14c. Part 3. Per speculum examination

Speculum Examination (Pelvic Speculum): A Clear, OSCE-Ready Clinical Guide

Why this matters

Speculum examination is a core clinical skill in gynaecology, sexual health, emergency care, and primary care. You're expected to communicate clearly, protect dignity, and examine systematically to visualise the vagina and cervix, recognise common pathology, and document findings accurately.

Equipment and setup

- Clean gloves and apron
- Water-based lubricant
- Appropriate-sized **bivalve speculum** (typically disposable plastic)
- Good **light source**
- Paper towels/tissue and clinical waste bin nearby

Environment & privacy: Offer a toilet beforehand, provide a sheet, and ensure a chaperone is present (and documented).

Communication, consent, and safety

1. **Introduce & identify:** Name, role; confirm patient's name/DOB.
2. **Explain the procedure** in plain language: you'll insert a small device (speculum) into the vagina to view the cervix and vaginal walls; it shouldn't be painful, but may feel uncomfortable; the patient can ask you to stop at any time. Light bleeding may occur after the procedure.
3. **Chaperone:** Offer and proceed only with agreement.
4. **Checks before starting:** ask about **pain** and whether the patient **may be pregnant**; offer the opportunity to **pass urine**. Provide privacy to undress and check before re-entering.

Patient positioning

- Confirm ongoing consent and position in **modified lithotomy**: "Slide your heels up to your buttocks, feet flat on the bed, and let your knees fall apart." Ensure comfort and adequate lighting.

Step 1 — External (vulval) examination

Before inserting the speculum, perform a **brief vulval exam** and palpate **inguinal lymph nodes** to screen for local pathology and lymphadenopathy.

What to look for on the vulva/perineum

- **Ulcers** (e.g., HSV)
- **Abnormal discharge** (BV, candidiasis, chlamydia/gonorrhoea, trichomoniasis)
- **Scarring** (episiotomy, **lichen sclerosus**), **architectural change**/atrophy (postmenopausal)
- **White patches (leukoplakia)**—consider lichen sclerosus

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- **Other lesions** (folliculitis, molluscum, warts), **masses** (e.g., **Bartholin's cyst**), **varicosities**
- **Female genital mutilation (FGM)**: know the definition and safeguarding duties (mandatory reporting in minors in some jurisdictions)
- **Vaginal prolapse**: a bulge at the introitus; asking the patient to **cough** can accentuate it

Clinical pearls

- **Bartholin's cyst**: classically a **unilateral, fluctuant** mass at 4 or 8 o'clock.
- **Lichen sclerosus**: white, thickened patches with pruritus and possible distortion of normal anatomy over time.

Step 2 — Prepare and insert the speculum

1. **Hand hygiene**; open the **speculum package** carefully without contaminating the device or inner wrap.
2. Express a small amount of **lubricant onto the inner packaging** and **dip the closed speculum blades** to lubricate.
3. **Warn** you are about to insert the speculum and ensure it is still okay to proceed.

Insertion technique (gentle and controlled):

- With your non-dominant hand, **separate the labia**.
- With the **blades closed**, insert the speculum **sideways** (handle at **3 or 9 o'clock**).
- Once fully inserted, **rotate 90°** so the handle faces **upwards**.
- **Open the blades slowly** until you obtain an optimal view of the cervix.
- **Tighten the locking nut** to secure the position.

Step 3 — Inspect the cervix and vaginal walls

Systematically evaluate and **describe what you see**:

Cervix

- **External os**: if **open in pregnancy**, consider **inevitable or incomplete miscarriage** in the appropriate context.
- **Eversion/erosion appearance**: **cervical ectropion** is common and benign but can resemble early neoplasia—correlate with symptoms (e.g., post-coital bleeding).
- **Masses or ulceration**: red flags for **cervical malignancy**; look for abnormal vascular patterns or friability.
- **Scarring** (e.g., prior LLETZ).

Vaginal walls and vault

- **Ulceration** (HSV), **atrophy** (post-menopausal), **foreign bodies** (retained tampon/condom), **abnormal discharge** (BV, candidiasis, trichomoniasis, chlamydia, gonorrhoea).

Background you should know for viva:

- **Cervical cancer** is associated with persistent **HPV** infection; **CIN** may precede invasive disease and is detected through screening—early lesions may appear as white/red patches, advanced disease as an ulcer or tumour.

Step 4 — Removing the speculum safely

- **Support the blades** with your non-dominant hand while **loosening the locking nut** with the dominant hand (prevents sudden snapping shut).

- **Withdraw slowly while partly closing the blades**, inspecting the **vaginal walls** on the way out.
- **Cover** the patient, explain completion, and provide **privacy** to dress and **paper towels** to clean lubricant. Dispose of equipment appropriately; remove PPE; **hand hygiene**.

Documentation & closing the loop

- Record **indication**, **consent**, **chaperone details**, **positioning**, key **findings** (cervix, vaginal walls, discharge), patient **tolerance**, and any **samples** taken.
- Provide a **clear summary** to the patient and discuss next steps.

If findings are abnormal or symptoms warrant, consider:

- **Urinalysis including β-HCG** (if pregnancy status uncertain)
- **Bimanual examination** (masses, cervical motion tenderness)
- **Vaginal/cervical swabs** (infection)
- **Pelvic ultrasound** (further evaluation)

Common OSCE pitfalls (and how to avoid them)

- **Skipping the vulval exam** before speculum insertion → always inspect externally first.
- **Poor communication** → narrate steps, check comfort, and re-confirm consent before insertion.
- **Inadequate lubrication or lighting** → ensure both to reduce discomfort and improve visualisation.
- **Letting the blades snap shut** on removal → support the blades while loosening the lock, then close gradually as you exit.
- **Forgetting chaperone documentation** → record their **name and role**.

Rapid “talk-through” template (for the examiner)

> “I explained the speculum exam and obtained consent with a chaperone present. After a brief vulval exam and inguinal node check, I inserted a lubricated, appropriate-sized speculum with the blades closed, initially sideways then rotated to upright, opened the blades to visualise the cervix, and inspected the cervix and vaginal walls for ectropion, ulceration, masses, foreign bodies, and abnormal discharge. I then supported the blades, loosened the lock, and withdrew while inspecting the walls. I covered the patient, disposed of equipment, washed my hands, and documented the findings and chaperone details. If indicated, I’d perform urinalysis (β-HCG), swabs, a bimanual exam, and arrange ultrasound.”

Quick checklist (memorise)

- Hand hygiene → intro/ID → explanation → **chaperone** → consent; offer toilet.
- Modified lithotomy, good light, external **vulval** inspection + **inguinal nodes**.
- Lubricate → insert **sideways** with blades closed → rotate **up** → open & **lock**.
- **Inspect cervix** (os, ectropion vs malignancy features, masses, scarring) and **vaginal walls** (ulcers, atrophy, foreign body, discharge).
- **Support blades** → unlock → withdraw slowly while re-inspecting → cover, thank, dispose, wash hands → **document** (incl. chaperone).

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Adapted for teaching from the Geeky Medics “Speculum Examination – OSCE Guide.”

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