This paper looks directly at women’s feelings about pelvic examination and their attitude towards chaperones being present during examination. It also reports on doctors’ conflicting opinions in this area.

This study was designed in response to guidelines from UK professional bodies on intimate examinations. The Royal College of Obstetricians and Gynaecologists guideline recommends the routine presence of a chaperone regardless of the doctor’s gender.¹ The Faculty of Family Planning and Reproductive Health Care (FFPRHC) guideline recommended with guidance more appropriate to the community setting, where many doctors are female and many patients probably do not want a chaperone during intimate examination. They recommend all patients should be aware that they can request a chaperone if they wish.²

In this study 1090 women attending family planning clinics (FPCs) were asked to complete patient questionnaires; the response rate was 90%. Only 11% of providers were male. Just over half the providers worked in general practice, 19% in family planning, and the remainder were hospital specialists, mostly in gynaecological or gynaecology.

Most women were less concerned about pelvic examination than doctors predicted; 17% of those aged 21–40 and 21% of over 25-year-olds said they did not mind and would not expect to find the procedure unpleasant. Two-thirds of women saw pelvic examination as somewhat unpleasant but tolerable. Only 23% of under 25-year-olds and 12% of over 25-year-olds felt anxious or distressed at the prospect and might even refuse examination. Most doctors predicted women would find pelvic examination unpleasant but tolerable.

Preferences for gender of the doctor, 20% of whom would only accept a female, 56% would prefer a female, 24% had no preference and 1% would prefer a male doctor. If the examining doctor was female, 11% of women would prefer a male doctor, 34% would rather not have a chaperone and 55% would have no preference. When the examining doctor was male, 62% of women would want a chaperone, 9% would prefer no chaperone and 29% did not mind.

Amongst providers, only 10% preferred the presence of a chaperone, most of these being males, who routinely used chaperones.

These results should be interpreted in light of the population studied; many women attend FPCs specifically to see a female doctor. Nevertheless these are important data to support the FFPRHC’s guidelines to offer but never impose a chaperone during intimate examination. They recommend all patients should be aware that they can request a chaperone if they wish.

References


Reviewed by Kate Weaver, MB ChB, MFFP

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Recent large randomised trials have made us re-evaluate the indications for hormone replacement therapy (HRT) and have increased interest in prescribing non-hormonal alternatives for menopausal symptoms. These two studies published in the same journal raise interesting concepts relating to menopausal symptoms.

The cross-sectional study by Whitman and colleagues suggests that lifestyle factors such as smoking and a high body mass index (BMI) may predispose a woman towards more severe or frequent hot flashes. Over 1000 US women aged between 40 and 60 years participated in a mailing survey entitled ‘Study of Women’s Health in Midlife’. Detailed hot flush and smoking histories were obtained together with extensive demographic information. BMI was calculated from self-reported height and weight at the time of the survey. Current smokers had 1.9 times the odds of never smokers for reporting moderate to severe hot flushes (95% CI 1.3–2.9). High BMI (>30 kg/m²) was also associated with an increased risk of moderate to severe vasomotor symptoms with an adjusted odds ratio of 2.1 (95% CI 1.5–3.0) compared to women with low BMI (<24 kg/m²). The cross-sectional nature of this study limits the conclusions that can be drawn and the authors emphasise the need for prospective studies in this field. However, smoking and high BMI are both potentially modifiable risk factors and this study may give the clinician some authority to persuade women to improve their general lifestyle.

Guttuso and colleagues evaluated the role of the anti-epileptic drug gabapentin, in the treatment of menopausal symptoms in a small, 12-week randomised trial. Gabapentin at a dose of 900 mg/day was associated with a 45% reduction in hot flush frequency and a 54% reduction in composite score (frequency and severity combined), compared with 29% and 31% reductions, respectively, for placebo. A total of 54 women completed the double-blind study, although four women (13%) withdrew from the gabapentin group and half the women in that group reported at least one adverse effect. Side effects included drowsiness and dizziness, although the authors claim these effects can be minimised by gradual titration of the initial dose. The mode of action of gabapentin in reducing hot flushes is unknown, although it is known to have an anxiolytic effect and the potentially sedative role may have reduced perception of night sweats. We need more agents to treat menopausal symptoms in women with contraindications to HRT or who feel that they have taken HRT in the long term and desire an effective alternative. Gabapentin shows good potential in this regard. Ongoing studies will provide further good quality clinical data and gabapentin should perhaps be used only with caution for this indication.

Reviewed by Aliska Gehrle, MRCOG, MFFP

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The authors, from Leeds, point out the important recommendation of the Royal College of Obstetricians and Gynaecologists (RCOG) that accurate, impartial, printed information would be used to support verbal advice to anyone contemplating a legal abortion (RCOG Evidence-Based Guidelines, No 7, 2000). They examined 44 leaflets that included advice regarding medical and/or surgical methods. These included leaflets from the three largest private abortion organisations in England and Wales together with leaflets provided by 41 National Health Service (NHS) hospitals. However, 16/60 providers contacted did not use leaflets at all. A total of 28/44 leaflets dealt with both surgical and medical methods. Each was assessed using a coding frame with points awarded for each item of information deemed relevant by the investigators. There seems to have been little attempt at scoring the leaflets according to the relative importance of each item.

The results were disappointing. Of the leaflets that discussed surgical methods, 60% scored above half the possible score for that method, and of those that discussed medical methods, 34% scored less than half the possible score. Of those that discussed abortion surgery, 25% scored less than half the possible score.

They also assessed the leaflets according to the Flesch Readability Ease scale. The results were as follows: 2% scored Difficult (equivalent to the Financial Times), 52% scored Easy Difficult (Daily Telegraph), 41% scored Standard (Daily Mail) and 5% scored Fairly Easy (Thin Man).

The authors comment that most of the leaflets contained incomplete information and were difficult to understand. They conclude that it is unlikely that the leaflets enabled women to make informed choices about their treatment options and/or prepare for subsequent procedures. Their main recommendation is that ‘abortion services should provide complete, accurate, relevant and unbiased written information about abortion method choices … this information should be informed by guidelines on the aims and timing of procedures of each abortion method and assessed for readability’.

These comments and recommendations serve to highlight the fact that it is particularly disappointing that many hospitals provide no leaflets. There is considerable room for improvement but how is this to be achieved? The construction of a leaflet to the high standards advocated in this paper is not at all easy. Probably the required expertise does not exist in every providing hospital or organisation. At present every provider who thinks of having a leaflet has to ‘invent the wheel again’? Would a nationally agreed leaflet be possible and desirable? Could the FPA provide such a leaflet?

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