



CLINICAL PRACTICE GUIDELINE

Vaginal procedures

This document should be read in conjunction with the [Disclaimer](#)

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Chaperoning

Follow NMHS [Chaperone Policy](#) (2018)

Cervical screening (previously Pap smear)

Aim

Inform staff of cervical screening eligibility criteria and provide guidance on the procedure for collecting a Cervical Screening Test (CST)^a.

National Cervical Screening Program (NCSP) recommendations ¹

- Routine screening with the CST: Primary HPV testing with partial geno-typing and reflex liquid-based cytology (LBC) when indicated.
- All women aged 25 to 74 years who have ever been sexually active (including any genital-skin to genital-skin contact) should have a CST every five years.
- Women with cervical abnormalities and/or positive HPV tests should be managed according to the [NCSP: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding](#) (2016 Guidelines).
- Women of any age who have symptoms should have a co-test (HPV and LBC) regardless of their cervical screening history.

Transitioning women to the renewed NCSP

- Women aged 25 and older with a normal screening history should have their first CST when they would have been due for their next Pap smear (i.e. two years after their last negative Pap smear).¹
- **Women of any age** who are undergoing follow-up for abnormalities detected in the Pap smear program, should attend this follow-up when due.
- For further information on transitioning women, refer to the [2016 Guidelines](#).

Cervical screening in specific populations

The 2016 Guidelines outline the management of women in specific populations.

These groups, and where to access the relevant recommendations, include:

- [Pregnant women](#)
- [Post-hysterectomy](#)
- [Women with abnormal vaginal bleeding](#)
- [Immune-deficient women](#)
- [Women exposed to diethylstilbestrol \(DES\)](#)
- [Screening in women who have experienced early sexual activity or have been victims of sexual abuse](#)

Cervical cancer information

For further information refer to the [WA Cervical Cancer Prevention Program HealthPoint site](#).

^a Cervical Screening Test- a provider collected cervical sample for HPV testing and reflex liquid-based cytology (LBC) when indicated, or a self-collected vaginal sample for HPV testing.

Procedure: Taking a cervical screening test

Cervical screening is the responsibility of physicians, nurses and midwives. Cervical screening courses are available through KEMH/WNHS: [DNAMER](#) (internal staff) and [Sexual Health Quarters](#).

Equipment

- Bi-valve speculum (plastic or metal)
- Cervex-Brush[®] / Cytobrush[®] / spatula
- Torch or extension light
- SurePath LBC collection vial
- Water based lubricating gel
- Kidney dish
- Sheet
- Examination gloves

Procedure

	Procedure	Additional information
1	Preparation	
1.1	Inform the woman: <ul style="list-style-type: none"> • The risks and benefits of screening • The follow-up required for positive and negative results. 	Prior to examination ensure: <ul style="list-style-type: none"> • The woman has been given enough information to make an informed decision² • Verbal permission is obtained² • Privacy is ensured² • The woman understands the role and benefits of the National Cancer Screening Register
1.2	Ensure a chaperone is available to attend irrespective of provider gender.	The chaperone signs the “Chaperone” stamp which is placed in the woman’s medical record after the examination.
1.3	Position the woman.	The supine position is usually the best, with knees bent and letting the knees fall apart.
1.4	Confirm: <ul style="list-style-type: none"> • Woman’s identification; and • Cervical screening history Complete pathology request form.	See WNHS policy: Patient Identification . Include on the pathology request form: <ul style="list-style-type: none"> • The reason for the test (i.e. routine screening); • Any relevant clinical information (i.e. immune-deficient); and • The test requested (i.e. HPV test).
2	Speculum insertion	
2.1	Refer to section in this guideline: Speculum Examination .	Provides instruction on performing a speculum examination.
3	Taking the cervical screening test	

	Procedure	Additional information
3.1	<ol style="list-style-type: none"> 1. Insert the speculum. 2. Inspect the cervix. Note if the transformation zone is visible and whether the cervix appears normal, a variation of normal, or abnormal. 	<p>Offering the woman self-insertion of the speculum may help reduce feelings of vulnerability and powerlessness.⁸</p> <p>Moisten and warm the speculum with warm water or a small amount of water-soluble lubricant.</p> <p>Any abnormality noted upon visual inspection of the cervix requires colposcopy referral.</p>
3.2	<p>If unable to locate the cervix:</p> <ul style="list-style-type: none"> • Ask the woman to lift her buttocks and place a rolled towel under them. • Withdraw the speculum, and palpate the position of the cervix. Reinsert the speculum in the direction of the cervix. • Use a different size speculum. 	<p>If the lateral vaginal walls are bulging inwards, consider using:</p> <ul style="list-style-type: none"> • A larger speculum; and/or • A condom over the speculum (cut off the reservoir tip of the condom).
4	Cervical Screening Test collection: GYNAECOLOGY	
4.1	<p>Take the sample, ensuring the transformation zone is sampled when possible, using appropriate implement(s) (Cytobrush[®], Cervex-Brush[®], spatula).</p> <p>A Cytobrush[®] should be used in conjunction to the Cervex-Brush[®] in⁹:</p> <ul style="list-style-type: none"> • Women who have undergone surgery for a previous cervical abnormality. • Women whose previous tests have shown no endocervical cells. • Post-menopausal women. • Situations when the transformation is not visible. 	<p>The Cervex-Brush[®] is used to collect both endocervical and ectocervical cells, and is the preferred implement for most women. The spatula is not commonly used or recommended. If the spatula is used, this must be in conjunction with the Cytobrush[®].</p> <p>An optimal cervical sample has:</p> <ul style="list-style-type: none"> • Sufficient mature and metaplastic squamous cells to indicate adequate sampling from the transformation zone.³ • Sufficient numbers of endocervical cells, to ensure screening for glandular abnormalities.
4.2	Using the Cervex-Brush[®]	
	<ul style="list-style-type: none"> • Insert the center of the brush into the endocervical canal. • Rotate the brush five times in a clockwise direction, keeping bristles in contact with the ectocervix. • Use the interior rim of the SurePath 	<p>If a large ectropion is present, ensure that a sample of cells is collected from beyond the border of this area as well.</p>

	Procedure	Additional information
	collection vial to pull off the head of the brush and deposit into the SurePath vial.	
4.3	Using the Cytobrush^{®3}	
	<ul style="list-style-type: none"> • Gently insert the Cytobrush[®] into the cervical os. • Gently rotate the Cytobrush[®] one quarter to one half of a turn in one direction. • Snap the head of the brush into the SurePath collection vial. 	Do not insert the Cytobrush [®] out of vision. To reduce unnecessary bleeding, do not over rotate brush.
4.4	Using the spatula	
	<ul style="list-style-type: none"> • Place the end of the spatula in the cervical os. • Rotate the spatula three times keeping the shoulder of the spatula in contact with the ecto-cervix and ensuring the transformation zone, if visible, is sampled. • Snap the head of the spatula into the SurePath collection vial. 	If a large ectropion is present, ensure that a sample of cells is also collected from beyond the border of this area. ⁹
5	Cervical Screening Test collection: OBSTETRIC	
5.1	Inform the woman that cervical screening can be performed safely in pregnancy ¹	Note: Pregnant women in whom vaginal examination is contraindicated (i.e. placenta previa, previous cervical incompetence, cervical suture insitu) should not be screened. Routine antenatal care should include cervical screening when due or overdue. A woman can be safely screened at any time during pregnancy. ¹
5.2	Collect the sample using the Cervex-Brush [®] brush as described above.	Do not use the Cytobrush [®] in pregnancy. ¹
6	Follow-up	
6.1	Advise the woman that a letter advising of the result and any needed follow-up will be sent to: <ul style="list-style-type: none"> • The woman herself; and • The woman's General Practitioner. 	The cervical test results for women attending Oncology and Colposcopy services are reviewed and managed by the attending doctor.

Interpreting results and recommended management¹

Cervical screening test (CST)		Risk of developing cervical cancer precursors in the next 5 years	Management
HPV result	Cytology result		
HPV negative	N/A	Low	Repeat CST in 5 years
Unsatisfactory HPV test	N/A	Unable to assess until further testing complete	Repeat CST in 6-12 weeks
HPV detected not 16/18	Unsatisfactory	Unable to assess until further testing complete	Repeat test in 6-12 weeks for LBC only
HPV detected not 16/18	Negative, possible low-grade squamous intraepithelial lesion (LSIL) or LSIL	Intermediate	Repeat CST in 12 months*
HPV detected not 16/18	Possible high-grade squamous intraepithelial lesion (HSIL), HSIL or any suspected or definite glandular abnormality	High	Refer for colposcopy
HPV detected 16/18	Any result, including unsatisfactory LBC	High	Refer for colposcopy

*** If the 12 month repeat test is HPV negative, the woman can return to screen in five years. If the 12 month repeat test is positive for HPV (any type) the woman should be referred for colposcopic assessment, regardless of the cytology result.**

Self-collection eligibility

Self-collection is an alternative screening option to increase screening participation in under-screened and never-screened women.¹ To be eligible women must:

- Be aged 30 years or older; and
- Have never-screened; or
- Be overdue for screening by two or more years (four or more years since last Pap smear; or seven or more years since last Cervical Screening Test); and
- Have declined a provider collected cervical sample.

Pregnant women and women with symptoms are not eligible for self-collection.

Procedure: Self-collection of a vaginal sample for HPV

PROCEDURE	ADDITIONAL INFORMATION
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	PROCEDURE	ADDITIONAL INFORMATION
1	Preparation	
1.1	Inform the woman: ³ <ul style="list-style-type: none"> The risks and benefits of self-collected and provider collected samples. That follow-up for a HPV positive result will require either returning for a cervical sample to be collected or being referred directly to a specialist for colposcopy. 	Prior to the woman self-collecting ensure: <ul style="list-style-type: none"> The woman has been given enough information to make an informed decision² The woman has been offered both a self-collected and provider collected test. Privacy is given for the woman to collect the sample² The woman understands the role and benefits of the National Cancer Screening Register.
1.2	Confirm: <ul style="list-style-type: none"> Woman's identification; and Cervical screening history Complete pathology request form.	See WNHS policy: Patient Identification . On the pathology request form, state 'HPV test, self-collected sample'. If the woman is not comfortable collecting her own vaginal sample, the sample may be collected by the healthcare provider. If this occurs, still request 'HPV test, self-collected sample' on the request form.
2	Self-collection of a vaginal HPV sample	
2.1	Provide the woman with a self-collection instruction sheet (if appropriate) and review with the woman the self-collection procedure.	The sample medium for a self-collected HPV test is the COPAN FLOQswab. Self-collection instruction sheets are available for downloading on the NCSP website
3	Follow-up	
3.1	Advise the woman that a letter advising of the result and any needed follow-up will be sent to: <ul style="list-style-type: none"> The woman herself; and The woman's General Practitioner. 	The cervical screening results for women attending Oncology and Colposcopy services are reviewed and managed by the attending doctor.

Self-collected samples: Interpreting results and management¹

HPV result	Risk of developing cervical cancer precursors in the next 5 years	MANAGEMENT
HPV negative	Low	Rescreen in 5 years with a provider collected sample
Unsatisfactory HPV test	Unable to assess until further testing complete	Repeat HPV test in 6-12 weeks
HPV detected 16/18	High	Refer for colposcopy. Cervical sample for LBC will be obtained at the time of colposcopy
HPV detected not 16/18	Unable to assess until further testing complete	Provider collected cervical sample for LBC only*

* The management of women with a positive HPV not 16/18 result will be guided by the cytology findings.

Resources to support cervical screening clinical practice

- Cancer Council Australia. **National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding**. 2016. Accessible at: http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening
- NPS MedicineWise. **National Cervical Screening Program**. 2017. Online modules accessible at: <https://learn.nps.org.au/mod/page/view.php?id=7804>
- Commonwealth Department of Health resources for healthcare professionals and women. Accessible at: <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/resources-menu>
- WA Primary Health Alliance. **Cervical Screening HealthPathway**. 2017. Accessible at: <https://wa.healthpathways.org.au/index.htm>
- WA Cervical Cancer Prevention Program online information accessible at: <http://ww2.health.wa.gov.au/Renewal>

Related cervical screening documents

- Department of Health WA: Safety & Quality in Healthcare: [Procedure Specific Information Sheets](#): NMHS: KEMH: Colposcopy and LLETZ (only available from WA Health Computers)
- Medical Services Advisory Committee (MSAC): [National Cervical Screening Program Renewal](#) (2014)
- Sexual Health Quarters (formerly Family Planning WA): [Cervical Screening for Nurses Course](#)

Speculum examination

Purpose

To provide guidance on the correct procedure to be followed when performing a speculum examination.

Key points

1. Hand hygiene shall be performed before and after patient contact.
2. Verbal consent shall be obtained before the procedure is commenced.
3. All women shall be offered a chaperone during any intimate physical examination / procedure. This will be the patient's choice. No assumptions should be made as to who is the most appropriate chaperone.
4. The patient may refuse a chaperone.
5. Health care providers performing a vaginal examination have the right to request another health care provider in attendance.
6. The chaperone shall sign the 'Chaperone' stamp in the woman's medical records. If the offer of a chaperone is declined, this shall be documented in the woman's notes.
7. The clinician and the chaperone shall discuss the role of the chaperone prior to the physical examination / procedure.

Types of speculum

Sims speculum

This speculum is designed to hold back the posterior vaginal wall allowing the anterior vaginal wall and the cervix to be visualised.⁴ It is useful when vaginal wall prolapse is suspected,⁵ and for examination of an enterocele.⁶ The woman is positioned in the left lateral position with her knees flexed.⁷

Cusco speculum

The Cusco speculum is classified as a bivalve speculum. It has been designed hold back the anterior and posterior vaginal walls after opening so that the cervix may be visualised, and has a screw for maintaining the open position during examination. Modifications have resulted in various sizes,^{6,7} and the speculum is now made of steel or disposable Perspex.⁴ The handle can be rotated in a posterior or anterior direction.

Graves speculum

The Grave speculum is classified as a bivalve speculum. It has wide arched blades that curve markedly, a fixed handle and comes in a range of sizes, including paediatric. It is suitable for sexually active and multiparous women as the curved blades separate the vaginal wall better.⁸ When using the Graves speculum the

handle faces downward. The posterior blade is longer than the anterior blade allowing for positioning into the posterior fornix of the vagina.

Positioning

Dorsal position

The woman lies on her back with her head on one pillow. The knees are flexed and dropped to the sides.

Lateral position

The woman lies on her left side with both knees flexed.

Sims position

The woman lies on her left side, but the inner left leg is kept extended while the right knee and leg is flexed.

Lithotomy position

A modified 'dorsal position' where the feet are held in stirrups, the thighs are abducted and flexed.

Possible problems encountered during speculum examination

Vaginal wall laxity

If the vaginal walls are lax and make visualisation difficult, consider using a wider or longer speculum.

A condom with the end cut off placed over the speculum may prevent the vaginal wall from collapsing. Ensure the woman has no latex allergy.

Difficulty in locating the cervix

Withdraw the speculum rather than continuing to manipulate it and locate the position of the cervix with a gloved hand (moistened with water, not lubricant). Re-insert the speculum again at the appropriate angle.

If the cervix is not visible consider asking the woman to "bear down" during insertion, which may assist relaxation of the vaginal muscles. It may be beneficial to consider asking the woman to self-insert the speculum.

Equipment

- Speculum – may be metal or disposable.
- Water based lubricant
- Unsterile examination gloves
- Adjustable light source
- Condom (if required)
- Long thick cotton swabs
- Sponge holding forceps
- Specimen collecting equipment (if required)

Procedure – Cusco speculum

Insertion

1. Explain the reason for the procedure and how it is performed. Offer the woman the opportunity to view the speculum and show her how it works.
2. Choose the appropriate sized speculum.
3. Ensure the bladder is empty.
4. Ensure the woman is appropriately covered and comfortable.
5. Position the light, perform hand hygiene and put on the gloves.
6. Part the labia minora with the non-dominant hand and inspect the external meatus and vulva.
7. Note the presence of:
 - abnormal skin conditions
 - lesions
 - vaginal discharge or bleeding
 - scar tissue
 - skin piercing
 - any evidence of female genital mutilation
8. If using a metal speculum, warm it in warm water if a pre warmed one is not available. Check the temperature on the gloved inner wrist (not done if premature rupture of membranes is suspected) and then on the woman's inner thigh.
9. Apply a small amount of the lubricant on the outer inferior blade of the speculum.
10. Using the non - dominant hand, part the labia minora with the thumb and fore finger and insert the speculum into the vagina. Ensure the blades are horizontal and remain together.⁶
11. Slide the closed speculum into the vagina following the axis of the vagina (45° downwards).⁶ The Cusco's speculum handle may face downwards if the woman's position, the examination bed or lithotomy position allows. If the woman is lying flat, the handle may be kept superior, but care must be taken not to traumatise the urethra or clitoris.⁶
12. Open the blades slightly to allow visual guidance towards the cervix.
13. Once the cervix is visualised, tighten the screw on the upper blade to retain the speculum in this position.
14. Observe the position and appearance of the cervix. Note the presence of inflammation, discharge, bleeding, lesions or any other abnormalities. The cotton swabs may be used to wipe away any excess mucus or discharge that may obstruct clear visualisation of the cervix.
15. Perform any investigations as indicated.

Removal

1. Loosen the screw on the upper blade, withdraw the speculum gently from the vaginal fornices, close the blades and remove by gentle downward traction.
2. Note any abnormalities on the vaginal walls.
3. Offer the woman a pad or tissues.
4. Discuss any findings with the woman.
5. Document the procedure and any findings in the woman's medical notes

Swabs: Low vaginal, high vaginal, endocervical & rectal

Quick reference guide

Pre-procedure:

1. **Consultation** (medical history, explain procedure & counsel, offer self-collection of LVS /rectal swabs if asymptomatic)
2. Gain **consent** & offer a **chaperone**. Inform and gain consent for the presence of students & further consent if student is examining the patient.
3. **Prepare:** Empty bladder, provide privacy, dorsal position, position light, attend hand hygiene & apply gloves / eye protection.

Procedure:

4. **LVS & Rectal** swabs: May be self-obtained by the woman if asymptomatic.
 - LVS: Insert swab 1-2 cm into vagina & place into transport tube (use charcoal medium tube for culture & a separate thin plastic/ wire shaft swab if PCR).
 - Rectal: Around/inside rectum just past external sphincter & place into charcoal tube.
5. **Inspect** the labia, external meatus & vulva; Insert speculum
6. **HVS:** Swab, make smear on glass slide & place in charcoal medium.
7. **ECS:** Pap smear first (if required), then clean mucous from cervix & take ECS PCR swab & place in tube. If pus/ inflammation of cervix, take ECS for culture, smear on glass slide & place in charcoal medium.

Post-procedure:

8. **Provide privacy** for redressing. Offer tissues as required.
9. **Document:** Procedure, consent, persons attending examination (e.g. chaperone, family), swab details (swab site, date, time, patient details- UMRN sticker or hand write with pencil on glass slides) on swabs and pathology form, findings & plan.
10. **Send** specimens to pathology.

Note: This QRG represents minimum care & should be read in conjunction with the full guideline. Additional care should be individualised.

Equipment

- Adjustable light source
- Biohazard labelled bag
- Sterile swab & Glass slide in a slide carrier- One for each smear site (LVS, HVS, ECS)
- Transtube swabs (charcoal transport medium) - One per site swabbed (e.g. LVS, HVS & ECS)
- Bi-Valve speculum if required
- Unsterile examination gloves
- Patient identification labels
- Pap Smear equipment, if required
- Sterile plastic/wire shaft fine swab (PCR for chlamydia)

Procedure

	PROCEDURE	ADDITIONAL INFORMATION
1	Consultation	
1.1	Obtain a medical / sexual history. ⁴ See also Clinical Guidelines: Gynae: STI.	Assess if the woman has had previous pelvic examinations and her knowledge of the procedure. Explanation of the procedure, giving a chance for questions and responding sensitively eases anxiety and shows respect for the patient. ⁹
1.2	Chaperone needs to be in attendance Explain the procedure to the woman, ^{4, 9} explain confidentiality of results and counsel about the test(s) being performed. ¹⁰	If symptomatic genital symptoms or suspected sexually transmitted infection, physical examination is best practice for diagnosis and treatment. ¹⁰
1.3	Offer her the option of self-collection of LVS / rectal swabs if appropriate. ¹⁰	
2	Consent	
2.1	Obtain verbal consent before the procedure is commenced. ^{2, 4, 9, 10}	If declined, explain the importance of the examination, offer a chaperone for support and if still declined, defer to another time or refer to another suitable practitioner and document plan. ⁹
2.2	Record consent and include anyone else attending the examination (e.g. family, chaperone, medical students). ⁹	If initial consent is withdrawn during the procedure cease the examination, discuss concerns, defer to another time / practitioner and document plan. ⁹ If the woman is unable to provide consent, refer to the WA Health Consent to Treatment Policy . Providing a surrogate decision maker to consent to the examination and a familiar individual (such as a family member or carer) to accompany the woman, may be appropriate. ⁹
2.3	Offer a chaperone to all women, irrespective of the gender of the examiner. ⁴ Document the chaperone's name and qualifications. ⁹ See also NMHS Chaperone Policy . It is recommended for practitioners conducting vaginal examinations or procedures to have another practitioner	If the offer of a chaperone is declined, document in the woman's medical records. If the practitioner would like a chaperone but the woman does not consent, the practitioner does not have to perform the procedure, and may refer to another practitioner or defer to another time, where appropriate. ⁹

PROCEDURE	ADDITIONAL INFORMATION
<p>in attendance.</p> <p>The woman should be informed in advance of any students to be present and that they have the right to decline student attendance during any examination or consultation.^{2, 9}</p> <p>2.4</p> <ul style="list-style-type: none"> In addition, explicit consent should be gained if medical students are to examine the woman for education / training.^{4, 9} 	<p>The chaperone / practitioner:</p> <ul style="list-style-type: none"> is an impartial observer⁹ must be qualified (e.g. Registered or Enrolled Nurse or appropriately trained to support the woman)⁹ must be approved by the woman (& a gender approved by the woman or carer)⁹ maintains confidentiality and respects the woman's privacy⁹ provides security for both the examiner and the woman^{4, 9} may give assistance if required
<h3>3 Preparation</h3>	
<p>3.1 Ensure the bladder is empty.⁴</p>	<p>An empty bladder increases the woman's comfort and allows a more accurate assessment of the pelvic organs.⁴</p>
<p>3.2 Ensure the woman is adequately covered and comfortable.</p>	<p>Provide privacy to undress & a sheet to cover herself.^{2, 4}</p>
<p>3.3 Position for speculum examination with head on pillow, lying in a dorsal position⁴ with knees flexed & hips abducted.</p>	
<p>3.5 Position the light.</p>	<p>Lighting is required for adequate inspection.⁴</p>
<p>3.6 Hand hygiene should be performed before and after patient contact.</p>	<p>See KEMH Infection Prevention and Management Manual: Hand Hygiene.</p>
<p>Put on gloves.^{9, 10}</p>	
<p>If there is risk of splash, wear eye protection.¹⁰</p>	
<h3>4 Inspection</h3>	
<p>Part the lips of the labia minora with the non-dominant hand and inspect the external meatus, and vulva.</p>	<p>Enables detection of:</p> <ul style="list-style-type: none"> abnormal skin conditions lesions vaginal discharge or bleeding scar tissue skin piercing

PROCEDURE	ADDITIONAL INFORMATION
	<ul style="list-style-type: none"> evidence of female genital mutilation.¹¹
<p>5 Insertion of the speculum</p> <p>See Speculum Examination section above</p>	<p>The practitioner should be responsive to any patient expressing undue distress during an examination.⁹</p>
<p>6 Collection of the swabs</p> <p>6.1 Low vaginal swab (LVS), High vaginal (HVS) & Endocervical swab (ECS)</p> <ul style="list-style-type: none"> Take a HVS and smear for pathogens.¹⁰ Clean away cervical mucous if necessary, then obtain an ECS¹⁰ <ul style="list-style-type: none"> If PCR / NAAT place swab back into container with no transport medium¹⁰ If culture (e.g. pus/ inflamed cervix) - obtain smear and swab into transport medium. 	<p>A smear <u>and</u> a swab must be collected when performing a LVS/HVS or ECS</p> <p>Label all samples with the woman's UMRN sticker, site (LVS, HVS, ECS), date and time of collection.¹⁰</p> <p>Store at room temperature¹⁰</p>
<p>Smear</p> <p>Swab the area using the sterile swab. Gently roll the swab 2-3 times in non-overlapping passes on to the middle of the glass slide. Discard this swab. Write the patient's name on the ground glass end of the slide with a pencil or use a patient ID sticker around the slide carrier. Allow the smear to dry in air before closing the slide carrier.</p> <p>Swab for Culture</p> <p>Use the transtube swab.</p> <p>LVS: Insert the sterile swab 1-2cm into the lower entrance of the vagina, and swab the sides of the vagina. The woman may prefer to collect her own (Low vaginal swab only), with instructions from the medical / midwifery</p>	<p>Non-symptomatic women may prefer noninvasive techniques such as first void urine and self-obtained LVS rather than a pelvic examination.¹²</p>

PROCEDURE	ADDITIONAL INFORMATION
<p>/ nursing staff.¹⁰</p> <p>Insert the swab into the transport medium and label with the woman's identification sticker and indicate the site of collection.</p> <p>Place the slide and the transtube in a specimen bag with the request form in a separate pocket and send to the Specimen Centre KEMH.</p>	
<p>6.4 Rectal Swab</p> <p>Pre-moisten swab with transport medium.</p> <p>The woman may prefer to collect her own swab, with instructions from the medical / midwifery / nursing staff.¹⁰</p> <p>The swab is inserted into the rectum past the external anal sphincter and the specimen is collected.</p> <p>The swab is then inserted into the transport medium and labelled with the woman's UMRN identification sticker, the site of collection, date and time.¹⁰</p>	<p>Allows easier insertion of the swab.</p> <p>See Clinical Guidelines, Obstetrics & Gynaecology: Antepartum Care: Infections in Pregnancy: GBS Disease</p>
<p>8 Post-Procedure</p> <p>Provide privacy for redressing⁹ and tissues if required.</p> <p>Document procedure, findings, consent, persons attending examination (e.g. chaperone, family),⁹ swab details (swab site, date, time, patient details- UMRN sticker or hand write with pencil on glass slides) on swabs and pathology form, and plan.</p> <p>Send specimens to pathology.</p>	<p>The samples should reach the pathology within 24 hours for optimal culture yield.¹⁰</p>

Vaginal examination in girls and young women

Aim

- To guide medical and nursing / midwifery practitioners in relation to the indications for, and the conduct of, vaginal examination in girls and young women.

Key points

1. The girl's / young woman's best interest (their physical and psychological health and wellbeing) are paramount and should guide all decision making.¹³
2. Best practice includes effective communication. Medical Officers, Nurses and Midwives should take the utmost care in explaining the procedure to the girl or young woman (and parent / guardian).¹³
3. Examinations should be conducted so as to minimise discomfort and distress.¹³
4. The girl's / young woman's dignity and privacy shall be maintained throughout the examination regardless of the presence of others. Provide privacy for disrobing and a suitable cover (e.g. gown or sheet) during examination.²
5. An appropriate adult witness, support person and/ or chaperone shall be present when examining a child at all times
6. When examining a young woman, the presence of a support person and / or chaperone should be encouraged and available.¹³ The person who is the chaperone shall be agreed to by the girl/ young woman.⁹ If the girl/ young woman is not comfortable with a particular chaperone, offer another chaperone. There should not be pressure to proceed if a suitable chaperone is not available.⁹ The young woman has the right to decline the presence of a chaperone and the Medical Officer / Nurse / Midwife has the right not to perform the vaginal examination if they deem it inappropriate to examine the young woman without a chaperone.^{9, 13} Document the chaperone's name and qualifications.⁹
7. Ensure there is valid consent from the young person and / or their parent or guardian prior to conducting a vaginal examination.¹³ Valid consent must be voluntary, informed and based on the capacity of the patient to consent.¹³ If required, an interpreter should be used to ensure valid consent to examination¹⁴. Practitioners should refer to state legislation regarding a child's capacity to consent.¹³ A girl's / young woman's capacity to consent is considered on an individualised basis and is not only related to age.¹³ Children can consent to a procedure if they have the capacity to understand the information and the implications of the procedure.¹³

8. Except in a medical emergency, vaginal examination should not proceed in the absence of valid consent.^{4, 9, 13}
9. When parents / guardians have consented on a girl's behalf, Medical Officers should explain the procedure and proceed only with the girl's / young woman's consent.¹³ Parental power to consent (or withhold consent) to treatment is limited that they may only validly consent to treatment that is in the child's best interests.¹⁴
10. Court authorisation for medical treatment of a minor is required if both the parents and the minor lack the capacity to consent in a non-emergency situation or if both parents refuse to consent to a necessary procedure.¹⁴
11. Special considerations shall be given to obtaining consent from patients who are¹³:
 - Intellectually impaired or mentally ill
 - Physically impaired or injured, in pain, or in shock
 - Drug or alcohol affected
 - Non-English speaking background
 - Sleep deprived
 - Unable to give valid consent.¹³
12. Digital or instrumental vaginal examination is very rarely indicated in prepubertal girls. Allegations of sexual abuse, vaginal bleeding, vaginal discharge or suspected genital malformation may require visual inspection of the vaginal vestibule and / or ultrasound examination. If this does not reveal the required information and further examination is medically necessary, examination under anaesthesia, including vaginoscopy, may be indicated.
13. In pubescent or postpubertal girls, digital or instrumental examinations should only be performed with informed assent from the girl and the consent of their parent / guardian.
14. If a girl / young woman states that she is not sexually active, digital or instrumented vaginal examination is only rarely warranted.¹³

Indications for speculum examination

- Papanicolaou (Pap) smear¹³
- Endocervical swab for investigation of possible infection¹³
- Endocervical swab for forensic investigation¹³
- Assessment for abnormal vaginal bleeding¹³
- Assessment for possible intra vaginal foreign body¹³
- Assessment of developmental abnormality (rarely)

If the Resident Medical Officer is unable to visualise the cervix, the Registrar / Senior Registrar must be contacted to complete the speculum / vaginal examination.

A result of the examination is to be documented in the patient's medical record MR 021/022.

Measures to minimise discomfort during pelvic examination

- Provide explanations tailored to the girl's / young woman's level of comprehension.^{9, 13} An adequate explanation informs about the nature of the examination and the information it will provide.²
- Ensure that the equipment used is appropriate for the size / age of the girl / young woman.
- Discuss the use of any swabs or components (e.g. speculum) that will be used. Show any equipment to be used and provide the opportunity for the girl/young woman to touch or hold it.¹⁵
- Where possible use anatomical models, pictures and pamphlets to provide information.¹⁵
- A familiar person (e.g. mother, relative¹⁵) should usually be present during the examination.⁹ Additionally, ensure a qualified chaperone (e.g. Registered or Enrolled Nurse) is present that the girl / young woman is comfortable with.⁹ The chaperone should be an impartial observer, which is different to a support person, though family may be used if there are no other options.⁹

Note: Be sensitive to the needs of the girl / young woman as she may feel embarrassed to undertake the examination in front of a relative.⁹

- Encourage the girl / young woman to provide feedback to the examiner if they are not comfortable, either physically or emotionally.¹⁵ Be alert for non-verbal indications of distress and respect any requests to discontinue the examination.⁹ Document any withdrawal of consent and relevant discussions.⁹
- Encourage the girl / young woman to empty her bladder prior to the examination.^{4, 15}
- Conduct the examination in a calm environment, and ensure privacy.^{2, 9} Unless the girl / young woman is having difficulty and requests assistance, do not assist with dressing or undressing.⁹

Refer also to NMHS [Chaperone Policy](#) (2018) as required for general considerations for all women, including further information on consent and chaperones applicable to all women.

Insertion and removal of a vaginal pack- Nursing care

Aim

The appropriate management and care of a woman during a vaginal pack insertion and removal.

Background

Vaginal packing is an emergency treatment for excessive bleeding per vagina, which can occur following cone biopsy, laser to cervix or trauma to the lower genital tract. It is usually performed in the emergency centre, outpatient or theatre area.

If required on the ward, it is performed in the treatment room, with the patient placed on the examination couch in the lithotomy position.

Insertion

Equipment

- Assorted sterile speculum –Sims and Bi-valve , various sizes
- Sterile scissors
- Sterile sponge holding forceps
- Gauze packs – 10cm radio opaque rolls. If more than one roll is required ensure they are tied together securely
- Obstetric cream
- Normal saline
- Sterile gloves
- Long sterile cotton buds
- Monsell's paste / silver nitrate sticks

Procedure

For count requirements, follow WNHS Policy [Procedural Count: Management and Procedure](#) (available to WA Health employees via Healthpoint)

1. Ensure privacy.
2. Explain the procedure to the woman and reassure her. Offer and administer appropriate analgesia.
3. Ensure woman's bladder is empty. (Catheterise if necessary)
4. Assist the Medical Officer as requested.
5. Following insertion ensure the woman is dry, warm and comfortable.
6. Dispose of all equipment appropriately.
7. Check for further loss every 15 minutes for 1 hour and document findings.
8. Inform the Medical Officer of any continuing loss.

Removal of a vaginal pack

Vaginal gauze packing is removed as ordered by Medical Officer.

Check number of packs that were inserted. This will be documented in the patient's medical notes.

Equipment

- Disposable gloves
- Sterile sponge holding forceps
- Receiver
- Contenance pad
- Personal protective clothing, including mask and goggles if a splash is anticipated.

Procedure

1. Explain the procedure to the woman. Analgesia or antianxiolytic may be required, although generally this is not a painful procedure.
2. Position on one pillow, if tolerated, and place the woman in the dorsal position and turn the bedclothes down.
3. Remove the perineal pad.
4. Perform hand hygiene. Don gloves.
5. Remove the vaginal gauze with sponge forceps or gather the gauze into the hand, gently drawing the visible end toward the perineum with downward and forward movement. Care must be taken withdrawing knotted strips. Apply a fresh perineal pad.
6. Record the removal on MR325 (report any discrepancy), Nursing Care Plan (MR286.01), the Observation Chart (MR 286) and the inpatient progress notes (MR 250).
For count requirements, follow WNHS Policy [Procedural Count: Management and Procedure](#) (available to WA Health employees via Healthpoint)
7. Check and sign for the number of packs removed against number inserted in Operating Theatre on the operation record sheet MR 325. Report any discrepancy.
8. Check the pad for excessive bleeding every 15 minutes for half an hour.
9. The woman should remain in bed for 30 minutes after removal of the pack.
10. Excessive vaginal bleeding post pack removal should be reported to the medical officer. Rarely is it necessary for the vagina to be repacked, see previous page if required.
11. Remove the IDC as ordered.
12. Assist the woman to the shower.

Insertion of a vaginal pack for uterine procedentia

Aim

The insertion of a vaginal pack to replace a prolapsed uterus.

Key points

1. For count requirements, follow WNHS Policy [Procedural Count: Management and Procedure](#) (available to WA Health employees via Healthpoint)
2. This procedure may be performed by nursing / midwifery staff.
3. If the prolapse is unreducible the woman must be reviewed by the Medical Officer.
4. This procedure is usually performed for a predetermined time prior to definitive surgery
5. The pack is usually replaced daily.
6. An indwelling catheter should be inserted for the duration of the pack being in situ.
7. The procedure is carried out using the principles of asepsis.

Equipment

- Sterile sponge holding forceps (optional)
- Sterile dressing pack
- Sterile scissors
- Sterile gloves
- Gauze pack, number of packs needs to be charted in patient's notes. 4"
- Sanitary pad
- Prescribed lotion

Procedure

1. Explain the procedure and gain verbal consent.
2. Offer appropriate analgesia.
3. Place the woman in the left lateral or supine position on a continence sheet (bluey). Cover appropriately to maintain dignity.
4. Ensure there is adequate light to perform the procedure easily.
5. For count requirements, follow WNHS Policy [Procedural Count: Management and Procedure](#) (available to WA Health employees via Healthpoint)
6. Tie the ends of the gauze together if more than one pack is required.
7. Soak the gauze in the prescribed in large receptacle of the dressing tray
8. Using a gloved hand, gently replace the prolapsed uterus.
9. Insert the soaked pack using sponge holding forceps or a gloved hand.
10. Place a sanitary pad in position.
11. Document the procedure in the woman's notes.

Vaginal irrigation

Aim

The administration of a vaginal douche to:

- Irrigate and cleanse the vagina prior to surgery.
- Control odour in the presence of infection or offensive loss due to a tumour.

Equipment

- Irrigation as prescribed
- Irrigation administration set (non sterile)
- Jug
- Disposable gloves
- Contenance sheet (bluey)
- Bedpan and cover
- Lubricating jelly

Procedure

1. Explain the procedure and gain verbal consent.
2. Ensure the woman's bladder is empty prior to performing the procedure.
3. Place a continence sheet under the woman's buttocks.
4. Place the woman on the bedpan with her knees flexed and legs abducted. Use a pillow for support. Cover the woman to maintain privacy.
5. Perform hand hygiene and don gloves.
6. Check the tubing and nozzle are securely connected.
7. Lubricate the nozzle.
8. Pour the solution into the irrigation bag. Prime the line, expel any air and clamp the tubing.
9. Gently part the labia and insert the irrigation nozzle approximately 5cm into the vagina.
10. Unclamp the tubing and allow all the solution to drain gently into the vagina.
11. When complete, reclamp the tubing and remove the nozzle.
12. Encourage the woman to cough or bear down to expel the fluid.
13. Remove the bedpan and clean and dry the woman.
14. Document the administration in the woman's notes and care plan.

Flagyl vaginal irrigation

- Preparation as for vaginal irrigation.
- Run the Flagyl solution at low pressure into the vagina.
- Following administration, dry area and cover with a clean sanitary pad or combine.
- Instruct the woman to remain supine for one hour.
- Document the administration in the woman's notes and care plan.

References

1. Cancer Council Australia. National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. 2016. Available from: http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening
2. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. C-Gyn 30: Guidelines for gynaecological examinations and procedures. 2016. Available from: <https://www.ranzcoq.edu.au/Statements-Guidelines>
3. NPS MedicineWise. National Cervical Screening Program. 2017. Available from: <https://learn.nps.org.au/mod/page/view.php?id=7804>
4. Bain C, Burton K, McGavigan C. **Gynaecology illustrated**. 6th ed. Edinburgh: Churchill Livingstone Elsevier; 2011.
5. Symonds EM, Symonds M. **Essential Obstetrics and Gynaecology**. 4 ed: Churchill Livingstone; 2004.
6. Chandrharan E, Arulkumaran S. Gynecological History and Examination. In: Arulkumaran S, Sivanesaratnam V, Chatterjee A, Kumar P, editors. *Essentials of Gynecology*. Kent: Anshan Ltd.; 2005. p. 19-26.
7. Monga A, Dobbs S, editors. *Gynaecology by Ten Teachers*. 19th ed. London: Hodder Arnold; 2011.
8. Klingman L. Assessing the Female Reproductive System. **American Journal of Nursing**. 1999;99(8):37-43.
9. Australian Medical Association. Patient examination guidelines: AMA; 2012. Available from: https://ama.com.au/sites/default/files/documents/Patient_Examination_Guidelines_2012_0.pdf
10. Communicable Disease Control Directorate. Guidelines for managing sexually transmitted infections: WA. Shenton Park: Department of Health Western Australia; 2013. Available from: <http://silverbook.health.wa.gov.au>
11. Pelvic Examination Family Planning Western Australia Guidelines for Clinical Practice. **Family Planning Western Australia**. 2006.
12. Stewart CM, Schoeman SA, Booth RA, Smith SD, Wilcox MH, Wilson JD. Assessment of self taken swabs versus clinician taken swab cultures for diagnosing gonorrhoea in women: Single centre, diagnostic accuracy study. **BMJ**. 2012;345:e8107. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23236033>
13. The Royal Australasian College of Physicians. Paediatrics & Child Health Division. Genital examinations in girls and young women: A clinical practice guideline Sydney, NSW: RACP; 2009. Available from: <http://www.racp.edu.au/docs/default-source/advocacy-library/genital-examinations-in-girls-and-young-women-a-clinical-practice-guideline.pdf>
14. WA Health Consent to Treatment Policy. Perth: Department of Health WA; 2016.
15. Braverman PK, Breech L, Committee on Adolescence. Gynecologic examination for adolescents in the pediatric office setting. **Pediatrics**. 2010;126(3):583-90. Available from: <http://pediatrics.aappublications.org/content/126/3/583.full-text.pdf>

Bibliography (from Cervical Screening Test chapter)

- Australian Institute of Health and Welfare. [Cervical screening in Australia 2014-2015: Cancer series No. 105](#). Cat no CAN 104 [Internet]. 2017.
- Cadman L, Waller J, Ashdown-Barr L, Szarewski A. [Barriers to cervical screening in women who have experienced sexual abuse: an exploratory study](#). *The Journal of Family and Reproductive Health Care*. 2012; 38(4):214-220. Accessible at:
- Cancer Council Australia. [Cervical cancer prevention policy—cervical cancer: causes](#). Sydney: Cancer Council Australia. 2014.
- National Centre for Immunisation Research & Surveillance. [Evaluation of the National Human Papillomavirus Vaccination Program Final Report](#). 2014.

National Centre for Immunisation Research & Surveillance. [Human Papillomavirus \(HPV\) Vaccines for Australians: Information for Immunisation Providers](#). 2016.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. [Guidelines for HPV vaccine: C-Gyn 18](#). 2015.

Related policies, legislation, resources

Legislation -

- [Children and Community Services Act 2004](#)
- [Commonwealth Family Law Act 1975](#)
- [Guardianship and Administration Act 1990](#)
- [Health Act 1911](#)
- [Health Practitioner Regulation National Law \(WA\) Act 2010](#)
- [Privacy Act 1988](#)

Related NMHS Policies –

- NMHS [Chaperone Policy](#) (2018)

Department of Health WA:

- [Safety and Quality](#): Consent
- OD 0657/16: [WA Health Consent to Treatment Policy](#) (2016) (including section 4.3.2- Children and Young People : Mature Minors)
- OD 0296/10 [Interagency Management of Children Under 14 Who are Diagnosed With a Sexually Transmitted Infection \(STI\)](#)
- OD 0606/15 [Guidelines for Protecting Children 2015](#)
- [Working with youth toolkit](#) and [legal resource](#) (PDF, 1.64MB) (assessment as mature minor)
- [About Child Abuse and Neglect](#): Mandatory [Reporting of Child Sexual Abuse](#)
- Mandatory Policy [MP 0051/17 WA Health System Language Services Policy](#)

Public Health: [Silver book](#); Specimens for Sexually Transmitted Infections (2011); [Nurse / Aboriginal Health Practitioner Initiated STI Treatment Code](#) (2018); Communicable Disease Control Directorate: [Chlamydia: Testing and Clinical Management](#) (self-obtained LVS instructions)






Related WNHS policies, procedures and guidelines

KEMH Clinical Guidelines:

- O&G, Standard Protocols, [Pathology & Ultrasound: Ordering by Midwife/Nurse/NP](#): Antenatal Tests: Requesting; Swabs: LVS: Request; HVS: Request; ECS: Request; GBS Antenatal Screening: Request
- O&G, [Wound Care](#): Collection of a Wound Swab
- Gynaecology: [Sexually Transmitted Infections](#) (Screening tests & specific STI information)
- Gynaecology: [Gynaecological \(Oncology\)](#) : Link to Classification and Staging of Cervical Cancers

WNHS Policies –

- [Language Services](#) (2017) (interpreter use); [Patient Identification](#) (2019); [Procedural Count: Management & Procedure](#) (2020)

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