Gynecology & Obstetrics
OSCE
Checklists
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Gynecology

Heavy Menstrual Bleeding (HMB)

Huda is a 43 year old G3 P2+1 presents to the emergency complaining of SOB and dizziness, she also complain of HMB for the past 6 months

Her abdominal exam and pelvic exam were not significant, her TA/TV US was normal, these are her labs:

HB: 7.9 **MCV:** 66 **Platelets:** 170,000/mm3 **WBC:** 7500/mm3

What is your Dx?	
Iron deficiency anemia (IDA) secondary to her HMB	
Mention 4 medical treatments you can offer her	
COCP	
IUS	
GnRH Analogue	
NSAIDs	
mention Investigations to order	
Endometrial sampling and hysteroscopy	
Mention surgical Mx you can offer to Huda	
Hysterectomy	
Endometrial Ablation	
Uterine artery embolization	

Menopause

Shireen is a 51 year old lady who presents to your clinic complaining of hot flushes and night sweats

Take relevant Hx	
Professionalism	0.5
Gravida, Para	0.5
LMP	0.5
Occupation: Teacher	0.5
Chief complaints	0.5
Analysis of CC	0.5
Assessing the severity of the condition	0.5
Urinary Sx: dysuria, urgency, frequency	0.5
Thyroid Sx	0.5
Menstrual Hx	0.5
Hx of DVT, PE	0.5
Hx of Fracture	0.5
Hx of Breast Ca	0.5
Family Hx: DVT, PE, Osteoporosis, Breast Ca	0.5
Smoking	0.5
Whats is the Treatment?	
HRT	0.5
What type of HRT?	
Combined estrogen and progesterone	0.5
Additional 2 benefits for the treatment	
Protective from osteoporosis	0.5
Protective from dementia	0.5
Protective from colon Ca…	0.5

Post-menopausal Bleeding

A 52 year old patient presents with post-menopausal bleeding.

What is the definition of post-menopausal bleeding	
Genital tract bleeding after 12 months after the menopause.	
What issues will you cover in Hx	
Bleeding Analysis: Onset? Duration? Recurrence?	
any associated symptoms e.g. discharge?	
Any obvious explanation? taking drugs e.g. HRT & anticoagulants?	
Is there any factor that might increase the risk of malignancy e.g. taking Tamoxifen, previous genital tract cancer or precancer, Family Hx of genital tract cancer?	
What will you look for in pelvic examination	
Benign or malignant conditions causing the bleeding. Valval ulceration. Atrophic	
Vaginal changes: ulceration. Foreign body in the vagina: pessary, inserted object. Cervical polyps, “erosions” or possible malignancy. Pelvic masses	
Vaginal infection, e.g. trichomonas or candida. Ovaries: Ovarian cancer (15% present post-menopausal bleeding)	
mention 3 further investigations you will do?	
Cervical smear	
US: TV: to measure thickness	
Endometrial sampling/hysteroscopy	
If clinical examination is normal, what advice will you give her about possible serious pathology	
20% risk of malignancy/hyperplasia is associated with postmenopausal bleeding., but you can still reassure the patient that the risk of serious disease is <10%. In addition, most of the serious conditions, such as endometrial hyperplasia and cancer are treatable though you cannot offer guarantees of cure.	

Postmenopausal Bleeding

A 68 year old who has been postmenopausal for the last 15 year presents to your clinic complaining of vaginal bleeding for 2 days

Take relevant Hx	
Age of menopause	0.5
Gravida, Para	0.5
Blood analysis: nature, onset	0.5
Precipitating Factors and Associated Sx	0.5
Previous Hx of bleeding	0.5
Age of Menarche	0.5
Pap Smear Hx	0.5
Medical Hx: DM, HTN	0.5
Medical Hx: Cancers	0.5
Drug Hx: Tamoxifen, anticoagulants	0.5
Drug Hx: HRT	0.5
Surgical Hx	0.5
Family Hx: Cancers, bleeding tendency	0.5
Sexual Hx	0.5
What is your DDx	
Endometrial atrophy/polyp	1
Endometrial hyperplasia/Ca	1
hormonal effect of cervical Ca…	1
What are the risk factors for endometrial cancer	
- Nulliparity/low parity - Middle/Higher social classes - Obesity - Early menarche and late menopause - White people - Tamoxifen use	

PCOS

Dana is 25 years and presents to your clinic complaining of excessive hair growth on her face.

What do you want to know?	
Married/single, fertility	0.5
Onset	0.5
Progression	0.5
Other sites, severity	0.5
Acne	0.5
Voice Changes, balding	0.5
Constitutional Sx: abdominal/pelvic pain, weight loss, anorexia	0.5
Hypothyroidism Sx: Weight gain, cold intolerance	0.5
Menstrual Hx	0.5
Drug Hx (medications)	0.5
Family Hx	0.5
What will you look for in Physical Exam?	
Severity/distribution scoring	0.5
2ry sexual characteristics / virilization	0.5
Acanthosis Nigricans	0.5
Pelvic exam	0.5
Abdominal exam: masses	0.5
Investigations for this patient?	
US	0.5
LH/FSH	0.5
Testosterone, DHEAs	0.5
TSH/Prolactin (PRL)	0.5

PCOS

A 20 year old woman presents with infrequent periods since the menarche at the age of 16. She has mild acne but no other abnormal feature. She wishes to conceive.

Q1: most likely Dx	
Polycystic ovarian syndrome (PCOS)	1
Q2: What investigations will you arrange?	
Ovarian scan	1
Follicular phase LH or LH:FSH	1
BMI	1
Semen analysis	1
Prolactin & Androgens	
Q3: What treatments will you arrange?	
Dietary advice and Weight loss	1
Clomiphene Citrate	1
Q4: What counseling will you give?	
Pre-pregnancy counseling	1
Side effects of clomiphene citrate: - Multiple pregnancy - Ovarian hyperstimulation: ovarian cysts and cancers	1
Q5: What follow up investigation will you arrange?	
Luteal phase progesterone to confirm ovulation once regular cycles have been established	1

PCOS

Dana is 25 years she is married for 3 years and she couldn't conceive

Take a focused Hx	
...	
What is the most likely Dx?	
PCOS	
What is the criteria for PCOS?	
- ESHRE/ASRM (2 of the following + R/O other causes): 1) Oligo and/or anovulation 2) Hyperandrogenism (clinical) &/or hyperandrogenemia (biochemical) 3) PCO on U/S (≥12 follicles/ovary, 2-9mm &/or ovary volume (>10ml))	
What are the tests you would like to order for her?	
- TSH - Fasting Blood Sugar (FBS) and lipid profile - Prolactin (PRL): ↑ in 40% 2ry chronic estrogen - Free Androgen Index - FSH and Estradiol (to exclude POF / FSH >25 + E2 <30)	
Mention 4 Mx options for PCOS	
1) Weight loss 2) Metformin 3) Clomiphene 4) Letrozole aromatase inhibitor 5) FSH/LH Injections 6) Laparoscopic Ovarian Drilling (LOD) 7) IVF	

Infertility

A couple married for 2 years, the lady is 35-year-old by still did not conceive

Take relevant Hx	
Professionalism	0.5
Communication skills	0.5
Age, LMP	0.5
Gravida, Para, MOD	0.5
Birth weight of her children	0.5
Severity of incontinence, number of pads	0.5
Impact on social life	0.5
Fluid intake	0.5
What investigations will you order	
TSH	
Prolactin	
FSH, LH	
Ovarian reserve tests: day 2-3 FSH, AMH, AFC	
Day 21 progesterone to check for ovulation	
Hysterosalpingogram	
Hysteroscopy	
Sperm Analysis	
On hysteroscopy and endomerioma was found, how would you treat this patient	
Laparoscopic cystectomy (not sure)	
How do you explain the cause of this condition to the patient (mention 3 theories)	
Retrograde flow	
Coelomicmetaplasia	
Lymphatic	

Ovarian Cancer

A lady was complaining of lower abdominal pain, physical examination was done and revealed bilateral masses with an ultrasound finding of fluid in the pouch of Douglas, CA125= 800 IU\l.

What is the most likely Dx	
Bilateral ovarian cancer	
What would you ask in the Hx	
Patient profile	
Gravida, Parity	
Use of COCP	
Personal Hx of malignancy	
FHx of malignancy	
Pressure Sx: GI, Urinary Sx	
Constitutional Sx	
METS Sx (SOB,..)	
What are the clinical signs you might find on examination	
…	
What is your Mx	
Surgery (TAH + BSO – staging)	
What is the RMI, and how to interpretate the results	
Risk of malignancy index, components: **RMI = U x M x CA125** - **U**: (1 point for each): * Multi-locular cyst * Bilateral * Solid areas * METS * Ascites - **M**: menopausal status (post = 3 / pre = 1) - RMI <25 low risk, 25-200 moderate, >200 high	

Vaginal Discharge

Take relevant Hx	
Introduce yourself	0.5
Professionalism	0.5
Gravida, Para	0.5
Chief complaint	0.5
Discharge analysis: character	0.5
Associated Sx: Itching, Redness	0.5
Previous similar Hx	0.5
Pelvic pain, Fever	0.5
Dysuria, dyspareunia	0.5
Birth control usage	0.5
Medical Hx: DM	0.5
Drug Hx: Antibiotics	0.5
STD Hx	0.5
What is your DDx	
Candidiasis	0.5
Bacterial Vaginosis	0.5
Trichomoniasis	0.5
Investigations	
Wet Mount	0.5
Whiff test for vaginosis by adding 10% KOH and wait for fishy odor	0.5
Vaginal pH	0.5
Vaginal Culture	0.5

Urine Incontinence

Samia is a 53 years old patient who presents to the outpatient clinic complaining of involuntary loss of urine for 2 years.

Take relevant Hx	
Professionalism	0.5
Communication skills	0.5
Age, LMP	0.5
Gravida, Para, MOD	0.5
Birth weight of her children	0.5
Severity of incontinence, number of pads	0.5
Impact on social life	0.5
Fluid intake	0.5
Frequency: day/not	0.5
Urgency, Dysuria	0.5
Urge incontinence	0.5
Stress incontinence: is it related to coughing, sneezing, laughing?	0.5
Chronic cough	0.5
Constipation	0.5
Feeling of a mass bulging from below	0.5
Medical Hx: DM, neurological diseases, spinal injuries	0.5
Drug Hx: Diuretics, HRT	0.5
Surgical Hx: Gynecological Surgical Hx	0.5
Family Hx: DM	0.5
Smoking	0.5
What do you want to know from the physical examination?	
BMI	0.5
Vital signs	0.5
Chest examination	0.5
Abdominal examination	0.5
Speculum	0.5
Bimanual exam	0.5
On examination you notice the Samia`s BMI is 35. She suffers from a second-degree Cystocele. What investigations will you order?	
Frequency volume chart	0.5
Bladder Diary	0.5
Urine analysis/culture	0.5
GTT (glucose intolerance test), random blood sugar	0.5
Urodynamic study	0.5

Mixed Urinary Incontinence

Sameeha is 65 year old lady. She presented to the clinic c/o leaking urine when she coughs and sneezes. She cannot always make it to the toilet when she needs to void. In addition, she mentioned that she voids 10 times during a day and has to rise at least twice at night to void. Her symptoms started 2 months ago.

Q1: What is your Dx		
Mixed urinary incontinence		1.5
Q2: Define the following?		
Stress urinary incontinence	involuntary leakage on effort or exertion, or on sneezing or coughing	1
Overactive bladder syndrome	Urgency + Frequency + Nocturia +/- Urge incontinence	1
Urgency	Sudden and compelling desire to pass urine	1
Q3: What investigations will you request?		
Bladder diary		0.5
Urine analysis		0.5
Urine culture		0.5
Urodynamics		0.5
Q4: What treatment options can you discuss with this lady?		
Fluid manipulation		0.5
Pelvic floor muscle training		0.5
Bladder retraining		0.5
Anti-muscarinics		0.5
Surgery		0.5
Q6: In such a presentation, which component of the mixed urinary incontinence we should treat first?		
Urge incontinence		1

COCP - Contraception

Teena is 25 yrs. She wants to use combined contraception.

Q1. Forms of combined contraception	
Pills	0.5
Patches	0.5
Vaginal Rings	0.5
Q2. What do you need to ask before you can prescribe COCP	
Gynecological Hx / Obstetric Hx	0.5
Menstrual Hx	0.5
Cervical smears	0.5
Previous contraception	0.5
Future pregnancy plan	0.5
Medical Hx: HTN, DVT, Migraine, Cancers…	2
Drug Hx	0.5
Family Hx: thrombosis	0.5
Smoking	0.5
STI risk	0.5
Q3: What do you need to check when you examine her	
BP	0.5
BMI	0.5

IUD - Contraception

Maha is a 33 yr old P3 woman who is interested in birth control. Her sister has an IUCD and she is wondering if an IUCD suits her as well?

Q1. She asks you, What IUCD exactly is? And how does it work? And how effective is it?	
A small 'T'-shaped device is inserted into the uterus. IUDs are a form of long-acting reversible contraception	1
Unknown but it is believed to cause a hostile inflammatory environment in the uterus	1
Very effective 97-99%	1
Q2. She heard that there are two different types. What are they? And how can you help her decide which type to choose	
Copper and hormonal IUCD	1
Other symptoms like menorrhagia	0.5
How long she wants birth control (copper 10 yrs, hormonal 5 yrs)	0.5
Price/ availability	0.5
Q3. When is the best time to insert an IUCD?	
After the period	1
Q4. What are the main complications of IUCD insertion?	
Infection	0.5
Perforation	0.5
Q5. Maha had an IUCD placed, she reports back 6 weeks after the insertion. Pelvic exam shows no threads, what are the possibilities and what investigations will order to confirm your diagnosis?	
Perforation/ expulsion/ threads were cut too short	1.5
US	0.5
Abdominal X-Ray	0.5

IUD Insertion

Take a relevant Hx	
Patient profile, LMP, G/P	
Contraindication	
Risk assessment	
Fertility plan	
When to follow up after insertion	
4 – 6 weeks	
Give DDx for missing thread & Mx	
Expulsion	
Perforation	
Short thread	
Pregnancy	
What are the complications of IUCD	
Expulsion	
Perforation	
Ectopic pregnancy	
Bleeding pattern, pain	
Vasovagal syncope	
Pregnancy	
Lost thread	

IUD Complication

33 year old patient presents to you with RLQ pain after inserting an IUCD a few weeks ago, she also had appendectomy a while ago

Give a DDx	
Perforation	
Adenomyosis	
Endometriosis	
Ovarian cyst/cancer	
PID	
Uterine fibroids	
Ectopic pregnancy	
Other (non-gynecological)	
How would you approach her?	
History, Physical Examination	
Speculum: looking for the thread	
…	
What will you order for her?	
CBC: R/O infections	
BHCG	
Imaging: US	
…	

DMPA - Contraception

A lady came counseling about DMPA because she is considering it

Efficacy (FR)
<4/1000 over 2 years
Name the side effects for using it
Menstrual changes
Irregular bleeding: unpredictable bleeding, spotting for 7 days or more, the frequency and duration of such unscheduled bleeding decrease with increasing duration of use
Amenorrhea: 50% of women will achieve amenorrhea after 1 year of use so doesn't need any investigation for 6 months from the last injection
Headache
Mood changes
Slow return of infertility (so not recommended for a newly married women who is concerned about her fertility and want it to return rapidly after discontinuation)
Osteoporosis specially in: a) young women, who have not yet attained their peak bone mass b) Perimenopausal women, who may be starting to lose bone mass and who may have reached menopause by the time of DMPA discontinuation, with no opportunity to regain the lost bone mass c) women who are immobilized/wheelchair bound
Discuss the non-contraceptive benefits for DMPA
- Compared with progestin-only pills (POPs): a) DMPA has **higher contraceptive efficacy** (typical use unintended pregnancy rates of 6 versus over 9%) b) **Ease of dosing** (Every 13 weeks compared with daily dosing within a 3 hour time interval) c) **Slower return to fertility** (up to 18 months!) unlike POPs d) DMPA does **not protect users from acquiring STD's** e) An **acceptable contraceptive option** (category 2) for women with known thrombogenic mutations or a history of DVT/PE

Tubal Ligation - Contraception

Sara is a 32 year old P4 patient who presents to your clinic for counselling regarding birth control, She is interested in tubal ligation

Q1: what questions would you ask her to figure out if she is a good candidate for this procedure?	
Married/not	
Why she wants it	
Medical diseases	
Surgical Hx	
Q2: How is it performed?	
Procedure is usually performed with laparoscopic approach and the tubes are closed by coagulation, clipping...etc	
Q3: What are the possible complications?	
Analgesia related: pneumonia, PE,…	
Laparoscopic related: vascular, bowel...	
Failure of the procedure	
Ectopic pregnancy in case of failure	
Q4: What is the FR?	
<1%	
Q5: What are the alternatives?	
Male vasectomy	
Mirena IUD	
Q6: if she complains of heavy periods, what would you recommend?	
Mirena IUD	

Speculum Exam

Do a pelvic exam & obtain a pap smear (Describe what you are doing)	
1	**Professionalism: WIPPE**
	Wash your hands **I**ntroduce yourself **P**ermission: you have to explain procedure & take a verbal consent **P**rivacy & chaperone (it is mandatory either male or female) **P**osition: lithotomy **E**xpose area
2	**prepare equipment:**
	- speculum at room temperature, - lubricants (you can also use tape water instead if it) - light and gloves
3	**start with inspection:**
	- Inspect the vulva - Ulcers (e.g. genital herpes) - Abnormal vaginal discharge (e.g. chlamydia or gonorrhea) - Scars from previous surgery (e.g. episiotomy) - Vaginal atrophy (secondary to post-menopausal changes) - Masses (e.g. Bartholin's cyst) - Varicosities (varicose veins secondary to venous disease/obstruction in the pelvis)
4	**Inserting the speculum**
	- Warn the pt you are about to insert the speculum (put lubricant) - Use your left hand (index finger and thumb) to separate the labia - Gently insert the speculum sideways (blades closed, angled downwards and backwards) - Once inserted, rotate the speculum back 90 degrees (so that the handle is facing upwards)

	- Open the speculum blades until an optimal view of the cervix is achieved - Tighten the locking nut to fix the position of the blades
5	**Inspection inside:**
	- Inspect the cervix - External os (note if open or closed) - Cervical erosions (e.g. ectropion) - Masses (e.g. cervical malignancy) - Ulcers (e.g. genital herpes) - Abnormal discharge (e.g. bacterial vaginosis)
6	**After finishing:**
	- leave the room for privacy and let her re-dressed - once dressed, tell her the findings and plan of management - documents

What are the indication of speculum examination	
Obstetric indications	**Gynecological Indications**
- pap smear - assess amount of bleeding - PROM - miscarriage - high vaginal swab	- visualization of the cervix - rule out any cervical lesion (like polyps..) - asses amount of bleeding - do High vaginal swab - do a Pap smear - insertion/ removal of IUCD or check the thread - to do colposcopy - to do HSG

Speculum Exam – Pelvic Exam

Muna is a 46 year old P3 lady who is complaining of menorrhagia and intermenstrual bleeding for the last year worse in the last 2 month. Muna doesn't have any medical illnesses and never had any surgeries.

Perform a pelvic exam	
Professionalism	
Privacy	
Wash hands	
Inspection: genitalia	
Warn patient before touching and explain the procedure	
Introduce speculum gently	
Comment on: vagina, cervix	
Remove speculum gently	
Introduces fingers gently	
Put 2nd hand on abdomen to feel pelvic organs	
Comment on uterus and adnexa	
Give 4 DDx	
Fibroids/polyps	
Cervical Ca, Endometrial Ca, Endometrial hyperplasia	
Hypo/Hyperthyroidism	
Dysfunctional uterine bleeding	
mention 4 Investigations to order	
Pap Smear	
Endometrial Sampling	
Pelvic US	
CBC, TFT	

Pap smear – Pelvic Exam

Manal is a 36 year old patient who presents to your clinic for a well woman exam.

Do a pelvic exam & obtain a pap smear (Describe what you are doing)	
Professionalism	
Privacy	
Wash hands	
Inspection: genitalia	
Warn patient before touching and explain the procedure	
Introduce speculum gently	
Comment on: vagina, cervix	
Perform pap smear	
Remove speculum gently	
Introduces fingers gently	
Put 2nd hand on abdomen to feel pelvic organs	
Comment on uterus and adnexa	
The result of pap smear is high grade intraepithelial lesion, what does that mean?	
Pre-cancerous condition	
What causes this condition?	
HPV (High grade: 16,18 / Low grade: 6,11)	
What is the next step?	
Colposcopy with biopsy	

Pap Smear – Pelvic Exam

What to do first?	
Introduction	
Prepare Equipment's	
Exposure	
Position (Lithotomy)	
Ask about: Previous pap smear	
Ask about: FHx	
Indications to do it? Screening or diagnostic	
Technique	
Inspection: Mass, Discharge, Bleeding, Changes	
Insert speculum	
What are the types: Cytobrush: 180 degree, Spatula: 360 degree	
What to do next	
I put it on the slide	
Why there is 2 slides?	
Slide to use and a substitute slide	
What do we add on the slides?	
Cohol Concentration	
How much is the concentration?	
96%	
Why do we take 2 swabs?	
We use a **Dry swab** for: Bacterial vaginosis (grey-white discharge, fishy odor) Candidacies (Cheesy white) And a **Wet swab** (normal saline) for: Trichomonas (yellow discharge) because if it was dry the M.O would die	

Hysterectomy Consent

A patient is scheduled for a laparoscopic hysterectomy due to prolapse

how to take consent from her (what would be written on the consent paper)
Patient name
National number
Doctor name
Hospital name
Date of consent, Date of surgery
Dx and indication for surgery
Explain the procedure
Explain the complications of the procedure: - Intra-op: Injury to other organs: ureters, bladder, rectum, bowel and blood vessels - Post-op: Thrombosis, adhesions, post-op blood transfusion, reopening, wound infection
Take the patient signature

What will you discuss with the patient?

PREPARE:

Procedure explanation
Risks (Intraoperative, post-operative)
Expectation of the patient
Preference of the patient
Alternatives discussed
Reasons or indications
Expenses of the procedure
Decision of the patient

What are the risks the patient prone of?

Intra-operative	Post-operative
- Complications of anesthesia - Injury to bowel, bladder, ureter - Bleeding - Risk of blood transfusion - Surgery (may be converted to abdominal (if vaginal) - Surgery may need reopening - Thromboembolic (we avoid by: shortening the time during surgery, hydration, pneumatic compression, blood replacement)	- Infection (UTI) - Infection of incisional wound - Recurrence of prolapse - Risk of death

What do we advise the patient post-operatively?

- Hygiene
- Avoid intercourse for 6 weeks
- Use laxatives for 2 weeks

+ mobility.

Post-TAH Evaluation

A patient in the 1st day post-TAH due to large fibroids

What do you want to ask her	
Ask for any complain	
Did she urinate normally	
Did she pass stool/gasses	
Did she drink fluid	
Did she eat anything	
Did she walk	
…	
What are the non-pharmacological things that can be done to decrease the DVT risk?	
Early mobilization	
Good hydration	
Leg exercise	
If her temperature is 38.4, what are the DDx?	
Atelectasis	
UTI	
After 1 weeks she came back with fever & discharge from the wound, how will you manage her?	
Admission	
Take swab & culture	
Clean the wound and dressing	
Give antibiotics	

Category	Day	Description
Wind	POD 1-2	the lungs, i.e. pneumonia, aspiration, and pulmonary embolism; atelectasis has been commonly cited as a cause of post-operative fever, but supporting evidence is lacking[2][3]
Water	POD 3-5	urinary tract infection, possibly catheter-associated (if a urinary catheter was inserted during surgery or remains in place currently i.e. Foley catheter)
Wound	POD 5-7	infection of the surgical incision(s), either superficial or deep[4]
(W)abscess	POD 5-7	infection of an organ or space[5]
Walking (or VEINS pronounced like "Weins")	POD 5+ (risk may persist for months post-operatively)	deep vein thrombosis or pulmonary embolism
Wonder drugs or "What did we do?"	Anytime	drug fever or reaction to blood products, either a febrile non-hemolytic transfusion reaction or transfusion-related acute lung injury
Wing/Waterway	Anytime	bloodstream infection, phlebitis, or cellulitis related to intravenous lines, either central or peripheral

Other cases with incomplete checklists

Case of Acute Abdomen
Take relevant Hx
Name a DDx
What tests would you like to order

Vaginal bleeding
21 year old presented with abdominal pain and vaginal bleeding
Take a relevant Hx
Give 2 DDx
What investigations would you like to order

Obstetrics

Obstetric Hx

Heba is a 35 year old pregnant woman, Please take a patient profile and history of current pregnancy an previous pregnancies (i.e Obstetric Hx)

Take a detailed Obstetric Hx		
G6P4+1		1
G1	FTNVD, alive Male, B.wt 4 kg, no antenatal neither post-natal complications, Breast fed for 1 yr, not admitted to NICU	1
G2	1st trimester complete miscarriage	1
G3	FT, alive female, B.wt 3.9kg, vacuum delivery for prolonged second stage, admitted to NICU, No antenatal complications, Retained placenta and MROP (manual removal of the placenta) Breast fed for 6months	2
G4	FTNVD, alive male, B.wt 4.2kg, no antenatal complications, PPH, blood transfusion 2 units, Breast fed for 6months	2
G5	FT, alive male, B.wt 3.8kg, no complications, emergency CS for fetal distress, Breast fed 10 months. The boy died 2 years in RTA ago at the age of 5.	2
G6	now, baby active, no complications	1

Components of Obstetric History

- YEAR
- SEX
- TERM/NOT
- PLANNED/WANTED
- MOD, USE OF INSTRUMENTS
- COMPLICATIONS (PRE, DELIVERY, POST)
- NICU
- BIRTH WEIGHT
- OUTCOME OF DELIVERY (ALIVE,..)
- BREAST FEEDING
- WHAT IS HE CURRENTLY DOING

Booking Visit

Hala is a 26-year-old who presents to your clinic for a booking visit (First prenatal care visit).

Take relevant Hx	
Gravida, Para	0.5
LMP	0.5
Menstrual Hx	0.5
Pregnancy planned? Wanted?	0.5
How pregnancy Diagnosed	0.5
Pregnancy Sx	0.5
Urinary/Bowel Sx	0.5
Abnormal vaginal bleeding	0.5
Obstetric Hx	0.5
Medical Hx	0.5
Surgical Hx	0.5
Drug Hx (Current medication)	0.5
Smoking? Alcohol?	0.5
Order investigations	
CBC	0.5
BG	0.5
Urine analysis / culture	0.5
Hep B surface antigen	0.5
Rubella IgG	0.5
HIV	0.5
Syphilis (Rapid plasma regain - RPR)	0.5

Prenatal Visit

Farah is a 22 year old women G1P0 who is 37 weeks pregnant (EDD 5/12/12) Pregnancy has been uneventful. She presents to your clinic for a regular prenatal visit

Q1. What Qs will you ask her	
Contractions	
Vaginal bleeding	
Leakage of fluids	
Fetal movements	
Q2. Perform an Obstetric exam	
Professionalism	
Measure B/P	
Fundal height	
Fundal grip (Part occupying the fundus)	
Lateral grip (Lie, position)	
1st pelvic grip (Pawlick's grip – presenting part)	
2nd pelvic grip (Engagement)	
Listen to fetal heart	
Q3. Fundal height is only 32 cm, what is your DDx?	
PROM	
IUGR	
Wrong date	
Q4: Assume Farah GA is 32 weeks and the fundal height is 35 cm, what is your DDx?	
Polyhydramnios	
Macrosomia	
Fibroid or Full bladder	

transverse Lie.

Postpartum Discharge

You have been called to assess a primiparous healthy lady who had uneventful ANC. She had a vaginal delivery 18 hours ago. Your task is to assess if she is fit for discharge

Q1. What Qs will you ask her, Take focused Hx	
1. Ask for any complain	0.5
2. Patients blood group & Rh	0.5
3. GA at time of delivery	0.5
4. was labour spontaneous or induced	0.5
5. Type of vaginal delivery	0.5
6. Fetal outcome	0.5
7. Any post-partum complications (bleeding)	0.5
8. Did she urinate normally	0.5
9. Did she start breast feeding	0.5
10. Hx of Episiotomy	0.5
Q2. What relevant clinical examinations would you perform	
1. General examination to exclude pallor	0.5
2. Vital signs (BP, Pulse)	0.5
3. Breast exam	0.5
4. Abdominal exam: - For distension, softness, tenderness - Well contracted and retracted uterus	0.5
5. Local inspection of pad or underwear for bleeding	0.5
6. Examine for episiotomy	0.5
Q3. On discharge, what are your advices for her	
1. Advice for breast feeding	0.5
2. Advice for early postnatal visit for mother and infant	0.5
3. Advice mother for family planning	0.5
4. Care for episiotomy	0.5

Obstetric Examination

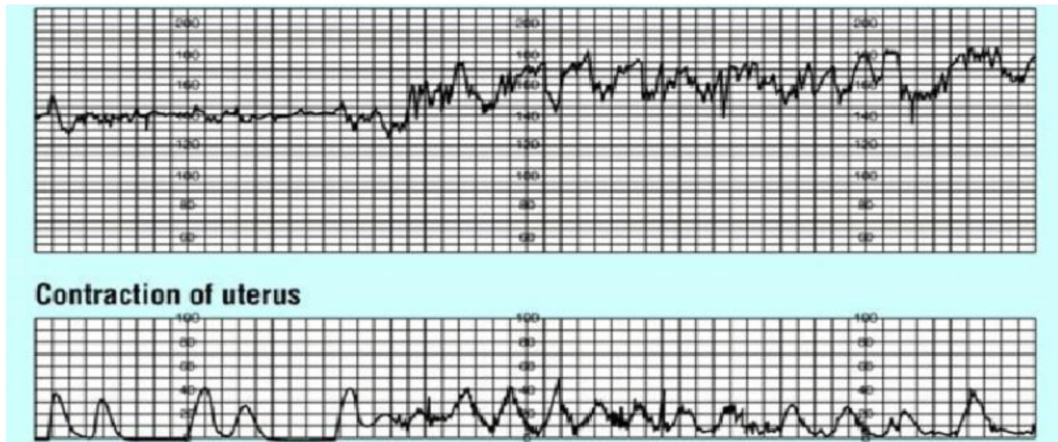
29 year old female G1 P0 came to your clinic for a regular visit, her pregnancy was uneventful, she is now 37 weeks of gestation

Take a relevant obstetric Hx	
Ask about the following (During this pregnancy)	
Ask about fetal movements	
Ask about fluid leakage	
Ask about bleeding	
Perform a Leopold's examination	
Professionalism	
Measure B/P	
Fundal height	
Fundal grip (Part occupying the fundus)	
Lateral grip (Lie, position)	
1st pelvic grip (Pawlick's grip – presenting part)	
2nd pelvic grip (Engagement)	
Listen to fetal heart	
If SFH was 32 what do you call it?	
…	

Mention DDx for low SFH	Mention DDx for high SFH
Error in EDD	Error in EDD
Fetus descent into the pelvis	Twins
IUGR / SGA	Macrosomia / Large for GA
Oligohydramnios	Polyhydramnios
Non-longitudinal lie	Breech birth
	Hydatidiform mole

Reduced Fetal Movements – Obstetric Examination

Maha is a 32 year old G2P1 who is currently 36 weeks pregnant. She has been under your care during this pregnancy. The pregnancy has been uncomplicate, She presents complaining of reduced fetal movements



Q1. What Qs will you ask her	
Contractions	
Vaginal bleeding	
Leakage of fluids	
Fetal movements	
Q2. Perform an Obstetric exam	
Professionalism	
Measure B/P	
Fundal height	
Fundal grip (Part occupying the fundus)	
Lateral grip (Lie, position)	
1st pelvic grip (Pawlick's grip – presenting part)	
2nd pelvic grip (Engagement)	
Listen to fetal heart	
Q3. What is her next step in Mx?	
CTG	
Q4. Read the CTG	
140`s, moderate variability	
Accelerations present, no decelerations, contractions present	

Spontaneous Labor

Mrs X is 39 weeks pregnant, she was admitted to the labor ward as a case of spontaneous labour (NVD), you were ask to see her

How will you assess her condition/What would you do to follow up	
1. Check anti-natal record, define risk	0.5
2. General examination: pallor, edema, BMI	0.5
3. Vital signs	0.5
4. Heart & Lungs	0.5
5. Urine dipstick	0.5
6. Abdominal Exam	0.5
7. Vaginal Exam	0.5
8. Position in labour	0.5
9. Monitoring progress in labour	0.5
10. Pain relief	0.5
What you will monitor in this lady and how often you need to do it " Investigations and physical examination)	
1. FH either continuously on intermittently every 15 minutes during 1st stage and every 5 minutes during the 2nd stage or every other contraction	1
2. PR every hour	1
3. VE every 4 hours	1
4. BP, Temp every 4 hours	1
5. Contractions every 30 minutes	1
For each point of these 0.5, and for the time being mentioned 0.5	

Vaginal Delivery

Nawal is a 32 year old lady G2 P2 she had a vaginal delivery 6 hours ago

Mention 4 criteria for NVD	
1) Onset Spontaneous expulsion 2) Singleton 3) Presented by vertex 4) Within a reasonable time (not <3h & not > 18hrs) 5) Alive 6) Through birth canal 7) Without complications for both 8) Term	
In a brief hx what would you like to ask Nawal	
1. Ask for any complain	
2. Patients blood group & Rh	
3. GA at time of delivery	
4. was labour spontaneous or induced	
5. Type of vaginal delivery	
6. Fetal outcome	
7. Any post-partum complications (bleeding)	
8. Did she urinate normally	
9. Did she start breast feeding	
10. Hx of Episiotomy	
On abdominal exam the uterus was found to be 2 cm above the umbilicus, mention possible causes	
1. Uterine atony	
2. Retained products of conception (RPOC)	
3. Full bladder	
4. Fibroids	
5. Ovarian mass	

C/S Delivery

A patient came to ask you some questions about her delivery (C/S)

What you should tell the patient first	
C/S has more complications than NVD	
How do you prepare the patient before the surgery	
Baseline lab tests	
Empty the bladder	
Anesthesia	
What do you recommend the patient for her post-natal care	
Encourage breast feeding	
Family planning options	
Immediate consult for any complaints	
Follow up for the incision	
Mobilization and eating	
Mention 2 late complications of C/S	
- DVT - Incisional hernia - Scarred uterus due to adhesions - Ectopic pregnancies - Placenta previa	
Name the advantages of pfannenstiel incision over classical midline	
- Cosmetic - Less pain post op - Less dehesince - Less incisional hernia	

Post Date Case

Mrs. Tamara who is worried because she passed her EDD.

Take relevant Hx	
Professionalism	
Age/Date of marriage	
Gravida, Para	
LMP, EDD, GA	
BG, Rh	
Chief complaint	
Hx of Current Pregnancy	
Hx of Antenatal Care	
Fetal Movements	
Medical Hx	
Surgical Hx	
Drug Hx, Allergy	
What clinical signs you will look for?	
General Exam, BP	
Obstetric exam: size, lie, presentation, engagement, fetal heart	
Vaginal examinations: Bishops score, pelvic adequacy	
Mention one important investigation that you would like to do to determine your management.?	
Modified biophysical profile (NST & AFI – amniotic fluid index)	
If your investigation is normal, what is your Mx?	
to wait for another few days (3-5 days)	

Puerperal Pyrexia Case

Eman is 24 years old, delivered with C/S last week. She presents to the emergency room complaining of generalized weakness and feeling hot.

Focused Hx	
Respiratory Sx: cough, chest pain, SOB	0.5
Breast Sx: mastalgia, nipple discharge, swelling	0.5
Wound site: pain, discharge	0.5
Urinary Sx: dysuria, pain, urgency, frequency	0.5
Vagina: bleeding, discharge (offensive)	0.5
Lower limb: pain, swelling	0.5
Q2: What will you call her condition?	
Puerperal pyrexia	0.5
Q3: Possible Causes of this condition?	
Chest infection	0.25
Breast problems: engorgement, mastitis	0.25
Wound infection	0.25
UTI	0.25
Genital tract infection or RPOC (retained products of conception)	0.25
Thromboembolic diseases	0.25
Q4: Investigations to orders?	
BG, CBC	0.5
Urine analysis/culture	0.5
CXR	
Pelvic US	
HVS (high vaginal) & endocervical swab, wound discharge swab	
Q5: on abdominal exam you note that her incision is red, hot and you also notice a discharge. What is your management?	
if mild: outpatient, if moderate to severe: inpatient	0.5
take a swab from the discharge	0.5
Cleaning and dressing	0.5
Broad spectrum antibiotics and we may add a topical one	0.5

Puerperal Pyrexia Case

26-year-old female, after 1 week of normal vaginal delivery she started complaining of fever and offensive vaginal discharge

Focused Hx	
…	
What will you look for on physical examination	
…	
Investigations to be done	
BG, CBC	
Urine analysis/culture	
CXR	
Pelvic US	
HVS (high vaginal) & endocervical swab, wound discharge swab	
What is your Dx	
UTI (most likely)	

Twins

A pregnant lady with twins (dichorionic, diamniotic) came to the clinic

What are the risk factors for twin pregnancy	
Previous twin pregnancy	
Family Hx of twins	
Older age	
Multi-parity	
Fertility treatments	
African-American	
Obesity/High stature	

What are the complications on the mother and the fetus	
Mother	**Fetus**
• Miscarriage • PTL • PET • GD • Abruption • Anemia • UTI • Anomalies • Polyhydramnios • Malpresentation • CS • PPH	• Prematurity (MC!) • PROM • Congenital anomalies • Umbilical cord: velamentous, prolapse, vasa previa • Discordance – unequal weights • TTTS (all MC carry risk) • Antepartum death of 1 twin • IUGR • unequal placenta surface • genetic syndrome • Cerebral palsy risk

Abdominal Pain

A pregnant lady 34 GA, presented with abdominal pain

Take a relevant Hx	
Patient profile	
SOCRATES	
Ask about contractions	
Ask about vaginal bleeding	
Fetal movements	
History of trauma	
Previous episodes	
S/Sx of UTI	

Name DDx

1) **labor pain** ,ask about passage of show, liquor

2) **APH,** if there was bleeding we think of abruption
* Placenta previa can be painful if mixed with abruptio or labor pain
* If no bleeding in placenta previa we think of abnormal placentation (accreta..)

3) **HELLP syndrome**: the most serious condition you want to r/o (high morbidity and mortality)
* Severe preeclampsia risk factors in this case is:
a) primigravida (g=1,p=0)
b) extreme of age (less than 20 and more than 40)

4) **complicated ovarian cyst of pregnancy** ..corpus luteal cyst

5) **Red degeneration of fibroid**

6) **UTI** ..dysuria is the main complaint in UTI in pregnancy, ask about rigors /chills (pyelonephritis)

7) **Gastroenteritis** ..N&V

8) **Cholecystitis**

9) **Appendicitis** ..its incidence doesn't change in pregnancy (no increase risk in pregnancy) but its site change into RUQ, more complicated, more peritonitis in pregnancy

Hypertensive Case – PET

Mrs. Johnson is 39 years old, G3P2, presented to emergency department, complaining of headache, her BP was 166/112.

Take relevant Hx	
Professionalism (wears a lab coat…etc)	0.5
Communication skills (did he introduce himself…etc)	0.5
LMP	0.5
Headache: site, duration, etc..	0.5
Associated Sx: epigastric pain, RUQ pain, blurry vision, oliguria, vaginal bleeding	1
Fetal movement	0.5
Current pregnancy complications	0.5
Prenatal care	0.5
Obstetric Hx	0.5
Medical Hx: HTN, DM, renal disease	0.5
Family Hx: HTN	0.5
Order Investigations?	
CBC, platelets (low platelets, RBC hemolysis)	0.5
Urine for protein, Urine Analysis (Proteinuria, oliguria)	0.5
KFT	0.5
LFT (Liver enzymes elevated)	0.5
Abdominal US	0.5
Medications to lower her high BP?	
Labetalol (β – Blocker)	0.5
Nifedipine (Calcium channel blocker)	0.5
Hydralazine (vaso-dilator)	0.5
How to manage the patient	
Delivery of the fetus even if preterm: if fetus <24 weeks then terminate pregnancy, if >32 weeks then there is no cause not to deliver the fetus	
Anti-hypertensive medications	
MgSO4 for prevention and control the convulsions	
Fluid Mx	

Pre-conception counseling for DM patient

When do you recommend contraception
Recommended 6 months to 1 year until glycemic control is achieved <6.5 but we attempt to achieve A1C <6 if this is possible without inducing significant hypoglycemia
Are Metformin and insulin safe?
Yes
What do you recommend an obese patient
They should be encouraged to reduce weight prior to conception
What aspects do you care about considering screening
Pregnancy screening for: HIV, syphilis, rubella IgG, hepatitis B
Monitoring for maternal medical complications (retinopathy, nephropathy, HTN, Cardiovascular, Ketoacidosis, thyroid disease
Monitoring for fetal, Obs complications: congenital anomalies, preeclampsia, macrosomia, preterm, C/S
What lab tests you want to order
A1C
Serum Creatinine
Estimated GFR
Aspartate aminotransferase & Alanine aminotransferase
TSH
Urine albumin creatinine ratio (spot urine or 24 hr collection for protein and creatinine)

examination for women with diabetes
Dilated funduscopic examination by an ophthalmologist
Examination for thyromegaly
Cardiac auscultation
Evaluation for carotid bruits and pulses present to the periphery
Blood pressure measurement in both arms and pulse, lying and standing to check for orthostasis
Lung auscultation
Check for succession splash if patient not fasting
Check sensation and check for tremor, hypo- or hyper-reflexia

Gestational Diabetes

A women attends the antenatal day assessment unit to discuss the results of her glucose tolerance test (GTT). She is 42 year old and this is her 6th pregnancy, all booking tests were normal. She is from Jordan. Her father and maternal aunt have type II DM

What criteria for the Dx of gestational diabetes	
Glucose challenge test (75gm/100gm)	
Fasting glucose 75 gm	
Fasting blood suger > 7.8	
Post-prandial blood surger > 11.1	
Mention 2 risk factors for this condition as mentioned in the hx given	
FHx	
Increased maternal age	
Other: - Age >25y, BMI > 25, previous GDM, FHx of DM in 1st degree relative, previous macrosomic baby (≥ 4Kg), polyhydramnios, large for date baby in current pregnancy, previous un explained stillbirth	
Mention 2 things you would examine and why?	
BMI	
BP	
FHR	

Mention 2 maternal and 2 fetal complications of GDM	
Maternal	**Fetal**
- ↑ risk of hypertension - ↑ risk of c –section, instrumental deliveries - ↑ risk (40-60%) of developing DMII within 20-15 y (hence woman should be screened annually)	- Macrosomia (>4kg) - increase C-section, instrumental deliveries, birth trauma (brachial plexus injuries, clavicular fractures) - ↑ in neonatal hypoglycemia (24%), hyperbilirubinemia, polycythemia - ↑ risk of DMII, obesity in life

PROM

You are the on call doctor in labor and delivery. Muna is a 28 yr old G2P1 (EDD 16/1/13) who presents with a big gush of fluids. No contractions or vaginal bleeding. Muna reports normal fetal movements. Muna had regular prenatal care and pregnancy was uneventful. Last baby delivered 2 years ago with NVD, Muna`s HR 92. B/P 120/70, RR 18, T 36.8

Fundal height 37 cm. Longitudinal lie, vertex presentation, Head 4/5th palpable abdominally, Membranes ruptured, Pelvis adequate, cervix anterior, soft, 3 cm dilated, -2 station, occipto-transverse position. 60% (1 cm) effaced. FHR 140`s. Variability moderate Accelerations present, no decelerations You admit Mona to labor and delivery.

Perform Obstetric Exam	
Professionalism	
Measure B/P	
Fundal height	
Fundal grip (Part occupying the fundus)	
Lateral grip (Lie, position)	
1st pelvic grip (Pawlick's grip – presenting part)	
2nd pelvic grip (Engagement)	
Listen to fetal heart	
Is the Cervix Favorable for induction	
Yes	
How will you manage her	
Induction of labor	
Oxytocin	
Muna `s labor is augmented with oxytocin. What is the minimum progress you expect every hr? How will you monitor fetal wellbeing?	
Oxytocin progression: Infusion starts at a rate of 1-2mU/min and increased Q 30 min (max 32mU/min), Increased until 4-5 contractions/10 min, Contraction start within 60 m & ends within 4 hr (From slides)	
Biophysical profile, CTG (Assumption :P)	

PROM

Mrs Sara 39 year old, G10 P7+2 all vaginal deliveries, presented to the labor ward at 36 w + 5 days complaining of watery vaginal discharge for the last 2 hours. You are the doctor covering the labor ward

List steps of obstetric exam (Leopold's)	
Professionalism	
Measure B/P	
Fundal height	
Fundal grip (Part occupying the fundus)	
Lateral grip (Lie, position)	
1st pelvic grip (Pawlick's grip – presenting part)	
2nd pelvic grip (Engagement)	
Listen to fetal heart	
What is the next step and why	
Speculum exam (PPROM) not PV	
If the presentation is breech, what is the most likely cause at term and do you know any maneuver to avoid C/S delivery	
Multi-parous (lax muscles – in this case)	
Other causes: septate uterus, unicorneate/bicorneate uterus, previous breech presentation, any uterine massesm, multiple gestations	
We try ECV (external cephalic version)	
If SFH goes with 40 weeks name possible causes for this	
Wrong date, multiple gestations, polyhydramnios, macrosomia, any masses in the uterus, placenta previa	

PROM

Mrs. Suzan G3 P2, EDD 1/12/2019, presented with gush of fluid (PROM)

What will you do for physical examinations	
General examination	
Vitals Signs	
Abdominal examination	
Leopolds maneuver (detailed)	
Speculum	
Bishops score	
Investigations to confirm (only the main, US & FHR are not counted)	
Investigations to confirm (mention only the main, FHR/US are not counted)	
Nitrazine test	
Ferning test	
Amnisure test	
Patient vitals are all normal, on bishops score (cervix anterior, soft, station (+3), length 1 cm, dilation 5 cm), calculate the score and is it a favorable cervix	
the score is 12 and yes she is favorable of having a normal vaginal delivery (>8)	
What will you do for her?	
…	
What is the progress of cervical dilatation	
She’s multipara: 1.2 cm/hour	
How would you monitor the FHR	
Every 5 minutes or after every other contraction	

Score	Dilation (cm)	Position of cervix	Effacement (%)	Station (-3 to +3)	Cervical Consistency
0	Closed	Posterior	0-30	-3	Firm
1	1-2	Mid position	40-50	-2	Medium
2	3-4	Anterior	60-70	-1, 0	Soft
3	5-6	--	80	+1, +2	--

PROM – Vaginal Discharge

This is a pregnant lady 32 year old, G3P2, complaining of vaginal discharge for the last 4 hours

Take relevant Hx	
Introduce yourself	0.5
Professionalism	0.5
Gravida, Para	0.5
LMP to determine GA	0.5
Chief complaint	0.5
Discharge analysis: character, color, amount, odor	0.5
Associated Sx: Itching, Redness	0.5
Discomfort	0.5
Fetal movement	0.5
Abdominal pain	0.5
Urinary Sx	0.5
Previous episodes	0.5
Smoking	0.5
What do you expect to find on the examination	
Fundal height less than GA	0.5
Speculum exam: pooling?	0.5
Give 2 DDx	
PROM	0.5
Leukorrhea	0.5
Vaginitis (UTI)	0.5
Urine incontinence	0.5
Mention 2 tests that may help you to confirm your Dx	
Nitrazine test	0.5
Ferning test	0.5
Amnisure test	0.5

Antepartum Hemorrhage (APH)

Suhair is 29 years, she is a healthy lady and she is pregnant 33 weeks with her third baby. She presents to the labor ward complaining of some bleeding that she noticed on her underwear 1 hour ago.

Take relevant Hx	
Gravida, Para	0.5
LMP	0.5
BG, Rh	0.5
Associated Sx: pain (+analysis), labor contraction, liquor passage	0.5
HTN	0.5
Trauma Hx	0.5
Sexual intercourse Hx	0.5
Bleeding elsewhere	0.5
APH Hx	0.5
Fetal Activity	0.5
Mode of deliveries	0.5
Whats Next?	
Physical exam	0.5
General, VS, BP, PR	0.5
Abdomen: SFH, tenderness, fetal heart	0.5
Speculum	0.5
Inspect the pad	0.5
Your 1st investigation	
US to localize the placenta	0.5
Next	
CTG	0.5
How will you manage her if she is stable and no more bleeding	
Conservative	0.5
Steroids	0.5

Antepartum Hemorrhage (APH)

Take the history of the present pregnancy	
LMP	
How this pregnancy was diagnosed (urine, blood test)	
Booking visit	
Antenatal care (regular/any event)	
Take history of presenting complaint	
Duration, Color	
Abdominal pain, associated Sx (Sx of PET)	
Fetal movement	
Hx of trauma	
What is the booking visit	
First visit to the AN clinic	
What should be done for the lady in the booking visit	
Detailed Hx	
Through examination, weight	
Vitals (BP, Temp, Pulse, RR)	
U/S (IUCS, FH, Number of fetuses, GA)	
Urine analysis, blood glucose level	
Name the steps for obstetric exam	
Inspection	
Fetal height	
SFH and GA	
Fundal grip	
Lateral palpation	
1st pelvic grip (Pawlick's grip – presenting part)	
2nd pelvic grip (Engagement)	
Listen to fetal heart	
Can you define NVD	
Term, singleton, vertex, alive, spontaneous, no complications	

Post-Partum Hemorrhage (PPH)

Sam is 35 years who had her 5th baby 30 minutes ago. You were called by the midwife to review the patient because of bleeding.

What do you want to know from the MW?	
Mode of delivery (MOD), progress of labor	0.5
Estimated blood loss (EBL) at the delivery	0.5
Placenta	0.5
Medical conditions: HTN	0.5
Antenatal (AN) complications	0.5
Syntometrin (Oxytocin)	0.5
Q2: What will you do?	
Assess bleeding amount	0.5
Call for help	0.5
ABC	0.5
2 large IV lines, CBC, clotting profile, X-match 4 units of blood	0.5
IV fluids	0.5
Catheter	0.5
Check the uterus for atony	0.5
Recheck the placenta	0.5
Check for trauma	0.5
Check for bleeding disorders	0.5
Q3: Mention 2 causes of PPH?	
Trauma	0.5
Atony	0.5
Q4: Types of PPH?	
Primary: <24 hr - Atony	0.5
Secondary: >24 hr – Retained tissue/infection	0.5

if there is use of instrumental delivery

Post-Partum Hemorrhage (PPH)

Mrs. X, a healthy 30 year old lady was admitted to the delivery room at 39 weeks of gestation. She has a spontaneous vaginal delivery supervised by the midwife and transferred to the postnatal ward. One hour later you were called because she started having heavy vaginal bleeding.

Name the possible causes? (4T's)		
Tone (70-90%)	• ***Antepartum***: - previous PPH - placenta previa - maternal obesity - baby >4kg - multiple pregnancy - IOL	• ***Intrapartum***: - Prolonged labor >12 hr - Prolonged 3rd labor stage - Sepsis
Thrombin	• ***Antepartum***: - PET - Sepsis - Anticoagulants - Inherited bleeding	• ***Intrapartum***: - Placental abruption - Sepsis
Trauma	Uterine/cervical/vaginal injury (instrumental, CS)	
Tissue	Retained products (placenta, membranes)	

Q2: What are the predisposing factors?	
Previous history of the same the condition	0.5
Overdistended uterus (weight of the baby)	0.5
Polyhydramnios or not	0.5
Any local causes	0.5
Bleeding tendency	0.5

Q3: How to Mx this case?	
Call for help, check ABC, vitals	B-lynch suture
Insert 2 large IV lines for fluids	Internal iliac artery ligation
Cross match, insert catheter, KFT, CBC	Hysterectomy
Medications: uterotonics	Arterial embolization
Examine uterus, vagina	Internal iliac artery ligation
Manual uterine massage	
Removal of retained placental tissue	
Trying off bleeding vessels	

Maternal Collapse – Uterine Rupture

A (para4) lady with a history of previous CS that was done because of a transverse presentation of the baby, she had delivered vaginally and now she is hypotensive with no evidence of hemorrhage.

Q: Name possible DDx for this case, and what is the most likely one

- Uterine Rupture (most likely)
- Uterine Inversion
- Uterine Atony
- Amniotic Fluid Embolism
- …

Mention the risk factors for this case

- Previous uterine scars (dehiscence of a CS scar is the mcc)
  - Classical C/S has x20 risk than LUS C/S
- Trauma (External/Obstetric)
- Excessive use of oxytocin
- Grand Multipara
- Uterus Distension (Polyhydramnios, Multiple Gestations)
- Placenta Percreta

What are the physical examination findings

…
1. Loss of uterine contractions
2. hematuria
3. Lower abd tenderness

What is your Mx?

- Call for help, resuscitation (blood transfusion)
- Good control: use of oxytocin, stop bleeding (ligation)
- Immediate laparotomy and delivery of the fetus
- Broad spectrum antibiotics
- Hysterectomy v.s uterine repair

Recurrent Abortions Case

Nada is a 30-year-old lady who presents to your clinic because of recurrent abortions.

Take relevant Hx	
Introduce yourself	0.5
Gravida, Para	0.5
Previous delivery: normal/not	0.5
Previous delivery: GA, weight	0.5
Previous delivery: with cervical tear/not	0.5
Previous miscarriages: GA	0.5
Previous miscarriages: painful/not	0.5
Normal babies on US	0.5
D/C Hx	0.5
Cervix procedures Hx	0.5
Cerclage Hx	0.5
Medical Hx: DM, HTN, SLE, hypothyroidism…	0.5
Medical Hx: DVT, PE, Thrombophilia	0.5
Smoking	0.5
What is your DDx	
Cervical incompetence	0.5
Uterine anomalies	0.5
Antiphospholipid antibody syndrome	0.5
Thrombophilia or balanced translocation chromosomal analysis	0.5
All the investigations came back normal. Nada wants to know what you can do in the next pregnancy to prevent this from recurring.	
Cervical Cerclage	0.5
At what GA?	
11-14 weeks	0.5

Miscarriage Case

Tania is 29 years and she has been married for 9 months. She presented with lower abdominal pain and blood spotting.

Take relevant Hx	
Gravida, Para	0.25
LMP	0.25
Onset of the pain in relation to the bleeding	0.25
Hx of similar attack	0.25
Bleeding analysis	0.25
Pain analysis (SOCRATES)	0.25
Bowel Sx	0.25
Urinary Sx	0.25
Anemia Sx (dizziness, fainting)	0.25
Vaginal Discharge	0.25
Dyspareunia	0.25
Menstrual Hx	0.25
Contraception	0.25
Previous Relationships	0.25
You do a physical examination	
Stable VS, soft, non-tender abdomen	
Next Step?	
US: TV/TA TV US: shows empty uterus and no adnexal masses, no collection in the pelvis	1
Investigation to request?	
β-HCG, BG, Rh, CBC (accept G&S or X-match)	1.5
BHCG is 789, What is your DDx?	
Early pregnancy VS Ectopic	1
How will you manage?	
Options: Conservative, Medical, Surgical	1.5
What is the medical treatment	
Uterotonic Agents (Misoprostol – from slides)	0.5
What advice will you give your patient if she receives the medical treatment?	
Not to get pregnant for 3 months	0.5
What information will you give the patient with a history of ectopic pregnancy if she is planning to get pregnant?	
Risk of recurrence, go to early pregnancy clinic once her period is missed	0.5

Miscarriage

Pregnant lady at 8 GA with vaginal bleeding.

Give DDx	
Miscarriage	
Ectopic pregnancy	
Molar pregnancy	
What investigations you want to order?	
BHCG	
Pelvic examination	
US	
US showed fetus with no fetal heart sound, what is the Dx?	
Missed miscarriage	
How would you manage the patient?	
The management is divided into 3 categories: 1) *Expectant*: most cases will progress to complete miscarriage 2) *Medical*: Misoprostol 3) *Surgical*: D/C	

Ectopic Pregnancy

A patient came complaining of abdominal pain and vaginal spotting

Take a relevant Hx	
…	
Mention 4 investigations that you'll want to do?	
BHCG	
US	
CBC	
ESR	
Triple swab for PID	
What is the most likely diagnosis	
Ectopic pregnancy	
What will you do for her and why?	
Salpingectomy if contralateral tube is healthy or salpingostomy if both tubes are unhealthy	
If you found fluid in the pouch of Douglas and no adnexal masses and you suspect ruptured ovarian cyst, how will you manage her?	
Observation, repeat US after 6 weeks, give OCPs to prevent future cyst formation	

Partogram

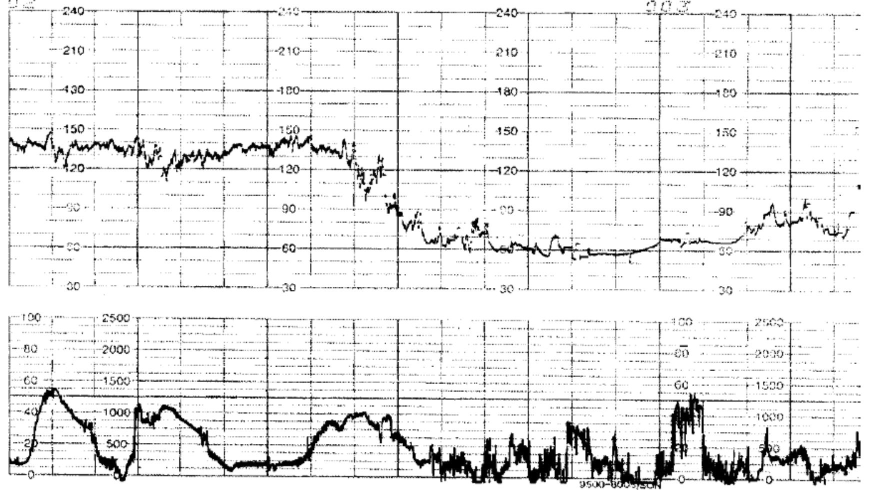
Mrs Mahs is a 29 year old woman P 2. She is full term. Admitted to labor at 0600 am.
In front of you is a partogram. After looking at the partogram answer the following questions

(They didn't put the picture, only the checklist…)

What was the likely action taken at 1100 am?	
ARM	1
How would you describe the progress of labor between 8 am - 12 pm?	
Prolonged active phase	2
What is the action taken at 12 pm?	
Start Oxytocin	1
You are called to see the patient at 0800 pm, what is your diagnosis?	
Failure of descent of the head	2
Mention 3 likely causes for this condition?	
CPD (Cephalopelvic disproportion – occurs when the baby's head is too large)	1
Malposition	1
Malpresentation	1
How would you deliver Maha?	
CS	1

Obstructed Labor / CTG Case

Sara is a 26 year Primigravida at 39 weeks. Her pregnancy was low risk without any complication. She was admitted to the labour ward at 0200 hrs in labour. On admission she was 4 cm dilated, vertex at spines. Artificial rupture of the membrane was done and she progressed smoothly. At 0800hrs she was fully. She started pushing at 0900 but the midwife called you because of this CTG. Her vaginal examination showed: fully dilated, Vx, LOA,+2station(below spines).



Q1. What is Your Dx	
Pathological CTG	1
Q2. What is your plan	
Instrumental Delivery	1
Q3. What instrument will you use? Why?	
Forceps / Vacuum	1
Rapid delivery, experience... etc.	1
Q4. Name 4 pre-requisites for any instrumental delivery	
Fully dilated	0.5
ROM	0.5
Adequate analgesia	0.5
Empty bladder	0.5
Q5. Mention 1 contraindication	
Position unknown	1
Q6. Name 2 maternal complications	
Trauma	0.5
PPH	0.5
Q7: The fetal head comes out but delivery becomes difficult. Dx?	
Shoulder dystocia	1
Q8: Mention 2 RF for this complication?	
DM	1
Macrosomia	1

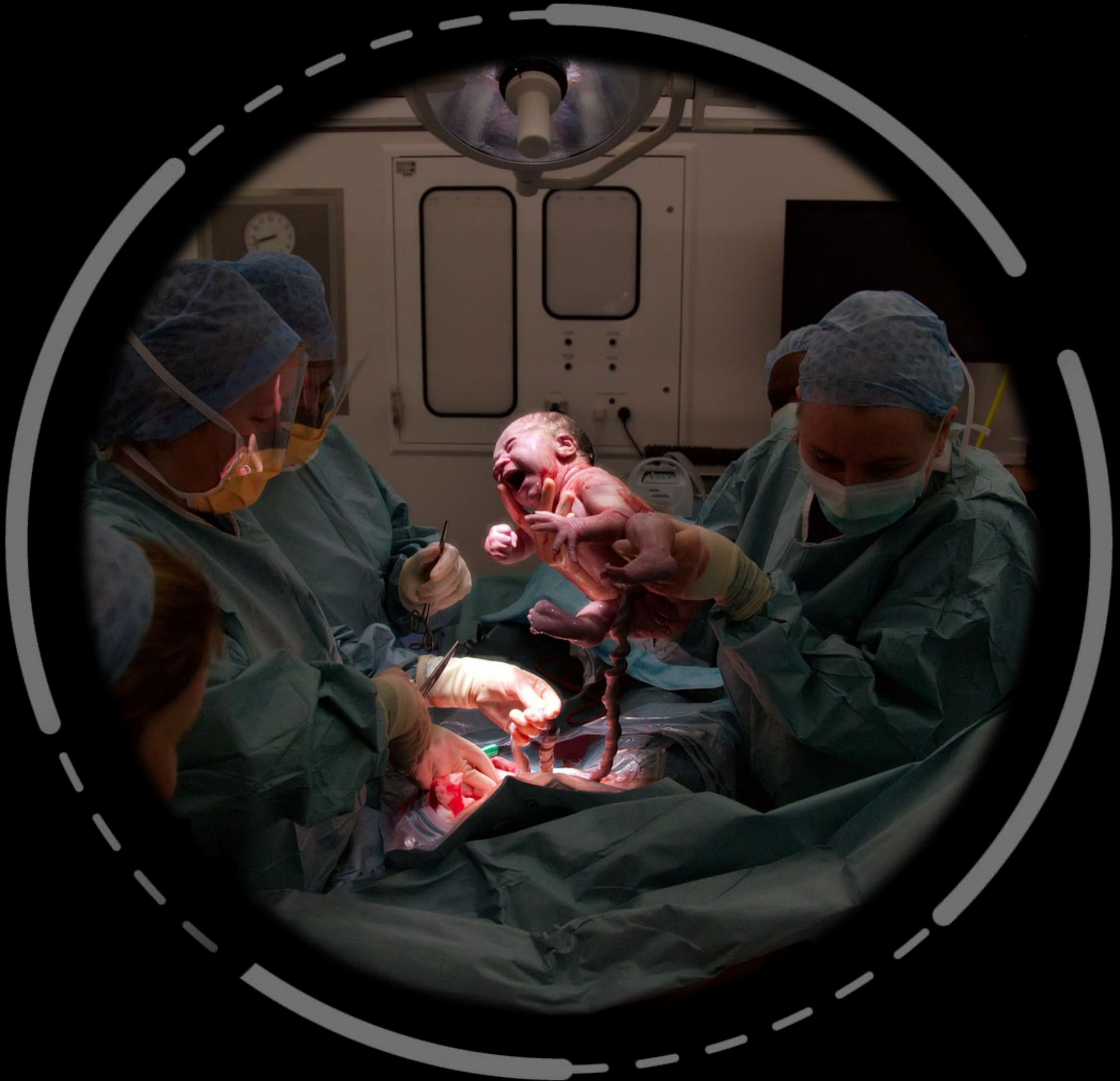
Other cases with incomplete checklists

Labor
35 year old female in the labor ward, she is at 39 weeks of gestation with spontaneous contractions
How will you assess the case
Possible causes of this condition

Preterm Labor (PTL)
Take a relevant Hx

Recurrent Abortions
Patient with recurrent pregnancy losses and she is now 10 week GA
Take relevant Hx
What are the investigations you want to order
What is the Mx
At what GA will you do the Mx?

The End, Best Wishes!



Done By: Yazan Alawneh