Abdominal, Vaginal and Pelvic Assessment

- Abdominal palpation, vaginal examination and ultrasound imaging are the three main methods of determining fetal lie, presentation, size and position
- Abdominal palpation should precede every vaginal examination
- Obtain permission from the woman (verbal consent)

Abdominal examination[1, 2]

- Abdominal examination involves:
  - Visual assessment
  - Fundal assessment
  - Lateral assessment
  - Pelvic palpation
  - Auscultation
- Encourage the woman to empty her bladder before the examination
- Assist the woman into a comfortable position
- Perform hand hygiene
- Wait for time between contractions to palpate

Palpate the abdomen and determine[1, 2]

- Symphysis fundal height
- Lie
- Presentation
- Position
- Engagement
- Descent
- Fetal heart rate

* Refer to relevant midwifery standard

- Measured in fifths, engagement of the fetal head occurs when the biparietal diameter (on average 9.5 cm) has passed through the brim of the pelvis[1]

5 / 5 The whole head can be palpated above the brim of the pelvis
4 / 5 Four fifths of the fetal head can be palpated above the pelvic brim
3 / 5 Three fifths of the fetal head can be palpated above the pelvic brim
2 / 5 Two fifths of the fetal head can be palpated above the pelvic brim. The widest transverse diameter has passed through the brim of the pelvis and the fetal head is engaged
1 / 5 One fifth of the fetal head can be palpated above the pelvic brim

Symphysis fundal height (SFH) measurement[3]

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- SFH measurement must be taken from the top of the fundus to the fixed point at the upper edge of the pubic symphysis. Measure along the fetal axis, using a non-elastic tape measure. The centimetre side of the tape should be face down
- Serial measurement of fundal height and plotting on a growth chart is a useful screening tool and is recommended

Vaginal examination

- The woman should be given the opportunity to ask for and have a chaperone[6]
- Health care workers also have the right to request a chaperone[6]
- Explain to the woman the rationale for vaginal examination, what is involved, what she can expect to feel and how long it may take
- Gain verbal consent
- Reassure the woman that you will immediately discontinue the examination at her request
- Maintain privacy and dignity for the woman
- Perform hand hygiene and put on gloves
- Apply lubricant to fingers (use either a water based lubricating jelly or obstetric care lotion such as chlorhexidine gluconate 1%)

External inspection

Inspect the external genitalia, noting:

- Blood loss
- Evidence of ruptured membranes - amniotic fluid and colour
- Discharge – amount, colour, odour
- Lesions on the perineum
- Oedema
- Varicosities
- Scarring or evidence of female genital mutilation (FGM). Record the type *(for further information refer to the PPG 'female genital mutilation')*

If spontaneous rupture of the membranes (SROM) is suspected

- Speculum examination
  - Nitrazine stick (Amnistix)
  - Test for ferning of amniotic fluid, under microscope
- If SROM is obvious enough, these are not necessary

Process

- With the non-examining hand, separate the labia and gently insert lubricated fingers into the vagina
- Throughout the examination, the clinician should remain alert to verbal and non-verbal indications of distress from the woman. Any request for the examination to be discontinued should be respected[6]

Vagina

Assess:

- If any presence of vaginismus

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- Vaginal dryness or excessive heat

Examination of the cervix

Locate the cervix and:

- Determine position (posterior, mid-position, or anterior)
- Length in centimetres
- Consistency (firm, average, soft)
- Dilatation in centimetres
- Record Bishop score if required (see Modified Bishop score table below)

Presenting part

Determine what the presenting part is and:

- Application of the presenting part to the cervix
- Position
- Caput
- Moulding
- Station relative to the ischial spines
- Membranes – intact or ruptured, bulging forewaters or well applied to the head

Pelvis

- Assess the pelvis by palpating the ischial spines and assessing for undue prominence
- Note the angle of the subpubic arch while withdrawing the fingers

Pelvic assessment

- Pelvic assessment is of clinical value in situations where the presenting part is not engaged

Assess

- Sacral promontory (not normally reached)
- Sacral curve
- Sacrospinous and sacrotuberous ligaments (breadth)
- Ischial spines (prominence)
- Subpubic angle (should be 90˚ or more)
- Antero-posterior diameter of outlet
- Intertuberous diameter (assess with closed fist on perineum)

Best practice notes

- Ensure the distance of the presenting part above the ischial spines is expressed in centimetres
- Do not estimate the station in relation to a caput succedaneum, when present. Relate only the bony part of the fetal head to the ischial spines

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- Prominent ischial spines and a reduced subpubic angle may indicate an android pelvis

Modified Bishop cervical score system5

Characteristic	0	1	2	3	Score
Dilatation (cm)	< 1	1-2	2-4	> 4	
Length (cm)	> 4	2-4	1-2	< 1	
Consistency	firm	average	soft	-	
Position of cervix	posterior	middle / anterior	-	-	
Station	-3	-2	-1 to 0	+1 to +2	Total

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Abbreviations

cm	Centimetre(s)
e.g.	For example
°	Degree(s)
SFH	Symphysis fundal height
SROM	Spontaneous rupture of membranes

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