



The Essential Role of the Patient-Centered Pelvic Exam: Enhancing Care Quality in Urgent Care



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Introduction: Case Study

Methods: Patient-Centered, Trauma Informed PE Techniques

Results: Case Resolution

22-year-old well cisgender female with history of nephrolithiasis and abdominal wall repair presents with 4 days of sharp, intermittent right lumbar back pain radiating to right groin (R>L), which she reports resembles prior episode of nephrolithiasis. She also complains of 2 days of dysuria, urinary frequency, and nausea without vomiting. She has had light vaginal spotting since this morning and has had some relief of pain with over-the-counter NSAID analgesics.

She has a history of irregular cycles, has a levonorgestrel implant in place for contraception and a monogamous male partner for the past 5+ years. Denies condom use. Review of Systems is negative for fever, vomiting, change in bowel habits, pelvic pain, change in vaginal discharge, or dyspareunia.

Physical Exam:
Afebrile with vital signs within normal limits. She appears to be non-toxic but uncomfortable sitting on the exam table.
Abdomen: Soft, non-distended, non-tender; no costovertebral angle tenderness or peritoneal signs.

Point of care (POC) diagnostics:
UA: 2+ blood; negative for leukocytes/nitrites.
Pregnancy test: Negative.

Initial Differential Diagnoses
Nephrolithiasis
Musculoskeletal back pain
Urinary tract infection / pyelonephritis
Pelvic Inflammatory Disease
Ovarian torsion
Adnexal mass



Abstract

The pelvic examination (PE) is the critical first-line diagnostic tool for women with abdominal/pelvic symptoms without an obvious non-genitourinary source of pain. "Classic stone pain" as presented by this patient may mask gynecologic conditions or emergencies. Prioritizing pelvic assessment as a part of the initial physical examination improves quality of patient care by avoiding potential diagnostic delays and unnecessary ED utilization.

In the US, 1 in 4 women have experienced actual or attempted sexual assault (SA) in their lifetime.³ SA survivors may experience increased anxiety, embarrassment, pain or discomfort or re-traumatization during a PE in any clinical setting³ and studies show that anxiety or fear of PEs has been reported in 21% - 64% of women.⁶ Patients felt most uncomfortable during PEs when they felt the clinician prioritized the exam of their bodies over their comfort, preferences and agency.⁴

Urgent care clinicians should learn more about how to do PEs in patient-centered, trauma informed ways so they feel more comfortable doing them when indicated and their patients feel as comfortable and supported as possible.

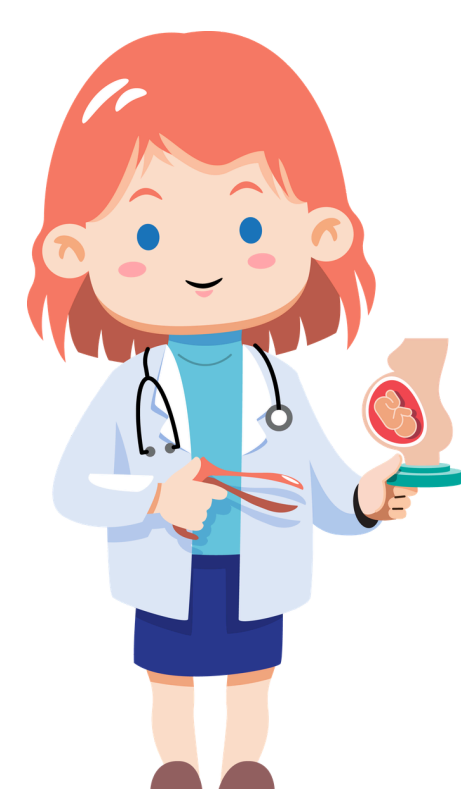
Pelvic Exam

Optimizing Workflow

Examination and Documentation:

- External genitalia** - lesions, ulcers, erythema, frank discharge from the vaginal canal, focal tenderness
- Speculum exam** - Visualize vaginal mucosa and cervix, note inflammation, presence of lesions, friability. Note presence and estimation of quantity of discharge or blood in canal and at cervical os
- Bimanual exam** - Using index and middle fingers of a gloved hand with lubrication to evaluate for presence of cervical motional tenderness or uterine, adnexal or ovarian fullness, masses or tenderness
- Full abdominal exam including CVA tenderness²
- Assess for inguinal lymphadenopathy
- Permission for photos to include if available

- Standardize bedside setup with support staff
- POC pH testing if available
- Warm speculums with warm water, lubricant¹⁰
- Chaperone if appropriate
- Waiting for results vs presumptive treatment?



What About Self-Swabs?

Self-collected specimens may be used as a screening tool to diagnose STIs in females,⁵ but in the Urgent Care setting if there is abdominal or pelvic pain reported, a PE is indicated.²

1

Pre-Exam: Build rapport

- Meet patient first while still clothed to introduce yourself and allow time for questions before undressing develops rapport⁴
- Explain what to anticipate before the PE, familiarize patient with equipment including speculum, swabs
- Build trust BEFORE inquiring about trauma⁸
- Ask about previous sexual trauma, including past PEs⁴
- Offer patient to place speculum herself, 90% of patients in a pilot study were more satisfied with the exam and would choose to do it again¹⁰

2

Exam preparation: Center on the patient

- Give patient the authority to pause or stop the exam at any time. Patients possessing more control during the exam conveys respect, transfers power and shares responsibility^{1,10}
- Skip foot rests if appropriate; one study patients reported decreased vulnerability and less physical discomfort with the exam when footrests were not used¹⁰
- Patient positioning - offer options of lying down flat, or at 30 or 45 degrees. Assess for comfort, some patients may want to maintain eye contact with clinician during the PE¹⁰
- Offer use of mirror so patient can observe exam while sitting at 45 degrees; one study shows 95% of patients prefer to be offered a mirror, even if they don't opt to use it^{3,7}

3

Communication during the exam: Clear and clinical

- Address patients by their name; use correct pronouns and preferred anatomical language, particularly for sexual and gender minority patients^{4,9}
- Offer a chaperone or support person (friend or family member), either in person or via phone, if desired.³
- Use accurate anatomical terminology (e.g., vulva, vagina, cervix)³
- Refer to the examination table rather than "bed," and footrests rather than "stirrups," when applicable.
- Use active, descriptive language (e.g., "I am going to place my hand here") rather than vague phrasing (e.g., "you will feel me touch you")³
- Avoid sexually suggestive or potentially uncomfortable phrasing; use neutral alternatives (e.g., "Let your knees fall to the side" rather than "open/spread your legs")^{3,10}

4

Throughout the exam: Ongoing monitoring and support

- Watch for non-verbal cues of discomfort: holding assistant's hand, closing/covering eyes, using hands to cover pubic area, placing the hands on the shoulders, legs, table, forehead, abdomen, breasts or behind head⁸
- Provide coaching on diaphragmatic breathing
- Encourage Valsalva maneuver during insertion of speculum, release before opening speculum to help relax the pelvic floor¹⁰
- Consider supporting mental imagery,¹⁰ or allowing them to play music to help increase comfort and relaxation.

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Speculum examination showed a small amount of brown blood in the vaginal vault with a closed cervical os and no cervical lesions or discharge. Cervical motion tenderness, as well as uterine and bilateral adnexal tenderness, were present. A wet prep demonstrated increased polymorphonuclear leukocytes (PMNs) but was otherwise unremarkable. Gonorrhea and chlamydia testing was performed, with results pending at discharge. The patient was presumptively treated for *pelvic inflammatory disease* with intramuscular ceftriaxone in clinic and prescriptions for doxycycline and metronidazole. Two days later, the *chlamydia test returned positive*. During follow-up, the patient reported clinical improvement with complete resolution of pain.

Discussion

Benefits of improving Patient-Centered PEs in Urgent Care include:

- Improved Patient Health:** Pain, powerlessness and anxiety during PEs have been shown to lead to adverse outcomes including pelvic and sexual pain disorders. Studies also show that early PE experiences set the tone for subsequent encounters, and a positive experience increases the chance the patient will seek appropriate care, including cervical cancer screening in the future.
- Increase patient trust in your Urgent Care Clinic:** Pelvic complaints are intimate and often anxiety-provoking. When a clinician says, "We can take care of this here," it communicates competence, respect and willingness to address sensitive issues, builds trust. A clinician who performs PEs with clear communication, patient-centered techniques and clinical confidence creates a sense of safety and professionalism that patients remember. **When patients trust urgent care for sensitive issues, they're more likely to return in the future.**
- Decrease unnecessary ED referrals:** When urgent care clinicians are skilled in pelvic exams, they can confidently evaluate pelvic complaints and concerns, meaning fewer "default" transfers to the ED simply because the clinician feels uncomfortable efficiently performing or interpreting the exam. A skilled pelvic exam allows urgent care to identify who truly needs ED-level imaging or intervention, and reassure and treat those who don't. When patients learn that urgent care can competently and sensitively handle pelvic concerns, they're less likely to go straight to the ED for issues that could be managed in your Urgent Care Clinic.

Conclusion: AMPLIFY your Pelvic Exams

- Optimize your workflow to allow for Patient-Centered PEs in your Urgent Care
- Prioritize patient privacy and confidentiality
- Use trauma-informed language and clear, clinical communication
- Explain all procedures and obtain ongoing consent throughout the PE
- Offer choices and control over as many aspects of the PE as possible
- Recognize and validate patient experiences and emotions

Learn More about Trauma-Informed Care!



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WHO Curriculum
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UCSF TRIADS
framework

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