14c. Part 5. Per rectal examination

Per Rectal & Rectovaginal Examination in Gynaecology: An OSCE-Ready Step-by-Step Guide

Purpose and scope

How to safely perform and interpret a **per rectal (PR)** and **rectovaginal (RV)** exam in gynaecology—what to say, how to position the patient, what to look and feel for, and how to document/complete the assessment. RV exam supplements the pelvic exam when you need a better feel of the **posterior pelvis** (uterosacral ligaments, rectovaginal septum, pouch of Douglas) or to help characterise **retroverted uteri** and **adnexal masses**.

Indications (gynae-focused)

- **Deep dyspareunia**, chronic pelvic pain, or suspected **endometriosis** (assess uterosacral nodularity/tenderness; pouch of Douglas).
- **Pelvic/adnexal mass** on history or bimanual exam (posterior location or poor windows).
- Suspected **rectocele**, posterior compartment prolapse, or symptoms with straining.
- **Postpartum** concerns about anal sphincter function (screen tone after OASI).
- As part of a complete **pelvic exam** when the posterior pelvis needs better characterisation.

RV exam is not a routine screening test in asymptomatic patients; use it **selectively** based on symptoms and exam needs.

Equipment

- Non-sterile gloves and apron
- **Water-based lubricant**
- Good light source
- Paper towels/tissues; clinical waste bin; chaperone available and documented

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Preparation, consent, and dignity

1. **Hand hygiene & PPE**, introduce yourself, confirm identity.
2. **Explain** in plain language: you'll examine the back passage (and, if needed, a combined vaginal–rectal exam) to assess the back of the uterus and nearby tissues; it may be uncomfortable but shouldn't be painful; they can ask you to stop anytime. Offer **toilet** beforehand.
3. **Chaperone:** offer and document. Re-check consent before touching.
4. **Exposure & privacy:** drape carefully. Ask about **pain** before starting.

Positioning

- **Left lateral (Sims') position**, hips and knees flexed toward the chest, is comfortable and standard for PR; ensure good lighting and patient comfort.
- RV exam can also be done in **lithotomy** if you're already completing a speculum/bimanual exam.

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Step 1 — External inspection (perianal & sacral area)

Separate the buttocks and look for: **fissures, haemorrhoids, fistula openings, scars, skin changes**, prolapse. Ask the patient to **bear down** (Valsalva) to accentuate prolapse/rectocele.

Step 2 — Digital Per Rectal (PR) examination

1. **Warn**, apply **lubricant** to your gloved index finger.
2. Gently place the finger-pad on the anal verge; as the sphincter **relaxes with a deep breath**, advance the finger **posteriorly** following the anal canal's axis.
3. Assess **resting tone** (on entry) and **squeeze tone** (ask the patient to "tighten").
4. Palpate the rectal walls **360°**: posterior, lateral, and **anterior** (toward the vagina/cervix) for masses, tenderness, or irregularity.
5. In women, the **anterior wall** may transmit the **cervix/uterus**—note tenderness or fixation.
6. Withdraw slowly, inspecting the glove for **blood, mucus, pus, stool**.

What you might feel (gynae context):

- **Normal:** smooth rectal mucosa; normal tone; posterior cervix possibly palpable; no tenderness.
- **Rectocele:** bulge of the **anterior rectal wall** on strain.
- **Posterior mass:** consider **ovarian cyst/fibroid** or cul-de-sac disease if felt anteriorly from rectum.

Step 3 — Rectovaginal (RV) examination (when indicated)

Why: improves assessment of the **posterior uterus**, **uterosacral ligaments**, **rectovaginal septum**, and pouch of Douglas; helps detect **retroverted uteri** and posterior **adnexal masses**.

How:

1. If you've just completed PR or PV, **re-glove/re-lubricate**.
2. Insert the **index finger into the vagina** and the **middle finger into the rectum**.
3. With your **external (abdominal) hand** applying gentle suprapubic counter-pressure, **sweep** between the two internal fingers to palpate the **rectovaginal septum**, **pouch of Douglas**, and **uterosacral ligaments** for **nodularity, thickening, masses, or tenderness**.
4. Ask the patient to **bear down** to assess for **rectocele** or posterior compartment prolapse.

Interpretation (examples):

- **Endometriosis**: **tender nodularity** along uterosacral ligaments or in the cul-de-sac; uterus may be fixed/retroverted. (RV exam is specifically used to better characterise posterior pelvis when suspected.)
- **Retroverted uterus**: posterior uterine surface appreciable; mobility and tenderness assessed.
- **Posterior adnexal mass**: discrete fullness/mass felt between rectum and vagina—consider **ovarian** pathology and correlate with imaging.

Completing the examination

- **Cover & reassure**, offer tissues, provide privacy to dress; dispose of equipment; remove PPE; **hand hygiene**.
- **Document**: indication, consent/chaperone, position, findings (tone, mucosa, septum, uterosacrals, cul-de-sac,

masses, tenderness), patient tolerance, and any complications.

What you'd add (if clinically indicated)

- **Pelvic exam completion** (speculum + bimanual) if not already done.
- **Urinalysis/β-HCG** (if pregnancy status unclear), **vaginal/cervical swabs** if infection suspected.
- **Pelvic ultrasound** to characterise masses; **MRI/endoanal ultrasound** in suspected OASI.
- **BP/urinalysis** if pre-eclampsia concerns, and targeted labs/imaging per differential.

Red flags & special notes

- **Severe pain**, fever, purulent discharge, or a **hard/irregular fixed mass** → urgent gynaecology/colorectal review.
- **Postpartum OASI** concerns (flatal/faecal incontinence, reduced tone) warrant **careful PR assessment**, documentation of tone, and appropriate follow-up/referral.

OSCE talk-through (concise template)

> "With a chaperone present, I explained and obtained consent. In the **left lateral position**, I inspected the perianal region, then performed a **lubricated PR**, assessing resting and squeeze tone and palpating circumferentially, including the **anterior wall**. I then performed a **rectovaginal exam** with index in the vagina and middle finger in the rectum while applying suprapubic counter-pressure. I palpated the **rectovaginal septum**, **uterosacral ligaments**, and **pouch of Douglas**—there was **no nodularity or tenderness**, the uterus felt **mobile**, and there were **no posterior masses**. I withdrew, covered the patient, disposed of equipment, washed my hands, documented findings including **chaperone**, and would complete with pelvic ultrasound or swabs as indicated."

Quick checklist (memorise)

- Hygiene → intro/ID → explanation → **chaperone** → consent; offer toilet.
- **Position**: left lateral (or lithotomy if already examining pelvis).
- **Inspect** perianal area; ask to **bear down**.
- **PR**: warn → lube → gentle insertion → **resting/squeeze tone** → 360° sweep → inspect glove.
- **RV**: index in **vagina** + middle finger in **rectum** → palpate **septum, uterosacrals, cul-de-sac**, uterus posterior surface; strain for rectocele.
- **Close**: cover, thank, dispose, **hand hygiene**, **document** (incl. chaperone) → arrange targeted tests/imaging.

FAQs (for viva)

- **When do you add an RV exam?** When posterior disease is suspected or **bimanual** doesn't adequately characterise the posterior pelvis or a suspected mass.
- **What extra can RV tell you? Uterosacral nodularity** (endometriosis), **rectovaginal septum** thickening, **retroverted uterus** assessment, and better appreciation of **posterior adnexal masses**.
- **Is RV a cancer screen?** No; it may be done when **checking for cancer or other problems** based on presentation, not as a stand-alone screen.

Prepared as a teaching summary using clinical skills guidance and gynae references (Geeky Medics, StatPearls, Stanford Medicine 25, Merck Manual, ACOG, and a state skills checklist).

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