In 1975, an estimated 23,000 women in the United States will die of genital tract cancers. Yet many of these cancers are curable, if diagnosed at an early stage. Therefore, annual pelvic examination and cytologic smears are essential in all women who are sexually active or over the age of 20 years. Gynecologic examination is also indicated for women with watery discharge; abnormal bleeding: excessive menstrual flow, intermenstrual, postmenopausal or postcoital bleeding; and before administration of medicinal or hormonal treatment. Pain is not an early symptom of pelvic cancer.

When indicated by an abnormal history or physical examination, tissue sampling is mandatory and may include: diagnostic or excisional biopsy of the vulva; tissue from the endometrium by aspiration curettage or fractional curettage under anesthesia; punch or cone biopsy of the cervix; or paracentesis. The colposcope, a binocular instrument with 20x magnification, is an aid to careful inspection of the cervix. Its proper use requires training and experience, but in skilled hands, with appropriate staining of the “erosion” or transformation zone, one can identify significant abnormalities and direct biopsy on an outpatient basis. For patients with atypical smears, in the absence of a trained colposcopist, or when the “directed” biopsy reveals carcinoma in situ, a cone biopsy of the cervix under anesthesia is required to rule out invasive carcinoma.

Although there are many variations, several basic procedures should always be included in the gynecologic exam. The technique of Dr. Saul B. Gusberg, Professor and Chairman of Obstetrics and Gynecology at the Mount Sinai School of Medicine, and Obstetrician and Gynecologist-in-Chief at the Mount Sinai Hospital, New York, New York, is detailed on the following pages.

**General Examination:** A quiet, warm room with sufficient privacy to prevent intrusion is not only considerate, but also necessary to relax the patient’s abdominal and pelvic muscles. Adequate lighting is essential. With the patient seated, inspect and palpate the lateral neck and supraclavicular regions for enlarged nodes. Also note any asymmetry or swelling of the thyroid. (For a guide to “Systematic Head and Neck Examination,” see the January/February 1974 issue of *Ca*, pp. 32-35.)

Careful breast examination is an integral part of the gynecologic examination and should never be omitted. While the
patient remains seated, inspect her breasts first with her arms at her sides and then with her arms overhead for signs of nipple retraction, skin dimpling, a dominant lump or eczema of the areola. Next, instruct the patient to lie supine with her hand, on the side you are examining, under her head and elbow flat on the examining table. Palpate each quadrant of the breasts and subareolar regions with the flat of your fingers. This may be an appropriate time to teach the patient breast self-examination. (A technique for "Standard Breast Examination" may be found in Ca, September/October 1974 issue, pp. 290-293.)

Now, inspect, palpate and percuss each quadrant of the abdomen to reveal ascites, the spasm of peritoneal inflammation, a mass above the pelvic brim or enlargement of the liver, spleen or kidneys. Uterine or ovarian masses may be found in the suprapubic and supravaginal regions. Firm, nontender, midline masses tend to be uterine and benign, while cystic, tender, lateral tumors may arise from the adnexal region and might be malignant; ascitic fluid is a suspicious finding. Next, check inguinal regions for enlarged nodes.

Inspection of External Genitalia: After the patient is placed in the lithotomy position with thighs and abdomen draped, inspect and palpate with a gloved hand the vulvar structures for ulceration, fissures, thickening or tumor masses. (Fig. 1.) It may be necessary to biopsy white, leukoplakic lesions or ulcerations for premalignant or malignant change and the application of toluidine blue can help direct the biopsy site. Excision biopsy of significant abnormalities should be performed in the operating room.
Inspection of Internal Genitalia: This is accomplished by the use of the vaginal speculum. Lubrication is unnecessary for its passage and should not be used as it may render cytologic smears inaccurate. Spread the labia with your gloved fingers and depress the perineum to avoid the sensitive anterior vulvar structures. Warm the speculum for the patient’s comfort and insert it with the un gloved hand, horizontally advancing it to the end of the vagina before opening the blades of the bivalve. (Fig. 2.) The cervix will usually come into view and should be inspected for exudation, ulceration and other abnormalities.

Now, withdraw the speculum by slowly and gently rotating its blades to inspect the vagina for any mucosal abnormality or tumor. Atrophy of the vaginal mucosa may be a source of staining in the postmenopausal patient but its presence should not preclude a complete examination.

The Cytological Smear: A gynecologic examination is incomplete unless a smear is obtained. Before performing a cytological examination, remove any excessive discharge from the cervix. By means of a cotton-tipped applicator moistened with saline and rotated in the endocervical canal, obtain endocervical cells and smear them on half of a clean glass slide. (Fig. 3.) Then, lightly scrape cells from the squamocolumnar junction with a wooden spatula and smear them on the remainder of the slide. (Fig. 4.) Immediately fix the smeared cells by placing the slide in a mixture of equal parts ether and 95 percent alcohol. Drying before fixation will invalidate the smear. Exfoliated cells from the cervix and endometrium may also be obtained in a specimen from the vaginal pool.
Bimanual Palpation: With sparsely lubricated gloved fingers, palpate the pelvic structures noting the size, shape, consistency, mobility and configuration of the cervix. If a mass is found, determine its spread to the lateral, anterior and posterior vaginal fornices. While resting your elbow on your knee, which is raised by a step at the base of the examining table, use index and middle fingers for bimanual examination. This elbow-knee examining posture prevents jerky, abrupt movements that disturb the patient and tense her muscles. While the patient breathes normally, palpate the pelvic organs simultaneously both with gloved fingers in the vagina and hand on the abdomen.

The Cervix: First, palpate the consistency and symmetry of the cervix and its axis in relation to the vagina by pressing the uterus down with the abdominal hand against the gloved fingers in the vagina. (Fig. 5.)

The Uterus: Next, elevate the uterus toward the abdominal hand to determine its length. Place fingers in the anterior fornix and move the uterus gently toward the retroverted position and then from side to side to determine its consistency, mobility and tenderness. (Fig. 6.) If the abdominal wall is thin and relaxed, you may notice even minor irregularities in the contour or consistency of the uterus. Remember that cancer of the corpus may be present in a normal-sized uterus and that many gross nodular enlargements of the uterus are caused by...
benign tumors. In older women, the uterus is frequently irregular due to uterine myomas or fibroids. A fibroid should regress after menopause; enlargement arouses suspicion of a sarcoma or adherent adnexal growth and requires exploration.

If the fingers in the vagina are very close to the hand on the abdomen when palpating, then the position of the uterus is retroverted. In this case, place your fingers in the posterior fornix and examine the uterus as described.

The Adnexa: Place your fingers in the left fornix of the vagina and bring both hands together at a point superior to the tube and the ovary. Then gently move your fingers towards yourself so the adnexa can be examined for enlargement or nodular masses. (Fig. 7.) The ovary is sensitive to pressure, aiding in its identification. Mildly enlarged, cystic ovaries are common in the reproductive years, but in postmenopausal women, any palpable ovary should be considered malignant until proven otherwise.

Rectovaginal Palpation: With index finger in the vagina and well-lubricated middle finger in the rectum, palpate the rectovaginal septum, cul-de-sac and posterior aspect of the uterus for nodules or thickening. (Fig. 8.) Sweeping the fingers laterally, palpate the parametria and side walls for inflammation or tumor extension. Only following rectovaginal palpation can carcinoma of the cervix be properly staged. Evaluation of the rectum is done at this time.