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

Preparation, consent, and dignity

- 1. Hand hygiene & PPE, introduce yourself, confirm identity.
- 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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WHERE CLASSICAL WISDOM MEETS INTELLIGENT LEARNING

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.
- 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,

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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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