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Editorial

THE NEED AND ADVANTAGE OF RECTAL EXAMINATION IN GYNECOLOGY*

IN obstetrics, because of the possibility of introducing infection, vaginal examination has now been almost completely replaced by rectal examination. When we say rectal examination, we really mean rectoabdominal examination since coordinated manipulations of both hands are necessary. Rectal exploration is easily done. The trained rectal finger can detect consistency and contour of tissues as well as the proximity and relative change of parts, the interpretation of which reveals the nature of the presenting part and the progress of labor.

This being the case, why do we not employ rectal examination more often in gynecology where so often information ordinarily obtainable by vaginal examination is not available. Rectal examination is somewhat of a moral obligation in virgins and during the menstrual flow. However, when the cervix must be visualized as, for instance, in case of troublesome bleeding from a soft polyp, the vaginal examination (both digital and visual) is indicated. Rectal examination is a necessity when vaginal examination is very painful as in vaginismus and the inflamed vagina and when vaginal examination is difficult or impossible as in the pathologically obstructed vagina.

The obvious limitations to the sweep of the exploring vaginal finger imposed by a short, stenosed, atrophied or inflamed vagina drive the gynecologist to employ rectal examination. In order to be proficient in diagnosis by rectal

manipulation the physician should as often as possible perform rectal examination after the vaginal examination and then compare the findings. Even in a certain proportion of nulliparous vaginas, especially if the patient is not very cooperative, it may be difficult or impossible during vaginal examination to extend the finger far enough laterally to palpate the adnexa or far enough upward to discover an abnormality of the uterus.

The contour of the uterus can often be easily made out by rectal examination. In fact, a pedunculated myoma low down in the uterus may be the more easily differentiated by rectal exploration. The size of the uterus or of a growth can usually be estimated by rectal examination performed in conjunction with coordinated abdominal manipulation. Knowledge of the position of the corpus uteri is often elicited early on rectal exploration. If the uterus is in retroposition, it can be palpated in the cul de sac; and if on following the cervix upward the rectal finger loses contact, the corpus would usually be in either mid or anterior position.

Just as in examination of the uterus, so also in the investigation of the adnexa and parametria the rectal exploration may be used to obtain information as to size, position, consistency, mobility, contour of parts and, as well the degree and nature of discomfort elicited. Especially in case of cancer of the cervix, rectal exploration may give valuable information as

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to palpable nodes and also the degree of fixation and induration.

During rectal examination one is impressed by the ease with which the cervix can be identified. Not only may its consistency be estimated but also a protruding polyp can be detected; or, actually, the type of an old cervical laceration may be determined. From rectal examination the correlation of findings (consistency, degree of fixation, nature and contour of parts) gives clues leading to the diagnosis of inflammations, growths, pregnancy, malpositions and so forth.

Exploration of the rectal side of the recto-vaginal septum can reveal abnormal thickening or irregularities such as occur in endometriosis and cysts. In case of a posterior colpocele the degree, site, nature and extent of the herniation can be determined only by rectal examination. Before performing rectal examination the examiner should explain to the patient the need and purpose of the procedure. Gentle and slow insertion of the well lubricated, gloved finger is imperative. The lower bowel must be empty.

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