

Women's Gynecologic Health, Second Edition

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Errata Sheet

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Dedication

To our best teachers: our students and the women for whom we have provided care; and
To our colleagues, friends, and family members who have been encouraging and patient throughout the
long labor of this second edition. There are too many to mention each of you by name, but you know
that we know who you are. We truly appreciate the support you provided

—*Kerri and Francie*

To:

My longtime practice affiliates Earl Williams, MD, James Irwin, MD, Kenneth Vanderkolk, MD, and
the late Joseph Moore, MD, whose consistent advocacy helped pave the way for advanced practice
registered nurses in Michigan to be credentialed and practice within their scope;

Virinder Moudgil, PhD, VPAA of Oakland University, who gave me the opportunity to work with the
wonderful students, staff, and faculty at Oakland University;

My parents, Marie and Don Hall, whose belief that I can do anything makes me believe that I can;
Judd for his humor and companionship;

My children, Mary, Sean, and Sarah, who bring me life's greatest joys; and
Bode for his unconditional love.

—*Kerri*

To:

My husband Zan, your love is my haven, and your support makes anything possible;

My nieces Katherine and Elizabeth, my sister Mary, and my mother Katey, I have the best days with you;
and

Robin, Amy, and Debi, your circle of friendship sustains me.

—*Francie*

complications, and outcome. Obtaining pertinent medical records may also be useful if the woman cannot supply sufficient information.

Urologic Health Topics include the occurrence and frequency of bladder infections, renal infections, incontinence, or other abnormal symptoms.

Cervical Cancer Screening Determine whether the woman has had previous cervical cytology screening. If so, find out the approximate date of the last test and if the results were abnormal. For a woman who has had an abnormal cervical cancer screening result, ask what follow-up occurred, and whether subsequent screening results have been normal.

Sexual Health Ask if the woman is sexually active. If so, determine whether this activity occurs with men, women, or both; whether she is satisfied with her sexual function; and whether she or her partner or partners have any concerns or problems. Further information about assessment of sexual health can be found in Chapter 11.

Contraceptive Use The contraceptive history is obtained from heterosexual women. Determine whether the woman or her partner is currently using a contraceptive method, whether she is satisfied with the method or desires a change, or if she has questions about her current

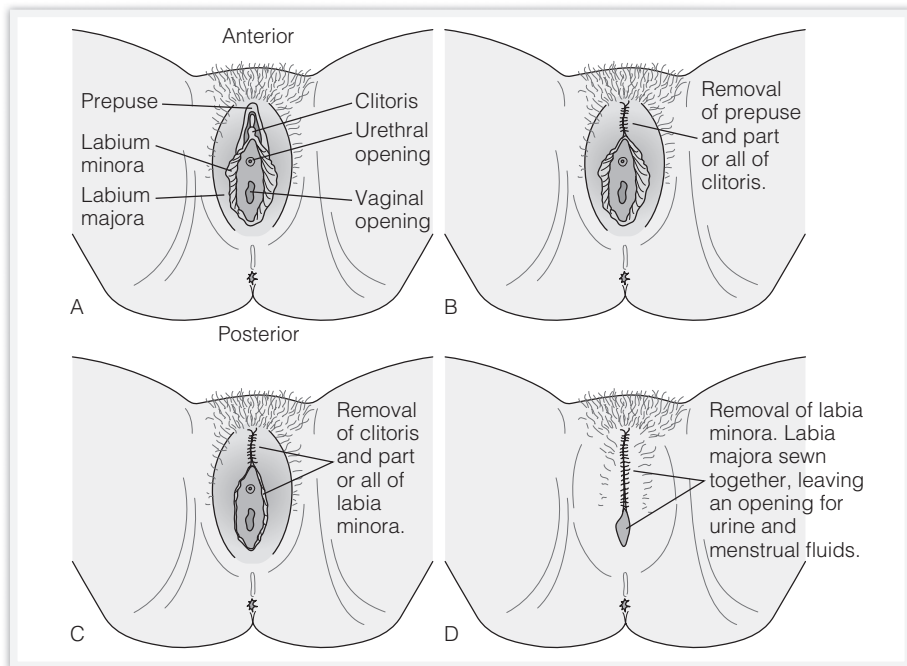


FIGURE 6-1 Female genital mutilation. A. Normal anatomy; B. Type I; C. Type II; D. Type III.

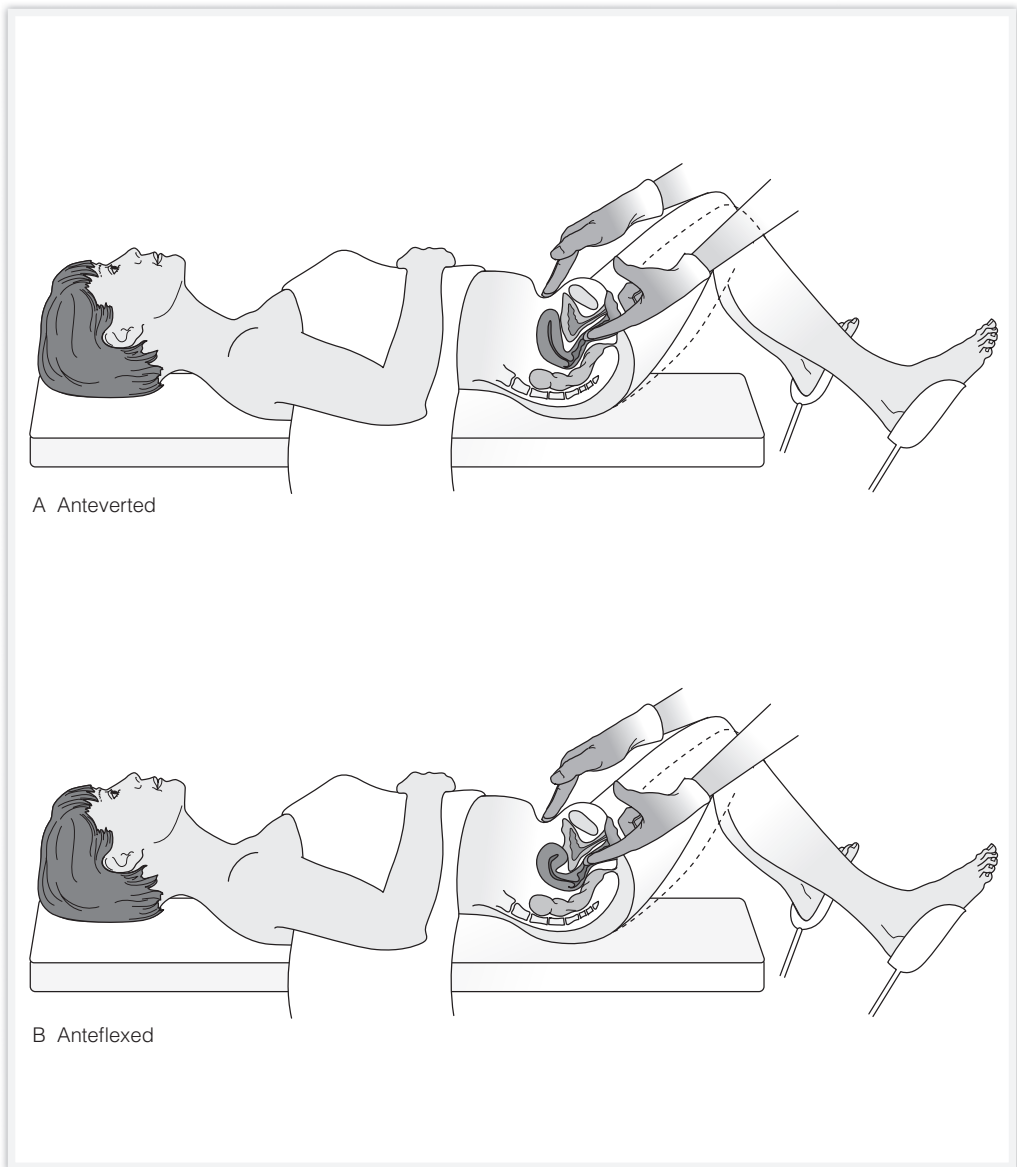


FIGURE 6-10 Variations in uterine position. A: Anteverted; B: Anteflexed; C: Retroverted; D: Retroflexed; E: Midposition of the uterus.

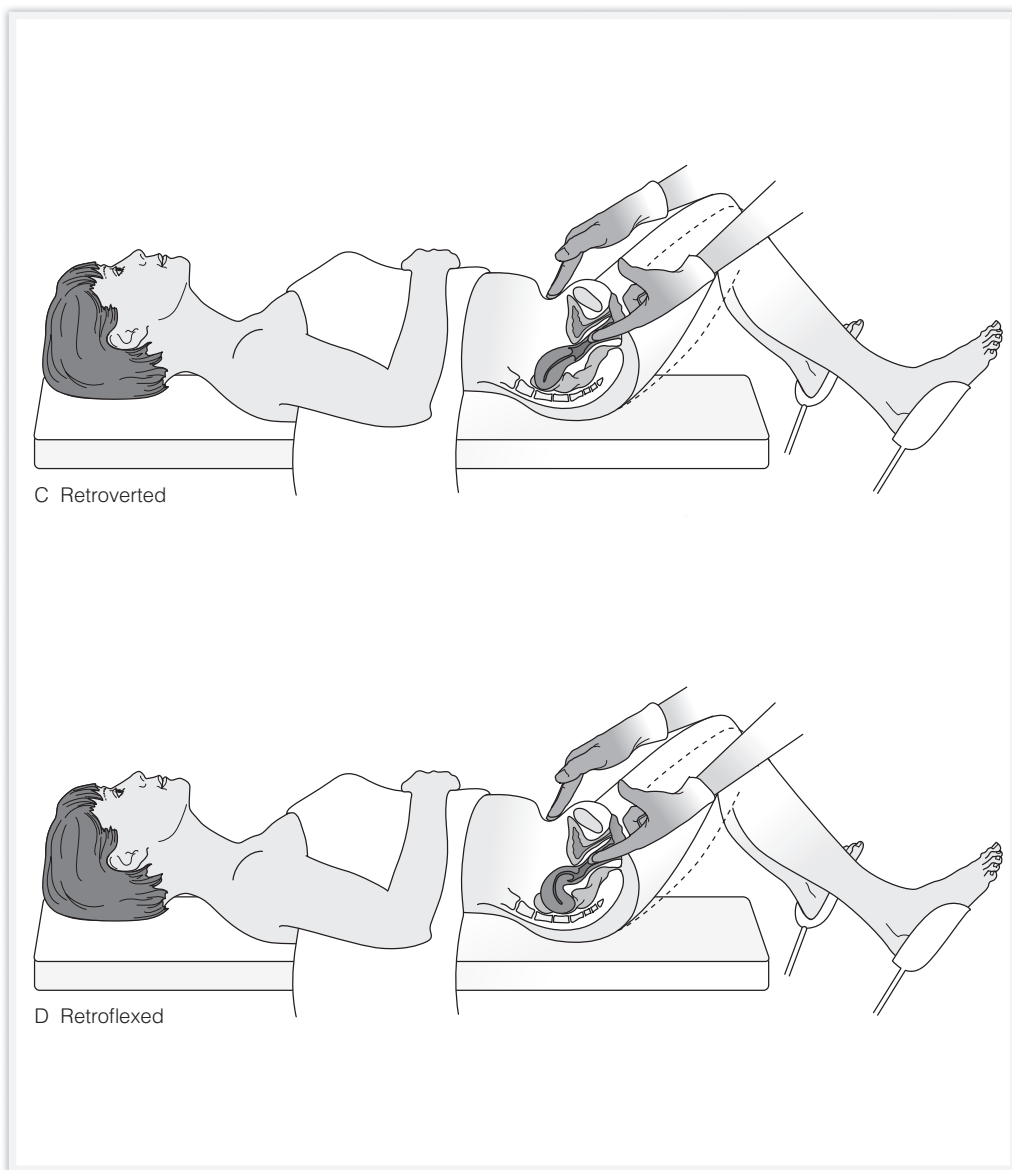


FIGURE 6-10 Variations in uterine position. A: Anteverted; B: Anteflexed; C: Retroverted; D: Retroflexed; E: Midposition of the uterus. (Continued)

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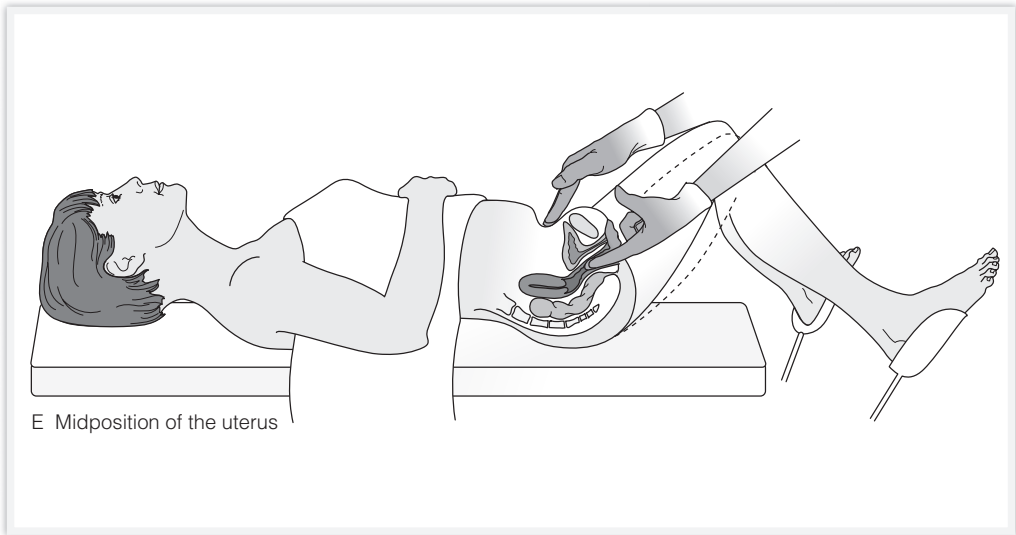


FIGURE 6-10 Variations in uterine position. A: Anteverted; B: Anteflexed; C: Retroverted; D: Retroflexed; E: Midposition of the uterus. (Continued)

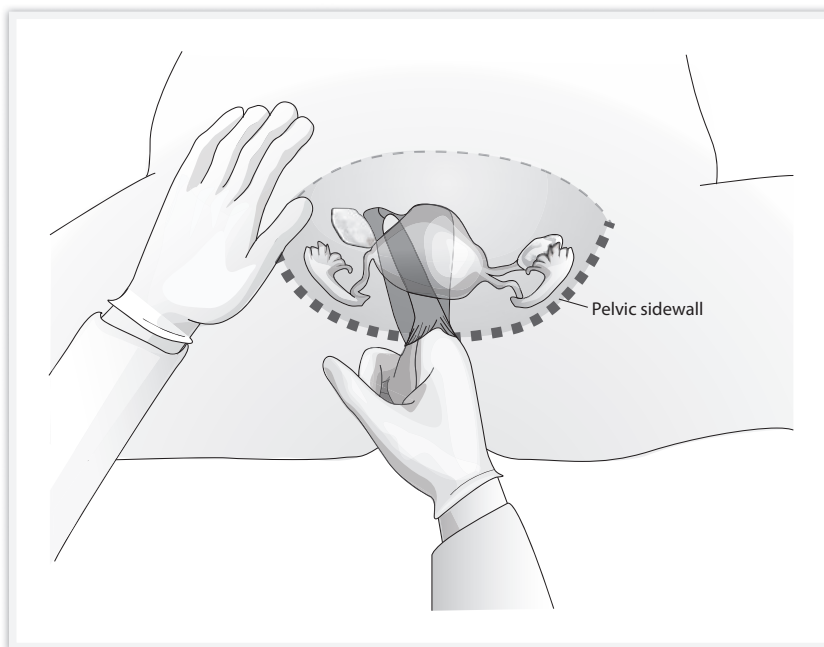


FIGURE 6-11 Adnexal examination.

TABLE 28-4 The 2001 Bethesda Categories of Epithelial Cell Abnormalities

ASC-US	Atypical squamous cells of undetermined significance This term is used when the squamous cells do not appear completely normal but it is not possible to determine the cause of the abnormal cells.
ASC-H	Atypical squamous cells—cannot exclude HSIL
LSIL	Low-grade squamous intraepithelial neoplasia Encompasses: HPV CIN 1 (mild dysplasia): lesion involves the initial 1/3 of the epithelial layer
HSIL	High-grade squamous intraepithelial neoplasia Encompasses: CIN 2 (moderate dysplasia): Lesion involves 1/3 to < 2/3 of the epithelial layer CIN 3 (severe dysplasia, carcinoma in situ): Lesion involves 2/3 to full thickness
Squamous carcinoma	Malignant cells penetrate basement membrane of cervical epithelium and infiltrate stromal tissue (supporting tissue) In advanced cases, cancer may spread to adjacent organs such as bladder or rectum, or to distant sites in the body via the blood stream and lymphatic channels.
<i>Note:</i> CIN = cervical intraepithelial neoplasia.	

testing can identify which women need a colposcopy as soon as possible and which ones can be followed by repeat cytology and high-risk HPV testing in 12 months (see Figure 28-12 later in this chapter) (ASCCP, 2009).

High-risk HPV DNA testing and genotyping are not recommended in the following circumstances:

- Adolescents, defined as women 20 years and younger (regardless of their cytology results)
- Women 21 years and older with ASC-H, LSIL, or HSIL cytology (note: “reflex” HPV testing is acceptable in postmenopausal women with LSIL)
- Routine screening in women before the age of 30 years
- In women considering vaccination against HPV
- For routine STD screening
- As part of a sexual assault workup
- HPV genotyping is not recommended for women with ASC-US
- HPV genotyping is not recommended as the initial screening test for women 30 years and older (ASCCP, 2009)

The American Society for Colposcopy provides guidelines for the appropriate use of the tests on its website (http://www.asccp.org/pdfs/consensus/clinical_update_20090408.pdf).

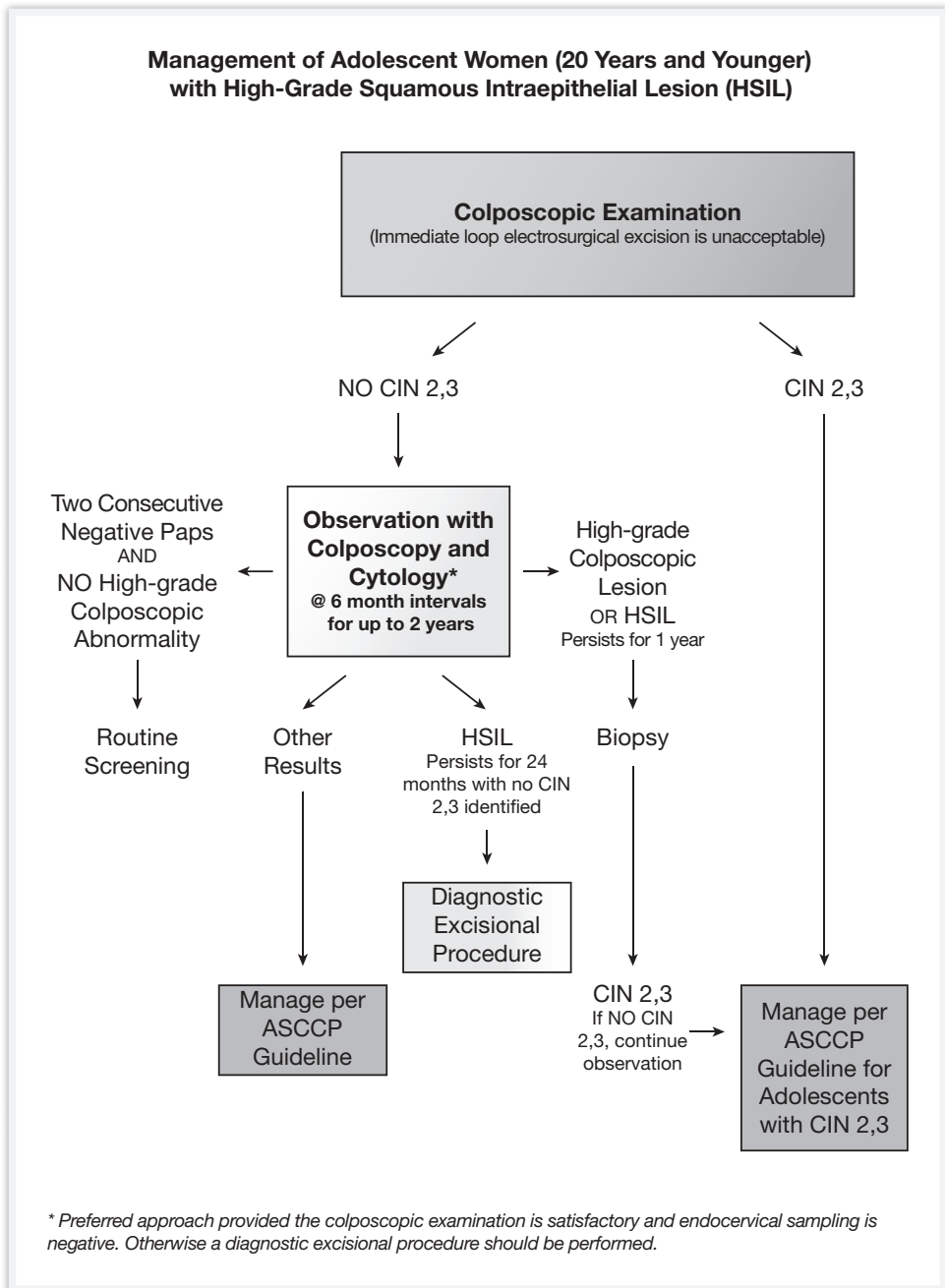


FIGURE 28-8 Management of adolescent women (20 years and younger) with high-grade squamous intraepithelial lesion (HSIL).

Source: American Society for Colposcopy and Cervical Pathology. (2007). The Consensus Guidelines algorithms are reprinted from *The Journal of Lower Genital Tract Disease*, Vol. 11, Issue 4, with permission of ASCCP. Copyright © American Society for Colposcopy and Cervical Pathology.



Pelvic Pain Assessment Form

Physician: _____ Date: _____

Initial History and Physical Examination

This assessment form is intended to assist the clinician with the initial patient assessment and is not meant to be a diagnostic tool.

Contact Information

Name: _____ Birth Date: _____ Chart Number: _____
 Phone: Work: _____ Home: _____ Cell: _____
 Referring Provider's Name and Address: _____

Information About Your Pain

Please describe your pain problem (use a separate sheet of paper if needed) : _____

What do you think is causing your pain? _____
 Is there an event that you associate with the onset of your pain? Yes No If so, what? _____
 How long have you had this pain? _____ years _____ months

For each of the symptoms listed below, please "bubble in" your level of pain over the last month using a 10-point scale:
 0 - no pain 10 – the worst pain imaginable

How would you rate your pain?	0	1	2	3	4	5	6	7	8	9	10
Pain at ovulation (mid-cycle)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain just before period	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain (not cramps) before period	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deep pain with intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain in groin when lifting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pelvic pain lasting hours or days after intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain when bladder is full	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle/joint pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Level of cramps with period	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain after period is over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burning vaginal pain after sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain with urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Backache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain with sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Provider Comments

What physicians or health care providers have evaluated or treated you for **chronic pelvic pain**?

<i>Physician/Provider</i>	<i>Specialty</i>	<i>City, State, Phone</i>

Demographic Information
 Are you (check all that apply):
 Married Widowed Separated Committed Relationship
 Single Remarried Divorced
 Who do you live with? _____
 Education: Less than 12 years High School graduate
 College degree Postgraduate degree
 What type of work are you trained for? _____
 What type of work are you doing? _____

Surgical History

Please list all surgical procedures you have had **related to this pain**:

Year	Procedure	Surgeon	Findings

Please list all **other** surgical procedures:

Year	Procedure	Year	Procedure

Provider Comments

Medications

Please list **pain medication** you have taken for your pain condition in the past 6 months, and the providers who prescribed them (use a separate page if needed):

Medication/Dose	Provider	Did it help?
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking

Please list all **other medications** you are presently taking, the condition, and the provider who prescribed them (use a separate page if needed):

Medication/Dose	Provider	Medical Condition

Obstetrical History

How many pregnancies have you had? _____
 Resulting in (#): _____ Full 9 months _____ Premature _____ Miscarriage/Abortion _____ Living children _____
 Where there any complications during pregnancy, labor, delivery, or postpartum?
 4° episiotomy C-section Vacuum Postpartum hemorrhaging
 Vaginal laceration Forceps Medication for bleeding Other _____

Family History

Has anyone in your family had: Fibromyalgia Chronic pelvic pain Irritable bowel syndrome
 Depression Interstitial cystitis Other chronic condition _____
 Endometriosis Cancer, type(s) _____

Medical History

Please list any medical problems/diagnoses _____

 Allergies (including latex allergy) _____
 Who is your primary care provider? _____
 Have you ever been hospitalized for anything besides childbirth? Yes No If yes, please explain _____
 Have you had major accidents such as falls or a back injury? Yes No
 Have you ever been treated for depression? Yes No Treatments: Medication Hospitalization Psychotherapy
 Birth control method: Nothing Pill Vasectomy Vaginal ring Depo-Provera
 Condom IUD Hysterectomy Diaphragm Tubal sterilization
 Other _____

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Menstrual History

How old were you when your menses started? _____
 Are you still having menstrual periods? Yes No

Answer the following only if you are still having menstrual periods.

Periods are: Light Moderate Heavy Bleed through protection
 How many days between your periods? _____
 How many days of menstrual flow? _____
 Date of first day of last menstrual period _____
 Do you have any pain with your periods? Yes No
 Does pain start the day flow starts? Yes No Pain starts _____ days before flow
 Are periods regular? Yes No
 Do you pass clots in menstrual flow? Yes No

Gastrointestinal/Eating

Do you have nausea? No With pain Taking medications With eating Other
 Do you have vomiting? No With pain Taking medications With eating Other
 Have you ever had an eating disorder such as anorexia or bulimia? Yes No
 Are you experiencing rectal bleeding or blood in your stool? Yes No
 Do you have increased pain with bowel movements? Yes No

The following questions help to diagnose irritable bowel syndrome, a gastrointestinal condition, which may be a cause of pelvic pain.

Do you have pain or discomfort that is associated with the following:

 Change in frequency of bowel movement? Yes No
 Change in appearance of stool or bowel movement? Yes No
 Does your pain improve after completing a bowel movement? Yes No

Health Habits

How often do you exercise? Rarely 1–2 times weekly 3–5 times weekly Daily
 What is your caffeine intake (number cups per day, include coffee, tea, soft drinks, etc)? 0 1–3 4–6 > 6
 How many cigarettes do you smoke per day? _____ For how many years? _____
 Do you drink alcohol? Yes No
 Number of drinks per week _____
 Have you ever received treatment for substance abuse? Yes No
 What is your use of recreational drugs? Never used Used in the past, but not now Presently using No answer
 Heroin Amphetamines Marijuana Barbiturates Cocaine Other _____
 How would you describe your diet? (check all that apply) Well balanced Vegan Vegetarian Fried food
 Special diet _____ Other _____

Urinary Symptoms

Do you experience any of the following?

- Loss of urine when coughing, sneezing, or laughing? Yes No
- Difficulty passing urine? Yes No
- Frequent bladder infections? Yes No
- Blood in the urine? Yes No
- Still feeling full after urination? Yes No
- Having to void again within minutes of voiding? Yes No

The following questions help to diagnose painful bladder syndrome, which may cause pelvic pain.

Please circle the answer that best describes your bladder function and symptoms.

	0	1	2	3	4
1. How many times do you go to the bathroom DURING THE DAY (to void or empty your bladder)?	3-6	7-10	11-14	15-19	20 or more
2. How many times do you go to the bathroom AT NIGHT (to void or empty your bladder)?	0	1	2	3	4 or more
3. If you get up at night to void or empty your bladder, does it bother you?	Never	Mildly	Moderately	Severely	
4. Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No					
5. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always	
6. If you have pain with intercourse, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always	
7. Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)?	Never	Occasionally	Usually	Always	
8. Do you have urgency after voiding?	Never	Occasionally	Usually	Always	
9. If you have pain, is it usually	Never	Mild	Moderate	Severe	
10. Does your pain bother you?	Never	Occasionally	Usually	Always	
11. If you have urgency, is it usually		Mild	Moderate	Severe	
12. Does your urgency bother you?	Never	Occasionally	Usually	Always	

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KCI ___ *Not Indicated* ___ *Positive* ___ *Negative*

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Coping Mechanisms

Who are the people you talk to concerning your pain, or during stressful times?

- Spouse/partner Relative Support group Clergy
 Doctor/nurse Friend Mental health provider I take care of myself

How does your partner deal with your pain?

- Doesn't notice when I'm in pain Takes care of me Not applicable
 Withdraws Feels helpless
 Distracts me with activities Gets angry

What helps your pain?

- Meditation Relaxation Lying down Music
 Massage Ice Heating pad Hot bath
 Pain medication Laxatives/enema Injection TENS unit
 Bowel movement Emptying bladder Nothing
 Other _____

What makes your pain worse?

- Intercourse Orgasm Stress Full meal
 Bowel movement Full bladder Urination Standing
 Walking Exercise Time of day Weather
 Contact with clothing Coughing/sneezing Not related to anything
 Other _____

Of all the problems or stresses or your life, how does your pain compare in importance?

- The most important problem Just one of many problems

Sexual and Physical Abuse History

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted Yes No No answer

Check an answer for **both** as a child and as an adult.

As a child (13 and younger) As an adult (14 and over)

- 1a. Has anyone ever exposed the sex organs of their body to you when you did not want it? Yes No Yes No
1b. Has anyone ever threatened to have sex with you when you did not want it? Yes No Yes No
1c. Has anyone ever touched the sex organs of your body when you did not want this? Yes No Yes No
1d. Has anyone ever made you touch the sex organs of their body when you did not want this? Yes No Yes No
1e. Has anyone forced you to have sex when you did not want this? Yes No Yes No
1f. Have you had any other unwanted sexual experiences not mentioned above? Yes No Yes No
If yes, please specify _____

2. When you were a child (13 or younger), did an older person do the following?

- a. Hit, kick, or beat you? Never Seldom Occasionally Often
b. Seriously threaten your life? Never Seldom Occasionally Often

3. Now that you are an adult (14 or older), has any other adult done the following?

- a. Hit, kick, or beat you? Never Seldom Occasionally Often
b. Seriously threaten your life? Never Seldom Occasionally Often

Leserman, J, Drossman D, Li Z. The reliability and validity of a sexual and physical abuse history questionnaire in female patients with gastrointestinal disorders. Behavioral Medicine. 1995;21:141-148.

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Short-Form McGill

The words below describe average pain. Place a check mark (✓) in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of the pain in your pelvic area only.

What does your pain feel like?

Type	None (0)	Mild (1)	Moderate (2)	Severe (3)
Throbbing	_____	_____	_____	_____
Shooting	_____	_____	_____	_____
Stabbing	_____	_____	_____	_____
Sharp	_____	_____	_____	_____
Cramping	_____	_____	_____	_____
Gnawing	_____	_____	_____	_____
Hot-Burning	_____	_____	_____	_____
Aching	_____	_____	_____	_____
Heavy	_____	_____	_____	_____
Tender	_____	_____	_____	_____
Splitting	_____	_____	_____	_____
Tiring-Exhausting	_____	_____	_____	_____
Sickening	_____	_____	_____	_____
Fearful	_____	_____	_____	_____
Punishing-Cruel	_____	_____	_____	_____

Melzak R. The Short-form McGill Pain Questionnaire. Pain. 1987;30:191-197.

Pelvic Varicosity Pain Syndrome Questions

- Is your pelvic pain aggravated by prolonged physical activity? Yes No
- Does your pelvic pain improve when you lie down? Yes No
- Do you have pain that is deep in the vagina or pelvis *during* sex? Yes No
- Do you have pelvic throbbing or aching *after* sex? Yes No
- Do you have pelvic pain that moves from side to side? Yes No
- Do you have sudden episodes of severe pelvic pain that come and go? Yes No

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Physical Examination – For Physician Use Only

Name: _____ Chart Number: _____

Date of Exam: _____ Height: _____ Weight: _____ BMI: _____

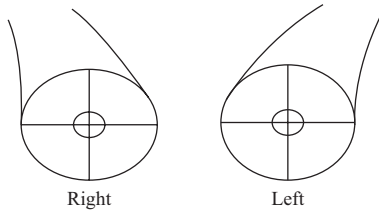
BP: _____ HR: _____ Temp: _____ Resp: _____ LMP: _____

ROS, PFSH Reviewed: Yes No Physician Signature: _____

General Appearance: Well-appearing Ill-appearing Tearful Depressed
 Normal weight Underweight Overweight Abnormal gait

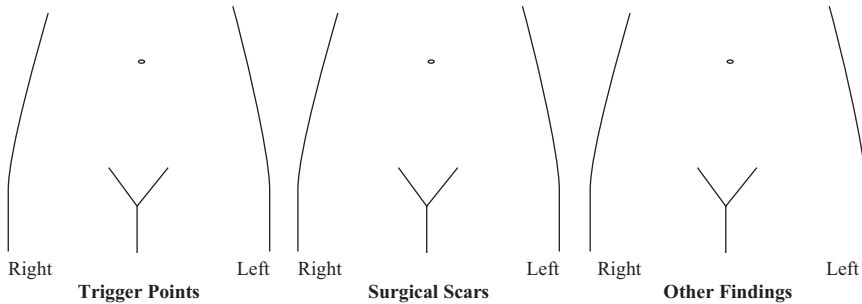
NOTE: Mark "Not Examined" as N/E

HEENT WNL Other _____ Lungs WNL Other _____ Heart WNL Other _____ Breasts WNL Other _____



Abdomen

- Nontender
- Tender
- Incisions
- Trigger points
- Inguinal tenderness
- Inguinal bulge
- Suprapubic tenderness
- Ovarian point tenderness
- Mass
- Guarding
- Rebound
- Distention
- Other _____



Back

- Nontender
- Tender
- Alteration in posture
- SI joint rotation _____

Lower Extremities

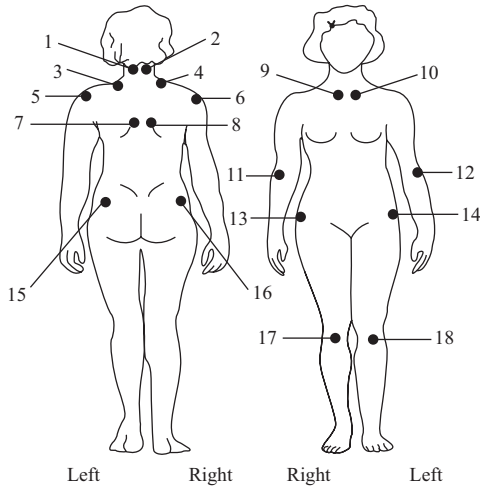
- WNL
- Edema
- Varicosities
- Neuropathy
- Length discrepancy _____

Neuropathy

- Iliohypogastric
- Ilioinguinal
- Genitofemoral
- Pudendal
- Altered sensation

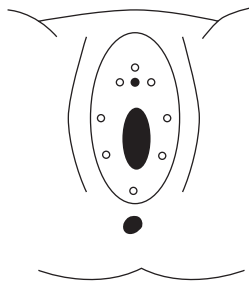
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Fibromyalgia/Back/Buttock

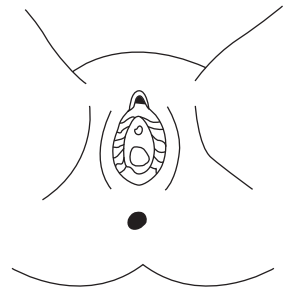


External Genitalia

- WNL Erythema Discharge Q-tip test (show on diagram) Tenderness (show on diagram)



Right Left



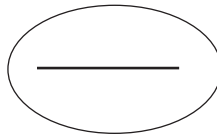
Right Left

Q-tip Test (score each circle 0-4) **Total Score** _____

Other Findings _____

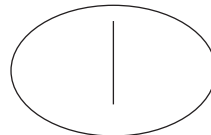
Vagina

- WNL Wet prep: _____
 Local tenderness _____ Vaginal mucosa _____ Discharge _____
 Cultures: GC Chlamydia Fungal Herpes
 Vaginal apex tenderness (post hysterectomy – show on diagram)



Right Left

Transverse apex closure



Vertical apex closure

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Unimanual Exam

- | | |
|--|--|
| <input type="checkbox"/> WNL | <input type="checkbox"/> Cervix |
| <input type="checkbox"/> Introitus | <input type="checkbox"/> Cervical motion |
| <input type="checkbox"/> Uterine-cervical junction | <input type="checkbox"/> Parametrium |
| <input type="checkbox"/> Urethra | <input type="checkbox"/> Vaginal cuff |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Cul-de-sac |
| <input type="checkbox"/> R ureter | <input type="checkbox"/> L ureter |
| <input type="checkbox"/> R inguinal | <input type="checkbox"/> L inguinal |
| <input type="checkbox"/> Muscle awareness | <input type="checkbox"/> Clitoral tenderness |

Rank muscle tenderness on 0–4 scale

- | | |
|---|--|
| <input type="checkbox"/> R obturator _____ | <input type="checkbox"/> L obturator _____ |
| <input type="checkbox"/> R piriformis _____ | <input type="checkbox"/> L piriformis _____ |
| <input type="checkbox"/> R pubococcygeus _____ | <input type="checkbox"/> L pubococcygeus _____ |
| <input type="checkbox"/> Total pelvic floor score _____ | <input type="checkbox"/> Anal sphincter _____ |

Bimanual Exam

- | | | | |
|--------------|---|--------------------------------------|--------------------------------------|
| Uterus: | <input type="checkbox"/> Tender | <input type="checkbox"/> Nontender | <input type="checkbox"/> Absent |
| Position: | <input type="checkbox"/> Anterior | <input type="checkbox"/> Posterior | <input type="checkbox"/> Midplane |
| Size: | <input type="checkbox"/> Normal | <input type="checkbox"/> Other _____ | |
| Contour: | <input type="checkbox"/> Regular | <input type="checkbox"/> Irregular | <input type="checkbox"/> Other _____ |
| Consistency: | <input type="checkbox"/> Firm | <input type="checkbox"/> Soft | <input type="checkbox"/> Hard |
| Mobility: | <input type="checkbox"/> Mobile | <input type="checkbox"/> Hypermobile | <input type="checkbox"/> Fixed |
| Support: | <input type="checkbox"/> Well supported | <input type="checkbox"/> Prolapse | |

Adnexal Exam

- | | | | |
|--|--|--|--|
| Right: | <input type="checkbox"/> Absent | Left: | <input type="checkbox"/> Absent |
| <input type="checkbox"/> WNL | <input type="checkbox"/> WNL | <input type="checkbox"/> WNL | <input type="checkbox"/> WNL |
| <input type="checkbox"/> Tender | <input type="checkbox"/> Tender | <input type="checkbox"/> Tender | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Fixed | <input type="checkbox"/> Fixed | <input type="checkbox"/> Fixed |
| <input type="checkbox"/> Enlarged _____ cm | <input type="checkbox"/> Enlarged _____ cm | <input type="checkbox"/> Enlarged _____ cm | <input type="checkbox"/> Enlarged _____ cm |

Rectovaginal Exam

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> WNL | <input type="checkbox"/> Nodules | <input type="checkbox"/> Guaiac positive |
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Mucosal pathology | <input type="checkbox"/> Not examined |

Assessment: _____

Diagnostic Plan: _____

Therapeutic Plan: _____



COLOR PLATE 29 Allergic contact dermatitis.
 Reprinted from Schlosser, B. J. (2010). Contact dermatitis of the vulva. *Dermatologic Clinics*, 28(4), 697–706.



COLOR PLATE 30 Lichen sclerosus.
 Reprinted from Goldstein, A. T., Taçi, D., & Luger, T. (2009). Topical calcineurin inhibitors for the treatment of vulvar dermatoses. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 146(1), 22–29.



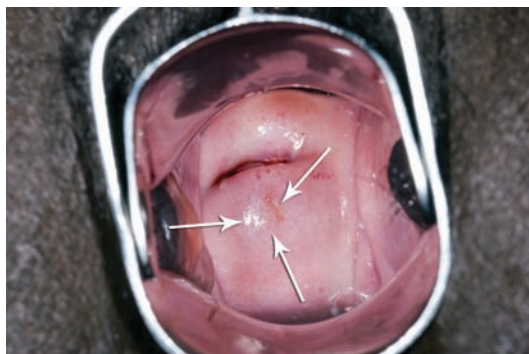
COLOR PLATE 31 Erosive lichen planus.
 Reprinted from Goldstein, A. T., Taçi, D., & Luger, T. (2009). Topical calcineurin inhibitors for the treatment of vulvar dermatoses. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 146(1), 22–29.



COLOR PLATE 32 Lichen simplex chronicus.
 Reprinted from Stewart, K. M. (2010). Clinical care of vulvar pruritis, with emphasis on one common cause, lichen simplex chronicus. *Dermatologic Clinics*, 28(4), 669–680.



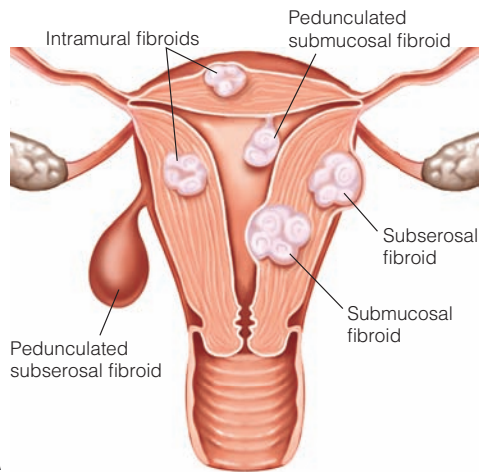
COLOR PLATE 33 Vulvar psoriasis.
 Reprinted from Stewart, K. M. (2010). Clinical care of vulvar pruritis, with emphasis on one common cause, lichen simplex chronicus. *Dermatologic Clinics*, 28(4), 669–680.



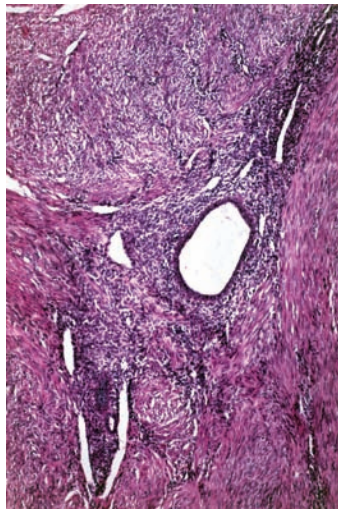
COLOR PLATE 34 Nabothian cyst.
 © Dr. P. Marazzi/Photo Researchers, Inc.



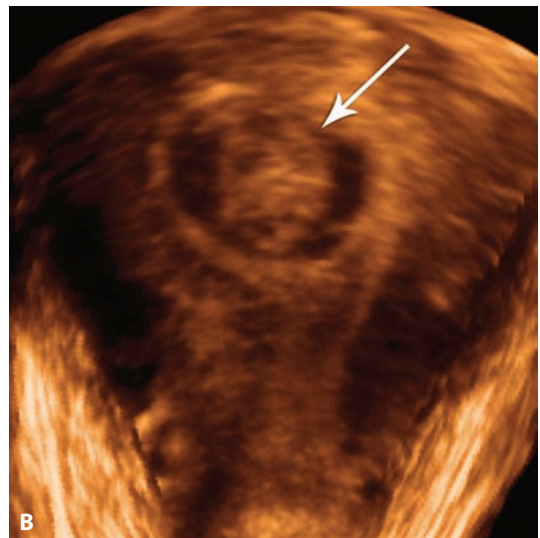
COLOR PLATE 35 Cervical polyp.
© Dr. P. Marazzi/Photo Researchers, Inc.



A

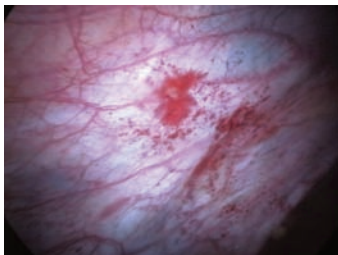


COLOR PLATE 37 Adenomyosis.
© Biophoto Associates/Photo Researchers, Inc.

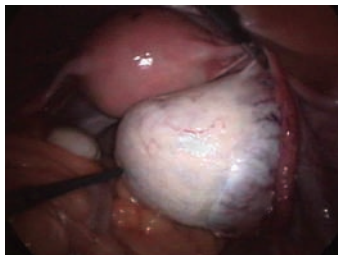


B

COLOR PLATE 36 Uterine fibroids: A. Classifications by location; B. Ultrasound image.
(B) © Dr. Najeeb Layyous/Photo Researchers, Inc.



COLOR PLATE 38 Endometriosis.
© Dr. Najeeb Layyous/Photo Researchers, Inc.



COLOR PLATE 39 Ovarian cyst.
© Dr. Najeeb Layyous/Photo Researchers, Inc.