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THE CLINICAL APPROACH TO STD PATIENTS

STD/HIV
Prevention
Training
Center of New England

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THE CLINICAL APPROACH TO STD PATIENTS

OBJECTIVES

1. List the key components of a routine STD history and the specific patient information that should be obtained in each component.
2. Discuss the advantages and disadvantages of open-ended and close-ended questions.
3. State specific provider techniques for history taking that will enhance patient-clinician relations.
4. Describe the integration of HIV risk assessment into STD history taking.
5. Discuss aspects of the STD sexual history that may identify potential sexual assault and identify appropriate referrals for a sexual assault victim.

THE FEMALE PHYSICAL EXAMINATION:

1. List the minimum equipment needed for a routine STD oriented examination of the female pelvis.
2. State the steps, in appropriate order, for conducting a complete routine female examination.
3. Discuss the principal abnormal findings relevant to an STD examination to be noted at each step of the pelvic exam.
4. Describe the correct technique in obtaining laboratory specimens for gonorrhea and chlamydia testing, cervical gram stains, and saline and KOH wet preparations of vaginal specimens.

THE MALE PHYSICAL EXAMINATION:

1. List the minimum equipment needed for a routine STD oriented examination of the male.
2. State the steps, in appropriate order, for conducting a complete routine male examination.

GOALS OF THE STD INTERVENTION

1. Diagnosis and treatment of active diseases
2. Detection of asymptomatic disease
3. Promotion of changes to protective behaviors
4. Protection of public health
5. Prevention of sequelae (pelvic inflammatory disease, HIV infection, etc.)

NOTES:

1.0 TAKING A SEXUAL HISTORY: GENERAL CONSIDERATIONS

A sexual history is to be taken in such a way so that it:

1. ensures confidentiality
2. establishes rapport
3. ensures accurate definition of the problem
4. determines level of HIV risk
5. leads to successful patient management

You should interview the patient alone or with an unrelated translator. You can start with safe questions first, such as the menstrual history in women. Explain to the patient why you are asking questions about sensitive topics such as drugs and sexual activities.

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GUIDELINES FOR LANGUAGE CHOICE

Use words that patients will understand, and be clear. The choice of words should be guided by the level of comfort of both the provider and the client. If unsure, start with more formal terms, and then follow the patient's lead and elicit the patient's explanation (their own words about a sexual experience, drugs, etc.). You don't want to use medical jargon that the patient won't understand ("cunnilingus"). On the other hand, you don't want to be offensive. Being tactful is key.

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ATTITUDE

Make no assumptions: marital status, socioeconomic status, age, education, etc., should not be used as markers of sexual behavior (eg: she is 50 years old and divorced, therefore she is not sexually active; he is a married executive, therefore he has no other sex partner than his wife; she is using oral contraceptives, therefore she does not have sex with women).

Don't act surprised by answers to your questions.

Be non-judgmental and sensitive. Patients need to feel the provider's receptiveness and comfort with drug and sexual issues. They need to feel that they can talk openly about their behaviors (avoid: "I can't believe you're not using condoms!")

Use gender neutral terms and concentrate on specific behaviors. Homosexual or lesbian patients may be reluctant to reveal their sexual orientation if you do not provide indications that you are open to hearing about their experiences (Do you have sex with men, women, or both?).

Avoid leading questions such as "you always use condoms, right?"

NOTES:

Use open-ended questions. When the patient describes a symptom, the use of open ended questions elicits more complete information (e.g. “Tell me more about it,” or “what was it like for you,”). Close ended questions elicit a quick response (Yes/no, a word, a short phrase). They can be used more efficiently, after the patient has finished with his or her story to focus on specifics. This is called open-to-close “cone technique” of interviewing, i.e going from general to the specific.

1.1 PATIENT HISTORY: REASON FOR THE VISIT

A. First, ascertain the **reason for the visit**. In the context of STDs, the reasons generally are one or more of the following:

1. A positive test result and now needs treatment or has questions
2. Symptoms recently or in the past
3. Desire for routine STD/HIV screening (new relationship, recent unprotected intercourse, worried-well, sexual assault)
4. Sexual partner with symptoms or recent STD diagnosis
5. Routine pelvic and/or birth control

B. Assess the **symptoms and duration** (chief complaint plus the presence of other symptoms that are not chief complaint)

1. Oral/pharyngeal symptoms
2. Lymph node swelling or tenderness
3. Urethral discharge or dysuria
4. Vaginal discharge/odor
5. Dysuria (frequency and urgency)
6. Itching or irritation (vulvar, anal, penile)
7. Abnormal vaginal bleeding (spotting between periods, abnormal menses)
8. Genital lesions or rashes (painful, recurrent)
9. Non-genital skin rashes
10. Pelvic pain/pain with intercourse (dyspareunia)
11. Testicular pain/swelling
12. Rectal/perianal symptoms (pain, discharge, bleeding, itching, sores)
13. Abdominal complaints (nausea, vomiting, constipation, diarrhea)
14. Systemic or constitutional symptoms
15. General health and pre-existing medical conditions
16. Acute arthritis symptoms
17. Time since last void

If they had symptoms did anything improve the symptoms?

Has this kind of symptom ever occurred in the past?

Any recent or past history of travel?

KEY POINTS

When taking a sexual history, remember the following considerations:

- Make no assumptions about a patient’s behavior based on his/her marital, educational or socioeconomic status.
- Reinforce confidentiality.
- Avoid leading questions and use gender neutral terms.

- Be non-judgmental and sensitive.

Past history of underlying genitourinary pathology or urologic procedure?
 Recent history of sexual practices such as masturbation, sex toys, "fisting,"
 "rimming," genital mutilation?

- C. Ask about **medications** taken in the past months. **Allergies** to medications in the past? Name of medication. Record type of reaction.

1.2 SEXUAL HISTORY: SPECIFIC INFORMATION TO BE ELICITED

A. Gynecologic History

1. Menstrual history
 - What is the length of menstrual cycles
 - Are they regular or irregular cycles
 - What was the first day of last menstrual period (LMP). Was it normal? Is the patient currently pregnant?
2. Parity (pregnancy history)
 - Gravida = number of times pregnant (also include tubal pregnancy)
 - Para = deliveries
 - Ab-sp = spontaneous abortions or miscarriages
 - Ab-in = induced abortions or termination of pregnancy (TOP)
3. Douching
 - How often, what do you use

B. Sexual Partners

1. Sex with men, women or both
2. Number of days since last exposure
 1. Number of days since last unprotected sexual exposure (without condom)
 2. Was that with a regular sex partner or a casual/new sex partner (may need to define)
3. Number of sexual partners in the past 2 months? How many of those were new sexual partners?
6. Total number of sexual partners in the past 12 months
7. Does the partner have other sex partners

NOTES:

- C. Sites of exposure in the past 30 days (explain why you are asking these invasive questions)
1. Penis to vagina
 2. Penis to mouth
 3. Penis to anus
 4. Mouth to penis/vagina/anus
- D. Current contraception, if needed as assessed by sexual partner's history
Method used, is it adequate
If no method, is pregnancy desired?
- E. Use of barriers for sexual practices (condom/dental dam use)
1. Determine the pattern of use (never, sometimes, always) with different sites of exposure (vaginal, rectal, oral)
 2. Ascertain if use with last sexual exposure with steady and non-steady partners
 3. Condom breakage and correct use
 4. Time to educate
 5. Time to discuss contraception
- F. Ascertain if past or present abuse
Have you ever been forced to have sex, or been physically touched against your will?
Do you have sexual concerns?
- G. Prior history of STDs
1. Note how many episodes and when last treated
Gonorrhea
Chlamydia
Nongonococcal urethritis (NGU)/urethritis (males)
MPC (females)
PID (females)
Syphilis - what stage or symptoms, what were they treated with, what year, what city or state, what was last VDRL/RPR titer, if known
Genital Herpes - note recurrence rate per year (oral or genital)
Genital warts - genital and/or anal
BV
Trichomoniasis
Hepatitis
Other

KEY POINT:

When taking a medical and sexual history, remember to ask about:

1. The reason for the visit
2. The chief complaint and other symptoms
3. The gynecologic history for women
4. The sexual partners
5. The sexual behaviors (site of exposures, barrier use, etc.)
6. Prior history of STDs and HIV risk assessment

H. HIV risk assessment

1. Previous HIV status and date of last test
2. Sexual contact with men who have sex with other men
3. Sexual contact with known HIV+ person
4. Sexual contact with injection drug user
5. Sexual contact with crack cocaine user
6. Patient history of injection drug use – shared needles
7. Patient history of crack cocaine use
8. History of exchanging drugs/money for sex
9. Greater than 4 sexual partners in the past 12 months
10. History of transfusion or hemophilia – note dates
11. History of occupational contact to bodily fluids

Indications of Risk

1. A history of an STD diagnosis or a sexual partner with an STD diagnosis in the last 12 months or sex partner with viral STD (HSV, HPV, HIV)
2. More than one sexual partner or a sexual partner with other sexual partners in the last 12 months
3. A history of injection drug use or substance abuse by a patient or sexual partners
4. A history of not using barrier contraceptive methods
5. A recent or past medical history of sexual assault or abuse
6. Age less than 25 (adolescents have the highest rate for many STDs)
7. A sexual history that doesn't seem to match the clinical picture or presentation
8. Resides in high prevalence area or has had sexual encounters in high prevalence area during travel

NOTES:

2.0 PHYSICAL EXAMINATION OF THE FEMALE

The minimum components of a routine STD female examination include:

1. Examination of the mouth
2. Examination of the lymph nodes
3. Examination of the skin on thorax, abdomen, limbs, palms
4. Examination of the external anogenital area and internal genitalia (speculum examination of the vagina and cervix, and bimanual pelvic examination)

Cooperation will also enhance the diagnostic yield. It is important to explain the examination procedure *prior* to having the patient undress. Ask about previous experiences with exams (such as fainting).

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BEFORE YOU PROCEED WITH THE EXAMINATION:

1. MAKE SURE THE PATIENT HAS VOIDED

A distended bladder interferes with the bimanual examination and makes the exam very uncomfortable. Collect the urine at that time for any tests you think are indicated (e.g. pregnancy test, urinalysis, etc.)

2. HAVE ALL MATERIALS READY AND EASILY ACCESSIBLE:

A good adjustable examination light

Gloves

Tongue depressors

Vaginal specula in assorted sizes

Lubricant (water soluble)

Gonorrhea culture medium or test collection kit

Chlamydia transport medium or test collection kit

Sterile normal saline (0.85%) solution in test tube

Potassium hydroxide (KOH) 10% solution

Clean slides with frosted edges and coverslips

Sterile swabs (urethral and standard)

pH paper (4-7)

Cotton applicators and large swabs

Any other transport medium as needed (ex: for herpes culture)

Any chemical treatment for HPV as needed (ex.: TCA)

Mirror (useful for showing to patient normal anatomy or abnormality)

Pap smear material: spatula, cytobrush, fixative, slide holder or thin prep kit

Magnifying glass and tissues

KEY POINTS:

Remember:

The pelvic examination usually evokes much anxiety, even for the woman who is not concerned about an STD. Therefore, every effort should be made to increase comfort during the examination.

3. LABEL ALL SPECIMENS AND SLIDES**4. WASH AND WARM HANDS. PUT ON GLOVES**

Develop a standard technique for handling clean and contaminated articles.

- ä 1 hand clean, 1 hand contaminated, remaining consistent throughout the examination.
- ä 2 hands gloved, removing 1 glove before touching any other clean surface area.

5. WARM SPECULA**2.1 EXAMINATION****WHILE THE PATIENT IS SITTING ON THE EXAMINATION TABLE:**

As you proceed with the examination, continue to talk to the patient, explaining what you are doing (but avoid talking down). Telling her about normal findings during the exam also helps relieve anxiety. Avoid any sudden movements.

- ä Note general appearance
- ä Inspect the oropharynx (gums, tongue, tonsils, soft and hard palate)
Look for thrush, ulcers/chancres, mucous patches, hairy leukoplakia, warts, lesions of KS, pus on tonsils. Obtain gonorrhea culture if indicated, swabbing posterior pharynx and tonsillar areas.
- ä Palpate lymph nodes
palpate cervical and axillary nodes
Note presence, consistency, number, size, mobility, tenderness
- ä Inspect the skin
inspect face, trunk, forearms, palms and legs; look for rashes and describe (macular/papular/vesicular/pustular, etc.)
Inspect soles of feet if syphilis suspected

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PREPARE THE PATIENT FOR THE PELVIC EXAMINATION

Help put the heels of the patient in the foot holders one after the other, and then ask her to move down to the edge of the table. Elevate her head and shoulders slightly to help her relax. She will also be better able to see your face and movements. Cover the thighs and knees with a drape sheet and keep the drape sheet depressed between the knees, to keep eye contact with the patient. Begin the examination by touching a non-genital area (eg upper inner thigh). Watch her face to monitor the reaction to the examination.

KEY POINTS FOR EXAMINATION TECHNIQUES

1. Explain examination procedure before undressing the patient
2. Touch a "non-genital" area of the body first
3. Make eye contact
4. Talk to the patient during exam, but avoid talking down
5. Watch for signs of discomfort (facial expressions, not relaxed, guarding)
6. Avoid lengthy discussions when patient is in a compromising position
7. Remove examination light off of genital area as soon as possible
8. Examine painful areas last

1. Examine the inguinal nodes
Assess size, consistency, tenderness, site, number.
2. Inspect the mons pubis
Look for pubic lice and nits, folliculitis, molluscum.
3. Inspect the external anogenital area
Examine the vulva: labia majora, labia minora, clitoris, urethral meatus, introitus, perineum.
Examine the anus: look for rashes, sores, discharge, fissures. Spread apart anus with your fingers to look for open sores. Culture anal site at this time if indicated by symptoms, signs or sexual history.
4. Examine the urethra and Skene's glands
Insert finger in the vagina and gently apply pressure upward on the urethra while moving your finger towards the introitus. Culture any exudate (GC, CT) from Skene's glands.
5. Palpate Bartholin's glands
Located at 5:00 and 7:00 o'clock on the face of the posterior fourchette. Palpate by placing the index finger in the vagina and thumb on the exterior. Normally not palpable and not tender. Look for abscess/cyst. Culture any exudate (GC, CT).
6. Examine the vagina and cervix
 - a) Assess the support of the vaginal outlet by asking the patient to strain down. Note any bulging (cystocele, rectocele, prolapse).
 - b) Select the appropriate size and shape of the speculum (a medium Pederson is a good choice either metal or plastic).
Lubricate with water only if necessary. Make sure speculum is warm.
 - c) Place two fingers at or near the introitus and gently press down on the perineum. With your other hand, while keeping the index finger on the anterior blade of the speculum to keep the blades closed, insert the speculum past your fingers, with a downward angle, blades closed and slightly oblique. Avoid anterior pressure, or catching the labia or pubic hair in the blades.
 - d) Remove the fingers from the introitus, rotate the blades horizontally, and slide the speculum fully inside the vagina, continuing to put pressure downwards. Gently open the blades and maneuver to locate the cervix. If you cannot locate the cervix, retract the speculum slightly and redirect (the cervix may be more anterior if the uterus is retroverted). Once the cervix is in full view, secure the speculum with the blades open by tightening the thumb screw (metal) or clamping (plastic: warn the patient that a noisy "click" may occur).
 - e) Inspect the cervix: evaluate for ectopy, Nabothian cysts; look for friability, mucopus, ulcers/chancres, petechia ("strawberry cervix" of trichomonas infection), warts, polyps.
 - f) Collect specimens as appropriate in the following sequence: take vaginal pH, collect vaginal sample for saline and KOH wet mount; collect cervical sample for gram

NOTES:

stain and swab test if mucopus is present, perform gonorrhea culture/test, chlamydia culture/test; perform Pap smear if indicated (see note at bottom of page).. In the absence of cervix (hysterectomy), collect urethral specimens for gonorrhea and chlamydia.

Proper Specimen Collection Techniques:

Vaginal pH: use a sterile swab or a Pap smear spatula to collect secretions from the mid to third inferior lateral vaginal wall, and apply to the pH paper. Alternatively, place the pH paper strip directly on the mid to third inferior lateral vaginal wall. Determine pH according to manufacturer's instruction and scale.

Saline Prep: use a sterile swab or a Pap smear spatula to collect secretions from the mid to third inferior lateral vaginal wall. Place the swab or spatula in a small test tube containing 0.85% sterile saline. Shake the swab or spatula to create a turbid solution. Using the swab or spatula in the saline, place a drop of the suspension onto the glass slide. Alternatively, place a large drop of 0.85% sterile saline on a slide. Collect sample from the mid to third inferior lateral vaginal wall with a sterile swab and mix with the saline drop to create a turbid solution. Add coverslip and read.

KOH Prep: use a sterile swab to collect a sample from the mid to third inferior lateral vaginal wall, then roll the swab on a slide. Add a drop of 10% KOH, and mix with a swab. Bring close to the nose to assess for amine odor ("whiff test"). Add coverslip. Wait 2 to 5 minutes to read.

Gram stain: remove external vaginal secretions or excess mucus from the cervix with a large cotton swab. Insert a sterile cotton swab into the endocervical canal. Rotate swab for 5 to 10 seconds to allow absorption of secretions. Roll gently swab back and forth on a clean slide to cover a surface of about 1 cm². Allow smear to thoroughly air dry.

Gonorrhea culture: Follow the same procedure as Gram stain for the collection of specimen for the gonorrhea culture. Then, holding the swab parallel to the plate, inoculate the $\frac{1}{3}$ to $\frac{1}{2}$ of the agar surface in a "Z" streak pattern, rotating the swab a full 360 degrees to express all of the exudate.

Chlamydia test: Obtain the endocervical sample after the GC sample, making sure the excess mucus has been removed to enhance collection of cells.. Insert manufacturer's sterile swab into the endocervix and rotate for 15 to 30 seconds (or according to manufacturer's instructions) to ensure adequate sampling for collection of columnar epithelial cells (especially important when using non amplified tests). Follow manufacturer's instructions for transport conditions.

- g) Withdraw the speculum slowly while inspecting the vagina. As the speculum clears the cervix, release the thumb screw (or unfasten plastic clamp). Maintain the open position of the speculum with the thumb. Note any abnormal discharge (color, consistency, inflammation), warts, ulcers. Close the blades as the speculum emerges from the introitus to avoid stretching or pinching the mucosa.

*bleeding induced by cervical swabs can potentially be a greater problem for the accuracy of the conventional Pap smear than for GC or CT testing, which is why some experts recommend that it be collected first. However, if STD tests are run on single sample as part of liquid-based cytology testing, sequence will not be an issue (see ref #6). In general, unless the patient is unlikely to return, it is best to defer the performance of the conventional Pap smear in the presence of MPC or a friable cervix until diagnosis and treatment has occurred. In the absence of MPC or friable cervix, specimens for STD testing may be collected first.

BIMANUAL EXAMINATION

- A. Lubricate index and middle fingers of one of your gloved hands, and from a standing position insert them into the vagina, again exerting pressure primarily posteriorly. Thumb should be abducted, ring and little fingers flexed into palm. Pressing inward on perineum with flexed fingers causes little, if any discomfort and allows you to position your palpating fingers correctly. Note any nodularity or tenderness in the vaginal wall, including the region of the urethra and bladder anteriorly.
- B. Palpate the cervix noting its position, shape, consistency, regularity, mobility and tenderness. Normally, the cervix can be moved somewhat without pain. Make eye contact with the patient and assess level of discomfort as you move the cervix. Palpate the fornix around the cervix.
- C. Place your other hand on the abdomen about midway between the umbilicus and the symphysis pubis. While you elevate the cervix and uterus with your pelvic hand, press your abdominal hand in and down, trying to grasp the uterus between your two hands. Note its size, shape, consistency and mobility, and identify any tenderness or masses. Now slide both fingers of your pelvic hand into the anterior fornix and palpate the body of the uterus between your hands. In this position the pelvic hand can feel the anterior surface of the uterus, and your abdominal hand can feel part of the posterior surface. If you cannot feel the uterus with either of these maneuvers, it may be retroverted. In this case, slide your pelvic fingers into the posterior fornix and feel for the uterus butting against your fingers.
- D. Next place your abdominal hand on the right lower quadrant, your pelvic hand in the right lateral fornix. Press your abdominal hand in and down, trying to push the adnexal structures toward your pelvic hand. Try to identify the right ovary or any adjacent adnexal structures between your fingers, if possible, and note their size, shape, consistency, mobility, and tenderness. Repeat the procedure on the left side. Ovaries are normally approximately the size of an almond (<3 cm) and somewhat tender.

They are usually palpable in slender, relaxed women, but are difficult or impossible to feel in women who are obese or poorly relaxed. Fallopian tubes are often not palpable.

RECTOVAGINAL EXAMINATION

This is not a routine part of the STD examination, but can be done if desired to palpate a retroverted uterus or assess the uterosacral ligaments (nodules d/t endometriosis may be present). Inform the patient of what you are about to do. Change gloves and use lubricant. Collect specimen if warranted.

- a) Place index finger into vagina and middle finger into rectum. Use abdominal hand as in bimanual.

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- b) Sweep fingers to the right and then to the left to assess a retroverted uterus, the posterior wall of the uterus, the uterosacral ligaments. Look for any posterior masses.

3.0 PHYSICAL EXAMINATION OF THE MALE

The minimum components of a routine STD male examination include:

1. Examination of the mouth
2. Examination of the lymph nodes
3. Examination of the skin on thorax, abdomen, limbs, palms
4. Examination of the external genitalia (penis, scrotum and testes) and anus (if complaints or in men who have sex with men)

As for the female examination, it is important to explain the examination procedure and what to expect prior to having the patient undress. Ask about previous experiences with exams (such as fainting).

1. STAFF SHOULD INFORM THE PATIENT NOT TO VOID PRIOR TO THE EXAMINATION

The patient should not have voided least *two hours* before specimen collection. The ideal is to examine the patient before the first morning void, but this is most often not possible.

2. HAVE ALL MATERIALS READY AND EASILY ACCESSIBLE

Adjustable exam light

Gloves

Lubricant

Cotton, dacron or if unavailable, calcium alginate urethral swabs

Sterile swabs (standard)

Cotton tipped applicators

Clean slides with frosted edge and coverslips

Tongue depressors

Gonorrhea culture medium or test collection kit

Chlamydia transport medium or test collection kit

Sterile normal saline (0.85%) solution in a test tube

Any other transport medium as needed (ex.: for herpes culture)

Any chemical treatment for HPV as needed (ex.: TCA)

3. LABEL ALL SPECIMENS AND SLIDES

4. WASH AND WARM HANDS

5. PUT ON GLOVES

As noted for the female examination, develop a standard technique for handling clean and contaminated articles

NOTES

3.1 EXAMINATION

WHILE THE PATIENT IS SITTING ON THE EXAMINATION TABLE:

As you proceed with the examination, continue to talk to the patient, explaining what you are doing (but avoid talking down). Avoid sudden movements and tell about normal findings.

- Note general appearance
- Inspect the oropharynx (gums, tongue, tonsils, soft and hard palate)
Look for thrush, ulcers/chancres, mucous patches, hairy leukoplakia, warts, lesions of Kaposi's sarcoma, pus on tonsils. Obtain GC culture if indicated, swabbing the posterior pharynx and tonsillar areas
- Palpate lymph nodes
Palpate cervical and axillary nodes. Note presence, number, size, consistency, tenderness
- Inspect the skin
Inspect face, trunk, forearms, and hands/palms and legs. Look for rashes and describe (macular/papular/vesicular/pustular, etc.). Inspect soles of feet if syphilis is suspected.

HAVE THE PATIENT STAND AND LOWER PANTS/UNDERPANTS TO KNEES TO EXPOSE GENITALIA AND INGUINAL AREA. HAVE THE PATIENT RAISE HIS SHIRT TO EXPOSE THE LOWER ABDOMINAL AREA

1. Examine the inguinal lymph nodes for swelling
Assess size, (abscess? Fluctuant?), consistency, number, swelling tenderness.
2. Inspect the mons pubis
Look for pubic lice and nits, folliculitis, molluscum.
3. Inspect the skin of the genital area
4. Palpate scrotal contents
 - a) Gently compress each testes and epididymis between your thumb and first two fingers. Note tenderness, shape, masses, swelling or presence of nodules. Assess for hydrocoele.
 - b) Identify spermatic cord and vas deferens. Note tenderness or swelling. Assess for varicocele.
 - c) Inquire and instruct about testicular self-examination.

At this point, the patient can be asked to lie down or sit on the examination table.

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5. Examine penis
 - a) Inspect skin. Retract the prepuce if present. Inspect glans. Look for balanitis, warts, ulcers, chancres, vesicles.
 - b) Locate the meatus. R/O hypospadias, epispadias.
Gently compress the glans between your thumb and index finger to open the urethral meatus. Look for warts, ulcers, lesions and stenosis. If no discharge is visible, strip or milk the shaft of the penis from the base of the glans
 - c) Collect specimens as appropriate (see below) and others as needed (wet mount, HSV, DF of lesion, etc.)

Proper Culture Specimen Collection Techniques - Urethra-Use a urethral swab

In the following sequence:

Gram stain: To be obtained if discharge is present, or symptoms of urethritis are present. If discharge is present, apply drop unto slide. If not present, insert swab 1 to 2 cm into the urethra, hold for 10 seconds and *roll specimen gently* on a slide to cover about 1cm².

Gonorrhea culture: Use the above swab to inoculate the $\frac{1}{3}$ to $\frac{1}{2}$ of the agar surface in a "Z" streak pattern, rotating the swab a full 360 degrees to express all of the exudate.

Chlamydia test: Insert swab 2 to 3 cm into the urethra and gently rotate 360° as you withdraw the swab. Place swab in transport medium according to the manufacturer's instructions.

6. Inspect anus and perineum
 - a) The exam may be performed in a knee-chest position or by asking the patient to stand and bend forward with hands positioned to the back to spread the buttocks apart.
 - b) Examine external areas for lesions, rashes, discharge and fissures. Spread apart anus with your finger to look for open sores. Collect specimens if indicated by symptoms, signs or sexual history.

Proper Specimen Collection Technique - Anal Canal

Gram stain: Insert cotton swab into the anus about 3 cm while exerting lateral pressure to avoid fecal material. Rotate the swab for ten seconds to sample crypts just inside the anal ring. If swab is fecal stained, discard sample and repeat specimen collection. *Gently roll* swab unto slide back and forth to cover a surface of 1 cm².

Gonorrhea culture: Use the same swab to inoculate the agar as described for the urethral specimen.

Chlamydia culture: Repeat the above procedure and insert swab in transport medium.

- c) Internal palpation. Lubricate gloved index finger and insert while exerting downward pressure. Look for masses and assess prostate for size and tenderness.
- d) Anoscopic exam if required per history or findings at the physical examination.

NOTES:

4.0 FIGURES

FEMALE ANATOMY

FEMALE ANATOMY CONT.



MALE ANATOMY

5.0 REFERENCES

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