Pelvic examination for detecting ovarian cancer

It was very disappointing to read Gill Wakley’s website review in the last issue of the Journal.1 Have we finally abandoned clinical common sense on the altar of guidelines and evidence-based practice? Nobody with any sense would advise a pelvic examination as a means of detection of ovarian cancer. The main reason for performing a bimanual examination prior to taking a smear is to enable that examination to be easier and more comfortable for the patient. It enables the smear taker to choose the correct speculum (extra long, virgin, etc.) and hopefully to locate the cervix at the first attempt. How else would one know that the uterus was sharply retroverted and the cervix anterior below the pubic symphysis? Repeatedly opening and closing the speculum in an attempt to find the cervix is very uncomfortable (I have been on the receiving end!). If one can locate the cervix first time, the procedure is much easier for everybody. I have lost count of the number of women who have said: “Is that all? Last time it took much longer.” A bad experience having a smear taken is often a reason for patients declining further screening.

Of course, all sorts of valuable information can be gained by a pelvic examination. Discomfort can prompt tactful questioning about dyspareunia, which is often not presented as a symptom. If the uterus is enlarged, direct questions about menorrhagia may elicit symptoms that have not been directly complained about. I have even seen cases where the retained tampon that may account for symptoms. As a hospital gynaecologist, I have on several occasions seen women referred with retained tampons that had not been detected as a speculum often pushes the tampon out of the way but does not discover it.

Then, of course, if one did find an ovarian cyst, could it not be better for the woman if it were found and acted on regardless of whether it is malignant? I will continue to advise trainees that I think the bimanual examination is part of the taking of a smear... but then I don’t write the guidelines!

Beth Devonald, MRCGP, FFHP
Family Planning Trainer and Associate Specialist in Colposcopy, The Mulberry Centre, Waddington, Lincoln LN5 9NX, UK. E-mail: Devonald@hineternet.com

Reference

Reply
There appear to be two main issues raised in this letter.

First, the website review is reporting the answer to a specific question. Dr Devonald raises another question by suggesting that the guidelines for taking a cervical smear should be altered to include a digital vaginal examination to establish the position of the cervix, before inserting the speculum. This is an excellent question for the NELM primary care question service, namely: ‘By how much does a prior vaginal digital examination impair the accuracy of a cervical smear sample?’ If the answer is that it does not, then there are training implications for the many nurses who take cervical smears but have not been trained to carry out a digital vaginal examination.

Second, Dr Devonald goes on to suggest that although it cannot reliably detect ovarian cancer, a pelvic examination is useful. But useful for what? An examination on a patient without symptoms is a screening test and it is quite clear from the literature that a pelvic examination fails to meet the criteria for a screening test.1,2 For example, it does not identify reliably, at an early stage, conditions that can be treated to prevent progression. It may do harm by identifying conditions that are not significant and expose the patient to unnecessary further investigations. It may do harm by giving false reassurance of normality.

As a preliminary investigation of a patient with symptoms, it may be useful, but is not accurate enough to preclude further investigation of symptoms by other means such as ultrasound or laparoscopy.3,4 A large number of questions and answers now appear in the women’s health section of this NELM service,5 many of which health professionals will find instructive and useful, as they are based on real clinical problems.

Gill Wakley, MD, FFHP
Visiting Professor in Primary Care Development, Staffordshire University and Freelance GP, Writer and Lecturer, Abergavenny, UK. E-mail: Gillwak@aol.com

References
5 http://www.nelh.nhs.uk/

COPYING CLINIC LETTERS TO PATIENTS

I read with interest Anna Glasier’s contribution to Personal View in the April edition of the Journal.1 However, I have found it difficult to draw precise conclusions from her small project. I should like to add our own findings from a more general patient population to support her impressions.

We conducted an audit into the system for ‘Copying Letters to Patients’, which had been set up at Barnsley Hospital NHS Foundation Trust in response to the Department of Health Initiative first noted in the NHS Plan.2 Our findings mirrored those of Anna Glasier: that patients were enthusiastic about the initiative, but that medical, nursing and administrative staff were much less so.

Eighty-five case notes were reviewed as an unselected sample of patients attending a first outpatient appointment in General Medicine, Orthopaedics, Rheumatology or General Surgery. Confirmation of a wish to receive a copy letter was present in 40 cases and all of these were asked to complete a questionnaire by post on their satisfaction or otherwise after receiving the copy letter. Some 130 clinical and administrative staff were asked to complete similar questionnaires. Both patients and staff were also allowed the opportunity in the questionnaire to comment by means of free text.

Staff were generally critical, regarding the initiative as time consuming, bureaucratic and a duplication of time and effort, potentially leading to increased work from telephone calls from patients. The criteria for a screening test.1,2 For example, it does not identify reliably, at an early stage, conditions that can be treated to prevent progression. It may do harm by identifying conditions that are not significant and expose the patient to unnecessary further investigations. It may do harm by giving false reassurance of normality.

As a preliminary investigation of a patient with symptoms, it may be useful, but is not accurate enough to preclude further investigation of symptoms by other means such as ultrasound or laparoscopy.3,4 A large number of questions and answers now appear in the women’s health section of this NELM service,5 many of which health professionals will find instructive and useful, as they are based on real clinical problems.

Gill Wakley, MD, FFHP
Visiting Professor in Primary Care Development, Staffordshire University and Freelance GP, Writer and Lecturer, Abergavenny, UK. E-mail: Gillwak@aol.com

References

Invisible contraception?

I thought others might be interested to hear a comment passed on to me in my family planning clinic today. My client noticed her friend’s Implanon® rod glowing under UV lighting while they were in a nightclub. It didn’t put her off having one fitted herself, but maybe we should warn people that their ‘invisible’ contraceptive method may be seen in these circumstances.

Emily Gwinnell, MRCGP, FFHP
GP and Clinical Assistant in Family Planning, Northamptonshire, UK. E-mail: emilygwinnell@doctors.org.uk
Invisible contraception?

Emily Gwinnell

*J Fam Plann Reprod Health Care* 2005 31: 337
doi: 10.1783/147118905774480725

Updated information and services can be found at:
http://jfprhc.bmj.com/content/31/4/337.5.citation

**Email alerting service**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/