BASIC PROFESSIONAL SKILLS INFORMATION

NECESSARY FOR UNIT 4

First off, what to expect…

Breast examination

Digital Rectal examination (Per rectal exam)

Male reproductive examination

Male catheterization

Gynecological physical examination + history

Obstetric physical examination (late pregnancy) + history

**Breast examination:**

Triple assessment (focus on no. 1 only)

1. HISTORY-TAKING & PHYSICAL EXAMINATION
   * Focus on the risk factors (major vs. minor)
2. RADIOLOGICAL INVESTIGATIONS (Mammogram, Ultrasound)
3. Histological investigation (Core needle biopsy, Fine Needle Aspiration Biopsy)

Breast physical exam technique:

1. Introduce yourself
2. Ensure privacy by closing the curtain
3. Say that professionally, a **third person should be observing** the exam (a nurse)
4. Ask patient for permission to examine her breast + put on gloves
5. If she agrees, **expose her down to the umbilicus only**
6. Seat her on the edge of the bed with hands on her laps
7. **Inspect the breasts**:
   1. **Nipples** for symmetry, retention/**inversion**
   2. Breast sizes, **contour**
   3. Any lesions, visible secretions, **bleeding**, rashes, **discoloration**
   4. Paget’s disease? **Cracked** nipples? **Mastitis**?
   5. Any abnormalities such as polythelia, **masses**, visible lumps
   6. **Montgomery’s tubercles** seen during pregnancy (sebaceous glands?)
   7. **Peau d’orange**, visible **dimpling**, retention/inversion
      1. Peau d’orange is due to a **block in lymphatics**, mostly due to cancer… “Inflammatory carcinoma”
      2. **Dimpling** and nipple inversion both can be symptoms of **fibrosis of the Cooper ligaments**/Suspensory ligaments, pulling them inwards
8. At one point or another, **suggest to the patient** or ask her if she does **self-exams**
9. Ask the patient to hold up her arms and put her **hands behind her head**
   1. Notice **symmetry in movement**
   2. Notice any visible masses or unusual changes
   3. Whether it **shows the dimpling (if any) more clearly**
10. Ask the patient to put her **hand on her hips or waist**
    1. **Pectoralis major** muscle should be **contracted**
    2. Any **invasive** carcinomas that attach to the chest wall **moves with it**
11. You may also ask the patient to **lean forward**
    1. Watch the breasts as they become **pendulous**… Check for **symmetry**
    2. Any unusual observations noted? **Dimpling**?
12. Ask the patient to lie down (**supine position**)
13. Based on the breast you examine, **place a pillow below that part of her back**, ***or*** let her **lie at 45 degrees**
14. **Palpation** of the breast (**BOTH** BREASTS!)
    1. First **ask if she feels any pain** anywhere in her breasts, if she does, **leave that area till the end**
    2. Use the **PADS of your fingers** + watch for **tenderness (on face)**
    3. **One hand to support** breast, **other to palpate**
    4. 1 of 3 ways (either ways, you must **cover all the quadrants** and the **tail of Spence** too! Don’t forget to **glide instead of jump**, and feel in **circular patterns**)
       1. Go in **concentric circles** around the breast from **in to out**
       2. Up and down from lateral to medial
       3. Inward and outwards all around
    5. Always **note any unusual masses** and **comment at the end**
    6. For masses:
       1. **Consistency** (*firm* like nose? *Hard* like forehead? *Soft* like lips?)

Comment on:

Site

Size

Shape

Consistency

Circumscribed

Mobility

Tenderness

* + 1. **Well-circumscribed or not**
    2. **Size** (2 cm?)
    3. **Shape** (*regular, irregular*?)
    4. **Mobile** (usually *benign*) **or attached** (usually *malignant*)
    5. **Tenderness** (painful?)
    6. **Site** (*WHICH QUADRANT*?)
  1. **Mouse of the breast** = **fibroadenoma** (always moves away from your finger)…

1. If there is any **complaints of nipple discharge**, **palpate the nipple** by **gently squeezing** it and noticing any discharge – usually **done in the SITTING POSITION** (note the characteristics if there actually is discharge – **color, consistency, quantity**) – **bleeding ~ intraductal papilloma**
2. **Axillary Lymph Node palpation** (**her arm on your non-working shoulder**)
   1. You should know the names of axillary lymph nodes, where they drain
   2. **Anterior, posterior, central, apical and lateral** (on arm)
   3. Classification based on levels (**LEVEL 1 = lateral/below to pectoralis minor, LEVEL 2 = deep to pectoralis minor, LEVEL 3 = medial/above to pectoralis minor)**
   4. Always **check both axilla**
   5. Warn the patient that it might hurt (you’re going to have push in deep for the apical lymph nodes)
   6. Axillary lymph nodes eventually drain into **supraclavicular lymph nodes**
      1. If they’re assholes, they’ll ask you to palpate for that
      2. **Stand BEHIND the patient for ANY NECK EXAMS**.
      3. Neither the supra or infraclavicular lymph nodes are normally palpable

**DIGITAL RECTAL EXAMINATION**

Again:

1. Introduce yourself
2. Ask for permission to examine the patient
3. **Close the curtains to ensure privacy** (YOU MUST DO THIS)
4. Ask for a third person for **witness** (nurse) but rarely for this exam…
5. **Expose** patient (remove pants I guess?)
6. What **positions** can be used??
   1. **Left lateral** position (lying on left side – MOST COMMONLY USED) with **right leg flexed**
   2. Supine
   3. Knee-chest position
7. **INSPECTION**: ALWAYS INSPECT: for **warts, ulcers, lesions, hemorrhoids, visible masses, piles, anal tags, fistulas, discharges**
8. Put on your **gloves** (sterile vs. non-sterile), **lubricate it**
9. Insert your **index finger** inside the anus slowly
10. **Assess the anal tone**
    1. Sometimes the sphincter will close itself
    2. Sometimes you can ask the patient to voluntarily do so
    3. Some people say you can massage the perineum
11. **Clock-wise rotation**
12. **Anti-clockwise rotation**
13. **Median sulcus** (separating the lateral lobes) of prostate gland
    1. **Posterior lobe (peripheral zone)** 🡪 mostly gets **carcinoma**, **transitional zone (middle lobe)** 🡪 mostly gets **benign prostatic hyperplasia** (BPH; affects urination)
    2. **Feel for any hardness** or irregularly growing mass
    3. **Ask the patient if feels pain** (or look for tenderness)
14. Slowly pull out your finger and **examine it for any blood and stool**

MALE REPRODUCTIVE EXAMINATION

As always:

1. Introduce yourself
2. Ask for permission and explain to the patient the purpose of exam
3. Say that ideally there’d be a third person (though unlikely for this exam)
4. **Close the curtains** to ensure privacy
5. Expose the patient **from the umbilicus downwards**
6. Best position to examine = **STANDING POSITION**
7. **Inspection** of penis and scrotum (whole gentialia)
   1. **Hair distribution** (triangular/diamond)
   2. Ask patient to push down genitalia to **examine pubic hair**
   3. **Vesicles, ulcers, warts, chancre, chancroids**
   4. **Urethral discharge**, **masses**, **discoloration**, reddening
   5. **Penile size** (normal or abnormal)
   6. **Penile deviation** or bending
   7. **Position of external meatus** (should be central)
   8. Hypospadias? Epispadias?
   9. **Scrotal size, skin color, NORMALLY LEFT ONE IS LOWER**
8. **Palpation**
   1. Examine the **shaft** of the penis by **pressing it using two fingers** and **thumb** (feeling the spongy urethra)
   2. Index finger and thumb pressed down **on glans** to check for **urethral discharge**
   3. Glans penis vs. corona vs. prepuce (= foreskin = not present if circumcised)
   4. **Palpate the scrotum** using **two fingers and a thumb** underneath
      1. Check for any **masses** and make sure you look at the patient’s face to check for any **tenderness**
      2. **Feel the epididymis** (posterior and superior to testis)
      3. Feel the **vas deferens** by going a bit upwards
      4. **Varicocele** 🡪 **most likely left side** (because the left testicular “pampiniform” vein joins left renal vein) and feels like “BAG OF WORMS”
      5. **Ask the patient to bear down** to check for **inguinal hernias**, but that’s not a part of this unit…

CATHETERIZATION

1. Introduce yourself
2. Ask for permission
3. Third person (nurse) to watch
4. Privacy (close curtains)
5. Tell the patient what you’re going to do
6. **Aseptic technique**, only **expose from umbilicus to mid-thigh** to prevent contamination + one hand gloved, the other isn’t
7. **Apply betadine (antiseptic) over the whole area**
8. **TEST THE INTEGRITY OF THE FOLEY’S CATHETER** (sizes: 12, 14 or 16)
   1. Use syringe to **fill in some air** (in reality, you’re supposed to use saline) and **check balloon forms**… If yes, remove the air again.
9. One hand (not gloved) holding penis
10. Other hand has **Xylocaine gel** (**anesthetic and lubricant** dual activity)
    1. **Insert into external urethral meatus/orifice of penis**
    2. **Wait** 2 – 3 minutes for it to take effect
11. **Place the tip of the catheter into the urethra**
    1. Keep pushing in until you **feel resistance,** but the most accurate sign you’ve reached the bladder 🡪 **urine might drip through catheter**
12. **Pump up the catheter** to ensure that it lodges in bladder (gently tug)
13. **Attach the urine bag** to the other hose
14. When **removing the catheter**, **ensure that you deflate it first** and carefully and slowly pull it out…

**GYNECOLOGICAL PHYSICAL EXAM + HISTORY**

History is based on the handout they gave us… Read the checklist:

* Gynecological history
* **Personal history** (name, **age**, **parity**, duration of marriage, nationality, **LNMP**)
* **Chief complaint** (if any) = complaint + duration
* **History of present illness** (if there was a complain)
* **Past medical history** (previous illnesses, operations, medications, allergies)
* **Obstetric history** (Ask only if she is not nulligravid)
* **Menstrual history** (**LNMP, age of menarche, regularity, duration, amount of blood loss, associated symptoms**)
* **Contraceptive history**
* **Sexual history** (dyspareunia?)
* Vaginal discharges? (color, volume, smell, consistency)
* **Social and family history** (education, living condition, weight, lifestyle, smoking, hobbies, any diseases/conditions running in the family?)
* **System review** and **summary**

Gynecological physical exam:

* Speculum exam (with pap smear, high vaginal swab)
* Bimanual exam
* Rectovaginal exam

1. Introduce yourself
2. Ask for permission
3. **Accompanying nurse = important**
4. **Privacy = close curtains (important)**
5. Patient position = dorsal position with **hip flexed and abducted**
   1. Our doctor called it the lithotomy position
6. **Wear gloves**
7. **INSPECTION:**
   1. External inspection (before applying speculum)
      1. Evidence of infection, ulceration, vesicles, warts, skin changes, redness, hair distribution in labia majora and mons pubis (inverted triangle)
   2. Internal inspection (during speculum exam)

SPECULUM EXAM

1. Explain to the patient everything you’re going to do and warn them, **maintain eye contact** when possible
2. Choose the **appropriate speculum size**
3. **Some doctors say to lubricate while others say to wash it with warm water ONLY (because it might affect the results of swabs)**
4. **Separate the labia minora** to make the introitus visible using one hand (make sure to **avoid the mons pubis and clitoris** while doing this, because it is a sensitive area and might be uncomfortable for the patient)
5. Insert the speculum **sideways** and **turn it upwards when inserted**
6. Push the speculum open to display the anterior (up) and posterior (down) vaginal fornices as well as the intravaginal cervix
7. Internal inspection:
   1. **Nulliparous 🡪 small circular os** + smooth cervix
   2. **Multiparous 🡪 slit-like transverse os.**
   3. Possible exposure of endocervical epithelium (called **ectropion**)
   4. Any abnormalities noticed? **Discoloration, discharge, bleeding**
8. Take a **high vaginal swab** using the wooden cotton swab
   1. Brush it against **posterior fornix** (deeper, more dependent area)
   2. Put it back into the **sterile tube** and send it to **MICRIOBIOLOGY lab** for investigation
9. **Pap smear**
   1. Pap stands for **papanicolaou** (just in case you’re asked)
   2. **Ayre’s spatula** (**wooden** spatula)
      1. Insert the bigger lobe of bi-lobed end into the external cervical os and turn it sideways to **take samples from the transformation zone (squamocolumnar junction) of cervix**
      2. Apply it on the **slide** and add the **methyl alcohol fixative**
      3. IF YOU THINK IT’S NECESSARY, use the other end of the spatula to obtain sample from the fornix
      4. Using the **endocervical brush**, take an **endocervical sample** by **rotating it 360 degrees**… Then add to **slide** and **fixate**…
      5. There’s a newer brush (that takes both ecto and endocervical samples ☺ - **thin prep**)
      6. Either ways, send sample to **CYTOLOGY LAB for assessment**
   3. **As you withdraw** the speculum, **inspect the lateral walls**
   4. Remove speculum the same way you put it in (closed)

**BIMANUAL EXAM:**

1. Tell the patient what you’re going to do
2. **BLADDER SHOULD BE EMPTY**
3. **Gloved fingers should be lubricated**
4. **Insert one finger (index finger) first** and then the second while the other hand separating the labia
5. Gently push in until you **feel the cervix**
6. Your other hand should be placed on the lower abdomen to try to feel the uterus in between
7. Uterus should **anteverted and anteflexed**
   1. You won’t be able to feel it if it is retroverted nor if the patient is severely overweight
8. Feel for the **position, shape, size and mobility** of the uterus, noting any **tenderness**…
9. It **should feel firm and slightly mobile + non-tender**
10. Place your **finger in the fornices** and your other hand concurrently on the **adnexia** (corner) to try to palpate for the ovaries
    1. **Normally, ovaries are non-palpable**
    2. Feel for any irregular masses
    3. Do the same for the other adnexia/ovary/fornix
11. Slowly withdraw fingers

Combined rectovaginal exam

* Same thing, except one finger in the rectum and the other is in the vagina
* Feel for the posterior vaginal wall and rectum for masses, fistulas, ect.

OBSTETRIC EXAM + HISTORY

I’m not gonna bother writing so much about this… Just remember the antenatal visit and you’re good.

1. Introduce yourself
2. Ask for permission
3. Third person to watch over you (nurse)
4. Close curtains to ensure privacy
5. Patient in supine position
6. Expose the patient from the **xiphoid process** to the **upper border** of the **pubic symphysis**
7. **Inspection**
   * **Distention** of abdomen
   * **Symmetrical** distention?
   * **Moves with respiration**?
   * **Striae gravidarum** (stretch marks)
   * **Linea nigra, spider nevi**
   * Any visible **scars**, **masses**
   * **Umbilicus… Inverted, everted (occurs late)**
   * **Hernias**?
8. **Palpation**
   * **Superficial palpation** (of the abdomen)
     + Ask the patient for any abdominal pain (**tenderness**) and where?
     + Feel all the parts of the abdomen gently and **go to the site of pain AT THE END**
   * **Obstetric**
     + **Fundal height** (**feel for fundus** going down from xyphoid process)
       - **Finger method** (Each finger below umbilicus = 1 week, each finger above umbilicus = 2 weeks)
       - **Tape method** (**apply tape upside down**, from upper border of pubic symphysis up to the fundus)
     + **Fundal palpation** (**two hands**)
       - Try to **identify** whether the **mass occupying the fundus** is soft and wide (buttocks) or small and hard (head)
     + **Fundal grip (one hand)**
       - Try to check if the **mass is ballotable (head)**
     + **Lateral palpation** (one hand stable, other hand feeling and then **switch hands**)
       - Make sure to **place whole hand down (FEEL IT)**
       - Long, continuous hard surface = back
       - Irregular, non-continous portions = limbs
     + **Pelvic palpation (first grip and second grip)**
       - **First grip (one hand)** 🡪 check if head or buttocks lies there
       - **Second grip (two hands)** 🡪 to tell if head/presenting part is **engaged** or not (descended into pelvis) – **your hands wont be able to meet**, **your BACK must be to the patient**
     + **Fetal heart auscultation**
       - **Depending on fetus’ lie** and **presentation** you need to know where is the best place to auscultate the heart
       - If cephalic and back is on the left = Left Occipital Anterior
       - Auscultate where the head meets the **shoulder (left)**
     + **Examine lower limbs for edema or varicose veins**
9. **SUMMARY OF OBSTETRIC EXAM** = VERY IMPORTANT!
   * **FUNDAL HEIGHT**
   * **FETAL LIE** (**Oblique, transverse, longitudinal**) – longitudinal = normal, also you must say either left lateral longitudinal or right lateral longitudinal..
   * **PRESENTATION** (breech or cephalic)
   * **ENGAGEMENT** (Engaged or not)
   * **POSITION** (Left Occipital Anterior = LOA, Right Occipital Anterior ROA, usually are the normal ones, they don’t ask about the others…)
     + Cephalic 🡪 can be either ROA or LOA depending on the back)
     + Breech 🡪 can be either RSA or LSA
   * **FETAL HEART RATE** (normal 120 – 160 bpm)
     + **Cephalic 🡪 heard below umbilicus** between **it and the anterior superior iliac spine** (depending on which side the fetus is lying)
     + **Breech 🡪 heard above umbilicus**

EXTRA STUFF TO KNOW:

IF YOU WANT TO BE VERY SMART, GO LEARN THE DIFFERENT KINDS OF VAGINAL DISCHARGES

NIPPLE BLEEDING 🡪 INTRADUCTAL PAPILLOMA, duct carcinoma, physiologic, duct etasia

**BREAST CANCER RISK FACTORS**

There are a lot, but remember the major and some minor ones include:

* + **Positive family history**
  + **Previously affected contralateral breast** (any previous lumps?)
  + **Age**
  + **Early menarche, late menopause**
  + **Nulliparous**
  + Obesity, alcohol, smoking
  + YOU FIND OUT YOURSELF!

**OBSTETRIC HISTORY TAKING**

* + - * Personal History
* Name, age, occupation, address, blood type, nationality, married
  + - * Chief complaint
* What, and for how long
  + - * History of present illness (if there is a complaint)
* SOCRATES – Site, Onset, Character, Radiation, Associated symptoms, Timing, Exacerbating and alleviating factors, Severity
  + - * **Current obstetric history/ current pregnancy**
* **Gravida, Parity, Abortion, Live**
* **Last normal menstrual period (LNMP), EDD using Nagel’s rule**
* **Gestational weeks currently**
* How did you know you were pregnant?
* What did you do to confirm that you’re pregnant?
* **Diet habits, nutritional supplements being taken**
* Based on the gestational weeks 🡪 quickening, etc.
* Planned or unplanned?
  + - * **Past obstetric history**
* Any complications during pregnancy (gestational diabetes, pre-eclampsia or diabetes induced hypertension, IUGR, abortions, emergency delivery)
* **Past deliveries**
  + Cephalic or breech presentation
  + Weight, male or female or twins
  + Duration of pregnancy in weeks (any preterm or premature?)
  + Complications during delivery? Retained placental, PPH
  + Puerperium problems – up to 6 weeks (first postnatal visit)
  + Type of delivery (caesarian or vaginal)
  + Breast feeding
    - * **Menstrual history**
* Age of menarche
* Menstrual cycle – duration of period and cycle, regular or not, heavy bleeding or normal
* Vaginal discharges?
  + - * **Past medical history**
* Any surgeries, medical conditions (inherited diseases or other problems like hypertension, diabetes, etc.)
* Did you stay in the hospital for any reason besides pregnancy?
  + - * **Family history**
* Anybody in your family has twins
* Breast cancer?
* Genetic diseases?
* Congenital diseases?
  + - * **Immunization, allergies, medications**
* …
  + - * **Contraceptive history and family planning methods**
* Are you using any forms of contraceptives?
* Are you planning to have any more children?
  + - * **Psychosocial history**
* Education level
* Smoking or drinking or not? (Both husband, wife, anyone else)
* Living circumstances (crowded or not?)
* Pets at home (think of cat)
* Hobbies?
  + - * **System review**
      * **Summary**
* **Name, age, parity, gestational age and why she is at the hospital**.