

# Reports of the Death of the Pelvic Exam Are Greatly Exaggerated

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Many of our colleagues are hating on the pelvic exam these days.

In the emergency department (ED), when it comes to lady

parts, "...we'll do whatever we can to get out of the pelvic exam," explains Rick Pescatore.<sup>1</sup> In one study measuring the time between patient rooming and resident self-assignment for 68 chief complaints, vaginal bleeding had the longest pick-up time.<sup>1</sup> "Vaginal bleeding" Ryan Radecki commented, "... is deservedly pulling up the rear."<sup>2</sup> (Deservedly?!) A 2015 retrospective review of pregnant ED patients with first trimester vaginal bleeding found that only 19% had a pelvic exam.<sup>4</sup> *Have we concluded that the pelvic exam should no longer be part of the ED assessment?*

A review on the utility of the ED pelvic exam looked at 43 articles, most of which were observational and provided a low level of evidence.<sup>2</sup> Nonetheless, the review concluded, "routine use of pelvic examination is not supported by the literature" when sonography is available. Should observational research with low level of evidence dictate that we omit the pelvic exam, or are we just making excuses?

Ultrasound is a crucial advancement in ED care, but it's a slippery slope to say it can replace (rather than supplement) the pelvic exam. Based on that logic, instead of performing abdominal exams, we could obtain an MRI for any abdominal complaint. Better yet, we could obviate all physical exams and pan-scan all patients on their way into the ED, no matter what the chief complaint. Will the only physicians left be radiologists and surgeons? Should the rest of us hang up our stethoscopes (and speculums)?

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The fact is there is no conclusive evidence that omitting pelvic exams is safe. Linden et al authored a prospective, randomized trial in *Annals of Emergency Medicine* concluding pelvic exams are unnecessary for pregnant ED patients with vaginal bleeding or lower abdominal pain.<sup>3</sup> However, limitations included the homogeneity of its population (non-English speakers were excluded), its subsequently underpowered sample size, and its reporting on outcomes it was not designed to study. Most importantly, all subjects had ultrasound-confirmed intrauterine pregnancies, so their conclusions are not applicable to the typical undifferentiated ED patient.

Theoretical concerns are that pelvic exams are time-consuming, or may cause some psychological and physical discomfort. Radecki argued in his commentary that pelvic exams detract from ED throughput.<sup>3</sup>

However, when Linden et al actually measured length of stay for ED encounters with vs. without pelvic exam, there was no significant difference. While they reported that patients for whom the exam was omitted were 12.5% less likely to report feeling uncomfortable, their methods were not designed to study this outcome.

Regardless, before discussing length of stay or comfort, we should be addressing safety. Similar to the pelvic exam, a rectal exam may be uncomfortable, and require additional time and a chap-erone; yet aren't rectal exams still indicated for patients with rectal bleeding or pain?

A prospective cohort study included pregnant and nonpregnant patients with abdominal pain and/or vaginal bleeding, and measured the utility of the ED pelvic exam.<sup>3</sup> Since unexpected findings that significantly changed management were present in "only" 6% of subjects, the authors concluded that "the pelvic exam rarely offered additional information." Rarely is misleading here; the likelihood of the pelvic exam yielding management-altering findings was similar to that of finding an intracranial bleed on non-contrast head CT in patients with stroke symptoms.<sup>3</sup> Applying this

logic, should we stop recommending head CT before thrombolytic therapy, since it rarely changes management?

Pelvic exam findings may contradict the history, and help determine the patient's appropriate treatment and disposition.

“*In the first place it's not so easy to even find your vagina. Women go weeks, months, sometimes years without looking at it ... You've got to get in the perfect position, with the perfect light, which then is shadowed somehow by the mirror and the angle you're at.*”

—Eve Ensler; *The Vagina Monologues*



## WOMEN IN EMERGENCY MEDICINE

A pelvic exam is required to diagnose pelvic inflammatory disease, a potentially life-threatening infection. How else should

we diagnose or treat a vaginal laceration, an abnormal mass, or a foreign body such as a forgotten tampon or that \$66 vaginal jade egg from Gwyneth Paltrow's new-age "wellness" company, GOOP? (Spoiler alert: jade eggs are porous, and likely a risk factor for bacterial vaginosis and toxic shock syndrome.<sup>3</sup>)

It should be noted there is no consensus definition of what constitutes the "ED pelvic exam." Complete versions may take several minutes and involve stirrups, a speculum, or specimen collection. Abridged versions, such as limited external and bimanual assessments, take under one minute. It would behoove us to determine the role of complete vs. abridged versions, because even the abridged exam may offer significant value in certain patients; that quick external look is essential in diagnosing primary herpes rather than a urine infection in patients presenting with dysuria.

So why does the pelvic exam get such a bum rap? There is a historical reluctance to address pelvic complaints. Remember the pudendal nerve and artery from anatomy class? "Pudendal" is derived from the Latin "pudendum" which translates to "parts to be ashamed of."<sup>3</sup> Perhaps this informs the exclusion of the female reproductive tract from the physical exam, even when not one single clinical trial provides solid evidence that doing so is safe. Since it's not about patient comfort or throughput; what is left, shamefully, is provider discomfort performing the exam. Those omitting pelvic exams may be serving self-interest rather than the patients'.

Men can see and palpate their own genitals, but for women, only the tip of the iceberg (the vulva) is easily accessible.

Logically, we should have a lower threshold to do pelvic exams than male genitourinary exams. A well-known emergency medicine maxim comes to mind: always check the feet of a diabetic with peripheral neuropathy. These patients may not know they have occult trauma, an infected ulcer, or a maggot infestation, so astute emergency physicians know to check.

Until we have solid, current evidence that its omission is safe, we propose that physicians always recommend a pelvic exam for women with vaginal bleeding or discharge, lower abdominal pain, or unexplained systemic symptoms, who cannot see and palpate their own vagina, uterus,

and ovaries. And, as no woman has the capability to completely examine their own genital organs, every woman presenting to the ED with these symptoms should have a pelvic exam. ●

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