THE EXAMINATION OF THE GYNÆCOLOGICAL PATIENT

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THE average practitioner is distrustful of his ability to make an effective gynæcological examination. As a student he gained little proficiency in this procedure, principally because of the fact that there is a limit to the number of vaginal examinations that can be made on a single patient even in a teaching hospital. As a young practitioner he found that his patients drew back from the idea of such an examination. Realizing his lack of proficiency, and feeling sensitively the patient's attitude, he probably refrained all too often from pursuing his righteous purpose, with the result that he remains inept in this particular branch of diagnosis.

In teaching students I have pointed out these circumstances and implored them to persist with pelvic examinations, even if the social resistance was great and the yield in enlightenment all too small. They are assured that the social resistance will lessen if they *creep up* on the examination, and that the examination will yield more enlightenment if they pay heed to the little clues and disregard the disappointment that comes of not feeling a pelvis full of gross pathological lesions. What I mean by "creeping up" on the examination is this. To reassure the patient first of all by obtaining a careful and searching history, and then to go on to an abdominal and general examination before doing the vaginal. What I mean by "paying heed to the little clues", etc., can be illustrated by taking a case of ectopic gestation. You can make a diagnosis in such a case without feeling the tubal swelling, if you have noted the cherry-coloured vaginal bleeding and the tenderness on moving the cervix and on pressing up into the fornix on the affected side; or in a case of acute salpingitis it is not necessary to feel the actual tube if you have noted the bead of pus in the urethra, the drop of muco-pus hanging from the inflamed cervix and the tenderness on moving the cervix, and in both postero-lateral fornices.

In taking a gynæcological history there are four things to remember: (1) That a patient will often lie deliberately if it is in her interest to do so. For example, a girl who is pregnant or has salpingitis will swear that she has never indulged in coitus; or a pregnant married woman desirous of any operation that will end pregnancy will tell you that she is menstruating regularly, or even *excessively*. (I have been told by four women who were pregnant that they were menstruating excessively. They had evidently heard from someone that excessive bleeding went with the sort of tumours for which a hysterectomy was done). (2) In describing symptoms women will generally withhold any information concerning coitus—for example if it is painful and distasteful, or normal and satisfactory—unless they are asked about it. (3) That in patients manifesting "neurotic" symptoms, it is important to know whether or not the sexual relations are satisfactory, since these symptoms will often clear up miraculously when such relations can be made satisfactory by the curing of dyspareunias and psychological misconceptions. (4) A family history of cancer should be elicited if it is present. For instance, in a woman with benign uterine bleeding and a chronic cervicitis where there was a family history of cancer the treatment would incline towards removal of the uterus and cervix rather than towards the use of radium and cauterization.

For examination purposes gynæcological patients can be divided into two groups: (1) those who can come to the office; (2) those who must be examined at home in bed. If the proper facilities are available an office examination is much more enlightening than a home examination. What are the proper facilities? First of all a table with leg or heel stirrups that will permit the lithotomy position; second, a good light; third, a bivalve speculum, preferably the Graves' pattern or some modification of it.

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THE ABDOMINAL EXAMINATION

Inspection. — Does the abdomen move with respiration? Is it distended? If it is distended, what sort of a contour has it from ensiform to pubes, and from side to side? The pubes-to-ensiform contour is different in different swellings. With a fibroid there is usually a gradual ascent from the pubes to the summit and a sharp drop above; with a pregnant uterus and an ovarian cyst the drop above is gradual. If the distension is due to free fluid there is a fairly sharp rise at both ends, with a flat plateau in the centre. The side to side contour with a tumour shows a rise to a central peak; with fluid there is a sharp rise on each side and a central plateau. Are fresh striæ gravidarum present?

Palpation.—If the patient complains of pain it is better to start palpating at a distance from the painful area, moving gradually towards it. This enables the patient to get used to the feel of your hand and to relax her muscles. If, in such an abdomen the tenderness increases to a maximum just above Poupart's ligament, and particularly if it is bilateral, one may safely presume that the cause of the pain and tenderness is a pelvic condition. Occasionally, a patient with low abdominal pain and tenderness will be tender in the right hypochondriac region. This is especially true of two conditions —salpingitis and ectopic gestation. In acute salpingitis the infection seems to travel up the right side to a sufficient extent to cause actual adhesions between the liver and the abdominal wall. In ectopic gestation the pain and tenderness in this area are due to the blood collecting in the right kidney pouch. It is therefore best to begin the palpation of the abdomen by starting in the left hypochondriac region and working down, before attempting the other side. In all cases where there is complaint of either acute or chronic iliac pain, one-sided or bilateral, the kidneys should be carefully palpated to rule out a renal infection. It is not so necessary actually to feel the kidney as to note whether or not it is tender. The kidney region can be palpated with one hand in the flank and one in front, or by using a hand on each side —a much better way of eliciting whether or not one side is more tender than the other. To do this the patient is grasped with a hand on each side so that the fingers lie just below the ribs in the back; the thumbs are pressed into the hypochondriac regions when she takes a deep breath and while she lets it out. Palpation of the kidney is a little less satisfactory, using this method, but the differentiation of slight degrees of unilateral tenderness is much more exact. In the neurotic, highly-sensitive type of woman it is important to come back to the tender areas more than once. One will often find that an area that was tender before is not now tender, and that an area not tender before is now tender.

The presence of rigidity and areas of hyperæsthesia should be noted, and their extent mapped out. If a tumour is present one should try to determine whether or not it is pelvic. The history as to the location of the tumour when it was first noticed may be a help. Try to dip the fingers under the tumour just above the pubes. If this cannot be done the tumour is very probably pelvic; but if one can dip beneath it the converse is not true, since a long-pedicled ovarian cyst may quite easily be moved about the abdomen at a certain half-way stage of its growth. If it is a hard tumour and lies principally in the left abdomen, its right edge should be carefully palpated for notches. Very frequently enlarged spleens have been diagnosed as ovarian tumours, until this simple procedure made the condition clear.

The feel of a tumour is usually a help in differentiating it, but, while a fibroid usually yields the sensation of density and hardness, it may, when degenerated, feel as soft as a pregnant uterus or even a cyst. On the other hand ovarian cysts usually feel soft, but if they contain papilliferous growth to any extent they will seem solid, and sometimes when they are very tense they feel solid.

Percussion.—When the abdomen is distended it should always be percussed. If the distension is due to free fluid the dullness will be in the flanks with an area of some resonance in the mid-abdomen. With a tumour the dullness will be over the tumour area, and there will be resonance in the flanks. But if the tumour is associated with free fluid, as is so often the case with solid ovarian growths and papilliferous ovarian cysts, there will be dullness in the flanks as well as over the tumour. If the tumour is small it may be completely masked by the accompanying ascites. If the flanks are dull the

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patient should be turned to one side to determine whether or not the dullness shifts. Percussion in the flanks should also be undertaken if there are signs of internal hæmorrhage, but it must be remembered that the effused blood does not usually give the characteristic dull note of free serous fluid, but something between dullness and resonance.

An ovarian cyst will yield a thrill, except under the following circumstances: (1) when it consists of a great number of locules; (2) when it contains much papilliferous growth; and (3) when its contents are very thick.

Auscultation, in the case of a large tumour, will determine whether or not a fetal heart is present.

The Vaginal Examination

If this examination is to be successful it is essential to get the patient into the proper lithotomy position, and it is usually on this rock that most vaginal examinations are wrecked. If the examining table is fitted with heel stirrups the patient should not take her shoes off, which she will sometimes do if not warned, since the heel of a shoe fits more solidly into the stirrup than the stockinged heel. It is now helpful psychologically to place a sheet over her knees, and for two reasons; first, the patient cannot see what you are doing and will not draw away at the approach of the speculum or any other instrument; and secondly, she does not feel so exposed. The next move is to get her to pull her clothes up under the sheet so that her legs are free and her knees can be separated. It is often difficult to persuade a patient to separate her knees; she wishes to keep them in the position of defence, and yet it is impossible to get her properly down the table unless she does so. With the knees separated she is encouraged with a hand under each buttock to slide down the table until the buttocks are well over its edge. The buttocks must be well over the edge if the speculum examination is to be satisfactory. This manœuvre is easier for the patient if the back of the table is raised so that she is in a semi-sitting position.

The vulva, perineum and anal regions are now inspected. Is the skin irritated or excoriated? Are pediculi present? Is there any discharge on the vulva, and what is its colour? Is the patient bleeding, and what is the colour of the blood? Has the discharge an odour? If the skin of the vulva is irritated chronically a sample of urine should be obtained and examined for sugar. Is there a swelling of the vulva, and, if so, is it in the region of Bartholin's glands? Has the patient protruding piles? Are there any warts on the vulva and surrounding skin? Does the vaginal orifice gape, and if it does is there prolapse of the vaginal walls?

The labia are now separated and the urethral orifice inspected. If there is any pus around the orifice it should be wiped away and the urethra milked by putting a finger into the vagina and pressing the urethra against the pubes. If there is pus in the urethra it will be brought to view as the finger descends, and if no pus comes from the upper part of the urethra it is most important to express anything that may be in Skene's tubules at the mouth of the urethra. If any pus is obtained a smear should be made of it for microscopic examination, although if it is yellow in colour and, particularly, if it has been expressed from Skene's tubules it is almost certain to be gonococcal. Such a bead of yellow pus in the presence of lower bilateral abdominal pain and fever is therefore almost confirmatory of gonococcal salpingitis.

The presence or absence of a vaginal hymen should next be noted. The total absence of a hymen, or its replacement by hymenal caruncles would suggest that the patient was not a virgin, and should certainly be set against a denial of coitus. I am not so sure that it proves coitus absolutely, since I have seen two or three young women, whose word I felt I could trust fairly implicitly, in which a definite hymen was not present and upon whom a vaginal and speculum examination could be made without the usual virginal distress and difficulty. On the other hand the presence of a definite hymen can be a help in diagnosis. For instance, in a girl with low abdominal pain and fever, who has a virginal hymen and no vaginal or urethral yellow discharge, whatever pelvic inflammation is present is not gonococcal and would likely be either tuberculous or appendicular in origin. But *the presence of a distinct virginal hymen does not rule out pregnancy.* I have seen four cases in which girls with very definitely virginal hymens were preg-

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nant. In all four there had been no penetration, but a history of "playing about" was obtained. Nevertheless impregnation without penetration is a comparatively rare phenomenon, and it is reasonably safe to conclude that a woman with a virginal hymen is unlikely to be pregnant in either the uterus or the tubes.

While inspecting the hymen one should look for the mouths of Bartholin's ducts. They will not be seen unless there is Bartholinitis, when they show up as little red dots.

The vulva may be gaping from old obstetric damage. If so, the patient should be told to strain down. A cystocele, rectocele or a prolapsing uterus may come into view. It is important to remember, however, that except in those cases where the vagina turns completely inside out, the amount of prolapse of these parts will be greater when the patient is working hard on her feet than when she is straining down on an examining table. If this fact is not kept in mind a prolapsed condition may be missed. In the case of those who come with the history that something comes down the front passage I always get them to stand up and examine them straining down in that position when the examination in the lithotomy position has proved inconclusive.

One now proceeds to the vaginal examination with the fingers. If the patient has complained of dyspareunia the hymenal region should be carefully palpated for a tender area or a tender tag. Sometimes this area or tag will be very small, yet so exquisitely painful as to take all the joy out of coitus. This area should be definitely mapped out since, if it be small, its removal may become so simple a procedure that it can be carried out under a local anæsthetic in the office.

The forefinger (lubricated) is now pushed into the vagina. It should be aimed at the hollow of the sacrum; if it is aimed horizontal with the table it will strike the sensitive area around the urethra and cause the patient to tense her muscles, or draw away up the table. Let us suppose one is dealing with a definitely virginal vagina. In such a case the finger should be introduced slowly. But in some cases, no matter how gently this is attempted, the patient is caused such pain, or is so apprehensive, that either the finger cannot be inserted completely, or, if it can be, the patient holds herself so tautly that an examination is impossible. In such a case it is better to give up the vaginal route and try the rectal—which I shall discuss later. Occasionally there will be the case where even the rectal method causes such a tightening of the muscles that any enlightenment is impossible. Such can only be properly examined under an anæsthetic.

Let us suppose that examination is possible. With the finger in the vagina pressure is made back against the perineum—it is really against the levatores ani—until these are tired out. The patient is then told to bear down and the middle finger is slipped into the vagina. This is not always possible, and sometimes one has to feel as best one can with the single finger, but such an examination is never as satisfactory as the two-finger method, and the latter should therefore always be used if it can be. It is surprising how often this can be done where at first sight it looks impossible. The trick is to first tire the muscles out by pressure with the forefinger and to get the patient to bear down, thus farther relaxing the levatores, while inserting the middle finger.

With either one or two fingers in the vagina, a *planned* procedure should be carried out. Since the cervix is the most prominent landmark and will often yield the most results it should be felt for first. Does the patient wince when it is touched? If she does, one thinks at once of pelvic infection. But the cervix will be painful on movement in other conditions—sometimes in ectopic gestation, sometimes where there is a laceration with chronic inflammatory induration in the tissues about it, and very often in those cases that we label "pelvic neuralgia". It can be taken as a maxim that in an acute abdomen where the cervix is tender on movement the condition is assuredly pelvic, and is likely to be, in the following order of frequency; salpingitis, ectopic gestation, pelvic appendicitis, peritonitis following a septic abortion, or ovarian cyst with a twisted pedicle. I stress the importance of this sign since it is often the most valuable one gained from a vaginal examination, and may, without the eliciting of any further information, fairly settle the diagnosis in acute abdominal conditions. For instance, if it has been elicited, together with a drop of yellow pus in the urethra, the diagnosis is almost certainly sal-

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pingitis; if it is associated with dark red vaginal bleeding the diagnosis is almost certainly ectopic gestation.

The next thing it to note the feel of the cervix. Has it the velvety feel of a simple erosion, or the ulcerated feel of a malignant ulcer? In the latter case push the finger into the crater of the ulcer and note if the tissue is mushy and friable, and if as a result of doing this the patient bleeds. Is there a tear of the cervix, and, if so, does it cause pain to press against the torn area? or is there a painful vaginal-vault scar associated with it? In a chronic case in which the cervix is tender ask the patient if she has dyspareunia. Is the cervix patulous, and if so can anything be felt protruding into it—a fibroid, a polypus, or the products of gestation? Is the cervix hypertrophied and hard? Has it the soft, yielding feel of pregnancy? Does it seem to lie fairly in the centre of the pelvis, or has it been pushed forward, backward, or to one side? The finding of the cervix far forward and lying directly against the pubes usually means that there is a mass in the pouch of Douglas forcing it there, since in a retroverted uterus the cervix does not usually lie directly in contact with the pubes.

The fornices are now examined in turn, making the complete circle of the vaginal vault. One should have an idea in one's mind of the pathological conditions that may cause tenderness on touching. In the lateral fornices a ureter, a pelvic cellulitis, or the scar from an old tear may be tender; in the postero-lateral the tubes or ovaries on both sides, a cancer or diverticulitis of the sigmoid on the left, or an appendix on the right; in the anterior fornix an inflamed bladder. In "pelvic neuralgia" all the fornices may be tender. Can you feel a swelling bulging any of the fornices? In what direction does such a swelling push the cervix? Is the swelling tender or not? Does it feel hard or cystic? Here again one should keep in mind the type of swelling likely to be found in each neighbourhood. For instance, a swelling in the anterior fornix is most likely to be a fibroid; in the lateral fornices, a pelvic cellulitis; in the postero-lateral fornices, an enlarged tube or ovary; in the posterior fornix, a retroverted uterus, a collection of blood or pus, a tube, or a tumour. A fibroid, of course, may cause a swelling in any fornix.

Not until this complete circuit has been made with the vaginal fingers should the bimanual method of examination be attempted. This is important. It has often been my experience that the bimanual has not added to the information already gained. On the other hand I have as often found, when hurried into doing a bimanual which yielded little information, that if I took the abdominal hand away and proceeded to search thoroughly with the vaginal fingers, I could actually discover definite lesions. This is particularly true in fat patients, and in those suffering from an acute pelvic condition where the abdominal muscles are tightly on guard.

In making the bimanual examination it is best to start by trying to locate the body of the uterus. Unless this is done you can never be sure that any swelling you may subsequently encounter is not the uterus. Since the organ is usually in the anteverted position the vaginal fingers are placed in the anterior fornix and the abdominal fingers just below the level of the sacral promontory. The two sets of fingers are brought together and the uterine body should be felt between them. If it is not felt, it is either retroverted or lying to one or the other side of the midplane. In this case the vaginal fingers are now moved to the posterior fornix and the same manœuvre carried out. If the uterus is retroverted it should be felt. If it is not felt the fingers should be moved to each side. Having gotten the organ between the two sets of fingers, one determines whether or not it is tender, its consistency, and its shape. If it is enlarged one notes the consistency of the enlargement and whether or not the lower uterine segment is thinned out (Hegar's sign), and if it is regularly or irregularly enlarged. It should also be noted whether the organ is movable easily or fixed, and if the examination has caused any discharge or blood to be expressed from it.

Having established the position of the uterus a circle of the pelvis is made with the following possibilities in mind: There may be felt bimanually, *anteriorly to the uterus*—a tender bladder, an inflammatory mass between the bladder and uterus, a cervical fibroid; *laterally*—the mass of pelvic cellulitis, a tender ureter of pyelitis or stone, a stone itself in a ureter, a fibroid, an extension of a carcinoma of cervix;

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postero-laterally—a swollen tube, an ovarian tumour, a fibroid, extension of carcinoma of the cervix, a mass of pelvic cellulitis; on the left side a mass in the sigmoid; on the right the mass of a pelvic appendicitis; *posteriorly*—swollen tubes, a pelvic abscess, a pelvic hæmatocele, an ovarian tumour, a fibroid, a retroverted uterus, and appendicular abscess.

Occasionally the mass of tuberculosis or cancer of the cæcum will be felt fairly high up between the palpating fingers on the right side, and may be either lateral or antero-lateral to the uterus. On two occasions I have encountered this, and where the mass is in a low-lying, fairly mobile cæcum it can easily be mistaken for an ovarian tumour.

Having discovered any abnormal condition in this search of the pelvis one should try to determine whether or not it is uterine, that is, can it be separated from the uterus and be moved separately from the uterus.

If a cystic swelling is found that does not move easily and presses up against the anterior abdominal wall one should make certain that it is not bladder. In some cases it is not enough to take either the patient's or a nurse's word that urine has recently been passed, since, despite such a history, a full bladder will sometimes be found when the catheter is passed. Further, in these cases it may be necessary to pass the catheter much farther in than usual before urine is obtained, as the bladder may have been drawn well up into the abdominal cavity. One is sometimes surprised to find that a bimanual examination in a woman with a reasonably thin wall and good relaxation will not even allow one to palpate the uterus. The impression is gained that there is something in the pelvis—impalpable, indistinct—that prevents an easy recognition of the anatomical parts. Perhaps I can best describe it by saying that one seems to be searching for the organs through a pelvis full of soft dough. In such cases, if the patient is asked when she urinated last, the almost invariable answer is that she has not done so for some hours. Even when she says she has a catheter should be passed. Once the bladder is empty the anatomy comes out of the fog. *Any cystic abdominal tumour associated with a mass in the posterior fornix which pushes the cervix far forward should be diagnosed a full bladder until the contrary can be proved by catheterization.*

Having completed the bimanual the efficiency of the levatores ani should be determined in all cases of relaxed outlet before withdrawing the vaginal fingers. This is done by turning the fingers over so that their palmar surface points backwards and pressing the tips first directly backwards and then backwards towards five and seven o'clock. This will show the extent of the relaxation. If the vulvar tissues are now grasped in these three positions between the two fingers inside and the thumb outside the thickness and degree of divergence of the levatores can be more fully determined.

So far I have made no mention of conditions in the rectum. Carcinoma of the rectum may be felt on vaginal examination, either as a tumour in close association with the posterior vaginal wall, or as a tumour in the pouch of Douglas. But the commonest rectal finding is fæces. Sometimes there is so much fæcal material present as to militate against a successful pelvic examination; this is particularly true when most of the mass is high in the rectum and appears as a tumour in the posterior fornix. The easy way to determine whether or not a posterior pelvic swelling is fæces is to press hard against it; if it is fæces it will pit, in which case a rectal examination will at once clear up any uncertainty. In such a case it is well to give an enema and re-examine the patient.

THE SPECULUM

Probably the most useful type of speculum is the Graves' modification of the bivalve. There is no difficulty in inserting it into a relaxed multiparous vagina, but unless a proper technique is used in cases of tight vagina its introduction may cause a good deal of pain. The vaginal examination with the fingers has aided in relaxing the sphincter, and one now introduces the forefinger of the left hand and pushes back towards the rectum. The speculum, turned so that the blades are vertical to the table, is placed against the fourchette to one side of the finger. If the patient is now urged to bear down, and at the same time the instrument pushed in the proper direction it will go in with a minimum of discomfort. It should be directed towards the middle of the

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sacrum. When it is in about halfway it can be turned so that the blades are horizontal and then shoved home. Now open the blades and try to get the cervix between them. If you fail to do this it is probably because the speculum has not been directed caudally enough. Close the blades and dip their tips. If the cervix does not now come between the blades one or more of three conditions may be present. (1) The vagina may be too long for the instrument. Get the patient to strain down, or if you have a longer speculum use it. (2) The patient's vaginal walls may be lax, and when the blades are open they force themselves between so that you cannot see the cervix. In such cases it is sometimes impossible to view the cervix unless the speculum blades are reversed so that it becomes a Sims', and lateral retractors are inserted along with it. (3) The cervix may keep slipping up to one side or the other and will not come fairly between the blades. Get the patient to strain down. Sometimes this will bring it into position. If not, close the blades, pull the speculum partly out, and repeat the manœuvre of thrusting it in and opening the blades. In spite of this there will be the odd case in which the organ remains elusive. If completely defeated, have the patient come back another day, when it will surprise you to find the cervix between your blades at the first attempt.

Having got the cervix in the speculum you proceed to view it. If there is any blood or pus in the way wipe it clear with a sponge-holder. If it is blood note whether it trickles from the canal or comes from the vaginal surface of the cervix. If there is muco-pus hanging from the cervix, or if there is an erosion or other sign of chronic cervicitis, take a smear from it for microscopic examination. If there is an erosion of the cervix is it bleeding, or has it bled as a result of your examination? If so take a small sharp curette and lightly scrape it. A simple erosion will give a gritty sensation, and nothing much will come away on the curette but mucus. If something definite comes away, and particularly if it comes from an area that appears mushy and friable, it is almost certainly carcinoma and the material should be sent to a laboratory for microscopic examination. Occasionally a hard, nodular, bleeding type of cancerous cervix will be encountered where you can get nothing much away with the curette. On manual examination this cervix feels thick and densely hard. Such a cervix should be diagnosed carcinoma until this can be disproved, which means until a section removed from it by the knife has been examined microscopically.

If the patient has a discharge an attempt should be made to determine where it is coming from. If there is an erosion of the cervix, or if there is muco-pus hanging out of the external os, the place of origin is clear. But if there is no evidence of cervicitis it may be difficult to determine its source. It may be coming from the uterus; it may simply be an excess of the normal secretion of the vaginal walls; or it may be caused by *Trichomonas vaginalis.* In the first two possibilities the discharge will be the typical "whites"; in the last it will be yellow in colour and will have bubbles in it. A drop of the trichomonas pus placed on a slide and mixed with water and examined at once under the microscope will reveal the motile organism.

The speculum is now withdrawn with the blades open in order to bring the vaginal mucosa into view throughout its entire length. Its colour should be noted. Is it red from irritation? Has it the purplish colour of pregnancy? Has it the little pin-point red spots seen in trichomonas infection? Is it ulcerated? Has it the strawberry appearance of actual vaginitis?

Rectal Examination

No pelvic examination is complete without a rectal, and this should *always* be done when a vaginal has been impossible. You can feel practically everything with a rectal and rectal-bimanual examination that you can vaginally, although the findings are perhaps somewhat blurred. In doing a rectal the same *planned* procedure should be carried out as with the other route. It is often very useful in clearing up the diagnosis of an acute abdominal condition. If, on reaching up as far as you can on the right you cause the patient to wince more than you could on pressing far up into the right vaginal fornix, the condition is probably appendicitis.

So much for an examination in the office.

Examination in the Home

Examination in the patient's home presents another problem. It is not likely to be as satis-

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factory, because it will have to be carried out in bed. Two procedures can be followed. The patient can either lie across the bed, with her buttocks well over the edge and her knees caught over the back of two chairs (with cushions interposed); or she can be examined in the Sims' position. If you use the first technique you proceed to carry out the examination very much as on your office table. If you use the Sims' position you must undertake a different technique. Using this position, the best results will be obtained if you get the patient lying diagonally across the bed with her buttocks over the edge. The upper knee must be thrown over the lower, her under arm should be out behind her back, and her upper shoulder should be as far over as possible, so that she is almost lying on her face. You now proceed to make your vaginal examination in the same *planned* way as described above. Then, turning your Graves' speculum into a Sims', you insert it and draw the blade backwards and slightly upwards to bring the cervix into view. Having finished the speculum examination you reinsert your fingers into the vagina, get the patient to turn over on her back, and proceed with the bimanual. It is my own conclusion after considerable experience examining in both the office and the home that the latter is never as satisfactory as the former.

There are three types of cases in which it may be necessary to examine the patient under anæsthetic—(1) the very fat patient; (2) the very resistant and apprehensive patient; (3) the patient who is bleeding irregularly and in whom a diagnosis of intracervical or corporeal cancer is a possibility and can only be cleared up by an exploratory curettage.

I have attempted in this paper to show that it is not always necessary for the purpose of diagnosis to feel or see actual pathological lesions. I want to drive the point further home by saying that the man who is so overcome by disappointment in not feeling or seeing gross pathological changes that he will not attempt to build up a diagnosis from all the *little departures from normal* he has noted, will never succeed in pelvic diagnosis. I have illustrated this point with regard to salpingitis and ectopic gestation by showing how in an acute lower abdomen where there was pus in the urethra and muco-pus hanging from an angry cervix, with tenderness on moving the cervix and pressing up into the postero-lateral fornices, that the diagnosis is most likely to be acute salpingitis, and where in the same acute abdomen there is dark red blood coming from the cervix with the cervix tender on movement and tenderness in one postero-lateral fornix the diagnosis is most likely to be ectopic pregnancy. Similarly in cases of benign uterine bleeding, if you have satisfied yourself that the bleeding is from the uterine endometrium, you are unlikely to feel anything on bimanual examination that will add greatly to your understanding of the case.

In all cases where there is irregular uterine bleeding and you suspect carcinoma — which means practically all cases of irregular bleeding —you should persist with your examination, even to the length of a diagnostic curettage under anæsthesia, until you have eliminated cancer. And if you do not feel competent to do this you should send the patient to someone who is.

The following may prove useful to those wishing to perfect themselves in the examination of the gynæcological patient.

1. Learn the normal by examining as many normal pelves as possible. This can be done quite legitimately by examining all your puerperal women six weeks after delivery.

2. Gain experience with the abnormal by examining *all* women coming with gynæcological symptoms.

3. Look out for the little signs and the gross signs will look after themselves.

4. Consider every irregularly bleeding woman to have carcinoma until you or someone else can prove she hasn't.

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