EXCELLENCE MATTERS

INTRODUCTION TO PELVIC OBSTETRIC AND GYNAECOLOGY PHYSIOTHERAPY

An Educational Resource

Published by the Pelvic, Obstetric and Gynaecology Physiotherapy
Contact: POGP Administration, Fitwise Management Ltd., Drumcross Hall, Bathgate, West Lothian EH48 4JT T: 01506 811077 E: info@fitwise.co.uk or visit the POGP website www.pogp.org.uk for further information.

Contents

Introduction

It is acknowledged that physiotherapists may become involved in the management of pelvic, obstetric and gynaecology patients with differing expertise; diverse skills and varying access to learning support. This aim of this handbook is to guide the learning of physiotherapists to extend knowledge and skills within this speciality.

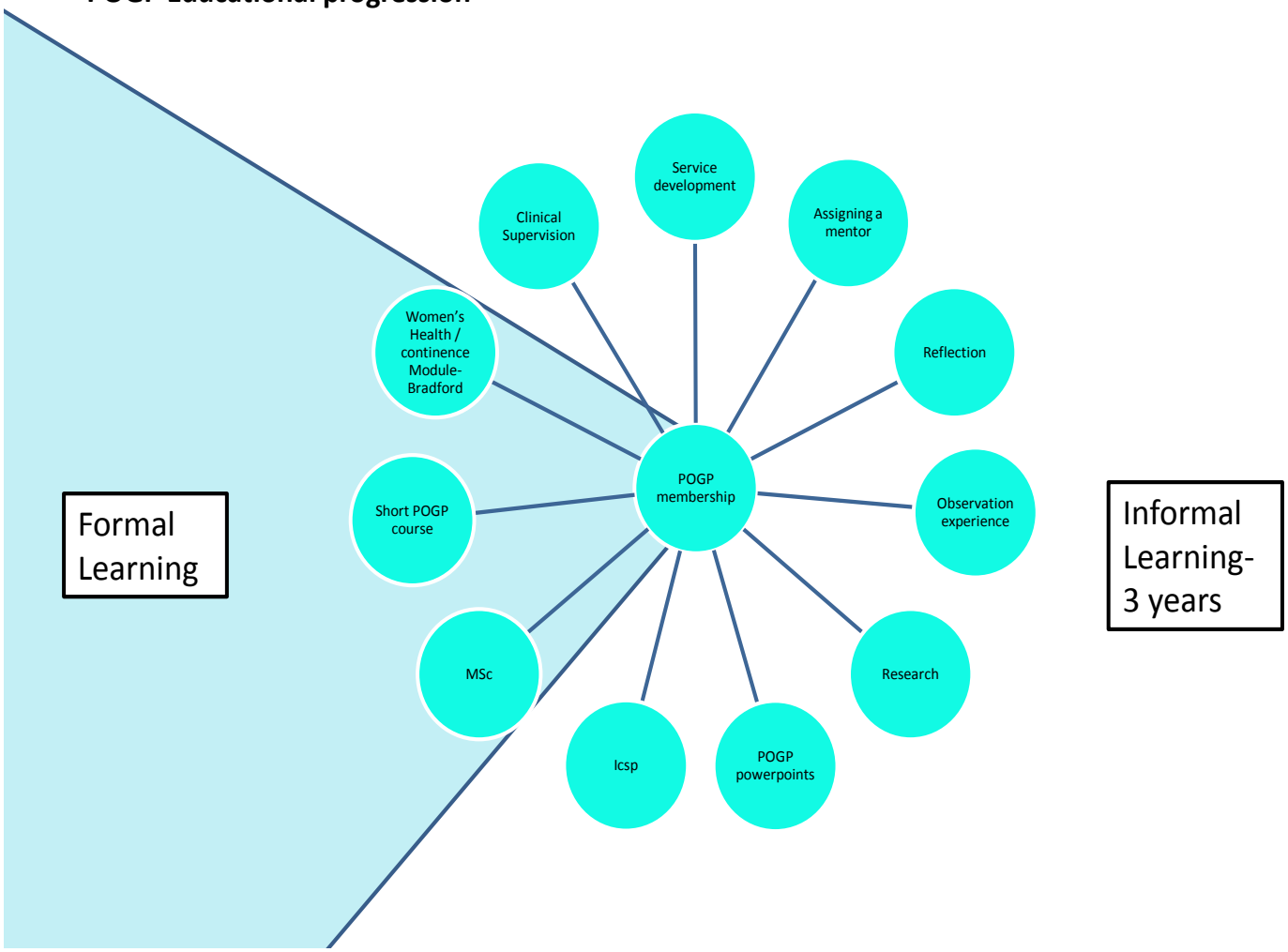
This handbook covers all aspects of the expanding role of the physiotherapist within this specialist area. You can select areas that are relevant to your current practise.

The handbook is divided into sections; it identifies learning objectives for each sub specialism that maybe included within your scope of practice. It has references to relevant research material; patient information and course details that you can access.

As an associate member of POGP we hope you find this resource valuable in validating your continued professional development and hope that you are aiming to become a member. There are four ways to achieve membership pogp.csp.org.uk- membership

Suggested POGP education routes

POGP Educational progression



Core Skill Framework

1. Understand normal posture and muscle function
2. Consider the application of general exercise physiology to the pelvic floor muscles.
3. Consider the different exercise methods such as Core stability, MSK techniques, Pilates and hydrotherapy
4. Understanding the roles of the MDT in your specific area
5. Demonstrate an understanding of cultural, social, ethnic and religious variation needs and adapt professional interaction to facilitate care
6. Demonstrate appropriate skills in communication in varying environments with particular attention to gaining informed, valid consent; the use of a chaperone and motivating patients to be compliant.
7. Demonstrate professional behaviour skills in empathy and sensitivity especially where problems maybe regarding bereavement or of a personal, social or intimate nature knowing who to refer to if further expertise is required.
8. Apply skills in accurate record keeping maintaining confidentiality
9. Understand the role of the physiotherapist in preventative care

Available Learning Resources

Websites

www.pogp.csp.org.uk

www.nice.org.uk

www.rcog.org.uk

Suggested reading

pogp.csp.org.uk _ The Role of the Women's Health Physiotherapist

Journal of the Association of Chartered Physiotherapists in Women's Health (ISSN 1367-7845)

Royal College of Obstetricians and Gynaecologists (RCOG) Guidelines

Courses

- University of Bradford PG Cert: Physiotherapy in Women's health
- University of Bradford PG Cert: Continence for Physiotherapists

Obstetrics

Obstetrics is the field of medicine that deals with pregnancy, delivery of the baby and the first six weeks after delivery. The role of the physiotherapist may vary considerably in obstetrics from face to face contacts; triage; parentcraft classes, hydrotherapy in inpatient and outpatient environments.

Learning objectives:

1. Understand normal posture and muscle function
2. Investigate the physiological and physical changes that occur in pregnancy; delivery and in the year following childbirth
3. Investigate the reasons which contribute to musculoskeletal dysfunction in obstetrics
4. Consider the effects of different exercise methods in pregnancy such as Pilates, hydrotherapy
5. Knowledge of red flags that may affect patients care- pre eclampsia, placenta previa
6. Select appropriate assessment and examination techniques for the musculoskeletal system and apply clinical reasoning skills to direct intervention
7. Develop and adapt therapeutic management skills including appropriate musculoskeletal techniques
8. Develop insight into the effects of obesity in the pregnant women on her health and the health of the unborn child. How can physiotherapists be proactive in the management of maternal obesity.

Antenatal period

- Consider the health promotion aspect of care to antenatal women especially to women with elevated body mass index and those with pre-existing musculoskeletal dysfunction.
- Investigate methods of educating women in the antenatal period including face to face, patient information leaflets and internet resources.
- Investigate the role of the "core muscles" in maintaining posture and function in the antenatal period.
- Review the factors which may contribute to pregnancy related low back pain and Pelvic Girdle Pain.
- Investigate common musculoskeletal conditions that are managed by physiotherapists including carpal tunnel syndrome and rib flare
- Explore the differential diagnosis of musculoskeletal pain such as avascular necrosis and metastatic spinal disease and complications of pregnancy that influence care.
- Evaluate the ways physiotherapy treatment may be provided such as telephone triage, classes, hydrotherapy etc.
- Investigate the role of physiotherapy in preparation for childbirth including positioning, relaxation techniques and pain management.
- Investigate bladder and bowel management in pregnancy
- Consider how you may develop services for antenatal women
- Review the Patient Information literature available to women in the antenatal period.

Available Learning Resources

Leaflets available through pogp.csp.org.uk

Fit for pregnancy

Fit and safe, for physiotherapists: Exercises in the Childbearing year

Fit for birth

Pregnancy related Pelvic Girdle pain (PGP) – for health Professionals

Pilates in women's health physiotherapy

The Mitchell method of simple relaxation

Aquanatal Guidelines: guidance on antenatal and postnatal exercises in water

ACPWH guidance on the safe use of transcutaneous electrical nerve stimulation (TENS) for musculoskeletal pain during pregnancy

Exercise and advice after the loss of your baby

Fit for the future

Suggested reading

Mantle J, Haslam J, Barton S (2004) Physiotherapy in Obstetrics and Gynaecology 2Ed

Vleeming A, Albert H.B, Ostgaard H.C, Sturesson B, Stuge B.2008 European Guidelines for the diagnosis and treatment of pelvic girdle pain. European Spinal Journal 17(6):794-819

Delivery

- Understand the progress of normal labour and recognise deviations from the normal and how this would need to be managed in the postnatal period.
- Identify the risks associated with delivery and how these can be prevented

Postnatal period

- Consider appropriate advice that would benefit all women in the postnatal period and how this should be conveyed to include those women who have experienced the death of a baby.
- How would this information need to be modified for women who had experienced a complicated delivery
- Recognise pelvic muscle trauma and post-partum bladder and bowel dysfunction and devise appropriate management plans
- Identify what musculoskeletal dysfunction can occur as a result of the antenatal period or delivery
- Investigate the methods by which you may manage women with musculoskeletal dysfunction in the post natal period such as Diastasis Rectus Abdominis and coccydynia

POGP workshops

Physiotherapy assessment and management of pregnancy related musculoskeletal conditions

The unique role of the women's health physiotherapist in antenatal care

Methods of enhanced learning- Suggested observations

- Antenatal clinic
- Antenatal ward
- Community midwife
- Ultrasound department
- Midwife classes
- Physiotherapy classes

- Physiotherapy assessment and treatment of musculoskeletal pain including carpal tunnel syndrome
- Early antenatal session
- Aquanatal class
- Full course parentcraft
- Partner's/companion's session(s)
- Young (teenage) class
- Refresher/multiparae class
- Pre-operative preparation for caesarean section
- Use of pelvic support belts
- TENS
- Witness normal delivery/ waterbirth/ repair of third degree tear/ forceps delivery/ ventouse delivery/ multiple delivery/ suturing of perineum/ caesarean section
- Postnatal ward
- Postnatal group
- Assessment and treatment of pregnancy related problems : Perineal oedema/bruising/haematoma/ Third or fourth degree tear/ Haemorrhoids/ Wound infection/delayed healing/ Urinary/defaecation problems/ Low back and pelvic girdle pain/ Coccygeal pain/ Divarificaton of rectus abdominus

Urology, gynaecology and colorectal services

The areas of paediatric continence; urology; gynaecology; urogynaecology and colorectal physiotherapy exist in many diverse settings but are often interlinked.

Learning objectives:

1. Understand normal bladder and bowel function and how this is maintained in the healthy adult
2. Identify the factors that may contribute to urological, gynaecological and or colorectal dysfunction
3. Investigate the physiological and physical dysfunctions of the urological, gynaecology and colorectal systems including incontinence; sexual function, pain and prolapse
4. Understand the physiology and muscle function of the pelvic floor and associated structures
5. Assess relevant subjective and objective information
6. Investigate how pelvic floor dysfunction is managed including exercise; lifestyle advice; group therapy and electrotherapy/ biofeedback
7. Investigate the role of the physiotherapist when a patient is admitted for surgical management of urological, gynaecology and colorectal problems

Paediatric continence

- Identify factors which may contribute to childhood incontinence.
- Identify the common paediatric bladder and bowel dysfunctions
- Consider the health promotion aspect of care to children with long term conditions that affect bladder dysfunction such as cystic fibrosis.
- Evaluate methods of treating children with bladder dysfunction including face to face; patient information leaflets and internet resources.
- Investigate the role of the pelvic floor and abdominal muscles in maintaining posture and bladder function.
- Review the Patient Information literature available to children with incontinence.
- Investigate the value of using medication in childhood incontinence

Female Urinary Continence

- Identify factors which may contribute to female urinary incontinence.
- Identify the common female urinary dysfunctions
- Consider the health promotion aspect of care to women in the

POGP.csp.org.uk- leaflets

Personal training for your pelvic floor

Fit following surgery: advice and exercise following major gynaecology surgery

Pilates in Women's Health Physiotherapy

Pelvic floor Muscle Exercises (for Men)

Pelvic floor Muscle Exercises (for Women)

Promoting Continence with physiotherapy

Do you have a problem with your bladder or pelvic floor?

antenatal and postnatal period and with long term conditions that affect bladder function such as neurological conditions, bronchiectasis and diabetes.

- Investigate the role of the pelvic floor and abdominal muscles in maintaining posture and bladder function.

- Evaluate methods of educating women with bladder dysfunction including face to face; group therapy; patient information leaflets and internet resources.

- Review the Patient Information literature available to women with incontinence.

- Investigate the value of using medication in female urinary incontinence

- Investigate the surgical management of urinary incontinence in women

- Identify appropriate advice and exercises to be given to women in the pre/post-operative period

Menopause

- Identify the biochemical and metabolic changes that occur in the perimenopause; menopause and postmenopausal periods

- Identify how health education can assist women in the menopause

- Investigate the beneficial effects of

Suggested reading

POGP statement re: ES for women with recent abnormal cervical cytology

Haylen B. T, De Ridder d, Freeman R.M, Swift S.E, Berghmans B, Lee J, Monga A, Petri E, Rizk D.E, Sand P.K, Schaer G.N 2009 An International Urogynaecological Association/ International Continence Society Joint Report on the Terminology for Female Pelvic Floor Dysfunction. Neurology and Urodynamics. 29:4-20

CSP Information paper –PD092-Pelvic floor examination-CSP expectations

CSP Information paper-PD104 ERUS-IP 24 Chaperoning and related Issues

European Association of Urology 2012. Pelvic floor function and chronic pelvic pain; Guidelines on chronic pelvic pain

Urinary Incontinence: the management of urinary Incontinence in Women-Updated NICE guideline. Clinical guidelines, CG171. September 2013

exercise and the types of exercise for women in the menopause

- Investigate the beneficial effects of acupuncture to menopausal women

- Investigate the use of medication in managing menopausal symptoms

Vaginal Prolapse

- Identify factors which may contribute to developing vaginal prolapse in women.

- Identify the types and classification of prolapse.

- Investigate the symptoms of prolapse.

- Consider the health promotion to women regarding constipation; heavy lifting and a caring role.

- Investigate the role of the pelvic floor and abdominal muscles in managing the symptoms of prolapse.

- Assess and provide pelvic floor muscle exercises to women with prolapse.

- Evaluate methods of educating women with lifestyle advice, pelvic floor and posture advice including face to face; group therapy; patient information leaflets and internet resources.

Appendices
Advanced clinical objectives for performing internal examinations

POGP workshops
Physiotherapy assessment and management of female urinary dysfunction
Understanding pelvic organ prolapse- assessment and conservative management
Physiotherapy and management of anorectal dysfunction

Resources
Icsp- assessment forms

Blogs/ Twitter/ Facebook
POGP/ Sandy Hilton/ Sue Croft/ Jessica Drumond/ Fiona Rogers/ Jo Milos/ Tracey Sher/ Jane Appleyard/ Alyssa Tait/ Ramona Horton/ Diane Lee/ Sherrie Palm/ Teresa Costello/ Julie Wiebe/ Michelle Lyons

- Review the Patient Information literature available to women with prolapse.

- Investigate the value of using pessaries and medication in prolapse

- Investigate the surgical management of prolapse in women

- Identify appropriate advice and exercises to be given to women in the pre/post-operative period

Male Urinary Continence

- Review the male urogenital system

- Identify the common male continence dysfunctions and the factors that contribute to its development

- Consider health promotion to men

- Investigate the role of the pelvic floor in male bladder and erectile function.

- Evaluate methods of educating men with bladder and erectile dysfunction including face to face; group therapy; patient information leaflets and internet resources.

- Review the Patient Information literature available to men with pelvic floor dysfunction.

- Investigate the value of using medication in male urinary

incontinence and erectile dysfunction

- Investigate the role of physiotherapy in the surgical management of prostate dysfunction

- Investigate the role of physiotherapy in overactive pelvic floor function

Bowel Continence

- Identify normal anatomy and physiology in normal bowel function including storage and defecation

- Consider the health promotion of bowel function.

- Investigate the reasons and contributing factors for altered bowel function such as slow transit, constipation, irritable bowel syndrome

- Identify the common bowel dysfunctions

- Evaluate the assessment of pelvic floor function related to anorectal structures

- Investigate the role of the pelvic floor in maintaining bowel function and use of techniques such as biofeedback.

- Evaluate methods of educating patients with bowel dysfunction including face to face; group

therapy; patient information leaflets and internet resources.

- Review the Patient Information literature available to patients with bowel incontinence.
- Investigate the value of using medication in bowel incontinence
- Investigate the role of the MDT in managing bowel incontinence

Chronic pelvic pain

- Identify musculoskeletal factors that may contribute to chronic pelvic pain including pudendal nerve neuropathy
- Define Vaginismus and Vulvodynia
- Reflect on approaches to persistent pain management
- Investigate theories for improved patient education
- Investigate methods of managing CPP including downtraining the pelvic floor; acupuncture; biofeedback; relaxation; Neurostimulation and injection
- Surgical management of CPP

Suggested Reading

Chronic Pelvic Pain and Dysfunction: Practical Physical Medicine. Leon Chaitow L, Jones R January 2012

Heal Pelvic Pain. Stein A. September 2008

RCOG Chronic Pelvic Pain, Initial Management (Green-top Guideline No. 41 May 2012

Engeler D, Baranowski AP, Elneil S, Hughes J, Messelink EJ, Oliveira P, van Ophoven A, de C. Williams A Guidelines on Chronic Pelvic Pain. February 2012

Methods of enhanced learning

Suggested observations

Inpatients

- Observation in theatre: *Total abdominal hysterectomy; Vaginal hysterectomy; Pelvic floor repair; Urethral sling procedure; fistula repair; TURP*
- Pre-operative/pre-admission session
- Post-operative care

Outpatients:

- Urology/ Gynaecology clinic
- Urodynamics
- Continence adviser
- Nurse specialist
- Vulvodynia clinic
- Specialist Paediatric continence services
- Bladder retraining
- Vaginal examination
- Anorectal examination;
- Treatment modalities including: *Lifestyle advice; Pelvic floor exercises; Posture re-education; Biofeedback; Neuromuscular stimulation; Manual Therapy; Devices e.g cones*
- Group therapy
- Pessary clinic

Breast Oncology

Learning objectives:

1. Investigate the lymphatic system
2. Understand breast cancer pathogenesis
3. Investigate the treatment of breast cancer to include surgical, radiological and chemotherapy
4. Identify the physiotherapy role in the management of patients in the surgical, radiological and chemotherapy environments to include manual therapy and exercise and identify the clinical considerations of care such as pain and fatigue
5. Investigate reducing oedema and fibrosis following medical management of breast cancer

Breast surgery

Observe the procedures used in breast cancer and reconstructive surgery

Explore the role of the physiotherapist within the surgical Multidisciplinary team

Discover the psychosocial impact of breast cancer and its treatment

Identify the non-musculoskeletal and musculoskeletal complications after surgery

Identify the primary and secondary induced health problems associated with chemotherapy; radiotherapy and hormone therapy

Investigate lymphoedema and its management through exercise, pressure garments and complex decongestive therapy

Explore how pain and cancer related fatigue may be managed via medication, physiotherapy and complimentary therapies

Explore safe exercises and what is the long term role of the physiotherapist in facilitating return to daily living activities and work

Identify the outcome measures that can be used to evaluate impact of care

Suggested Reading

Association Oncoplastic breast surgery –A guide to good practice

NICE guideline CG80 Early and advanced breast cancer diagnosis and treatment 2012

Neely ML, Campbell KL , Rowe BH, Klassen TP, Mackey JR, Courneya KS. Effects of exercise on breast cancer patients and survivours: a systematic review and meta analysis. CMAJ 2006: 175:34-41

Markes M, Brockow T, Resch KL, Exercise for women receiving adjuvant therapy for breast cancer. Cochrane database Syst rev 2006 Oct 18; (4): CD005001

Goomide LB, Matheus JP, Candidodos Reis FJ. Morbidity after breast cancer treatment and physiotherapeutic performance. Int J Clin Pract 2007; 61: 972-82

Broderick JM, Guinan E, O'Donnell DM, Hussey J, Tyrell E, Normand C. Calculating the costs of an 8-week, physiotherapy-led exercise intervention in deconditioned cancer survivors in the early survivorship period (the PEACH trial). Physiotherapy 2014; 100 182-184

Appendix 1: Obstetric abbreviations

AID Artificial insemination with donor's semen
AIH Artificial insemination with husband's semen
AN Ante natal
ANC Ante natal Clinic
APH Antepartum haemorrhage
ARM Artificial rupture of membranes
BBA Born before arrival (at hospital)
BKFO Bent knee fall out
Ceph Cephalic
CCT Continuous cord traction
CPD Cephalo pelvic disproportion
CTG Cardiotocograph
DRAM /RAD/DRA Divarication rectus abdominis
EAS External anal sphincter
ECV External cephalic version
EDD Expected date of delivery
EL LSCS Elective lower segment caesarean section
EM LSCS Emergency lower segment caesarean section
ERPC Evacuation of retained products of conception
EPAU Early Pregnancy Assessment Unit
FD Forceps delivery
FHH(R) Fetal heart heard (regularly)
FM Fetal Movements
GA General Anaesthetic
GIFT Gamete intra fallopian transfer
G Gravida (no. of pregnancies)
IAS Internal anal sphincter
IDDM Insulin dependent diabetes mellitus
IOL Induction of labour
IUCD Intrauterine contraceptive device
IUD Intrauterine death
IUGR Intrauterine growth retardation
IVF In vitro fertilisation
K(R) FD Kiellands (rotation) forceps delivery
LBW Low birth weight
MROP Manual removal of placenta
NBFD Neville Barnes (Barnes-Neville's) forceps delivery
N(V)D Normal vaginal delivery
NE Not engaged
NICU Neonatal intensive care unit
NND Neonatal death
NNU Neonatal unit
NICU Neonatal Intensive Care Unit
OA Occiput anterior
OASIS Obstetric anal sphincter exercises
OP Occiput posterior
P Parity – number of live births over 20/40
PGP Pregnancy – related pelvic girdle pain
PIH Pregnancy induced hypertension
PN Post-natal
POP Persistent occipito posterior
PP Posterior presentation
PPH Postpartum haemorrhage
Primip Primiparous
PROM Prolonged rupture of membranes
PAIVMS Passive accessory intervertebral movements
PAWS Pregnancy and Wellbeing service
PET Pre-eclamptic toxaemia
PFME'S Pelvic Floor Muscle Exercises
SB Stillbirth/Stillborn
SCBU Special Care Baby Unit
SIDS Sudden Infant Death Syndrome
SPD Symphysis pubis dysfunction
SR (O) M Spontaneous rupture of membranes
SRM Spontaneous rupture of membranes
SVD Spontaneous vertex delivery
UTI Urinary tract infection
V (V) E Ventouse (vacuum) extraction
VABC Vaginal birth after caesarean
WFD Wrigley's forceps delivery

Appendix 2: Obstetric terminology

Abortion-Death of the foetus before the 24th week of pregnancy; the same as miscarriage.
After pains-Painful uterine contractions occurring during the puerperium.
Amenorrhea-Absence of menstrual flow.
Amnion-The tougher inner membrane enclosing the foetus in utero.
Android pelvis-Type of pelvis which has features that render it less well adapted for childbearing than gynaecoid pelvis.
Antenatal-Before birth, that is, during pregnancy.
Antepartum haemorrhage (APH)-Bleeding from or into the genital tract between the 24th week of pregnancy and the birth of the baby; there are **3 types**:
Revealed – bleeding which can be seen per vagina (PV);
Concealed – bleeding in utero not seen per vagina; Mixed – both.
Causes Placenta praevia: where part of the placenta lies in front of the foetus. This could be revealed or concealed. Placental abruption: separation of placenta, or part of the placenta, from the uterine wall. This could be revealed or concealed. Cervical/vaginal bleeding: bleeding from cervix or vagina caused by polyp, carcinoma or post coitus (after intercourse).
Anterior fontanel-Large 'soft spot' at front of skull
Antibody-A protein made by the body in response to a foreign substance entering the circulation, e.g.
Rhesus antibodies.
Anti-D-Gamma globulin that is rhesus antibodies given to rhesus negative mothers after delivery to prevent rhesus antibody formation; it confers short-term passive immunity.
Apgar score-A method of evaluating the condition of the new-born infant, considering 5 points: heartbeat/ respiration**/** colour**/** muscle tone**/** response to stimulus and giving a score of 0, 1 or 2 to each point at 1, 5 and 10 minutes after the birth.
Areola-The pigmented area of the breast surrounding and including the nipple.
Asphyxia-When the foetus fails to breathe properly at birth, although there is a heartbeat present.
Attitude-The relationship of the foetal limbs and head to the trunk, namely flexed or extended, flexed being the normal.
Augmentation-Acceleration or re-establishment of labour at any stage when contractions have weakened or stopped altogether, eg by oxytocin.
Biparietal diameter-The widest, therefore the most important, diameter of the foetal skull between the two parietal eminences, usually 9.5cm.
Breech presentation-A foetus with the buttocks instead of the head in the lower pole of the uterus so that they will emerge first at delivery; may present as extended or footling.
Caesarean hysterectomy-A hysterectomy performed at the time of caesarean section.
Caput succedaneum-Oedema of the presenting part formed during labour and after rupture of the membrane.
Cephalhaematoma-An effusion of blood beneath the periosteum of one of the bones in the skull vault, commonly the parietal bone.
Cephalic-Pertaining to the head. E.g. cephalic presentation.
Cephalopelvic disproportion
A discrepancy in size between the foetal head and the mother's pelvis.
Cervix-The lowest part of the uterus, which inserts into the upper anterior wall of the vagina, is canal shaped and connects the uterine cavity and vagina.

Chorion-The outer of the two membranes enclosing the foetus in the uterus; it is continuous with the placenta.
Colostrum-Highly nutritious cloudy fluid secreted by the breasts prior to lactation.
Conception-Fusion of the male and female gametes.
Cord, umbilical-Structure connecting foetus and placenta in utero which carries the blood vessels; one vein and two arteries.
Corpus luteum-The yellowish mass of cells in the ovary which proliferate and secrete oestrogen and progesterone.
Crowning-The point during delivery when the biparietal and sub-occipito bregmatic diameters are born; extension of the head then begins.
Decidua-The specialised endometrium of pregnancy.
Deep transverse arrest-Arrest of the foetal head with the sagittal suture in the transverse diameter of the outlet of the pelvis, usually associated with prominent ischial spines.
Denominator-A fixed point on the foetus, e.g. the occiput, which is compared to a fixed point on the maternal pelvis to indicate the position of the foetus in utero, e.g. right occipito anterior.
Descent-The downward movement of the foetus through the birth canal during labour.
Dilation or dilatation-The opening of the external os of the cervix.
Divarication rectus abdominis-Separation or diastasis of the two rectus abdominis muscles.
Döderlein's bacillus-An organism (also known as lactobacillus) which normally inhabits the vagina and produces lactic acid from the breakdown of glycogen; this creates in the vagina an acid medium which is bactericidal.
Dystocia-Difficult or abnormal labour.
Ectopic pregnancy-A pregnancy occurring outside the uterus that is in the fallopian tubes or abdominal cavity.
Effacement or taking-up of the cervix-Shortening of the cervix as it is drawn up into the lower uterine segment as labour begins; not to be confused with dilation of the cervix.
Embryo-The fertilised ovum for the first eight weeks of intrauterine life; after this time it is termed a foetus.
Endometrium-The lining mucosa of the uterine cavity.
Engagement of the head-When the widest diameter of the foetal skull, that is the bi parietal diameter, has passed through the brim of the pelvis.
Engorgement-Engorgement of the breasts is a painful condition where the breasts are over distended with milk.
Entonox ('gas and air')-A mixture of 50% nitrous oxide with 50% oxygen which is used as inhalational analgesia in labour.
Epidural-Outside the dura mater of the spinal cord; the location for regional analgesia in labour in the first stage especially, that is epidural block.
Episiotomy-Incision of the perineum to aid delivery.
Ergometrine-An oxytocic drug which specifically causes the uterus to contract after delivery in order to prevent excessive bleeding.
Face presentation Where the head is presenting but in a completely extended state instead of the normal such as complete flexion.
Flexion-A bending movement and the normal attitude for the foetus in utero.
Foetus-The unborn child in utero from eight weeks of pregnancy until birth.

Forceps-The obstetric forceps for assisting delivery of the baby in the second stage of labour. Types in common use are: Neville Barnes (Barnes-Neville's), Wrigley's, Kielland's for rotation of the occiput before delivery.
Forewaters-The bag of membranes and liquor lying in front of the presenting part in utero.
Gestation-Length of pregnancy, in humans approximately 9 months, or 280 days.
Gonad-A sex gland, namely ovary or testis.
Gonadotrophin-A substance which acts on a gonad, e.g. chorionic gonadotrophin.
Gravid-Pregnant; a primigravida is a woman who is pregnant for the first time.
Gravida-The number of times a woman has been pregnant
Guthrie test-A blood test carried out on day 7-8 of life to detect phenylketonuria.
Gynaecoid pelvis-Typical female pelvis that is suitable for childbearing.
Hyperemesis gravidarum-Excessive vomiting in pregnancy.
Hypertonic-Having too much tone, for example uterine muscle during strong contraction.
Hypotonic-Having too little tone, for example uterine muscle during weak contraction.
Implantation-The embedding of the ovum (after fertilisation) in the endometrium of the uterus, now known as decidua.
Infertility-Primary – in a couple who have never achieved a pregnancy. Secondary – in a couple who have previously achieved at least one pregnancy.
Involution-The return of any organ or system, especially the uterus, to normal after pregnancy.
Ketonuria-When fats are metabolised ketones (acetone) are excreted in the urine and indicate acidosis.
Kernicterus-Staining of the basal ganglia of the brain with the toxic form of bilirubin e.g. in rhesus incompatibility.
Konitican-Vitamin K.
Labour-The expulsion of the products of conception from the uterus, there are three stages:
first stage –from the outset of true labour to the full dilation of the cervix;
second stage – from full dilation of the cervix to the complete expulsion of the baby
third stage – separation and expulsion of the placenta and membranes.
Lactation-Secretion of milk by the breasts.
Lanugo-The fine downy hair on the body of the foetus in utero, seen on babies born prematurely.
Levatores ani-The large muscles forming the major part of the pelvic floor (singular levator ani).
Lie-The relationship of the long axis of the foetus (that is the spine) to the long axis of the uterus, the normal being longitudinal.
Live birth-An infant which has breathed or had a heartbeat after delivery.
Liquor amnii-The amniotic fluid surrounding the foetus in utero.
Lithotomy position-Position in which the woman lies supine, with thighs abducted and flexed on to the abdomen and maintained in this position by supports.
Lochia-The discharge from the uterus after childbirth.
Lower segment-The thinner lower part of the uterus at term, which has developed from the isthmus of the non-pregnant uterus; passive in labour.
Malpresentation-An abnormal or unfavourable presentation of the foetus instead of the normal vertex presentation, e.g. a breech or face presentation.
Malposition-An unfavourable position of the presentation, e.g. an occipito posterior position of the vertex.

Mastitis-Inflammation of the breast.
McRoberts Manoeuvre-The McRoberts manoeuvre is named after William A. McRoberts, Jr.It is employed in case of shoulder dystocia during childbirth and involves hyper flexing the mother's legs tightly to her abdomen. It is effective due to the increased mobility at the sacroiliac joint during pregnancy, allowing rotation of the pelvis and facilitating the release of the foetal shoulder.
Mechanism of labour-The series of passive movements which the foetus undergoes on its passage through the birth canal.
Meconium-The dark green viscid substance present in the bowel of the new-born infant.
Membranes-The chorion and the amnion.
Mentum-The chin.
Mortality-Deaths, e.g. maternal mortality – deaths of mothers due to childbirth;
infant mortality – deaths of babies in the first year of life;
neonatal mortality – deaths in babies in the first month of life;
perinatal mortality – stillbirths and deaths of babies in the first week of life.
Mortality rate-Number of deaths per thousand.
Moulding-Alteration of the shape of the foetal skull in labour, in order to accommodate to the rigid bony pelvis; the presenting diameter becomes shorter and the one at right angles to it become longer.
Multipara-A woman who has given birth to a live child after each of at least two pregnancies (plural
multiparae).
Multiple pregnancy-More than one foetus: twins, triplets etc.
Myometrium-Uterine muscle.
Naevus-A birthmark.
Obstetric cholestasis
Is a multifactorial condition of pregnancy characterised by pruritus in the absence of a skin rash with abnormal liver function tests (LFTs), neither of which has an alternative cause and both of which resolve after birth.
Oligohydramnios-Less than the normal amount of liquor amnii, that is 1.5 litres at term.
Ophthalmia neomatorum-A purulent discharge from the eyes of the new-born baby within 21 days of birth; if gonococcal it may lead to blindness: a notifiable disease.
Ovulation-The shedding of the ripe ova from the Graafian follicle into the peritoneal cavity.
Oxytocin-Extract from the posterior pituitary which stimulates uterine muscle to contract.
Parous-Having borne one child or more
Parity -Is the condition of having borne children or the number of children born that are over twenty weeks.
Partogram-Chart for recording the progress of labour.
Parturition-Childbirth.
Pelvic Girdle Pain-Is defined by pain experienced between the posterior iliac crest and the gluteal fold, particularly in the vicinity of the sacroiliac joints (SIJ). The pain may radiate in the posterior thigh and can also occur in conjunction with/or separately in the symphysis. The endurance capacity for standing, walking, and sitting is diminished. (European Guidelines)
Penylketonuria-A metabolic disease where the infant is unable to utilise a specific amino acid, phenylalanine; if untreated it leads to gross mental retardation.

Placenta Praevia-When the placenta is inserted wholly or in part into the lower segment of the uterus. It is classified by ultrasound imaging according to what is relevant clinically: if the placenta lies over the internal cervical os, it is considered a major praevia; if the leading edge of the placenta is in the lower uterine segment but not covering the cervical os, minor or partial praevia exists.
Placenta accreta, increta and percreta-The placenta penetrates through the decidua basalis into and then through the myometrium,
Polarity-The neuromuscular harmony between the upper and lower uterine segments in labour upon which normal taking up and dilation of the cervix is dependent.
Polyhydramnios-An excessive amount of liquor amnii, e.g. more than 1.5 litres at term.
Posterior fontanelle-Small 'soft spot' at back of skull.
Postmaturity-When a pregnancy has gone 2 or more weeks past the expected date of delivery that is more than 42 weeks.
Postpartum haemorrhage-Primary – bleeding from the genital tract up to 24 hours post-delivery of an amount of 500ml or more, or less if detrimental to the mother's condition (usually from the placental site).
Secondary – any bleeding from the genital tract during the puerperium, excluding the first 24 hours (usually due to infection).
Pre-eclampsia-A disease peculiar to middle and late pregnancy which is characterised by oedema, a raised blood pressure and proteinuria; if not treated it may progress to fulminating eclampsia, which is characterised by the occurrence of major epileptiform convulsions.
Premature-A baby born before 37 weeks of pregnancy; not to be confused with "light for dates".
Presentation-The part of the foetus which occupies the lower pole of the uterus and therefore lies over the pelvic brim.
Primipara-A woman who has given birth to one live child.
Prolapse of the umbilical cord-When the cord escapes through the cervix after the rupture of the membranes to lie in front of the presenting part.
Puerperium-The period following the delivery of the baby during which the body returns to its normal pre pregnant state; this usually takes about one month.
Quickening-The perception of foetal movements by the mother: usually about 18-20 weeks of the first pregnancy, 16-18 weeks of a subsequent pregnancy.
Retraction-Slight permanent shortening of the muscle in the uterus during labour.
Rhesus factor-A blood factor present in 85% of the population in this country; the remaining 15% are termed rhesus negative.
Rotation-Changing the position of the foetus; in normal labour the occiput rotates anteriorly in order to be born (this movement can be assisted by Kielland's forceps in the second stage of labour).
Shirodkar suture-Suture placed around the cervix at the 14th week of pregnancy to prevent an incompetent cervix dilating
Show-The expulsion of the mucous plug as a slightly blood-stained mucous discharge in early labour.
Sickle-cell disease-A hereditary haemoglobinopathy which may be exacerbated in pregnancy.
Sinciput-Brow or forehead; the area between the supraorbital ridges and the bregma.
Small for dates-A baby born at any stage of pregnancy who weighs less than the normal.

Sonicaid-High frequency sound used to detect sounds, e.g. that of the foetal heart.
Speculum, vaginal-An instrument designed for the examination of the vagina and cervix, e.g. Sims's, Cusco's and Auvard's
Stillbirth-The delivery of any child, which shows no sign of life, after the 24th week of pregnancy.
Striae gravidarum-The so-called 'stretch-marks' of pregnancy, which are seen on the abdomen and breasts, may be a sign of pregnancy or a previous pregnancy.
Surfactant-Agent secreted by the foetal lungs which reduces the surface tension and allows adequate expansion of the alveoli; the absence or lack of surfactant causes respiratory distress syndrome (hyaline membrane disease) in premature babies.
Syntocinon-Synthetic form of oxytocin.
Tears (lacerations) – Classification and Terminology of Perineal Tears by I International Consultation on Incontinence and RCOG
First degree injury to perineal skin
Second degree injury to perineum involving perineum muscles but not involving the anal sphincter
Third Degree injury to perineum involving the anal sphincter complex (EAS and IAS)
3A Less than 50% of EAS thickness torn
3B More than 50% of EAS thickness torn
3C Both EAS and IAS torn
Fourth Degree Injury to perineum involving the anal sphincter and anal epithelium
Thrush-A monilial infection which can affect both mother and baby; in the former manifesting as vaginitis and in the latter as an intestinal tract infection, particularly in the mouth.
Transverse lie-When the foetus lies at right angles to the long axis of the uterus.
Trichomonas vaginalis-An organism which commonly infects the vagina.
Ultrasonic scan-The use of high frequency sound waves to locate, define or measure certain structures within the body, e.g. a foetus or a placenta; the conversion of the sound into light allows an image to be seen on a screen.
Unstable lie-Repeated changes of foetal position.
Upper segment-The very muscular upper part of the uterus at term which has developed from the body of the non-pregnant uterus; it is the active part of the uterus in labour.
Vernix-White greasy substance covering the foetus in utero after the 30th week of gestation.
Version-Changing the presentation of the foetus, usually external cephalic version, that is turning the baby round from a breech or shoulder presentation to a cephalic presentation, the hands coaxing the baby round through the abdominal wall.
Vertex-Area of the skull between the anterior and posterior fontanels and the two parietal eminences.

Appendix 3: Urology/ Gynaecology terminology

Abortion (miscarriage)-The expulsion from the uterus of the products of conception before the 24th week of pregnancy. There are several types:
Threatened – the pregnant woman develops vaginal bleeding, possibly with mild uterine contractions but the cervix remains closed; the pregnancy may continue.
Inevitable – uterine contractions become stronger leading to dilation of the cervix; the pregnancy will not continue.
Incomplete – some of the products of conception remain in the uterus.
Complete – all the products of conception have been passed; the uterus is empty.
Missed – the dead embryo and placenta are not expelled spontaneously.
Amenorrhoea-Absence of menstruation.
Apareunia-Absence or impossibility of coitus
Cervical carcinoma-Cancer of the cervix:
Stage 0 – cervical intraepithelial neoplasia (CIN)
CIN I – mild dysplasia.
CIN II – moderate dysplasia.
CIN III – severe dysplasia and carcinoma-in-situ.
Metaplasia – normal transformation of cellular tissue.
Dysplasia – abnormal development or growth cells.
Dyskaryosis – abnormality of the nuclei of cells.
(The terms above denote cellular changes which can be seen in the cervical epithelium when there is no invasion of deeper tissues; these conditions do not invariably progress to malignancy.)
Stage I – lesion invasion but confined to cervix, usually squamo-columnar junction.
Stage II – lesion extends beyond the cervix to the upper vagina and parametrium, but not the pelvic side walls.
Stage III – lesion reaches one or both pelvic side walls and the lower third of the vagina.
Stage IV – spread involves the bladder and/or rectum; there may be distant metastases.
Cyesis-Pregnancy
Debulking-Debulking is used for ovarian tumours and may include removal of ovaries, uterus, cervix and omentum.
Dysfunctional uterine bleeding (DUB)-Bleeding caused by hormone imbalance.
Dyspareunia-Difficult or painful intercourse.
Ectopic pregnancy-One that implants in sites other than the uterus, usually the fallopian tube.
Endometriosis-Disease characterised by growth of the endometrium in places other than the lining of the uterus.
Female genital mutilation (female circumcision FGM) – any procedure removing part or all of the external female genitalia.
Fibroids (myomata)-Benign tumours of the uterus.
Haematometra-Trapped blood in the uterus caused, for example, by an intact hymen or cervical stenosis.

Haematuria-Blood in the urine, on urinalysis
Incontinence-Urinary incontinence- the involuntary loss of urine:
Stress urinary incontinence – involuntary leakage on effort or physical exertion or on sneezing or coughing
Urgency – complaint of involuntary loss of urine associated with urgency
Urge urinary incontinence – involuntary leakage (of urine) accompanied by or immediately proceeded by urgency.
Mixed urinary incontinence – involuntary leakage (of urine) associated with urgency and also with exertion, effort, sneezing or coughing.
Nocturnal enuresis – loss of urine occurring during sleep.
Insensible urinary incontinence – complaint of urinary incontinence where the woman has been unaware of how it occurred
Coital incontinence – Complaint of involuntary loss of urine with coitus. This symptom might be occurring with penetration or intromission and that occurring at orgasm
Postural incontinence - complaint of involuntary loss of urine associated with change of body position, for example, rising from a seated or lying position
Overactive bladder syndrome – urgency, with or without urge incontinence, usually with frequency and nocturia.
Overflow incontinence – incontinence associated with over-distension of the bladder.
Detrusor Overactivity – urodynamic observation characterized by involuntary detrusor contractions during the filling phase which may be spontaneous or provoked.
Urodynamic stress incontinence – stress incontinence as witnessed on urodynamic Investigation.
Inguinal Node Dissection-Lymph nodes near the vulva are removed usually following a vulvectomy (may be unilateral or bilateral) with drain(s) in situ for a few days.
Interstitial cystitis-Chronic inflammation of the bladder giving rise to symptoms including frequency, urgency and pain in the absence of infection.
Intrauterine contraceptive device (IUCD); not to be confused with IUD, intrauterine death.
Large Loop Excision of the Transformation Zone (LLETZ) out-patient treatment for cervical dysplasia (pre-malignant lesions) aims to totally remove the abnormal cells from the cervix. A wire loop with an electric current (diathermy) is used to shave off these cells.
Menorrhagia-Abnormally heavy bleeding at menstruation.
Metrorrhagia-Irregular bleeding.
Nocturia-Complaint of the interruption of sleep one or more times because of the need to micturate
Omentectomy-This involves removal of the fatty tissue overlying the bowel.
Pelvic Node Dissection-In cases of suspected malignancy, pelvic and para-aortic nodes may be excised. The extent/type of dissection depends on the type of gynaecological malignancy being treated. Enlarged nodes are also removed to facilitate sterilization of any micrometastases.
Pelvic Organ Prolapse-The diagnosis by symptoms and clinical examination, assisted by any relevant imaging, involves the identification of descent of one or more of the anterior vaginal wall
Urethrocele – prolapse of urethra (affects anterior vaginal wall).
Cystocele – prolapse of bladder (affects anterior vaginal wall).
Rectocele – prolapse of rectum (affects posterior vaginal wall).

Enterocele – prolapse of pouch of Douglas (affects posterior vaginal wall).
Uterine prolapse – may occur to a variable degree.
Pelvic inflammatory disease (PID)
Procidentia-Third-degree uterine prolapse.
Suprapubic catheter-A long-term catheter surgically inserted above the symphysis pubis.
Uterine adnexa-Fallopian tubes and ovaries.
Uterovaginal prolapse-Displacement of one or more of the pelvic organs causing a bulge into the vagina; there are several types:
Urodynamics-Conventional bladder test to diagnose bladder dysfunctions including incontinence. Involves artificial bladder filling via urethral catheter, bladder pressure measurement via second urethral catheter and abdominal pressure measurement via rectal catheter subtracting bladder pressure from abdominal pressure gives detrusor pressure.
Vaginal vault-The top of the vagina that remains after surgical removal of the cervix.

Appendix 4: Gynaecology Surgery terminology and abbreviations

Abdominal hysterectomy- Abdominal incision and removal of uterus.
Abdominal sacral colpopexy-Repair of vaginal vault prolapse by attaching the vault to the pre-sacral fascia e.g. with surgical mesh
Anterior repair/colporrhaphy-Repair of the anterior vaginal wall for cystocele and/or urethrocele, performed vaginally.
Botulinum toxin A-Botulinum toxin A injected via cystoscopy for an overactive bladder which is resistant to other treatments.
BSO/LSO/RSO-Bilateral/left/right salpingo-oophorectomy (may be combined with hysterectomy). May be performed abdominally or laparoscopically.
Colposcopy-Use of a colposcope to examine the upper part of the vagina and cervix.
Colposuspension-Sling suspension operation to restore the urethrovesical angle in cases of stress incontinence; a sling of (usually) vaginal tissue is formed to support the bladder neck and is attached to the ileopectineal ligaments; may be performed abdominally or laparoscopically.
Cone biopsy-Removal of a conical segment from the cervix for diagnostic purposes or in the treatment of cervical cancer.
Cystoscopy-Using a cystoscope to look inside the bladder.
D & C-Dilation and curettage.
ERPC-Evacuation of retained products of conception.
EUA-Examination under anaesthetic.
Excision of Bartholin's cyst (marsupialisation)-Removal of a cyst from the gland at the base of the labia minora.
Fentons-Operation for enlargement of the vaginal introitus.
Hysterectomy-Removal of part or all of the uterus:
Total abdominal (TAH) – removal of the whole of the uterus through an abdominal incision.
Subtotal – the cervix is left in place and only the body of the uterus is removed.
Vaginal – removal of the uterus vaginally for uterine prolapse; the cardinal and uterosacral ligaments are shortened during the operation, which may be combined with other repair surgery.
Extended – removal of the uterus, ovaries, fallopian tubes and a 'cuff' of vagina.
Wertheim's – removal of the uterus, ovaries, fallopian tubes, broad ligaments, the upper third of the vagina and adjacent lymph nodes.
Hysteroscopy-Using a hysteroscope to look inside the uterus.
Laparoscopic sterilisation-Sterilisation by banding the fallopian tubes via two small stab wounds.
Laparoscopy-Examination of the pelvic contents by laparoscope via a small sub-umbilical incision.
LAVH (laparoscopic assisted vaginal hysterectomy)-Using a laparoscope (abdominally) to aid vaginal removal of the uterus.
Myomectomy-Removal of fibroids.

Oophorectomy-Removal of an ovary.

Ovarian cystectomy-Removal of an ovarian cyst.
Pelvic exenteration-Removal of the uterus, bladder, and/or rectum with transplantation of ureters and colostomy.
Periurethral bulking agents-A procedure for stress incontinence. Collagen or another agent is injected into the periurethral tissues at the urethro-vesical junction (bladder neck). The aim is to increase resistance to involuntary urine loss by narrowing the lumen of the urethra.
Posterior repair/colpoperineorrhaphy-Repair of an enterocele or rectocele and/or defective perineum.
Sacrospinous fixation-Vaginal repair of vaginal vault prolapse by suturing the vault to the medial portion of the sacrospinous ligament.
Salpingectomy-Removal of a fallopian tube.
Salpingolysis-Removal of peritubal adhesions.
Salpingo-oophorectomy-Removal of a fallopian tube and ovary.
Salpingostomy-Removal of a blocked or damaged portion of a fallopian tube to restore patency.
TCRE-Transcervical resection of the endometrium, performed for excessive menstrual bleeding.
Tubal section and ligation (TS&L)-Sterilisation by cutting and tying both fallopian tubes through a small transverse incision.
TVT (tension free vaginal tape)-A procedure performed for stress incontinence. A prolene mesh tape is positioned around the midurethra and is drawn upwards within the abdominal cavity on each side to the abdominal skin, the mesh becoming an integral part of the abdominal skin and underlying soft tissues. The aim is to create a solid floor beneath the urethra so that a sudden rise in intra-abdominal pressure (e.g. cough, sneeze) will compress the urethra against the tape, occluding the urethra and thus preventing involuntary urine loss. Unlike other procedures, tension is applied only on episodes of physical stress.
TVTO (tension free vaginal tape obturator) and TOT (trans-obturator tape)-Procedure similar to TVT but producing a wider angle of support on the urethra. The tape exits laterally via the obturator foramen.
VTOP/STOP-Vaginal/suction termination of pregnancy.
Vulvectomy, simple or radical- varies in extent from simple excision of skin in the vulval area to excision of the whole of the vulva and inguinal glands.

Appendix 5: Colorectal terminology

Anal abscess-an infected cavity filled with pus found near the anus or rectum.

Anal canal-short tube at the end of your rectum through which stool leaves your body

Anal cancer-cancer that develops from the lining 'mucosa' of the anal canal

Anal fissure-split which occurs within the distal part of anal lining. This usually causes severe anal pain and fresh bleeding on passing stools

Anal fistula-small tunnel like structure (tract) that develops between the back passage (anal canal) and the skin surrounding the anus

Anal sphincters-ring of muscle surrounding the anus which controls opening and closing of the anus and play a major part in maintaining control of faeces

Anterior resection and total mesorectal resection (TME)-surgical removal of the rectum and the entire fatty tissue around the rectum (TME) to reduce the risk of recurrent local cancer, with a join made between the two ends of the bowel. This type of surgery is usually carried out for cancers of the rectum

Anorectal physiology-tests that look at the strength of the muscles in your anal canal to see if they are working normally, and also checks the sensitivity of the rectum to small volumes of air and its response to distension

Anus-back passage. It is lined with sensitive skin and surrounded by important muscles which control bowel emptying

Banding of haemorrhoids- involves using a small instrument to put a very tight elastic band over the haemorrhoid. This band cuts off the blood supply so that the haemorrhoid should drop off, usually within 3-7 days after the banding

Bowel-name given to describe the intestines. The term large bowel is sometimes used to describe the colon and rectum. The term small bowel is often used to describe the upper part of the intestine, which includes the duodenum, jejunum and ileum

Colectomy-surgical removal of all or part of the large intestine

Colitis-inflammation of the colon which may have several different causes

Colon-part of the intestine or bowel that follows the small intestine. The colon leads to the rectum and anus. The function of the colon is to absorb water

Colonoscopy: is an examination of the entire length of the large bowel using a flexible fibreoptic telescope

Colon cancer-cancer which develops from the 'mucosal' lining of the large bowel (colon). This type of cancer usually develops from a non-cancerous polyp which if detected early may be removed to prevent cancer developing

Constipation-feeling that you are not passing stools (faeces) as often as you normally do, or that you have to strain more than usual, or that you are unable to completely empty your bowels or that your stools are unusually hard

Crohn's disease-condition that causes inflammation of the gastrointestinal tract (gut). The disease may affect any part of the gut

Diverticular disease-small pouches sticking out of the side of the large intestine (colon)

Endorectal ultrasound- procedure where a probe is inserted into the rectum and high frequency sound waves (ultrasound waves) are generated. The pattern of echoes as they bounce off tissues is converted into a picture (sonogram) on a television screen

Enhanced recovery program for elective surgery- recovery programs designed to reduce hospital length of stay by shortening the postoperative recovery period

Faecal incontinence-defined as an inability to control the passage of gas, liquid or solid stools from the back passage which is associated with urgency to rush to a toilet and at times accidents

Gall bladder disease- most common reason for gallbladder disease is gallstones. This is a common condition with a wide variety of symptoms from discomfort to severe pain which mainly begins after food. In severe cases the patient can suffer from jaundice, nausea and fever. The most common reason for gallbladder disease is gallstones

Haemorrhoids (Piles)-swellings of the blood vessels within the anus. They are very common. The common symptoms are bright red bleeding, pain, itching, swelling and popping out (prolapse) whilst passing a stool or at other times

Hemicolectomy- removal of part of the colon (large bowel or intestine) either the right or the left side

Hernia-a piece of tissue, or organ which pokes through the muscles which make up the wall of the abdomen, and pushes out under the skin. This appears as a bulge in the abdomen or groin

Inflammatory bowel disease- name of a group of disorders that cause the intestines to become inflamed (red and swollen)

Perianal abscess-an acute painful swelling containing pus which is next to the anus

Piles (Haemorrhoids) - swellings of the blood vessels within the anus. They are very common. The common symptoms are bright red bleeding, pain, itching, swelling and popping out (prolapse) whilst passing a stool or at other times

Pilonidal disease- a chronic infection of the skin in the region of the buttock crease. The condition results from a reaction to hairs embedded in the skin, commonly occurring in the cleft between the buttocks

Polyp- benign (non-cancerous) growth in the lining of the bowel

Proctectomy- the surgical removal of the rectum. Where there is a very low rectal or anal cancer this may involve removal of the anus as well

Proctoscopy: is an examination of the lowest part of the rectum and anal canal using a very short telescope. This is usually done in the outpatient clinic

Pruritus ani-common symptom which describes itching and or soreness around the anus. It may be due to a number of different causes

Rectum-last part of the large intestine. The main function of the rectum is to act as a reservoir for stools

Rectal cancer-cancer that develops from the lining 'mucosa' of the rectum

Rectal prolapse-occurs when part or all of the wall of the rectum slides out of place, sometimes sticking out of the anus

Restorative proctocolectomy and ileoanal pouch anastomosis-surgical removal of all of the colon, rectum and anus and formation of a new reservoir with the small bowel which is reattached to the anu**s**

Rigid sigmoidoscopy- procedure by which a doctor inserts either a short and rigid tube into the rectum to examine the lower portion of the large intestine (or bowel)

Ulcerative colitis- condition which causes inflammation in the rectum and colon. Part or the entire large bowel may be involved

Appendix 6: Advanced clinical objectives for performing internal examinations

Skills

1. Assess and treat a patient with continence problems, including the use of frequency/volume charts

2. Ascertain an active contraction of the pelvic floor muscles by digital examination if appropriate

3. Logically prepare and teach an exercise regime to strengthen these muscles taking into account progress, motivation, adherence etc.

4. Make appropriate use of biofeedback and electrotherapy in the treatment of gynaecological conditions including incontinence

Professional Behaviour

1. Demonstrate sensitivity and empathy towards those suffering from incontinence

2. Demonstrate a positive approach to the promotion of continence and the management of incontinence

3. Promote the role of the physiotherapist, while being aware of the need to liaise with, or refer to, other professionals, for example the continence adviser, urologist, gynaecologist or colorectal surgeon

4. Understand the psychological and emotional needs of gynaecological patients and their partners

5. Demonstrate an understanding of the need to evaluate physiotherapy practice

6. Discuss the potential role of the physiotherapist in the treatment of dyspareunia

7. Discuss the need for valid consent for vaginal examination.

(See CSP Rules of Professional Conduct and PD092)