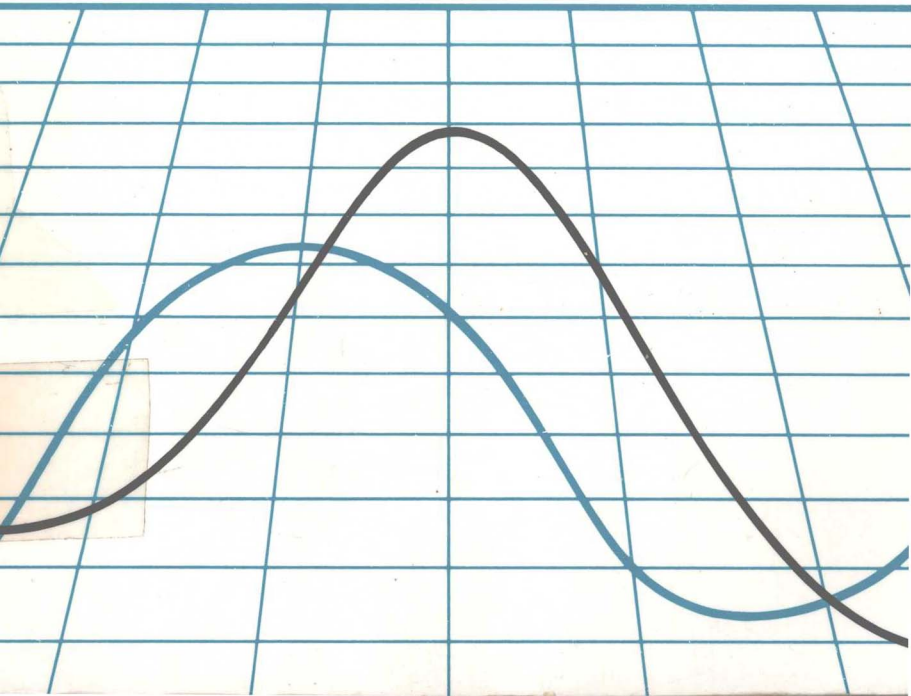
Clinical Manual of
GYNECOLOGY

SECOND EDITION

Stovall / Summitt / Beckmann / Ling



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SECOND EDITION

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Foreword

Gynecology in the 1990s is an exciting specialty, pivotal to almost all of medicine. Indeed, women comprise half of the population, and particularly in younger women gynecologic problems are never far from the horizon. Conversely, gynecological disorders interact with a host of disorders from other medical disciplines—psychiatry, internal medicine, general surgery, and pediatrics. The age groups of gynecologic concerns extend from the neonatal to the geriatric years. Even if physicians did not accept the pivotal role of gynecology, patients would remind us. Gynecological problems are the current darlings of the media—contraception, infection and AIDS, infertility, menopause. Moreover, today's patients are not only desirably well informed but often demanding.

Concomitant to the increased interest in gynecology by the public and the medical profession alike has been marked advances in the scientific basis and thus clinical characterization and treatment for gynecological disorders. In previous decades, gynecological disorders received relatively little scientific attention, perhaps because the specialty as a whole did not emphasize academic pursuits. This inevitably meant that gynecological diseases imparted to many the comfortable, albeit not satisfying, air of immutability. Not so at present. The host of new scientific advances and new clinical investigations means new and better diagnostic and treatment modalities.

Yet these advances are not without responsibilities. Every physician wants to offer his or her best effort. Keeping up with gynecologic advances is enervating, especially for the student, physician-in-training and the nongynecologist. Although existing texts are lucid and accurate, they often prove laborious to the uninitiated and to those pressed to refresh one's memory concerning a disease manifested by a patient in the next room. In particular, exhaustive gynecologic texts are not realistic to the nongynecologist.

The editors of *Clinical Manual of Gynecology* have addressed the above dilemmas in this crisp volume. As a group, they are complete gynecologists. As individuals, they represent expertise in sub-specialties of pelvic surgery, urogynecology, medical education, and psychosomatic medicine. Contributors complement the editors' expertise, representing still other areas of gynecology. Throughout the volume the reader is provided with the essential scientific basis for understanding current diagnostic criteria and treatment.

This manual is easy to read, yet eschews overly simplistic approaches. *Clinical Manual of Gynecology* should find a place on the shelves (and pockets of white coats!) of students, house officers, and attending physicians.

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Preface

Here is a guide for the clinician who is involved with the health care of women. For this revised edition we have updated the information to reflect current practice and to emphasize the immediacy and practical nature of the content. Its outline format and pocket size are designed for maximum usability and accessibility. We believe that residents, staff, and faculty of obstetrics and gynecology, medicine, surgery, emergency medicine, and family medicine will find this text useful. Each chapter was written with the practical management of gynecologic patients as a primary focus. A thorough review of pathophysiology and complete differentials are not included, but we have attempted to provide information that is needed from a practical standpoint. We believe that this balance of information will be helpful.

This work is the result of the efforts of many authors, who have worked numerous hours on their contributions. We wish to thank our secretaries, Martha Mitchum and Ruthe Brady, for their input into manuscript preparation. In addition, we wish to give praise to Jill Keir and Nat Russo for their editorial advice and help with production.

We welcome your feedback on this work as we look to continually improve its quality and practicality.

We wish to dedicate this book to our wives, Donna, Peggy, Claudia, and Janis, and to our children, Elliott, Elizabeth, David, Katherine, Mandy, and Trevor.

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Part I

General Care of the Patient

CHAPTER 1

History and Physical Examination

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Interacting with the patient in a confident personal manner will allow for a relaxed examination and a professional future relationship. The history and physical examination is important not only to obtain information, but also to allow opportunity to develop a professional rapport with the patient.

I. Initial interaction with the patient

- **A. Setting.** A private setting is important for history taking. Good eye contact and communication in addition to having the clinician seated at the same level as the patient is essential.
- **B. Greetings and getting started.** Greeting with a handshake is mannerly yet demonstrates warmth. Using surnames is best, although some clinicians find it useful to ask the patient how she would like to be addressed. "How may I help you today?" is an example of a useful neutral question. Taking notes while interviewing the patient is not a distraction if preceded by an explanatory statement.
- **C. Personal or embarrassing topics.** Many issues (such as sexually transmitted diseases) may evoke strong emotional responses. Such responses can be avoided in most cases by an explanatory preamble such as: "I must ask some questions which are quite personal. I am not doing so to pry into your private life. I am just seeking the information I need to provide you with the best health care." Such a preamble is not needed in all cases.

II. History

- **A. The chief complaint** is the reason for the patient's visit. It should be presented in proper chronological sequence.
- **B. Menstrual history**
  1. **Menarche** is the age at which menses began. The first few menses may be quite irregular in character.
  2. **Menstrual history** includes the duration, frequency of, and interval between menstrual periods. The last menstrual peri-

od (LMP) is dated from the first day of the last normal menses. Any intermenstrual bleeding or contact bleeding should be noted. Menstrual flow can be estimated by the number of pads or tampons used during menses or the size of menstrual clots if passed. Menstrual pain is abnormal when it interferes with normal daily activities. Perimenstrual symptoms (e.g., fluid retention, anxiety) should be noted.

3. **The climacteric** includes irregularity in menstrual frequency and duration often associated with hot flashes, mood changes, and dry mucous membranes. A history of hormonal or psychoactive medications is important. Surgical or medical oophorectomy should be noted.
4. **Postmenopausal bleeding** (bleeding 6 months after cessation of menses) should be documented or stated as a pertinent negative.

C. **Obstetric history** includes the number of pregnancies (gravidity) and outcomes of each (parity) and is abbreviated by:

Gravida (G) **a** Para (P) **b c d e**

where: a = Number of pregnancies; b = Number of term pregnancies; c = Number of preterm pregnancies; d = Number of abortions (spontaneous or induced) and ectopic pregnancies; e = Number of living children. Specific information about each listing above should be included.

D. **Gynecologic history**
   1. **Breast history** should include previous or existing breast disease, history of breast feeding, the use of breast self-examination techniques, previous mammography or breast biopsy, and a family history of breast cancer.
   2. **Previous gynecologic surgery.** Questions should include type of surgery, for what reason, when, where, and by whom, and results. Surgical records should be obtained.
   3. **Infectious diseases.** Vaginitis and other diseases local to the vagina should be reviewed as to the characteristics, frequency, duration and treatment. Past history of sexually transmitted diseases should be documented including episodes of pelvic inflammatory disease (PID).
   4. **A history of infertility** should include questions about previous diseases or surgery that may affect fertility, previous pregnancies, and duration of time in which pregnancy has been attempted (but not achieved).
   5. **Diethylstilbestrol (DES)** use by the patient's mother during her pregnancy should be noted.

E. **Sexual/contraceptive history**
   1. **Sexual history.** Data to be elicited should include:
      a. Age at first intercourse
      b. The patient's present sexual partner(s) and their sex
      c. Types of sexual practices
      d. Level of satisfaction with their sex lives
   2. **Contraceptive history** should include the contraceptive method currently used, the reason for its choice, when