Team Name: Regional Perinatal Team Lead: Regional Director-Acute Care Approved by: Executive Director - Mid	Reference Number: CLI.5810.SG.014 Program Area: Obstetrics Policy Section: General
Issue Date: August 1, 2017 Review Date: Revision Date:	Subject: Pelvic Exam

STANDARD GUIDELINE SUBJECT:
Pelvic Exam

PURPOSE:
To assist in determining when or when not a pelvic exam is needed, and the process of performing a pelvic exam.

DEFINITIONS:
Dilation: Progressive opening of the cervix from 0 – 10 centimetres (cms), whereas 0 cms is a closed cervix and 10 cms in completely dilated and effaced.

Station: Where the fetal head lies in the pelvis in relation to the maternal ischial spines.

Effacement: The length of the cervix, noted in percentage, whereas 0% (4 centimetres) effaced is no thinning of the cervix and 100% (0 centimetres) effaced is completely thinned.

Cephalopelvic disproportion: A condition in which the fetal head is too large to pass through the maternal pelvis. This condition may be due to an abnormal maternal pelvis, an abnormally large fetal head or a combination of both.

Cervical OS: The opening to the uterus.

Leopold Maneuvers (Leopold's): A set of external abdominal examinations to determine the position of the fetus and engagement of the fetus in the maternal pelvis.

Position: How the presenting part of the fetus is positioned in the maternal pelvis.

Presentation: The part of the fetus entering the pelvis first. The fetus may be vertex, breech or transverse.

Per vaginal (PV): – pelvic exam, also called a vaginal exam.

IMPORTANT POINTS TO CONSIDER:
Indications for a pelvic exam:
- Signs of labour – to assess status (in the absence of the below contraindications),
- Post rupture of membranes with an atypical/abnormal fetal heart rate (FHR), decreased fetal movement or if the fetal head was not well applied,
- Unsure of presentation via Leopold's manoeuvres (in the presence of labour),
- To illicit a fetal response using scalp stimulation,

- To assess the progress of active labour (minimum every 4 hours) (keep PV's to a minimum when rupture of membranes has occurred),
- Prior to giving any analgesic – must be done less than 30 minutes prior to administering,
- Signs of second stage of labour,
- Prior to allowing an actively labouring patient to use the bathroom to have a bowel movement or
- Atypical/abnormal FHR pattern.

Relative contraindications to a pelvic exam (consider a speculum exam instead):

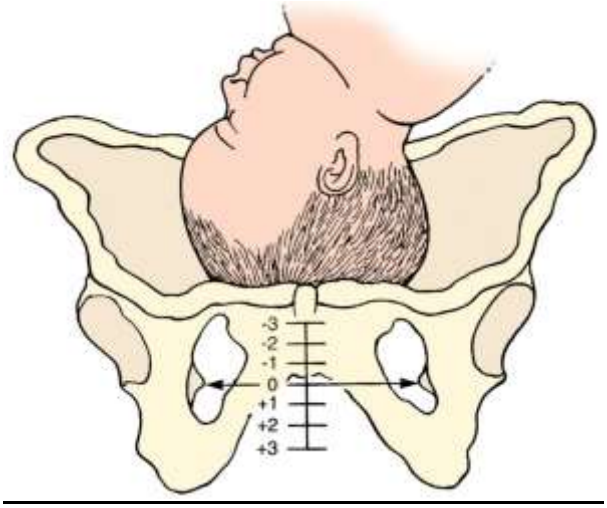
- Vaginal bleeding of unknown cause,
- Rupture of membranes without any evidence of labour and with a normal FHR, fetal movement and the fetal head well applied or head engaged as determined by Leopold's or
- Prematurity, unless the patient has signs of labour.

Absolute contraindications to a pelvic exam:

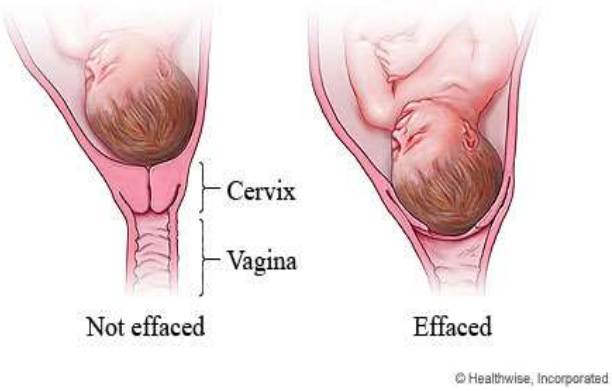
- Known or suspected placenta previa or vasa previa or
- Evidence of an active genital herpes infection (an active condyloma infection is not a contraindication for a PV).

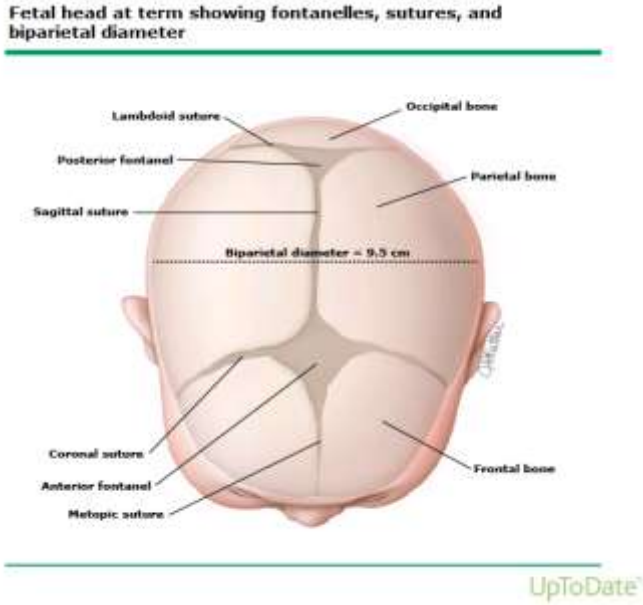
PROCEDURE:

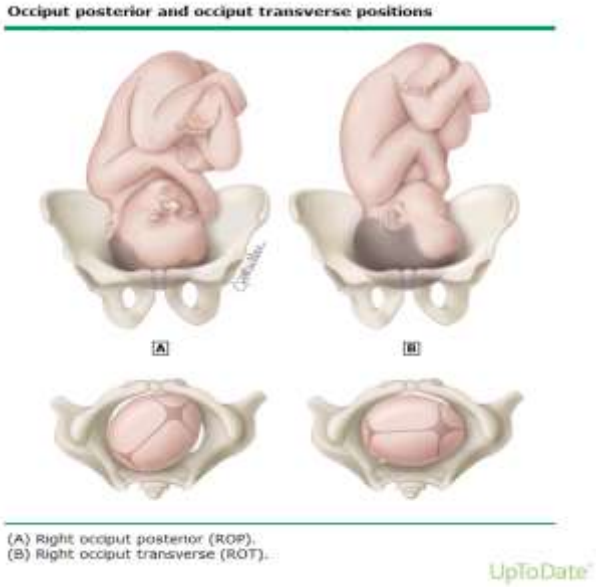
1. Ensure privacy.
2. Explain to the patient what you are doing and why.
3. Have the patient empty her bladder, if there is time, as this will help make the procedure more comfortable.
4. Do Leopold's prior to PV, if there is time.
5. Observe the perineal area for signs of infections/lesions, any leaking fluid/bleeding. Note the odour/colour of any amniotic fluid or vaginal loss.
6. Wash hands and don sterile gloves.
7. Lubricate the fingers of your dominant hand – Be aware that lubrication can alter the results of a nitrazine and/or ferning test.
8. Insert two lubricated fingers of your dominant hand gently into the vaginal canal, taking note of the diameter/consistency.
9. Use the ischial spines (at 4 and 8 o'clock positions) to determine the fetal station. Use the -3 to +3 scale to report the station (see photos below). Note any molding or caput present. Do not use caput to measure fetal station – ensure you are measuring where the bony plate of the skull lies. An enlarging caput may be mistaken as descent (progression) when in reality may indicate a cephalopelvic disproportion. Move fingers laterally along the side of the fetal head until bony plate felt to accurately measure station.
10. Determine the cervical dilation – 0cms indicates the cervix is completely closed. 10cms indicates that the cervix is completely dilated (fully dilated).
11. Determine effacement – 0% (4 centimetres) is completely un-effaced and not thinning, 100% (0 centimetres) is totally effaced and feels paper thin.
12. Determine the fetal position by feeling for the sagittal suture line and the fetal fontanels (see photos below). If uncertain or unable to feel suture line, consider asking for a second assessment (may be another nurse or primary care provider).
13. Assess membrane status (none felt, present or bulging) and feel for any cord presentation. If the membranes are bulging, try not to rupture them while you are doing the PV.
14. If the membranes do rupture during the PV, keep your fingers in the vaginal canal until the amniotic fluid gush has subsided then feel for a prolapsed cord. Assess FHR as soon as possible post rupture of membranes.
15. Clean the patient up and explain your findings.

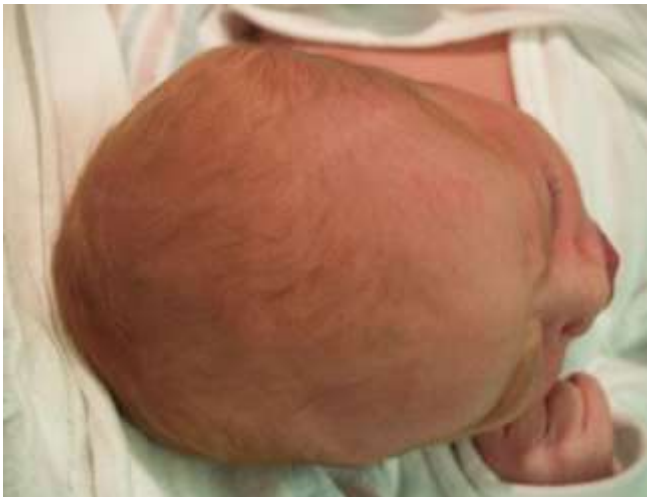


FETAL STATION









MOULDING

CAPUT

REFERENCES:

Fetal Station retrieved from https://booshy.files.wordpress.com/2012/02/station.jpg

Molding retrieved from http://med.stanford.edu/newborns/professional-education/photo-gallery/head.html

Caput retrieved from http://med.stanford.edu/newborns/professional-education/photo-gallery/head.html

Salus Global Corporation. (2014). Vaginal Birth after Caesarean Section (12th ed.). Retrieved from More^{OB} website: https://secure.moreob.com/en?t=/contentManager/onStory&e=UTF8&i=1317992669064&l=0&active=no&sort=Price&StoryID=1218589799198