Sexually transmitted infections in women: history and examination

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Abstract

Sexually transmitted infections (STIs) are common. Sensitive, non-judgemental history taking and careful examination are crucial steps in facilitating the correct diagnosis in symptomatic women as well as in providing the basis for delivering safe and effective treatment to the patient and her partner(s). The article provides detailed information about how to do this, including sample questions to ask.

Keywords Bimanual examination; sexual history; sexually transmitted infections; speculum; symptoms; vaginal examination

What's new?

- Recognition of the prevalence of unreported non-volitional sex and intimate partner violence and its impact on women in particular
- Increasing recognition in women of the need to sample additional anatomical sites as well as the vaginal tract, given increasing sexual repertoire
- Integrated sexual health care, requiring practitioners to take a complete sexual infection risk and reproductive history, dealing with risk reduction for infection and contraception needs

Setting the foundations

Many generic sexual health services and general practitioners (GPs) provide screening tests for sexually transmitted infections (STIs) in asymptomatic women, but a more comprehensive assessment — comprising detailed history and genital examination[1] — is usually necessary when symptoms are present or a risk identified. In this article we explain how best to take a sexual history and undertake a comprehensive genital examination in women, pointing out some 'tricks of the trade' and useful sample questions. For more detail, see the recently published BASHH 'Guideline for Consultations requiring sexual history taking'.[2] Like other areas of medicine, sexual history taking and genital examination require practice and skill development.

Both patients and doctors often find it difficult to talk about sex. A good sexual history is facilitated by conducting the consultation in a private, comfortable environment, establishing a good professional relationship with the woman, and preserving her confidentiality. A non-judgemental attitude is important, as is the use of questions and choice of words that are both appropriate to the consultation and readily understood. Appropriate body language and maintaining eye contact (if culturally acceptable) can reassure the patient. It may be necessary to explain the rationale behind some of the questions asked. The presence of an observer, such as a student, should be allowed only with the woman's consent. If necessary, arrangements should be made for a sign or foreign language interpreter to be present, or for Language Line to be available. Relatives should never be asked to interpret for a sexual history.

Initial questions should be open and should establish the woman's presenting concerns, which can then be further explored. If genital symptoms are present, direct questions to elicit relevant details such as duration are generally expected. In other circumstances (e.g. a teenager requesting contraception), it may be necessary to broach the subject with a question such as: '*Are you in a regular relationship?*' Competency and safeguarding concerns should also be explored for young people and particularly in those aged under 16 with reference to local and General Medical Council guidelines.[3]

History

Symptoms

Common symptoms of STIs are:

- discharge
- genital skin problems — sores, lumps, bumps and rashes
- pain on intercourse
- pain in the pelvis.

Vaginal discharge is a common presenting complaint that does not necessarily indicate infection. Physiological discharge varies with the menstrual cycle, and may be altered by hormonal or intrauterine contraception. Symptoms suggesting an infection are itching, soreness or smell.

- '*Do you have a discharge?*' '*Has there been any change in your discharge?*'
- '*Does it itch?*' — pruritus is usually caused by *Candida*, or sometimes trichomoniasis.
- '*Is it sore?*' — soreness may also be associated with *Candida* or trichomoniasis.
- '*Have you noticed an odour?*' — if yes, '*What does it smell of?*' — a fishy-smelling discharge is highly suggestive of bacterial vaginosis.

Dysuria: urethral dysuria is commonly caused by a urinary tract infection, but can also occur in urethral infection with

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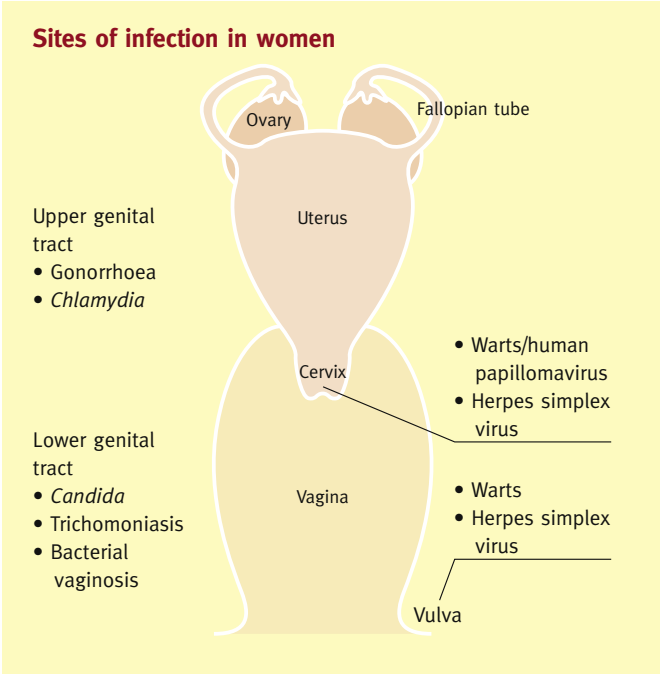

Figure 1

gonorrhoea, chlamydia and trichomonas. Dysuria can also occur in the presence of herpes ulcers.

- '*Does it hurt when you pass urine?*' — if yes, elicit other urinary symptoms such as frequency, and ask: '*Does it hurt where the urine comes out, or around the outside?*'

Genital lesions and rashes: when the woman complains of sores, lumps, bumps or rashes, elicit the duration and site, and whether there are associated symptoms of itching or pain. Sores may follow scratching associated with pruritus or may occur spontaneously. The sores of genital herpes are usually very painful, whereas the primary chancre or secondary lesions of syphilis are generally painless. Rashes may relate to infections, such as molluscum contagiosum, a viral infection producing characteristic umbilicated pearly papules, or non-infective conditions such as lichen sclerosus (Figure 1).

- '*Have you ever had anything like this before?*' — recurrence suggests warts or genital herpes; the history of the latter is characteristic, with tingling in an area followed by blisters and then sores, which then dry and heal.
- '*Have you put any cream or anything else on it?*' — over-the-counter topical remedies have generally not been formulated for genital use and can often lead to reactions.
- '*Do you have any problems in your mouth, or elsewhere on your skin?*' — many generalized skin conditions can give rise to genital disease. Any suspicion should prompt a general examination, with particular emphasis on the finger webs (scabies), knees and elbows (psoriasis), flexures (eczema) and mouth (lichen planus, Behçet's disease).

A generalized illness with rash, lymphadenopathy and sometimes mouth and genital lesions can result from secondary syphilis or the seroconversion illness of HIV infection. A detailed drug history should also be taken as severe allergic reactions can cause mucosal ulceration including the genital area.

Pelvic pain may be physiological in association with ovulation or menstruation, or may result from pelvic pathology, such as infection, ectopic pregnancy or ovarian cysts. A detailed menstrual history is useful to identify this.

- '*Do you have any pain in your tummy?*' — if yes, determine the duration, severity and site, and ask: '*Is it present all the time?*', '*Does it hurt when you have sex?*' and '*Is it related to your periods?*' If pain on intercourse is present, elicit whether it is deep in the pelvis or in the vulva or vagina. Deep dyspareunia is suggestive of pelvic infection, but may have a non-infective cause such as ectopic pregnancy. Superficial dyspareunia is often related to candidal infection.

Sexual history

The details required depend on the presentation and the possible differential diagnosis. Generally, information about all sexual partners during at least the last 3 months is necessary to allow for the window period for detection of STIs and also for contact tracing of at-risk partners.[4] Tact is important when infidelity seems likely or following sexual assault.

- '*When did you last have any type of sex?*'
- '*Is that a regular or a casual partner?*' — if casual, '*Is that someone you know or was it a one-off episode?*' If the gender of the partner has not already been stated, it may be relevant to ask, '*was that with a male or female partner?*'
- '*Was that with your permission?*' '*Did you want it to happen?*' or '*Have you ever felt pressured to have sex?*' are useful questions to ascertain whether sex was consensual; women often find sexual assault or rape hard to disclose unless they are asked directly. If someone has been sexually assaulted, ask about other types of abuse, as women experiencing intimate partner violence (IPV) may need medical, social and psychological support. The HARK questions (see Box 1) were developed for general practice but can be useful in other settings.[5] If IPV is identified, then safeguarding issues should be considered for the woman and any children she has, and advice provided about referral services and further management.

The HARK questions

H HUMILIATION
Within the last year, have you ever been humiliated or emotionally abused in other ways by your partner or ex-partner?

A AFRAID
Within the last year, have you been afraid of your partner or ex-partner?

R RAPE Within the last year have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

K KICK
Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner.