OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Vaginal procedures

(includes cervical screening, examination, speculum, swabs, insertion and removal of vaginal packs)

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas

This document should be read in conjunction with this Disclaimer

Contents

Chaperones, students and observers

- Follow NMHS Chaperone Policy (available to WA Health employees through Healthpoint).
- See also RANZCOG guideline (external website): 'Gynaecological examinations and procedures (C-Gyn 30)'
- All patients shall be offered a chaperone during any intimate physical examination / procedure.
- The chaperone will be a health care worker employed by NMHS and meet the requirements in the NMHS Chaperone policy. A person of the patient's choice can also be present if the patient requests.
- **Documentation**: The chaperone shall sign the 'Chaperone' stamp in the woman's medical records. Where no stamp is available, document the name and professional delegation of the chaperone in attendance. If the offer of a chaperone is declined, this shall be documented in the woman's notes.

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 [2]

- Routine screening with the CST: Primary human papillomavirus (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.
- Self-collection of vaginal samples for HPV testing should be offered as an option to women 30 years of age or over who; have never participated in the NCSP or are overdue for cervical screening by two years or longer, and have declined a clinician collected sample[3] (see NCSP Self-Collection Policy (external website)). **Note**- changes to self-collection are planned for mid-20**22**.
- 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 (NCSP Guidelines) (external website)
- Women of any age who have symptoms suggestive of cervical cancer require diagnostic testing and should be managed in accordance with the NCSP Guidelines (external website), regardless of their cervical screening history.

Transitioning women to the renewed NCSP

- All women aged 25 to 74 years should have now transitioned to the renewed NCSP. If they have not had a CST or follow-up test since their last Pap smear, they are now overdue.
- Women aged 25 and older with a normal screening history should have had their first CST when they were due for their next Pap smear (i.e. two years after their last negative Pap smear).[2]
- **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, refer to the NCSP Guidelines (external website)

[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.

Cervical screening in specific populations

The NCSP guidelines outline the management of women in specific populations. These groups, and where to access the relevant recommendations, include:

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

Cervical screening information

For further information refer to the Cervical cancer prevention for health professionals WA Health site.

To access patient cervical screening histories, contact the National Cancer Screening Register (NCSR) on 1800 627 701 or look up via the online NCSR Healthcare Provider Portal (external website).

Procedure: Taking a CST

Cervical screening is the responsibility of physicians, nurses and midwives. Cervical screening courses may be available through Sexual Health Quarters (external website).

Equipment

- Bi-valve speculum (plastic or metal)
- Cervex-Brush® / Cytobrush®
- 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: • The risks and benefits of screening • The follow-up required for positive and negative results.	Prior to examination ensure: • The woman has been given enough information to make an informed decision[4] • Verbal permission is obtained [4] • Privacy is ensured [4] • The woman understands the role and benefits of the National Cancer

	Procedure	Additional information
		Screening Register (external website)
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: • Woman's identification • Cervical screening history • Indigenous status; ➢ No ➢ Yes, Aboriginal ➢ Yes, Torres Strait Islander ➢ Yes, both Aboriginal and Torres Strait Islander • Country of birth; and • Main language other than English spoken at home Complete pathology request form (where the form does not allow for the above items to be collected, clearly write the information obtained in an appropriate space on the form)	See WNHS policy: Patient Identification. To access the patient's screening history contact the NCSR on 1800 627 701 or look up via the online Healthcare Provider Portal (external website). Include on the pathology request form: • The reason for the test (e.g. routine screening); • Any relevant clinical information (e.g. immune-deficient); and • The test requested (e.g. 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 CST**	
3.1	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.	Offering the woman self-insertion of the speculum may help reduce feelings of vulnerability and powerlessness. Moisten and warm the speculum with warm water or a small amount of water-soluble and carbomer-free lubricant (taking care to avoid the tip of the speculum) (See Use of Lubricants for Cervical Screening (external website)). Any abnormality noted upon visual inspection of the cervix requires colposcopy referral.

	Procedure	Additional information
3.2	If unable to locate the cervix: • 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.	If the lateral vaginal walls are bulging inwards, consider using: • A larger speculum; and/or • A condom over the speculum (cut off the reservoir tip of the condom).
4	**CST collection: GYNAECOLOGY**	
4.1	Take the sample, ensuring the transformation zone is sampled when possible, using appropriate implement(s) (Cervex-Brush®, Cytobrush®). A Cytobrush® should be used in conjunction to the Cervex-Brush® in: • 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	The Cervex-Brush® is used to collect both endocervical and ectocervical cells and is the preferred implement for most women. An optimal cervical sample has: • Sufficient mature and metaplastic squamous cells to indicate adequate sampling from the transformation zone. • Sufficient numbers of endocervical cells, to ensure screening for glandular abnormalities.
4.2	**Using the Cervex-Brush®**	
	• 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 collection vial to pull off the head of the brush and deposit into the SurePath vial.	If a large ectropion is present, ensure that a sample of cells is collected from beyond the border of this area as well.
4.3	**Using the Cytobrush®**	
	• Gently insert the Cytobrush® into the cervical os. • Gently rotate 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.

	Procedure	Additional information
5	**CST collection: OBSTETRIC**	
5.1	Inform the woman that cervical screening can be performed safely in pregnancy [2]	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. [2]
5.2	Collect the sample using the Cervex-Brush® as described above.	Do not use the Cytobrush® in pregnancy.[2]
6	**Follow-up**	
6.1	Advise the woman that a letter advising of the result and any needed follow-up will be sent to: • 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 management [2]

CST result		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
	Negative, possible low-grade squamous intraepithelial lesion (pLSIL) or LSIL	Intermediate	Repeat CST in 12 months *****
	Possible high-grade squamous intraepithelial lesion (pHSIL), 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.
- HPV (16/18) detected, the woman should be referred for colposcopic assessment, regardless of the cytology result.
- HPV (not-16/18) detected, with LBC prediction of negative, pLSIL or LSIL, the woman is regarded as still at intermediate risk and should have a second HPV follow-up test in a further 12 months' time (unless higher risk population**^**)[1].

New recommendation 2022- If the 12 month follow-up CST is HPV (not-16/18) detected, with LBC prediction of negative, pLSIL or LSIL the woman is regarded as still at intermediate risk and to have a second HPV follow-up test in a further 12 months' time (earlier if higher risk population- see below**^**).[1]

^ Women at higher risk of high- grade abnormality should have referral to colposcopy if HPV (any type) is detected at 12 months, regardless of result of reflex cytology[1]. This includes the following groups[1]:

- Women two or more years overdue for screening at time of initial screen
- Women who identify as being of Aboriginal and / or Torres Strait Islander descent
- Women aged 50 years or older

Self-collection eligibility

Self-collection is an alternative screening option to increase screening participation in under-screened and never-screened women.[2] 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 CST); and
- Have declined a provider-collected cervical sample.

Self-collection may be considered during pregnancy in never-screened or under-screened women, following counselling by a health care professional regarding the risk of bleeding.[2]

Women with symptoms are not eligible for self-collection.

Note: From 1 July 20**22** changes are planned to expand self-collection. More details will be provided closer to the time.

Procedure: Self-collection of a vaginal sample for HPV

	Procedure	Additional information
1	**Preparation**	
1.1	Inform the woman: • The risks and benefits of self-collected and provider-collected samples. • That follow-up for an HPV positive result will require either returning for a cervical sample to be collected by a provider or being referred directly to a specialist for colposcopy.	Prior to the woman self-collecting ensure: • The woman has been given enough information to make an informed decision [4] • The woman has been offered both a self-collected and provider collected test • Privacy is given for the woman to collect the sample [4] • The woman understands the role and benefits of the NCSR.

1.2	Confirm:
	• Woman's identification
	• Cervical screening history including eligibility for self-collection
	• Indigenous status;
	  ○ No
	  ○ Yes, Aboriginal
	  ○ Yes, Torres Strait Islander
	  ○ Yes, both Aboriginal and Torres Strait Islander
	• Country of birth; and
		See WNHS policy: Patient Identification.
		To access the patient's screening history contact the NCSR on 1800 627 701 or look up via the online Healthcare Provider Portal (external website).
		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.

	Procedure	Additional information
	• Main language other than English spoken at home Complete pathology request form (where the form does not allow for the above items to be collected, clearly write the information obtained in an appropriate space on the 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 Cervical Screening Resources website (external 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: • 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 management [2]

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 (CST)
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 (updated 2020). 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 **National Cervical Screening Program** Cervical Screening Resources (for healthcare professionals and the public). Accessible at: https://www.health.gov.au/initiatives-and-programs/national-cervical-screening-program/cervical-screening-resources
- National Cancer Screening Register **Healthcare Provider Portal**
- 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: https://ww2.health.wa.gov.au/Articles/A_E/Cervical-screening

Related cervical screening documents

- Department of Health WA: Safety & Quality in Healthcare: Procedure Specific Information Sheets: NMHS: KEMH: Colposcopy and LLETZ (WA Health employees access through Healthpoint)
- National competencies for cervical screening providers (external site) – see Appendix F of the NCSP Quality FrameworkMedical Services Advisory Committee (MSAC): National Cervical Screening Program Renewal (external website)
- Sexual Health Quarters (formerly Family Planning WA): Certificate in Sexual and Reproductive Health (Nursing)- Cervical Screening (external website)

See additional references and resources at end of document.

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 patients shall be offered a chaperone during any intimate physical examination / procedure. Refer to NMHS Chaperone policy for details.

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.[5] It is useful when vaginal wall prolapse is suspected[6], and for examination of an enterocele.[7] The woman is positioned in the left lateral position with her knees flexed or Sims position.[6]

Cusco speculum

The Cusco speculum is classified as a bivalve speculum. It has been designed to 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,[7] [6] and the speculum is now made of steel or disposable perspex.[5] 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 appropriately sized speculum.
3. Ensure the bladder is empty. Consider pathogen PCR testing (i.e. chlamydia) of the urine before it is discarded.
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.[7]
11. Slide the closed speculum into the vagina following the axis of the vagina (45º downwards).[7] 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.[7]
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

Quick Reference Guide

Pre-procedure:

1. **Consultation** (medical history, explain procedure and counsel, offer self-collection of LVS / rectal swabs if asymptomatic)
2. Gain **consent and** 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.

   *Consider pathogen PCR testing of the urine before discarding (i.e. chlamydia).

Procedure:

4. **LVS and 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**: Cervical screening test 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.

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

Equipment

- Adjustable light source
- Biohazard labelled bag
- Sterile swab and 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 and ECS)
- Bi-Valve speculum if required
- Unsterile examination gloves
- Patient identification labels
- CST 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.[5] 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	Explain the procedure,[5, 9] explain confidentiality of results and counsel about the test(s) being performed.[10]	
1.3	Offer the option of self-collection of LVS / rectal swabs if appropriate.[10]	If symptomatic genital symptoms or suspected sexually transmitted infection, physical examination is best practice for diagnosis and treatment.[10]
2	**Consent**	
2.1	Obtain verbal consent before the procedure is commenced.[9] [4, 10]	If declined, explain the importance of the examination, offer the option to bring a support person of their choice to be present during the examination 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

	Procedure	Additional information
		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.[5] Document the chaperone's name and qualifications.[9] See also NMHS Chaperone Policy and chaperone section at beginning of this document. It is recommended for practitioners conducting vaginal examinations or procedures to have another practitioner in attendance.	
2.4	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.[9] [4] • In addition, explicit consent should be gained if medical students are to examine the woman for education / training.[9] [4]	
3	**Preparation**	
3.1	Ensure the bladder is empty*.[5] *Consider pathogen PCR testing of the urine before discarding (i.e. chlamydia).	An empty bladder increases the woman's comfort and allows a more accurate assessment of the pelvic organs.[5]
3.2	Ensure the woman is adequately covered and comfortable.	Provide privacy to undress and a cover sheet to cover herself.[4]
3.3	Position for speculum examination with head on pillow, lying in a dorsal position[5] with knees flexed & hips abducted.	
3.5	Position the light.	Lighting is required for adequate inspection.[5]
3.6	Hand hygiene should be performed before and after patient contact. Put on gloves. If there is risk of splash, wear eye protection.[10]	See WNHS Infection Prevention and Management Manual: Hand Hygiene.

	Procedure	Additional information
4	**Inspection**	
	Part the lips of the labia minora with the non-dominant hand and inspect the external meatus, and vulva.[6]	Enables detection of[6]: • abnormal skin conditions • lesions • vaginal discharge or bleeding • scar tissue • skin piercing • evidence of female genital mutilation
5	**Insertion of the speculum**	
	See Speculum Examination section above	The practitioner should be responsive to any patient expressing undue distress during an examination.[9]
6	**Collection of the swabs**	
6.1	**Low vaginal swab (LVS), high vaginal (HVS) and endocervical swab (ECS)** • Take a HVS and smear for pathogens[10] • Clean away cervical mucous if necessary, then obtain an ECS[10] ➢ If PCR / NAAT place swab back into container with no transport medium[10] ➢ If culture (e.g. pus/ inflamed cervix) - obtain smear and swab into transport medium. **Smear** Swab the area using the sterile swab. Gently roll swab 2-3 timed in non-overlapping passes on to middle of 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.	A smear **AND** a swab must be collected when performing an LVS/HVS or ECS. Label all samples with the woman's UMRN sticker, site (LVS, HVS, ECS), date and time of collection.[10] Store at room temperature.[10]

	Procedure	Additional information
	Swab for culture Use the transtube swab. **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 (LVS only), with instructions from the medical / midwifery / nursing staff.[10] Insert the swab into the transport medium and label with the woman's identification sticker and indicate the site of collection. Place the slide and the transtube in a specimen bag with the request form in a separate pocket and send to the hospital Specimen Reception.	Non-symptomatic women may prefer non-invasive techniques such as first void urine and self-obtained LVS rather than a pelvic examination.
6.4	**Rectal swab** Pre-moisten swab with transport medium. The woman may prefer to collect her own swab, with instructions from the medical / midwifery / nursing staff.[10] The swab is inserted into the rectum past the external anal sphincter and the specimen is collected. 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]	Allows easier insertion of the swab. See Clinical Guidelines, Obstetrics & Gynaecology: Antepartum Care: Infections in Pregnancy: GBS Disease
8	**Post-procedure**	
	Provide privacy for redressing[9] and tissues if required. 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. Send specimens to pathology.	The samples should reach the pathology within 24 hours for optimal culture yield.[10]

Vaginal examination in girls and young women

Aim

- To guide medical, nursing and 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.[11]
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). [11]
3. Examinations should be conducted so as to minimise discomfort and distress.[11]
4. The girl's / young woman's dignity and privacy shall be maintained throughout the examination regardless of the presence of others.[11] Provide privacy for disrobing and a suitable cover (e.g. gown or sheet) during examination.[4]
5. An appropriate adult witness, support person and / or chaperone shall always be present when examining a child.
6. When examining a young woman, the presence of an appropriate support person and / or chaperone should be encouraged and available.[11] 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, 11] Document the chaperone's name and qualifications.[9] See also NMHS Chaperone policy and Chaperone section and beginning of this guideline.
7. Ensure there is valid consent from the young person and / or their parent or guardian prior to conducting a vaginal examination.[11] Valid consent must be voluntary, informed and based on the capacity of the patient to consent.[11] If required, an interpreter should be used to ensure valid consent to examination.[12] Practitioners should refer to state legislation regarding a child's capacity to consent.[11] A girl's / young woman's capacity to consent is considered on an individualised basis and is not only related to age.[11] Children can consent to a procedure if they have the capacity to understand the information and the implications of the procedure.[11]
8. Except in a medical emergency, vaginal / genital examination should not proceed in the absence of valid consent.[5, 9, 11]

9. When parents / guardians have consented on a girl's behalf, medical professionals should explain the procedure and proceed only with the girl's / young woman's assent.[11] 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.[12]
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.[12]
11. Special considerations shall be given to obtaining consent from patients who have or are[11]:
    - Living with an intellectual or physical disability
    - Experiencing mental health problems
    - Injured, in pain, or in shock
    - Drug or alcohol affected
    - Culturally and linguistically diverse
    - Sleep deprived
    - Unable to give valid consent
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 post-pubertal 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 instrumental vaginal examination are unlikely to be indicated.[11]

Indications for speculum examination

- ECS for investigation of possible infection, when symptoms are present[11]
- ECS for forensic investigation[11]
- Assessment for abnormal vaginal bleeding[11]
- Assessment for possible intra-vaginal foreign body[11]
- 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, 11] An adequate explanation informs about the nature of the examination and the information it will provide.[4]
- 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.[13]
- Where possible use anatomical models, pictures and pamphlets to provide information.[13]
- A familiar person (e.g. mother, relative[13]) 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.[13] 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.[5, 13]
- Conduct the examination in a calm environment, and ensure privacy.[4, 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 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

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
- Continence 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 dressing pack
- Sterile gloves
- Prescribed lotion / lubricant gel
- Sterile scissors
- Sanitary pad
- Packing gauze 10cmx2

Note: Usual regime is estrogen cream (e.g. ovestin) and clinigel ointment; estrogen cream needs to be prescribed on medication chart, clinigel does not. Clindamycin is also sometimes prescribed.

Procedure

1. Explain the procedure and gain verbal consent.
2. Offer appropriate analgesia.
3. If it is the first time to insert the vaginal pack, first reduce the procendentia, insert IDC then the vaginal pack(s).
4. Daily- Remove pack prior to patients shower then reinsert new pack after shower, it is optimal if patient has bowels open whilst pack is out.
5. Open dressing pack and prepare equipment, creams, packs, scissors, sterile gloves, wash hands (aseptic hand wash) and don sterile gloves.
    a. For count requirements, follow WNHS Policy Procedural Count: Management and Procedure
    b. For 1 pack (if estrogen cream is prescribed) mix one full tube estrogen cream with one full tube lubricant gel, use forceps to mix these together in the tray in dressing pack. If two or more packs are required continue to use only one tube ovestin and two or more tubes of lubricant gel as required.

   c. If using two or more packs tie firmly together prior to soaking and insertion into the vagina.
   d. Soak pack(s) in the mixture, ensuring coverage over the whole length

6. Place the woman in the left lateral or supine position on a continence sheet (bluey). Cover appropriately to maintain dignity.
7. Ensure bed is at the correct working height for you and there is adequate light to perform the procedure.
8. If clindamycin cream is prescribed measure the dose out – usually one full applicator, insert ½ into vagina using applicator and put other ½ onto tip of pack and this tip will be inserted first.
9. Transfer the soaked pack/s in sterile tray close to woman's vagina.
10. Using a sterile gloved hand, gently replace the prolapsed uterus.
11. Insert the soaked pack(s) using gloved hand.
12. Place a sanitary pad and assist patient (as required) to a position of comfort.
13. Document the procedure in the woman's notes on MR 263 (Wound Management & Care Plan).

Note: If pack falls out within 24 hours it needs to be replaced but ovestin cream is only to be used once per day. For subsequent insertion of vaginal pack only clinigel should be used.

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Additional resources (from CST chapter) (external websites)

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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.

Cancer Council Australia. Cervical cancer prevention policy—cervical cancer: Causes. Sydney: Cancer Council Australia. 2018.

National Centre for Immunisation Research and Surveillance [NCIRS]

- Evaluation of the National Human Papillomavirus Vaccination Program Final Report. 2018.
- Fact Sheets and other resources- Human papillomavirus: Human Papillomavirus (HPV) Vaccines for Australians: Information for Immunisation Providers. 2020.

NPS MedicineWise. National cervical screening program. 2020. Available from https://learn.nps.org.au/mod/page/view.php?id=7804

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists [RANZCOG]. Guidelines for HPV vaccine: C-Gyn 18. 2019.

Related policies, legislation, resources

Legislation (external websites)-

- *Children and Community Services Act 2004*
- *Commonwealth Family Law Act 1975*
- *Guardianship and Administration Act 1990*
- *Health (Miscellaneous Provisions) Act 1911*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Health Services Act 2016*
- *Privacy Act 1988*
- *Public Health Act 2016*

Related NMHS Policies –

- NMHS Chaperone Policy

Department of Health WA:

- Mandatory Policy: MP 0051/17 WA Health System Language Services Policy
- Mandatory Policy: MP 0166/21 Mandatory Reporting of Child Sexual Abuse Training Policy
- WA Health Consent to Treatment Policy (2016) (including section 4.3.2- Children and Young People: Mature Minors)
- Guidelines for Protecting Children 2015
- Website: Safety and Quality: Consent
- WA Youth Health Policy 2018-2023 Toolkit- Resources for Health Professionals and legal resource (PDF, 3.88MB) (assessment as mature minor)
- HealthyWA website: Sexual assault

Public Health:

- Silver book
- Nurse / Aboriginal Health Practitioner Initiated STI Treatment Code (2018);
- Self-collection patient information:
  - How to self-collect specimens to test for sexually transmissible infections (PDF, 729KB)
  - Communicable Disease Control Directorate: Chlamydia: Testing and Clinical Management (self-obtained LVS instructions)

Related WNHS policies, procedures and guidelines

WNHS Clinical Guidelines, Obstetrics and Gynaecology:

- Gynaecology (Non-oncological): Care following a Simple / Radical Vulvectomy
- Gynaecological (Oncology) : Link to Classification and Staging of Cervical Cancers
- Perioperative: Preparation and Management
- Sexually Transmitted Infections (screening tests and specific STI information)
- Wound Care: Collection of a Wound Swab

WNHS Policies –

- Language Services (2021) (interpreter use)
- 'Pathology and Ultrasound: Ordering by Midwife/Nurse/NP' [moving to a WNHS policy]: including Antenatal Tests: Requesting; Swabs: LVS: Request; HVS: Request; ECS: Request; GBS Antenatal Screening: Request
- Patient Identification (2019)
- Procedural Count: Management and Procedure (2020)

Sexual Assault Resource Centre (SARC) (access to WA Helath employees through HealthPoint) and SARC consumer website

Keywords:	speculum, sims, cusco, grave, chaperone, cervix, Low vaginal, high vaginal, rectal swab, speculum, transtube, pathology, chaperone, LVS, HVS, ECS, vaginal specimens, agar plate, Cervical Screening Test, CST, cervical screening, Pap, Pap smear, cervical screening, cervical cancer, National Cervical Screening Program, NCSP, cervical cancer prevention, human papillomavirus, HPV, HPV test, HPV vaccine, HPV vaccination, cervical screening in pregnancy, Cervical Screening Test report, cytology screening, colposcopy, Thin-Prep, SurePath, liquid-based cytology, self-collect cervical screening, self-collect HPV test, cervical screening results, cervical screening result management, thin-prep, Vaginal examination, VE, adult witness, chaperone, consent, young woman, gynaecological examination of a girl, adolescent, medical examination, examining a child, pelvic examination, internal examination, parental consent for examination, vaginal pack, vaginal pack insertion, vagina pack removal, vaginal bleeding, procedentia, prolapse, douche, vaginal irrigation, vagina, vaginal infection, vaginal tumour
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Version history

Version number	Date	Summary
1	Sept 2017	First version. Amalgamated these 7 individual guidelines (3 from section Gynaecology and 4 from O&G, dated from August 1999) into one document: 1. Speculum Examination [O&G] 2. Swabs: LVS, HVS, ECS, Rectal [O&G] 3. Papanicolaou (Pap) Smear [O&G] 4. Vaginal Examination in Children and Young Women [O&G] 5. Insertion of a Vaginal pack for Uterine Procedentia [Gyn] 6. Vaginal Irrigation [Gyn] 7. Insertion and Removal of a Vaginal Pack [Gyn]
2	Mar 2018	Full content review • The ‘Pap smear’ has changed to Cervical Screening Test. • Chaperoning –see NMHS chaperoning policy
2.1	June 2020	Fixed links and added link to new ‘Procedural Count: Management and Procedure’ WNHS policy
3	Feb 2022	Full content review. • Changes to CST screening ➢ All women 25 to 74 years should have transitioned to the renewed NCSP. If not, they are now overdue. ➢ Women of any age who have symptoms suggestive of cervical cancer require diagnostic testing and should be managed in accordance with NCSP guidelines, regardless of their cervical screening history. ➢ Add indigenous status, country of birth and language.

		➢ **If a 12 month follow-up CST is HPV (not-16/18) detected,** with LBC prediction of negative, pLSIL or LSIL, the woman is regarded as **still at intermediate risk** and to have a second HPV follow-up test in a further 12 months' time (earlier if higher risk population- see below^). ➢ ^Women at higher risk of high- grade abnormality should have referral to colposcopy if HPV (any type) is detected at 12 months, regardless of result of reflex cytology. This includes the following groups: o Women ≥2 years overdue at time of initial screen o Women who identify as Aboriginal and / or Torres Strait Islander o Women aged 50 years or older • Consider PCR testing of urine (chlamydia) before discarding • 'Vaginal Irrigation' removed- no longer performed • 'Insertion of a vaginal pack for uterine procidentia' procedure updated- read procedure. If pack falls out within 24 hours, it needs to be replaced but ovestin cream is only to be used once per day. For subsequent insertion of vaginal pack only clinigel should be used.