The Pelvic Examination and Obtaining a Routine Papanicolaou Smear

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Procedure Goals and Objectives

**GOALS:** To perform a thorough pelvic examination (PVE) in a female patient in a manner that preserves the patient’s comfort while maximizing the likelihood of identifying abnormal findings and obtaining a sample for a Papanicolaou (Pap) smear.

**OBJECTIVES:** The student will be able to:

- Define the indications, contraindications, and rationale for performing a PVE.
- Describe the essential anatomy and physiology associated with the performance of a PVE.
- List the logical order of the steps used to perform a PVE.
- Describe normal and abnormal findings associated with a PVE.
- Understand the recommendations for obtaining a Pap smear.
- Understand the Bethesda System for interpretation of abnormal Pap smears.

Background and History

Many women dislike having a PVE performed. The lithotomy position makes some women feel vulnerable. This examination may invoke feelings of anxiety or embarrassment. It is the examiner’s responsibility to put the patient at ease while conveying the importance of the examination. The challenge is to make this experience educational, comfortable, and not to be feared in the future.

The PVE is an extension of the abdominal examination in the female patient. The Pap smear is one aspect of the PVE and was developed in the 1920s by Dr. George Nicolas Papanicolaou, an anatomist and cytologist in the United States. Dr. Papanicolaou identified characteristic cellular changes associated with cervical cancer. The original technology allowed for cytologic evaluation of cervical cells exfoliated from the female genital tract. Approximately 20 years elapsed before the technique named for him, the Papanicolaou smear, was accepted as a cancer screening procedure. The Pap smear was initially used to detect asymptomatic invasive cervical cancer; as time passed, the importance of preinvasive disease was recognized. The Pap smear remains a screening test. It does not provide a diagnosis. Current standard of care requires further workup of any abnormality found on a Pap smear. This workup typically includes a screening for human papillomavirus (HPV), a colposcopy, and a biopsy of cervical samples.

Indications

Epidemiologic data have shown Pap smear screening to decrease the incidence and mortality rate of cervical cancer. In the United States approximately 12,700 new cases...
of cervical cancer are reported per year, with an annual mortality rate of roughly 4300.4 American women have a 0.68% chance of developing cervical cancer in their lifetime. Death from cervical cancer has decreased from 3.49 per 100,000 in 1999 to 2.42 per 100,000 in 2007.8 Accurate sampling with the Pap smear is key to this reduction. Most cases of cervical cancer in the United States occur in women who do not get screened.3

Debate exists on recommended standards for obtaining a Pap smear, such as age to begin screening, frequently of screening, and age to cease screening. Guidelines are available from the U.S. Preventive Service Task Force, the American Society for Colposcopy and Cervical Pathology (ASCCP) and the American College of Obstetricians and Gynecologist (ACOG). The ACOG produced the most recent recommendations.1 These standards have significant changes from prior guidelines. Both ACOG and ASCCP recommend Pap screening beginning at age 21, regardless of sexual history, and sampling only every 2 years.

It is the responsibility of all providers to familiarize themselves with these new recommendations and help patients understand the change from the prior standard yearly Pap screening to which most woman have become accustomed. The ACOG recommendations are summarized in Box 18-1 and Table 18-1.

Factors thought to increase the risk for an abnormal Pap smear can be divided into two broad categories: those related to coitus and those related to nonsexual factors. Coitus-related factors include a young age at first intercourse, multiple sexual partners, sexually transmitted disease, and HPV infection. Nonsexual factors include tobacco smoking, illicit drug use, diet, oral contraceptive use, and a history of abnormal Pap smears. Although these factors may play a part, the presence of or exposure to HPV is now accepted as the leading risk factor for an abnormal smear and development of cervical cancer.10 HPV types 16 and 18 are thought to be the most oncogenic. The natural history of how HPV infection progresses to cancer is still poorly understood.

**CONTRAINDICATIONS**

There are no absolute contraindications to performing a routine PVE. Permission to perform the examination should be obtained.

**POTENTIAL COMPLICATIONS**

False-negative Pap smear results do occur. Common causes of a smear being interpreted as normal when the cervical epithelium is abnormal include the following:
- Sampling error because of poor technique or small, peripherally located lesions missed on sampling
- Lesions that do not shed cells well
- Interpretation error

The most publicized error is misinterpretation. Using the proper technique to obtain the Pap smear can significantly decrease the incidence of false-negative results resulting from sampling error. New technologies have been developed to decrease the false-negative rate from errors in interpretation. Other sources of Pap smear screening errors are failure of the clinician to understand or respond appropriately to Pap smear results or failure of the patient to follow the clinician’s recommendations.

**ESSENTIAL ANATOMY AND PHYSIOLOGY**

**EXTERNAL ANATOMY**

The vulva consists of the mons pubis, the labia majora, the labia minora, the clitoris, and the glandular structures that open into the vagina (Figure 18-1). The shape, size, and
The color of the structures vary among individual women and racial groups. Normal hair distribution is in the shape of an inverted triangle centered over the mons pubis. The labia majora are two mound-shaped structures composed primarily of adipose tissue originating at the mons pubis and terminating in the perineum. They form the lateral boundaries of the vulva. Underlying the skin is a poorly developed muscle.

**BOX 18-1 American College of Obstetricians and Gynecologists Guidelines on Screening for Cervical Cancer**

**The following recommendations are based on good and consistent scientific evidence (Level A):**

1. Cervical cancer screening should begin at age 21 years. Screening before age 21 should be avoided because it may lead to unnecessary and harmful evaluation and treatment in women at very low risk for cancer.

2. Cervical cytology screening is recommended every 2 years for women between the ages of 21 and 29 years.

3. Women aged 30 years and older who have had three consecutive negative cervical cytology screening test results and who have no history of cervical intraepithelial neoplasia (CIN) 2 or CIN 3, are not human immunodeficiency virus (HIV) infected, are not immunocompromised, and were not exposed to diethylstilbestrol in utero may extend the interval between cervical cytology examinations to every 3 years.

4. Both liquid-based and conventional methods of cervical cytology are acceptable for screening.

5. In women who have had a total hysterectomy for benign indications and have no prior history of high-grade CIN, routine cytology testing should be discontinued.

6. Co-testing using the combination of cytology plus human papillomavirus (HPV) deoxyribonucleic acid (DNA) testing is an appropriate screening test for women older than 30 years. Any low-risk woman aged 30 years or older who receives negative test results on both cervical cytology screening and HPV DNA testing should be rescreened no sooner than 3 years subsequently.

**The following recommendations are based primarily on consensus and expert opinion (Level C):**

1. Regardless of the frequency of cervical cytology screening, physicians also should inform their patients that annual gynecologic examinations may still be appropriate even if cervical cytology is not performed at each visit.

2. Women who have been immunized against HPV-16 and HPV-18 should be screened by the same regimen as nonimmunized women.
layer—the tunica dartos labialis. The labia majora contains numerous sweat glands. The internal and external pudendal arteries and a branch of the perineal artery provide the arterial blood supply to the labia majora. The venous drainage is extensive and provided primarily by the perineal, posterior labial, external pudendal, and saphenous veins. Lymphatic drainage occurs through two systems: one superficial and one deep within the subcutaneous tissue, primarily draining into the inguinal nodes.

The labia minora are two skin folds medial to the labia majora that begin at the base of the clitoris and extend posteriorly to the introitus. The arterial supply is from the superficial perineal artery. The venous drainage is to the perineal and vaginal veins. Lymphatics pass to the superficial and deep subinguinal nodes. The innervation is supplied from branches of the pudendal nerve, which originates from the perineal nerve.

The clitoris is the homologue of the dorsal aspect of the penis. The blood supply is rich, with the dorsal and pudendal arteries supplying arterial blood. Venous drainage consists of a rich plexus draining into the pudendal vein. The lymphatics coincide primarily with those of the labia minora. Innervation to the clitoris is from the terminal branch of the pudendal nerve. Nerve endings in the clitoris vary, from woman to woman, from total absence to a rich supply.

### TABLE 18-1
**Comparison of Screening Recommendation Guidelines for Cervical Cancer**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>ACOG and ASCCP</th>
<th>USPSTF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial screening age</td>
<td>21 years</td>
<td>3 years after onset of sexual activity or age 21 years</td>
</tr>
<tr>
<td>Screening frequency, ages 21-29 years</td>
<td>Every 2 years</td>
<td>At least every 3 years</td>
</tr>
<tr>
<td>Screening frequency, age ≥30 years</td>
<td>Every 3 years with prior consecutive negative test results and no high-risk comorbidities</td>
<td>After age 30 years with three consecutive negative test results; screen every 2-3 years</td>
</tr>
<tr>
<td>Screening after hysterectomy</td>
<td>Discontinue if TAH for benign reasons and no history for high-grade CIN</td>
<td>None after TAH if for benign condition</td>
</tr>
<tr>
<td>Screening discontinuation</td>
<td>Age 65-70 years if three normal Pap results within last 10 years</td>
<td>After age 65 years</td>
</tr>
<tr>
<td>Screening for HPV</td>
<td>Recommended for age ≥30 years</td>
<td>Insufficient evidence</td>
</tr>
</tbody>
</table>

ACOG, American College of Obstetricians and Gynecologists; ASCCP, American Society for Colposcopy and Cervical Pathology; CIN, cervical intraepithelial neoplasia; HPV, herpes papillomavirus; TAH, total abdominal hysterectomy; USPSTF, U.S. Preventive Services Task Force.

![FIGURE 18-1 External anatomy of the vulva.](image-url)
The vestibule is the space bordered by the labia minora and includes the entrance to the vaginal canal, or the introitus. The vaginal opening can be obscured by the hymenal ring or hymen. The hymen is a membrane that partially or wholly occludes the introitus. The shape and opening of the hymen can vary greatly (Figure 18-2), but only a completely imperforate hymen is pathologic. The arterial supply to the vestibule and hymen is from an extensive capillary plexus from the perineal artery. The venous drainage is also extensive and involves the same areas as the arterial network. The lymphatic drainage terminates in the superficial inguinal nodes and the external iliac chain. The urethra is positioned between the clitoris and the vaginal opening and is not difficult to visualize.

The Skene glands are posterior to the urethral orifice and are often difficult to locate. The Bartholin glands lie inferior and lateral to the posterior vestibule, are less superficial, and are usually not visible. The arterial supply and venous drainage is along the pudendal vessels. The lymphatics drain directly via the perineum into the inguinal area. The innervation of the Bartholin glands is a small branch of the perineal nerve.

**INTERNAL ANATOMY**

Figure 18-3 illustrates the female internal anatomy. The vagina is a muscular canal lined with mucosa or rugae and is approximately 7 cm long, extending from the uterus to the vestibule. It meets the cervix of the uterus at an angle of 45 to 90 degrees. The cervix projects into the upper portion of the anterior vaginal wall, thereby making the anterior vaginal wall slightly shorter than the posterior vaginal wall. The vaginal arterial supply is from the vaginal branch of the uterine artery, and the veins follow the course of the arteries. The lymphatics drain into the external iliac and inguinal nodes. Both sympathetic and parasympathetic nerves innervate the vagina. The perineum is the tissue between the vaginal opening and the anus.

The uterus is a pear-shaped, thick-walled muscular organ about 7 to 8 cm in length and 4 to 5 cm at its widest in the nonpregnant adult woman. It consists of three parts: the fundus, the body, and the cervix (Figure 18-4). The uterine cavity opens into the vagina below and into the fallopian tubes above. It is supported by ligamentous attachments to various pelvic structures, including the vagina. The cervix is the portion of the uterus that can be visualized during the PVE and is the structure sampled to obtain
The Pap smear. When viewed during the PVE, the cervix appears as a round bagel-like mound with a circular or slit type of opening that varies with parity (Figure 18-5) and leads to the endocervical canal.

The fallopian tubes extend from the lateral portions of the uterine fundus and terminate in a fringed, cone-shaped conduit that arches toward the ovaries (Figure 18-6). The ovaries are oval organs measuring about 2.5 to 5 cm in length, 1.5 to 3 cm in breadth, and 0.7 to 1.5 cm in width. The fimbriated ends of the fallopian tubes overhang the upper part of each ovary. The ovarian artery is the chief source of blood for the ovary, and the ovarian veins follow the course of the arteries. Lymphatic channels drain retroperitoneally to the lumbar lymph nodes. The lymphatic channels in the ovaries are extensive and
may provide additional fluid to the ovary during periods of preovulatory swelling. The ovaries produce ova and hormones, including estrogen and progesterone.

All the pelvic organs are supported within the lower abdominal cavity by a system of muscles, ligaments, and fascia.

**STANDARD PRECAUTIONS** Practitioners should use standard precautions at all times when interacting with patients. Determining the level of precaution necessary requires the practitioner to exercise clinical judgment based on the patient’s history and the potential for exposure to body fluids or aerosol-borne pathogens (for further discussion, see Chapter 2).

**PATIENT PREPARATION**

As noted previously, some women may be reluctant to have a PVE performed. If a patient has had several previous examinations, she knows what to expect. If this is her first, she has most likely heard about it from others. Your responsibility as the examiner is to explain what is ahead and provide education to decrease anxiety.
FIRST PELVIC EXAMINATION EXPERIENCE

This examination will set the tone for all that follow.
- Schedule enough time to allow a complete explanation of the PVE from beginning to completion.
- It is helpful to have a diagram or model of the female anatomy to aid the explanation.
- Have the actual equipment to be used on hand to show your patient. Explain all aspects of the PVE and the Pap smear.
- Show your patient, using your closed fist to simulate the cervix, how you will sample her cervical cells (Figure 18-7). Explain that relaxing her pelvic muscles eases the insertion of the speculum (again, demonstrate with your fist; see Figure 18-7).
- Allow and encourage your patient to ask questions.
- Explain terms she may have heard and been fearful about, such as: “blades,” “scraping,” and “stirrups.”
- Educate her about the lithotomy position: why it is necessary and how it allows visualization of the cervix.
- Offer opportunities that empower the patient, such as the semi-sitting position and a hand-held mirror if she desires to observe the examination and visualize her own anatomy while the examination is in progress.
- Assure your patient that this examination is indicated and that the PVE should not be painful. Tell her you will be gentle and that if she wants you to stop at any time during the examination, you will.
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THE RETURNING PATIENT

- Always ask the patient if she has any particular concerns about this examination.
- Reassure her that you will be gentle and that there should be no pain associated with the PVE.
- Assure her that she can ask questions at any time during the examination.
- Tell her to alert you immediately if she experiences any discomfort and you will stop and redirect your attempt.
- Explain every step of the examination as it unfolds.

CHAPERONE IN ATTENDANCE FOR ALL PATIENTS

Having a chaperone in attendance is mandatory for this examination. This is required even if the examiner is female. In addition to providing assistance with the examination, the presence of another member of the staff helps reduce the likelihood of a patient filing an unfounded accusation regarding inappropriate conduct of the clinician during the examination. Explain that the chaperone is in attendance to assist with any needs during the examination. Avoid statements such as “he (or she) is here to watch and observe.”

MATERIALS

THE VAGINAL SPECULUM

Several types of speculums are available (Figure 18-8):

- Pedersen speculum, metal and reusable: This type of speculum comes in short and long sizes. The Pederson speculum should be used if at all possible because it has a narrow blade and is more comfortable for most women.
- Graves speculum, metal and reusable: This speculum also comes in short and long sizes. The Graves has a duckbill-shaped blade and is a better choice for viewing the cervix if the patient is significantly overweight, has a lot of redundant skin surrounding the introitus, or has a severely retroverted uterus.
- Disposable speculum: This type of speculum is made of hard, clear plastic, usually has the Graves-type blades, and makes a loud click when locked into place. Warn patients about the upcoming click, and use great care not to pinch the patient’s surrounding skin on insertion.
Pediatric speculum: This speculum is useful for children and virginal or geriatric women. This speculum is also preferable when explaining a first PVE to a patient. Its small size reduces undue anxiety and fear of pain about the pending examination.

**NOTE:** It is all right to switch speculums during the examination if there is trouble viewing the cervix. Avoid comments such as “I have to get a bigger speculum.” Women may feel sensitive to implications that their anatomy is too large. Rather state, “I am having difficulty visualizing your cervix and I don’t want you to experience any discomfort, so I am going to change speculums to make this examination more comfortable for you.” Whichever speculum is chosen, be sure that you understand how to open it, insert it, and lock it into place before you begin.

Other equipment needed to complete the examination may include the following:

- Cytobrush (Figure 18-9)
- Wooden spatula (see Figure 18-9)
- Plastic broom (see Figure 18-9)
- Pap smear slide or vial of preservative solution
- Good light source
- Water-soluble lubricating jelly
- Gloves

**NOTE:** The choice of a wooden spatula, a cytobrush, or a plastic broom to collect samples is dictated by the sampling system available. The spatula or cytobrush is typically used with fixation of the specimen on a slide. The plastic broom is preferred for liquid-based preparation of the specimen.
PELVIC EXAMINATION AND OBTAINING CERVICAL CELLS

The examination itself is divided into three parts: inspection of the external genitalia; the internal examination, which includes obtaining the Pap smear; and the bimanual examination.

1. Before beginning the examination, have all your equipment ready and your chaperone in the room.
2. Extend the foot stirrups. Keep in mind the stirrups are often cold and uncomfortable. If possible, have the stirrups covered with a soft, warm material or allow the patient to keep her socks on. When prepared, ask the patient to lie back in the lithotomy position (hips flexed and abducted, feet in stirrups, and buttocks slightly beyond the edge of the examining table). Place a sheet as a drape over her. Most women will indicate if they prefer to be fully draped with the sheet to their knees blocking their view of the examination or if they prefer to be able to see you throughout the examination.

NOTE: Although most examiners have patients lie flat on the examining table, some women prefer to be in a semi-sitting position (Figure 18-10). The semi-sitting position works just as well for the examiner and makes some women feel more comfortable.

Be prepared to explain each step to the patient as it is being performed. Encourage her to ask any questions she may have. Continue to talk to her and monitor her status throughout the examination. If she tenses her abdomen or buttocks, ask her to relax them. Once the patient is as comfortable as possible, the examination of the external genitalia should begin.

External Examination

3. Don gloves and be seated comfortably on a rolling stool at the table end, adjust the light source, and begin inspecting the external genitalia.
4. First examine the mons pubis, labia, and perineum. Note the pubic hair for its pattern, any lice or nits, infected hair follicles, or any other abnormality, and then inspect for any lesions, erythema, swelling, nodules, or discharge on the skin.
5. Expose the clitoris, urethral orifice, and the vaginal opening by gently retracting the labia minora. Inspect for any cysts or other lesions. Inspect the area of the Bartholin glands. Normal Bartholin glands cannot be seen or felt.
6. If enlargement or redness is noted, or if indicated by symptoms, examine the Bartholin glands by inserting your index finger into the vagina and your thumb outside (Figure 18-11) and palpate the tissue between the internal and external fingers. Check for any discharge from the duct. If discharge is noted, a culture should be obtained using the appropriate medium.
7. Next, ask your patient to perform the Valsalva maneuver or bear down while you check for cystocele, rectocele, or uterine prolapse.

Internal Examination

8. Warm the previously selected vaginal speculum under running water. Water warms the instrument and acts as a lubricant to ease insertion. Other lubricants cannot be used because they may interfere with the cytologic studies.
9. A digital examination performed by inserting a finger into the vaginal canal helps locate the cervix (it has a consistency similar to the end of the nose). Insertion of the speculum can then be directed toward the cervix for easy visualization and comfort of the patient. This technique eliminates the
need to "search" for the cervix with the speculum, a maneuver that can be uncomfortable for the patient (Figure 18-12, A).

10. Once the blades are fully inserted, rotate the speculum to the appropriate angle and open blades to allow visualization of the cervix (see Figure 18-12, B). Avoid pressure on the more sensitive anterior wall, urethral orifice, or clitoris.

11. If there is still a problem locating the cervix, withdraw the speculum and reposition it (usually more posteriorly). Apply gentle pressure to the posterior vaginal wall and try again.

12. Avoid excessive movements of the speculum while searching for the cervix, because this can be uncomfortable.

13. Once the cervix is visualized, lock the speculum in place. Your hands are now free to obtain the Pap smear sample and any other needed cultures or samples.

14. Collecting the Pap smear sample—spatula: A wooden spatula can be used to obtain cells from the cervix and the vaginal wall (Figure 18-13). Studies show 30% to 80% sensitivity using the spatula to obtain samples.7

   ▪ Use the pointed or longer end of the spatula and insert it into the external cervical os.
   ▪ Apply mild pressure while turning the spatula 360 degrees to obtain cells from the squamous–columnar junction or the transformation zone.
   ▪ Use the opposite, rounded end of the spatula to sample cells from the vaginal wall.
   ▪ Apply the obtained cells to a slide by gently dragging the spatula with the samples from the external cervix and the vaginal wall down the slide.

15. Collecting the Pap smear sample—cytobrush: The cytobrush (see Figure 18-13) is used to obtain cells from the endocervical canal.

   ▪ Insert this brush into the cervical os until the bristles are no longer seen and turn two full revolutions.

   **NOTE:** Always warn the patient that this may induce uterine cramping and mild bleeding.

   ▪ Immediately place obtained cells on a slide by rotating the brush counterclockwise while moving the brush from left to right on the slide (Figure 18-14).

16. Collecting the Pap smear sample—plastic broom:

   ▪ Insert the long central bristles into the os until the lateral bristles bend against the ectocervix. Rotate the broom three to five times in both directions.
   ▪ Transfer the material onto a slide with a stroke of both sides of the broom placing the second stroke exactly over the first.
   ▪ Or if using a vial of preservative solution, place the entire broom tip into the solution and stir vigorously to transfer material.2 Then remove tip and discard broom or leave in solution based on laboratory preference.

17. Transfer cells collected from the Pap smear quickly to the appropriate transport medium:

   ▪ The object is to quickly but evenly spread the cellular material in a monolayer on the slide or into the vial of preservative solution.
   ▪ When using a slide, thin out large clumps of material as much as possible, while avoiding excessive manipulation, which can damage cells.
   ▪ Transfer material from both sampling instruments to the slide within a few seconds.
Lubricating jelly can be used during this portion of the examination because the cytologic samples have been procured.

18. After collecting the sample or samples, unlock the speculum and slowly withdraw the instrument while inspecting the vaginal wall for any abnormalities. Allow the speculum blades to close naturally as they are withdrawn.

19. Once the speculum is removed and the samples are preserved, proceed to the bimanual examination.

**Bimanual Examination**

20. Inform the patient that you are going to examine her uterus and ovaries. Tell her this includes a digital rectal examination.

**Lubricating jelly** can be used during this portion of the examination, because the cytologic samples have been procured. This lubricant makes this portion of the PVE more comfortable for your patient.

21. Push upward on the cervix with your internal fingers while pushing downward on the uterine area of the abdomen with the external hand. Palpate the uterine fundus as it rises toward your external fingers.

Continued
22. Then palpate the ovaries by moving the internal fingers to the right and left of the cervix while sweeping down on either side of the uterus with the external hand.

**NOTE:** Ovaries should be palpable in women until menopause. A palpable ovary in a post-menopausal woman needs further workup. Most women can tell when you palpate their ovaries and can offer feedback.

23. The rectovaginal examination is the final step in the PVE. Insert your index finger in the vagina and your middle finger in the rectum and repeat the maneuvers of the bimanual examination.

**NOTE:** This approach allows assessment of the retroverted uterus and the region behind the cervix.

24. The examination is complete. Remind your patient to push back on the table before trying to sit up. Provide your patient with a towelette to remove any excess lubricant used during the examination.
SPECIAL CONSIDERATIONS

Pediatric genital examinations, when necessary, often can be performed using the “frog leg” position (Figure 18-15). Special attention must be given to semantics and patient education when examining children. Keep in mind that most children have been taught not to allow anyone to touch their genitals.

In the geriatric population, frequency of PVE can often be decreased. Any posthysterectomy patient can receive less frequent examinations, varying from every 3 to 5 years. Some practitioners cease doing examinations altogether unless circumstance dictates. If the ovaries are still present, bimanual examination can still be important. Postmenopausal women often have dryer atrophic vaginas. This can make the PVE uncomfortable or painful. Care should be taken to use the smallest possible speculum and not tear the thin tissue.

FOLLOW-UP CARE AND INSTRUCTIONS

The patient should receive follow-up care and instructions as follows:

- Inform the patient of the results of the examination, taking care not to imply that everything is completely normal until all test results are received.
- Educate her about when to return for her next screening examination. If anything was noted on examination, explain the possibilities and what follow-up may be necessary.
- Let her know what correspondence to expect from your office and the time period within which to expect it. Specifically tell her how she will receive her Pap smear results (e.g., letter, phone call, report).
- Ask her to call the office requesting her results if she has not heard anything within the specified period.
Invasive cervical cancer most often occurs from lack of or inadequate PAP screening.

Patient education handouts explaining Pap smear results are helpful and should be sent home with the patient. These handouts may increase the patient’s understanding of Pap smears and increase compliance with the recommendations made based on the Pap smear results.

The PVE and the Pap smear are important parts of providing comprehensive well-woman care. Patient education and examiner sensitivity and competence increase compliance of the female patient in regard to this life-saving examination. For all examiners, competence and sensitivity toward the patient help make this examination repeatable for the patient and the next provider.

**INTERPRETATION OF THE PAP SMEAR**

The Bethesda System introduced in 1988 and updated in 2001 is used to interpret Pap smear findings.\(^6,9\) This system includes information on the following:

- Whether the Pap smear is an adequate sample
- Incidental findings, such as evidence of infection
- Evidence of lesions: Low-grade squamous intraepithelial lesion (LSIL), high-grade squamous intraepithelial lesion (HSIL), atypical squamous cells (ASC or ASC-US), atypical glandular cells or uncertain significance (AGC-US) (Box 18-2).

This system provides that the:

- Pap smear analysis is considered a medical consult.
- Pathologist is responsible for diagnosis and recommendations regarding follow-up.
- Referring health care provider provides history.
- Report must have a statement of adequacy.

Providers performing the PVE and obtaining Pap smears must understand how to interpret the results to avoid errors in interpretation from failure of the clinician to understand or respond appropriately to Pap smear results.
REFERENCES


BIBLIOGRAPHY


