Reproductive – Assessment of External Genitalia – Male

Strength of Evidence Level: 3

PURPOSE:
To adequately assess the external reproductive system of the male patient.

CONSIDERATIONS:
Few males realize the need for monthly genital self-examination or yearly clinical examination.

EQUIPMENT:
Towel or blanket to drape the patient
Gloves

PROCEDURE:
1. Adhere to standard precautions.
2. Don gloves.
3. Have the patient stand in front of you, if able. If not able to stand, have patient lay down.
4. Inspect the base of the penis and pubic hair.
   a. Note pattern of hair and look for infestations.
   b. Inspect the skin of the shaft for rashes, lesions and lumps. Normally would be wrinkled and hairless and without skin abnormalities listed.
   c. Palpate the shaft. Should be soft, flaccid and nontender.
   d. Inspect the foreskin. If needed, refer to care of the uncircumcised male.
   e. Observe the glans. Should be smooth, free of lesions and redness.
5. Note the location of the urinary meatus which should be located in the center of the glans.
6. Palpate for any urethral discharge. None should be noted.
7. Inspect size, shape and position of the scrotum. Should hang below level of penis, with the left side lower than the right. Size and shape depend on temperature.
8. Inspect the scrotal skin. Should be thin and crinkled, with little hair. Color is slightly darker than penis. Sebaceous cysts may be found.
9. Palpate scrotum. Note size, shape of testes. Normally about 3.5 to 5 cm long. They should move freely.
   [NOTE: Testes are normally sensitive to pressure.]

AFTERCARE:
1. Document:
   a. Findings from assessment.
   b. Communication with physician.
   c. Instructions given to the patient and or caregiver.
Reproductive – Assessment of External Genitalia – Female

Strength of Evidence Level: 3

PURPOSE:
To adequately assess the external reproductive system of the female patient.

CONSIDERATIONS:
Assessment of the internal genitalia should be completed yearly via gynecological exam.

EQUIPMENT:
Towel or blanket to drape the patient
Gloves

PROCEDURE:
1. Adhere to standard precautions.
2. Place patient in the lithotomy position. With knees flexed.
3. Drape patient for privacy.
4. Don gloves.
5. Inspect the mons pubis and vulva:
   a. Note the pattern of pubic hair.
   b. Look for infestations.
   c. Observe for skin color and condition.
   d. Inspect labia majora and labia minora. Should appear symmetrical with intact skin, with a smooth to wrinkled appearance.
   e. Inspect the clitoris. Should appear 2 cm long x 0.5 cm in diameter without lesions.
   f. Inspect urethral meatus. Should be midline, size of a pea and slit-like in appearance. There should be no discharge, swelling or redness.
   g. Inspect vaginal introitus. Mucosa should be pink and moist. There may be a clear to white discharge that is free of odor.
   h. Inspect perineum. Should appear smooth, intact and may be slightly darkened.
6. Allow the patient to relax.
7. Have the patient get dressed.

AFTER CARE:
1. Document:
   a. Findings from assessment.
   b. Communication with physician.
   c. Instructions given to the patient and or caregiver.
Reproductive – Assessment of Sexually Transmitted Infection

SECTION: 8.03

Strength of Evidence Level: 3

PURPOSE:
To assess for sexually transmitted infection (STI).

CONSIDERATIONS:
1. Any sexual activity is a potential risk factor for STIs.
2. The fastest growing population for STIs is adults over the age of 40 years.

EQUIPMENT:
None

PROCEDURE:
Assess for signs and symptoms of the following STI’s by physical exam (See Reproductive - Assessment of External Genitalia - Female and Assessment of External Genitalia - Male) or by obtaining a thorough history.

1. Chlamydia: Signs and Symptoms:
   a. Painful urination.
   b. Lower abdominal pain.
   c. Vaginal discharge in women.
   d. Discharge from the penis in men.
   e. Pain during sexual intercourse in women.
   f. Testicular pain in men.
2. Gonorrhea: Signs and Symptoms
   a. Thick, cloudy or bloody discharge from the penis or vagina.
   b. Pain or burning sensation when urinating.
   c. Frequent urination.
   d. Pain during sexual intercourse.
3. Trichomoniasis, Signs and Symptoms:
   a. Greenish yellow, possibly frothy vaginal discharge.
   b. Strong vaginal odor.
   c. Vaginal itching or irritation.
   d. Pain during sexual intercourse.
   e. Painful urination.
   f. Light vaginal bleeding.
4. HIV: Early HIV Signs and Symptoms May Include:
   Severe symptoms of HIV infection may not appear for 10 years or more after the initial infection.
   a. Fever.
   b. Sore throat.
   c. Swollen lymph glands.
   d. Rash.
   e. Fatigue.
   f. Swollen lymph nodes — often one of the first signs of HIV infection.
   g. Diarrhea.
   h. Weight loss.
   i. Fever.
   j. Cough and shortness of breath.
   k. Persistent, unexplained fatigue.
   l. Soaking night sweats.
   m. Shaking chills or fever higher than 100.4° F (38° Celsius) for several weeks.
   n. Swelling of lymph nodes for more than three months.
   o. Chronic diarrhea.
   p. Persistent headaches.

AFTER CARE:
1. Follow up with physician if any signs or symptoms are noted.
2. Instruct on prevention of STIs, risk factors and use of male and female condoms.
PURPOSE:
To assess for the presence of vaginal infection.

CONSIDERATIONS:
1. Risk factors for vaginal infections include but are not limited to pregnancy, perimenopause/menopause, poor personal hygiene, tight undergarments, synthetic clothing, frequent douching, allergies, oral contraceptives, use of antibiotics, diabetes and intercourse with infected partner.
2. Foul smelling discharge of any color may indicate vaginitis or cervicitis.
3. Health, medication and sexual history are important for the assessment of vaginal infections. Questions to ask the patient would include, but are not limited to:
   a. Are you experiencing any vaginal discharge that is unusual in terms of color, amount or odor?
   b. Are you experiencing any pain or itching of the genital or groin area?
   c. Ask about risk factors listed above.

EQUIPMENT:
Cotton tip specimen swab
Normal Saline Solution

PROCEDURE:
1. Adhere to standard precautions.
2. Verify physician order and verify that you have the correct patient.
3. Place patient in lithotomy position: Lay patient flat on their back, knees flexed perpendicular to the bed.
4. Drape the client for privacy.
5. Don gloves.
6. Inspect for any discharge coming from vagina.
7. Moisten cotton tip specimen swab with normal saline solution.
8. Insert the swab into the vagina and rotate against the vaginal wall, anterior and lateral to the cervix.
9. Withdraw the swab.
10. Place the secretions on a glass slide, cover with second glass slide.
11. Label the slide as instructed by the lab with name, date of birth (DOB), test to be completed, and any additional information required by the lab.
12. Transport vaginal swab to the lab for analysis.

AFTERCARE:
1. Make patient comfortable.
2. Document:
   a. Patient’s response.
   b. Findings of assessment.
   c. Instructions given to patient and/or caregiver.
   d. Communication with physician.
   e. Test to be completed from swab and lab where transported
PURPOSE:
To provide instruction regarding how to perform a clinical breast exam.

CONSIDERATIONS:
1. Women in their 20s and 30s should have a clinical breast exam (CBE) as part of a periodic (regular) health exam by a health professional, at least every 3 years. After age 40, women should have a breast exam by a health professional every year.
2. CBE is a complement to mammograms and an opportunity for a woman and her doctor or nurse to discuss changes in their breasts, testing, and factors in the woman's history that might make her more likely to have breast cancer.
3. Breast self exam (BSE) is an option for women starting in their 20s. Women should be told about the benefits and limitations of BSE. Women should report any breast changes to their health professional right away.

EQUIPMENT:
None

PROCEDURE:
1. Adhere to standard precautions.
2. Identify the patient and explain procedure to patient.
3. Have patient undress from the waist up. First, have the patient sit up with her hands on her hips. Inspect the breasts for size, shape, and symmetry. Then ask the patient to squeeze her arms inward as she continues to keep her hands on her hips. Inspect the breasts again, as above. Have the patient raise both arms above her head and inspect the breasts again. Finally, ask the patient to bend forward at the waist and inspect the breasts again.
4. Visually observe the patient's breast for abnormalities in size or shape, or changes in the skin of the breasts or nipple.
5. Ask the patient to lie down for the rest of the breast exam. Examine one breast at a time. Using the pads of your fingers, gently palpate the patient's breast. Use the finger pads of your 3 middle fingers. Use overlapping dime-sized circular motions of the finger pads to feel the breast tissue. Use 3 different levels of pressure to feel all the breast tissue. Light pressure is needed to feel the tissue closest to the skin, medium pressure to feel a little deeper, and firm pressure to feel the tissue closest to the chest and ribs.
6. Special attention should be given to the shape and texture of the breasts, location of any lumps, and whether such lumps are attached to the skin or to deeper tissues. The area under both arms should also be examined.
7. Move the breast around in an up and down pattern starting at an imaginary line drawn straight down the side from the underarm and moving across the breast to the middle of the sternum. Be sure to check the entire breast area going down until you feel only ribs and up to the neck or clavicle.
8. Have patient sit up and get dressed.

AFTER CARE:
1. Document in patient’s record:
   a. Patient's response to procedure.
   b. Results of breast exam.
   c. Any instructions given to caregiver, if needed.
   d. Call patient's physician with report on exam, if needed.
PURPOSE:
To provide guidance on the care and proper hygiene of an uncircumcised adult male.

CONSIDERATIONS:
1. The foreskin that covers the penis should be intact and uniform in color with the penis.
2. Any discoloration of the foreskin may indicate scarring or infection.
3. Note any changes in the skin, noting blisters, warts or other abnormalities.
4. Note any discharge from underneath the foreskin. Normally there may be a small amount of whitish material known as smegma.

EQUIPMENT:
Water
Towels
Soap
Gloves

PROCEDURE:
1. Adhere to standard precautions.
2. Don gloves.
3. Gently retract the foreskin. The foreskin should retract easily. If you are unable to retract it, notify the supervisor or physician.
4. Cleanse the area and dry thoroughly.
5. Replace the foreskin to the penis.

AFTER CARE:
1. Document exam and findings.
2. Report any unusual findings to a supervisor or physician.
Reproductive – Pelvic Muscle (Kegel) Exercises

SECTION: 8.07

Strength of Evidence Level: 3

PURPOSE:
To increase muscle bulk and muscle strength of the pelvic muscles.

CONSIDERATIONS:
1. One of the greatest obstacles to pelvic muscle exercises is the inability of the patient to correctly identify and isolate the muscles.
2. An effective program must be individualized for the patient and should be based on an understanding of pelvic muscle physiology and strength training.
3. If the patient feels discomfort in his/her abdomen or back, he/she is probably doing the exercises wrong.
4. Significant improvement may take up to 8 weeks of consistent exercise.
5. Patients can often isolate the pelvic muscles by attempting to interrupt their urinary stream. If the muscles are weak, this may be difficult.
6. An ultimate goal of 30 to 45 repetitions per day is ideal. Dividing this into three sets, one laying, one sitting, and one standing will help achieve the goal.

EQUIPMENT:
None

PROCEDURE:
1. Have the patient empty the bladder.
2. Assist the patient into a comfortable position.
3. Instruct the patient to tighten the pelvic muscle and hold for a count of 10.
4. Relax the muscle completely for a count of 10.
5. If the patient is unable to hold for count of 10, have them start with what they can do and slowly increase that number each day.
6. After a few weeks of completing the exercises, have the patient vary the technique they are using:
   a. Contract and relax the muscles on each number as he/she counts to 20.
   b. Slow down the exercise by contracting slowly. As he/she counts to 20, contract a little bit more every 5 numbers until you reach full contraction by 20.

AFTER CARE:
1. Document in patient's record:
   a. Instructions given to the patient.
   b. Patient’s response.
   c. Communication with the physician, if needed.
Reproductive – Reproductive History

Strength of Evidence Level: 3

PURPOSE:
To obtain a history related to the reproductive system.

CONSIDERATIONS:
1. Since the urinary system is closely tied with the reproductive system, you may want to start with urinary and move to reproductive.
2. Clinicians should ease into this assessment due to patients feeling uncomfortable with some topics.
3. All questions may not apply to every assessment, but do not assume that age has an impact on sexual relations or the need for sexually transmitted infection (STI) assessment.

EQUIPMENT:
None.

PROCEDURE:
1. Complete health history related to reproductive system by asking about the following:
   a. Major illnesses/chronic diseases.
   b. Surgeries related to reproductive system.
   c. History of infections to the reproductive system.
   d. History of Mumps and Rubella.
   e. Status of immunizations.
   f. Use of alcohol, tobacco and/or recreational drugs.
   g. Medication history
   h. Pregnancies:
      (1) How many?
      (2) Have you ever had a Miscarriage?
      (3) Have you ever had an Abortion?
      (4) Could you be pregnant now?
   i. Any family history of breast, uterine, ovarian or prostate cancer?
   j. Any problems with urination or constipation?
   k. Are you circumcised? (male or female)
      (1) If not, (male) are you able to retract and replace the foreskin easily?
   l. At what age was the onset of menstruation?
      (1) Is menstruation regular or irregular?
      (2) Do you have spotting or bleeding between periods?
      (3) Last date of menstruation?
      (4) How long do periods last?
   m. Have you begun menopause?
      (1) At what age was the onset?
   n. Do you have any pain with intercourse?
   o. Have you had any changes in your sex life in the past year?
      (1) If so, what kind of changes?
   p. Have you had any trauma to your penis or scrotum?
   q. Have you noticed any sores, lumps or ulcers to your genitalia?
   r. Do you use birth control?
      (1) What type?
      (2) Do you use this every time you have sex?
   s. Have you had a vasectomy?
   t. When was your last pap test?
   u. Have you ever been in a relationship with someone who hurt you?
   v. Have you ever been forced into sexual acts as an adult or a child?
   w. Do you experience erectile dysfunction?
   x. Do you experience difficulty with vaginal lubrication?
   y. Questions related to STIs:
      (1) Are you sexually active?
      (2) How many partners do you have currently?
      (3) How many partners have you had in the last 6 months?
      (4) What is your sexual orientation?
      (5) Do you use protection against sexually transmitted diseases?
         (a) What type?
         (b) Do you use this for every sexual encounter?
      (6) Have you or a partner of yours ever had an STI?
         (a) What type?
         (b) When were you/they diagnosed?
         (c) What treatments are you/they currently taking?
         (d) Have you told all sexual partners about your diagnosis?

AFTER CARE:
1. Document findings in clinical record.
2. Document instructions given to patient.
3. Communicate with the physician as needed.