis**, **bleeding disorders**, **epilepsy**, **migraines with aura**, **thromboembolism**, **autoimmune** conditions.

6. **Past surgical/anaesthetic history**

- Pelvic/abdominal surgeries (appendicectomy, myomectomy, LSCS, laparoscopy), complications, **blood transfusions**.

7. **Medications & allergies**

- Prescribed, OTC, **herbal/traditional**, **hormones**, **anticoagulants**; exact **allergen** and reaction (rash, anaphylaxis).

8. **Family history**

- **Breast/ovarian/uterine/colon** cancers (consider hereditary patterns—BRCA/Lynch), **fibroids**, **Endometriosis**, **diabetes**, **twins**.

9. **Psychosocial & lifestyle**

- **Diet**, **physical activity**, sleep; **tobacco**, **alcohol**, **substances**; occupation; **stress, mood**; support systems.
- **Adolescent HEADSSS** (Home, Education, Activities, Drugs, Sexuality, Suicide, Safety) when appropriate.

10. **Systemic review (targeted)**

- **Thyroid** (heat/cold intolerance), **galactorrhoea**, **hirsutism/acne** (hyperandrogenism), **weight change**, **bone pain** (perimenopause).

11. **Summary back to patient**

- Paraphrase key points; confirm priorities; obtain consent for exam/investigations.

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3) Life-Stage Adaptations

Adolescent

- Common: cycle irregularity in first 2 years post-menarche, primary dysmenorrhoea, acne/hirsutism (PCOS screening), sexual health education.
- Consent: consider **assent** and guardian involvement per law; ensure confidentiality regarding sexuality unless safety risk.

Reproductive age

- AUB, dysmenorrhoea, fibroids, endometriosis, infections, contraception, fertility planning. Always exclude **pregnancy** in amenorrhoea or AUB.

Perimenopause

- Cycle variability, vasomotor symptoms, **HMB** from anovulatory AUB-O; screen for **PMB** (red flag). Review co-morbidities and medicines affecting bleeding.

Postmenopause

- **Any PMB = malignancy until proven otherwise**; ask about **HRT**, anticoagulants, GSM symptoms (dryness, dyspareunia, recurrent UTI), continence and prolapse.

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4) Red Flags That Change Your Pace

- **PMB**, **PCB**, **post-menopausal discharge with blood**
- **Acute severe lower abdominal pain** with syncope/vomiting (consider ectopic, torsion)
- **Foul discharge with fever**, pelvic tenderness (PID)
- **Rapidly enlarging mass**, early satiety, weight loss (ovarian malignancy)
- **Unexplained weight loss, pruritus vulvae in elderly**, persistent ulcer/lesion (vulvar neoplasia)
- **Violence or coercion**, suicidal ideation.

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5) From History to Differential—How You Think

- **Heavy, regular bleeding** from menarche → likely **coagulopathy** or **fibroids/adenomyosis** (PALM).
- **Irregular, infrequent cycles** + acne/hirsutism → **PCOS** (COEIN-O).
- **Cyclical deep dyspareunia + dysmenorrhoea + subfertility** → **endometriosis**.
- **Offensive discharge, postcoital bleeding** → **cervicitis** vs **cervical ectopy** vs **neoplasia** (screening status?).

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- **PMB → endometrial atrophy** common, but **rule out cancer/hyperplasia**.

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6) Sensitive Question Phrasing (Examples)

- “Some people have pain during intercourse. **Is this ever a concern** for you?”
- “Have you ever had **bleeding after sex**?”
- “To plan safely, which **birth control** are you using now, if any?”
- “Do you **feel safe** in your relationship(s)?”
- “We ask all patients about infections. **Have you or a partner** ever been treated for an STI?”

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7) Documentation — What Your Case Sheet Should Capture

Section	Minimum elements to record
Identifiers	Name/age, contact, MRN/date, informant, language
CC & Duration	Symptom(s) with time course
Menstrual profile	Menarche, cycle length/regularity, duration, flow, clots, dysmenorrhoea, LMP/FMP, IMB/PCB/PMB
Obstetric	G-P-L-A with details of each pregnancy outcome
Sexual & fertility	Activity, dyspareunia, contraception, fertility duration/goals
Discharge	Colour/odour/itch, amount, triggers, STI risk
Urinary/bowel/pelvic floor	LUTS, incontinence type, prolapse symptoms, constipation
Medical/surgical	Comorbidities, operations, transfusions
Drugs & allergies	Name, dose, duration; reaction specifics
Family & social	Hereditary cancers/metabolic disease; IPV, stressors
Screening	Pap/HPV/breast screening dates & results; vaccinations
Summary & plan	Problem list, red flags, agreed next steps, consent for exam/tests

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8) OSCE-Style Mini-Algorithms You Should Recite

AUB triage (non-pregnant):

1. Hemodynamic status → resuscitate if unstable.
2. Exclude pregnancy (urine/serum β-hCG).
3. Classify using **PALM-COEIN** from history.
4. Decide first-line tests: CBC, TSH, pelvic USG; endometrial sampling if **≥45 y** or risk factors.

Discharge triage:

1. Colour/odour/itch/pain profile.
2. Risk assessment for **STI/PID**.
3. Speculum swab if indicated; syndromic treatment per protocol.

Pelvic pain triage:

1. Rule out pregnancy, torsion, PID.
2. Time relation to menses/sex; GI/urinary clues.

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9) Sample Focused Histories

Case 1: Heavy regular periods (HMB) for 1 year

- Quantify flow, flooding, clots, anaemia symptoms; obstetric desires; contraception; dysmenorrhoea; pressure symptoms (fibroids) vs intermenstrual/PCB (endometrial/cervical pathology). Drugs (anticoagulants). Family bleeding history.

Case 2: Secondary amenorrhoea

- LMP, pregnancy test; lactation/stress/weight loss; galactorrhoea, headache/visual symptoms (prolactin); thyroid; hot flushes (POI); prior D&C (Asherman's).

Case 3: Postmenopausal bleeding

- FMP date; HRT/anticoagulants; quantity; pain; weight loss; diabetes/obesity; cervical screening status.

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10) Common Pitfalls

- Skipping **pregnancy test** questions in reproductive-age patients.
- Assuming monogamy or marriage; using judgmental language.
- Not asking about **IPV** or **mental health** when cues exist.
- Poor documentation of **LMP** and **screening dates**.
- Forgetting **drug causes** (anticoagulants, hormonal therapy).

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11) Ten High-Yield Revision Points

1. Always start with **LMP** (or **FMP** in postmenopause).
2. Use **PALM-COEIN** to think through AUB.
3. **PMB is a red flag**—requires endometrial evaluation.
4. Discharge with **itch + curdy** → candidiasis; **thin, fishy odour** → BV; **frothy, yellow-green** → trichomonas (ask STI risks).
5. **Dysmenorrhoea + deep dyspareunia** → endometriosis until proven otherwise.
6. In infertility, record **duration**, **coital frequency**, any **male factor** evaluation.
7. Record **contraception** and side effects; discuss LARC.
8. Ask about **urinary and pelvic floor** symptoms in all parous/postmenopausal women.
9. **HPV/Pap** history is essential in PCB/IMB and routine screening.
10. Summarise and **reflect back** to confirm understanding and consent for exam.

Assessment

A) MCQs (one best answer)

1. The **first question** to exclude in reproductive-age amenorrhoea is:
   A. Thyroid disease B. Pregnancy C. Prolactin excess D. PCOS
   Answer: B
2. Heavy but **regular** bleeding since menarche suggests evaluating for:
   A. Coagulopathy B. Ovulatory dysfunction C. Endometrial polyp D. Iatrogenic cause
   Answer: A
3. **Postcoital bleeding** most strongly prompts assessment for:

A. Ovarian cyst B. Cervical pathology C. Adenomyosis D. PID only
Answer: B

4. The **PALM-COEIN** classification is used for:
   A. Vaginal infections B. Pelvic pain C. Abnormal uterine bleeding D. Prolapse
   Answer: C
5. In a discharge history, **curdy white discharge with itching** suggests:
   A. BV B. Trichomonas C. Candidiasis D. Atrophic vaginitis
   Answer: C
6. Which is a **red flag** in the history?
   A. Dysmenorrhoea in teenager B. Intermenstrual spotting once C. Postmenopausal bleeding D. Occasional dyspareunia
   Answer: C
7. In infertility history, the **minimum duration** before labelling (age <35 y) is:
   A. 3 months B. 6 months C. **12 months** D. 24 months
   Answer: C
8. **Deep dyspareunia + dysmenorrhoea + infertility** point to:
   A. Fibroid submucous B. Endometriosis C. PID acute D. Adenomyosis only
   Answer: B
9. In perimenopause, irregular heavy bleeding most often reflects:
   A. Coagulopathy B. Ovulatory dysfunction C. Cervical cancer D. PCOS
   Answer: B
10. When taking a sexual history, the **best** approach is:
    A. Skip if married B. Use closed, judgmental questions
    C. **Use neutral, patient-centred language with consent** D. Ask in front of relatives
    Answer: C

B) Short Answer Questions (3–5 lines each)

1. List the elements of a **complete menstrual history** and how you quantify flow.
2. Outline the **PALM-COEIN** classification.
3. What **three questions** screen for IPV safely?
4. Write a focused **history set** for **postmenopausal bleeding**.
5. How do you **differentiate primary vs secondary dysmenorrhoea** on history?

C) Long Answer Questions

1. Describe a **structured approach** to gynaecological history taking across life stages. Explain how you would triage **AUB**, **vaginal discharge**, and **pelvic pain** using history alone to frame the first-line differential and investigations.
2. Write a **full case sheet** for a 28-year-old with **secondary amenorrhoea**, showing how each history element narrows the differential and guides safe next steps.

D) OSCE Stations (structured checklist)

- **Station 1: AUB history (5 min)**
  Candidate takes history focusing on cycle pattern, flow quantification, anaemia symptoms, pregnancy exclusion, PALM-COEIN sorting, drug history.
- **Station 2: Discharge history (3 min)**
  Candidate elicits colour/odour/itch/pain, STI risk, partner treatment, prior antibiotics, screens for PID warning signs.
- **Station 3: Sensitive conversation (3 min)**
  Candidate demonstrates consent, neutral language for sexual history and IPV screening; offers resources if positive.