Cases :

- AUB
- Post-menopausal bleeding
- Vaginal Discharge
- Urine Incontinence
- Pelvi-abdominal mass
- Infertility
- APH
- PROM
- HEG
- puerperal pyrexia
- chronic DM
- GDM

كل موضوع فيهم شامل سلايدات الموضوع ودوسية ضياء ودوسية الهاشمية وcheck list يزن وشوية نوتات من دكتورة نادين

دعواتكم 💚

الموضوع :

الـــدرس :

AUB

① past menstrual cycle: Regular, Frequency, Duration, Amount

Dysmenorrhea (primary, secondary) / (# of pads/clots)

② Analysis of current Bleeding:

- Regular / Frequency / Duration / Amount / Seventy ↔ # of pad affect daily activities.
- Associated symptoms: pain, Fever, mass; Discharge
- IMB, PCOB. → pelvic pain / Dysparunia
- Bleeding from other orificies (Hematuria/epistaxis/ Braising)
- Anemia symptoms ⇒ Diziness, LOC, palpation, SOB, Fatigue.
- preceded by trauma, procedure, IUD, sexual intercourse pelvis surgery.

③ Medical Hx → looking for systemic causes of Bleeding.

- Bleeding disorder (Bruising /Gum bleeding
- Thyriod diz → hypo/ hyper
- Hyperprolacteinemia → Galctorrhea / visual disturbance
- DM/ HTN / Liver failure.
- cancers (endometrial / ovarian / Breast / cervical / colon)

④ Drug Hx: Anticoagulant (Heparin), Tamoxifen. (end. hyperplasia)

→ Contraceptive pills → missed pill

→ IUD → think about perforation.

⑤ Family Hx:

- cancer> (ovarian/ endometrial /cervical/ Breast /colon)
- Bleeding disorder. ◦ DM/HTN.

⑥ social Hx: smoking / Alcohol.

الموضوع :

الـــدرس :

⑦ Age & mensis →

* prebuipital → precocious puberty / Foreign body
* post-menopausal → DDx.
* Childbearing

→ exclude pregnancy (test) ⇒ By Hx : LMP + if she have Regular cycles / not Lactating + symptoms of pregnancy : N&V. Breast tenderness. , Urine frequency , constipation

→ exclude complication of contraception (missed pills → withdrawal bleeding , IUD)

→ Going to PALM coien to know wether structural or non structural cause :

PALM

- Leomyomata = fibriod ⇒ pressure symptoms ⇒ (urine frequency or retention , constipation)
  ⇒ Recurrent pregnancy loss (submucosal)
- Adenomyosis ⇒ HMB + Dysmenorrhea (more PG)
- Malegnancy ⇒ wt loss , anorexia , pallor , mass .

COEIN

- Anovulation ⇒ Dysfunctional Uterine bleeding (By exclusion).
  (ovulatory Dysfunction)
  Hypothalamic Dysfunction ⇒ Low BMI anorexia nervosa excessive excersise
  Hypothyroidism. / Hyperprolactinemia
  PCOS (Irregular cycles / Hirsutism / Acanthosis Nigricans. Obesity)

⑧ previous Investigation : US / TFT / Pab smear / Biopsy.

الموضوع :

الـــدرس :

physical exam: Vitals + BMI → stable ?

General
- signs of anemia : pallor, tachycardia.
- signs of Hypo/Hyperthyriodism. → tachy
  - ↳ BMI ↑, Bradycardia
- signs of metastsis → jaundace, cachexia, ↓BMI.

Neck thyroid exam

Breast Galcterrhea, masses

Abdomin ascitis, mass. ,spider ,navei (liver dz)

peluic
- Inspect vulva + perinum (mass / fissure)
- speculum → vagina + cervix → ulcess / mass / polyp.
- Bimanual → uterus + adnexa → size + shap / mass.

Investigation

- pregnancy test
- CBC
- Ultrasound ⇒ looking for structural causes + pick up endometrial thickness
  - ↳ Biopsy
- TFT + prolactin.
- coagulation profile.
- LFT, KFT
- pab smear.

الموضوع : .....

الـــدرس : .....

Treatment

- correction of anemia.
- treatment depends on age/ cause/ desire of fertility.

Medical

- Hormonal ⇒ Mirena (1st of choice) Levonorgestrl
  - progestgens. Northisterone
    - (٢٦-٥) ⇐ not contraceptive ⇐ يوم ٢١ بعطيها
  - COCP
- Non Hormonal ⇒ Tranexamic acid 1gm x 3
  - (٤-١) ⇐ during period بعطيه
  - antifibrinolytic / Risk of thrombosis
  - ⇒ Mefanemic acid (NSAID)(PGSI)
- GnRHa (٥-١) ⇐ during period بعطيه
  - 500 mg x 3

Surgical

1. Endometrial Ablation ⇒ Destruction of 5mm of Basalis.
   - 2 generation
     - resectoscopic ⇒ Resection
     - non-resectoscopic ⇒ thermal, cryo microwave, heated fluid
2. Uterine Artery Emobliz~~ation~~ us.
3. Hysterectomy.

الموضوع :

الـــدرس :

Post coital bleeding / contact Bleeding.

DDx:

1. Acute / chronic Cervicitis ⇒ mucopurlent discharge ⇒ Doxycline (Broad spetrum) 100 mg x2 / 7day
2. Cervical ectropion ⇒ more columnar proliferation
   ⇒ more estrogen ⇒ pregnancy / CCCP.
   - conservative ⇒ 3 month after delivery / stop CCCP
   - Cautarization ⇒ thermal, Cryotherapy.
3. Cervical ca. ⇒ Do pab smear
4. Cervical polyp. ⇒ polypectomy + send histopathology.

* Atrophic Vaginitis
* STD.

IMB

- physiological ⇒ mid cycle spotting at time of ovulation
- Iatrogenic ⇒ Contraceptive pill withdraw, By IUCD
- Infection ⇒ endometritis, cervicitis, vulvovaginitis.
- Benign ⇒ polyp, fibriod. ectropion
- Malignant ⇒ cervical endometrial ca.
- Bleeding dz.

Post-menopausal Bleeding الموضوع

الـــدرس :

Hx * Age / GP

① Analysis of bleeding ⇒ Duration , Amount , color clots , how it impact life (severity) , previous episodes

- symptoms of anemia ⇒ dizziness , LOC , palpation SOB , fatigue .
- Associated symptoms ⇒ vaginal discharge ⇒ Infection (clamydia , gonorrhea) (trichomonas / candida) pain , mass , back pain , wt loss . related to intercoarse ?

② Risk factor of endometrial ca. اسباب

- early menarche + Late menopause + Nulliparity
- PCOS + Obesity
- Tamoxifen + ERT
- DM + HTN
- white Race + high socio-economic status .

- age of menarche
- age of menopause
- GP ?

③ Past medical Hx : or ④ Family Hx of :-
endometrial , cervical , ovarian , breast , colon Ca ?
→ Thyriod dz , Bleeding dis ?

④ Drug Hx : HRT , Tamoxifen , Anticoagulant ?

⑤ Menopausal Symptoms : Hot flushes + Dryness of vagina .

الموضوع : .....

الـــدرس : .....

⑥ past Gyne Hx: • Age of menarch + menopause
• contraception Hx
• pap smear
• previous Gyn procedures / operation

DDx ⇒ • Atrophic endometritis / vaginits.
• endometrial Hyperplasia / ca. 10%
• endometrial / cervical polyp.
• exogenous estrogen.
• Trauma / uterine sarcoma / cervical ca.
• Infection.

PE

vitals + BMI ↳ ↓ wt for malignancy. obesity is Risk factor of endo. ca.

General • signs of anemia. ⇒ palor / Tachycardia / conjunctival pallness / ↓ BP.

• signs of malignancy

cachexia, lymphadenopathy, ascitis, abdominal mass or pelvic, LL edoma.

pelvic exam ① Inspection → vulva + perinum
mass / Fissure / hemorrhoids.

② speculum
pessary !
↖ Foreign bodies / polyp / ulcers / Atrophic changes.
Dryness / pallor / absent Rugae / thin mucosa. ↵

③ Bimanual ↳ Adnexal mass
↳ uterine size / mobility

④ Take pap smear.

الموضوع : .....

الـــدرس : .....

→ post-menopausal bleeding

Investigation:

① pap smear

② TVS → thickness → >4m → ③ endometrial biopsy

DEC / Hysteroscopy / pipelle.

Treatment → according to cause.

* Atrophic endometris → local estrogen . combined HRT.
* endometrial Hyperplasia / polyp / ca → جراحة
* Infection → according to micro-organism . الجرثوم

الموضوع: Vaginal Discharge / Leukorrhea

الـــدرس:

Hx * Age / Gravida + para / LMP.

① Analysis of discharge ⇒ amount / color / odor / consistency
mixed with blood.

- associated with itching or irritation
most irritant ⇒ candidiasis / mild irritant = trichomoniasis.
- associated with menustration
- Fever / pain (abdomial or pelvic) / maliase → PID
mostly at night → pinworm (?)
- urinary symptoms ⇒ Frequency / Dysuria / Urgency
- IUD / procedures : D&C / HSG / Hysteroscopy.
- Use of Irritant ⇒ soap, spermicides., creams
change the vaginal PH → less acidic → risk for infection
- Barriers method of contraception (condom / diaphragm / cap)
protective

* Medical Hx: DM.
* Drugs : Antibiotics (Resistance)
Steriods / chemotherapy (↓ immunity)
- previous similar Hx
- previous STDs.

الموضوع :

الـــدرس :

DDx :

1. Baderial vaginosis ⇒ Fishy odor, nd irritant / profuse
2. Candidiasis ⇒ extremly irritant / scanty / youghurt like.
3. Trichomoniasis ⇒ mild irritant / profuse / yellowish (STD)
4. Cerviciti; ⇒ Mucopurlent discharge → chlamydia + gonorrheca
5. Acute PID ⇒ Fever / Acute lower abdominal pain / Foul smelling discharge
6. Atrophic vaginiti; ⇒ menopause or use antiestrogen drugs.
7. STD ⇒ Gonorrhea → mucopurlent discharge + urinary symptoms + similar symptom with husband.
8. UTI / vesicovaginal fistula.
9. endocervical polyp
10. Cervical ca ⇒ think about adenocarcinoma of endocervix !

physical exam

Vitals → Fever / tachy + BMI.

- Inspection → Foriegn bodies / Lesions
- Per speculum → signs of Inflammation : Redness
  - → source of discharge
  - → Analyse the discharge.
  - → lesions : ulcers / Nodules / mass
- Bimanual + PV → Jumping sign / motion tenderness → Acute PID
  - → Adnexal fullness or tenderness → Tubo-ovarian Abcess / cyst.

الموضوع :

الـــدرس :

Investigation :

① Microscopic exam: = wet Mount (slide with normal saline)

- Bacterial vaginosis → clue cells
- candidiasis → hyphe / Buds → like shoe print
- Trichomoniasis → flagellated or motile protozoan. (يعني مثل تفرعات الشعرة)

② KOH → disolve non fungal elements so you can detect hyphe → candidiasis.

③ Whiff test → add KOH & look for fishy odor → Bacterial vaginosis.

④ Vaginal PH → Nitrazine PH paper

- Bacterial vaginosis & Trichomoniasis → more Alkaline
- candidiasis → more acidic

Normal PH = 3.8 - 4.5.

⑤ Vaginal culture.

⑥ Cervical culture. ⇒ N. Gonorrhea / chlamydia Trachomatis (mostly Both.)

الموضوع :

الـــدرس :

Treatmeht :

* Bacterial Vaginosis ⇒ Metronidazol 500mg X2 / 7days.
* Candidiasis ⇒ Fluconazole 150 mg → single dose.
* Trichomoniasis ⇒ Metronidazol → 2gm → single dose + treat the partner → STD

* Acute cervicitis → polymicrobial → Doxycline → 100mg X2 7days.
* Acute PID → polymicrobial → Doxycline → 100 mg X2 14 days
  - mild
    - effective gonorrhea → Ceftriaxone IM single dose
    - anerobic → Metronidazol 500 mg X2 14 days.
  - severe → IV cephalosporin
    - Doxycyclin.

الموضوع :

الـــدرس :

Urine Incontinence

تعريفات

- urge incontinence = Overactive Bladder = Detroser Over-activity Incontinence
- Stress Urinary Incontince = Urodynamic incontinence
- Mixed UI = SUI + DO / DOI
  - DO: overactivity without incontince.
  - DOI: you see ↑ Intravesicular pressue do to involuntary contraction without seeing incontince (pass urine)

⇒ Urge Incontince ⇒ Involuntary passage of urine preceded by sudden strong desire to pass urine

⇒ SUI ⇒ Involuntary passage of urine associated with ↑ IAP (cough, Lough, sneeze, strain)

⇒ Mixed ⇒ Having Both....

⇒ Over-active Bladder syndrom = Urgency + Frequency + Nocturia ± Urge Incontinence

⇒ Functional incontinence ⇒ involuntary passage of urine Due to physical or mental impairment, not related to Lower urinary tract dysfunction.

الموضوع :

الـــدرس :

Hx ⇒ Age / LMP / GP ... دائماً ابدأ فيهم ،

① Type of incontinence

1 ⇒ stress urianiary I ⇒ Involuntary leak with ↑ IAP : sneeze, cough, Lough, carry heavy object

2 ⇒ Urge Incontinence ⇒ " when she need to viod, can't make it to toielt " ⇒ Incontinence preceded by urgency + Frequency + Nocturia.

3 ⇒ Overflow incontinence ⇒ continuous dribling + feel of incomplete emptying
↳ think about Neurogenic bladder.

4 ⇒ Mixed UI ⇒ more than one.

5 Functional incontinence ⇒ impaired mobility (Arthritis) → Depression / Delirium.

② Analysis of Incontinence ⇒ physical or mental impairment ?

Duration, Frequncy, Severity ⇒ how many pads
↳ how it affect daily activity

③ Ask about other urinary symptoms.

Frequency, Nocturia, Urgency, dysuria, hematuria, Hesitancy
Feel of incomplete emptyings.

④ Ask about fluid intake, caffiene, alcohol, smoking.

كم كاسة تقريباً ،

⑤ Ask about trauma

الموضوع :

الـــدرس :

Fecal incontinence.

In case of stress incontinence ⇒ has two causes

① POP ② Hypermobile urethra ⇒ Rare.

mass protruding from vagina (?) حتى وهي بسأل هاي بالأسئلة .

causes 1 * Multiparity ⇒ parity (?)

(past obs)

space between pregnancies

prolonged Labor / Instrumental delivery

tears / Laceration.

Large babies.

2 * Menopause ⇒ Remember ↓ estrogen = weak ligaments.

↳ symptoms = hot flushes., difficult sleep.

3 * connective tissue abnormalities =

flat foot, hernias, varicose.

* predisposing factor of POP

chronic cough, chronic constipation, obesity, ascitis

↳ COPD, congestive HF.

الموضوع :

الـــدرس :

② Medical Hx : Neurological dz.

DM / MS / (Neurogenic bladder) overflow incontinence.

prolapse / COPD / Asthma / UTI

③ Surgical Hx :

- pelvic surgeries (?) / Hysterectomy (valvlt prolapse)
- spinal surgeries (?)

④ Drug Hx :

Diuretics , Anticholinergic / musde Relaxant.

HRT , TCA - ACEI / CCBs (?)

HRT ← Menopause (?)

TCA → depression

⑤ Family Hx : DM , Marfan's dz.

الموضوع :

الـــدرس :

DDx of Urinary Incontence :

Reversible ⟹ DIAPPERS.

Delirium , UTI , Atrophic vaginitis , Pharmaceutical , psychological

Excess urine Output (↑ fluid intake / caffiene / alcohol / diuritics

DM) ↑ polyuria ?

Restricted Mobility , Stool impaction .

Genitourinary causes

- stress Incontinence
- DO
- Mixed UI
- Urogenital fistula → vesicovaginal / urethrovaginal
- Urethral Diverticulum.

Non Genitourinary

- Functional → impaired mobility / mental dis.
- Drugs.
- Neurogenic → DM / MS.

الموضوع :

الـــدرس :

PE

① General → vitals + BMI (obesity ↔ DM)

↑ Intraabdomical pressure → POP → SUI

→ if pt is mobile / mental status.

chest exam ⇓ chronic cargh / COPD.

② Abdomin → scars, mass (press the bladder), hernias

→ costovertebral tenderness

③ Neurologic exam → Inspection → Back: deformity, hair tuft (sacral reflex)

lower extremeties : sensation

strength / Deep tendon Reflex.

(pedendal nerve) perinum → sensation.

④ pelvic exam = → speculum + Bimanual → pelvic mass

- Atrophic vaginitis :

loss of rugue / pale mucosa / thin mucosa

- Cystocele →

put sims speculum at posterior vaginal wall

cough → look at mass from ant vaginal wall.

- Urethral Diverticulum :

→ palpate suburethral area → mass

→ tenderness

→ watery discharge with compression.

- Hyper-mobile urethra

Q-tip test.

(+) ≥ 30° لو تحركت أكثر من

Collagen ⇒ peri-urethral injection.

الموضوع :

الـــدرس :

Investigation:

1. Urine Analysis + Urine culture ⇒ exculde UTI.
2. Bladder Diary.
   - pt record → Fluid intake
   - # of voiding (day/night)
   - # of incontinence.

   } لتقييم Follow up response to treatment.
3. Urodynamic study

3 stages

Uroflowmetry
(Free Flow study)

look for

1. voided volume >150ml
2. Flow Rate 15 ml/second
3. Residual volume By US < 50 ml.

Filling Cystometry

look for:

1. Filling pressure of bladder.
   - involuntary contraction + ↑ Intravesicular pressure > 15 cmH2O → DO
   - ask pt to cough → urine pass → SUI

Voiding Cystometry
(pressure Flow study)

- obstruction →

Detrusor pressure > 50 cmH2O

other complex investigation

- cystourethroscopy = cystoscopy.
- Imaging study

  RMI

  Bladder wall thickness > 5mm → Detrusor Overactivity.

* if obese → OGTT, Random blood sugar / HbA1c.

الموضوع :

الـــدرس :

Management :

* Any type of UI → Lifestyle modification :

↓ Fluid intake , caffeine, Alcohol, smoking , wt loss

* SUI

① Conservative

- pelvic floor muscle Training. ⇒ at least 3 month.
- Urethral device : Ring / Donut.

② Medical

Duloxetine. → tight the sphincter / Antidepresant.
→ need month to start / Nausea

③ Surgical ⇒ Defentive

1. Sub-urethral tapes → Trans-Vaginal Tapes TVT
   → Trans Opturator Tapes TOT

2. Colposuspension → 2 stiches at vagina → suspend it.

3. Urethral Bulking Agent

الموضوع :

الـــدرس :

OAB ⇒ Life style modification / pelvic floor muscle Training .

Need to complete

الموضوع : .....

الـــدرس : .....

Pelvi-abdominal Mass

* Age, GP, LMP.
* Analysis of mass : (endo-metrioma)

Sudden or Gradual / Duration / site / Rate of Growth / Related to menustration / come & go / pain (2) → SOCRATES.

* GI symptoms : N&V, constipation, diarrhea, Bloating
* Urinary symptoms : urgency, frequency, incontinence retention.
* Genital symptoms : amnorrhea, HMB, Discharge.
* constitutional symptoms of malignancy :

Anorexia, loss of wt, night sweating, Fever (?)

Go to DDx

Pregnancy Related

1. Normal Intrauterine pregnancy
2. Ectopic pregnancy

Gyne Related

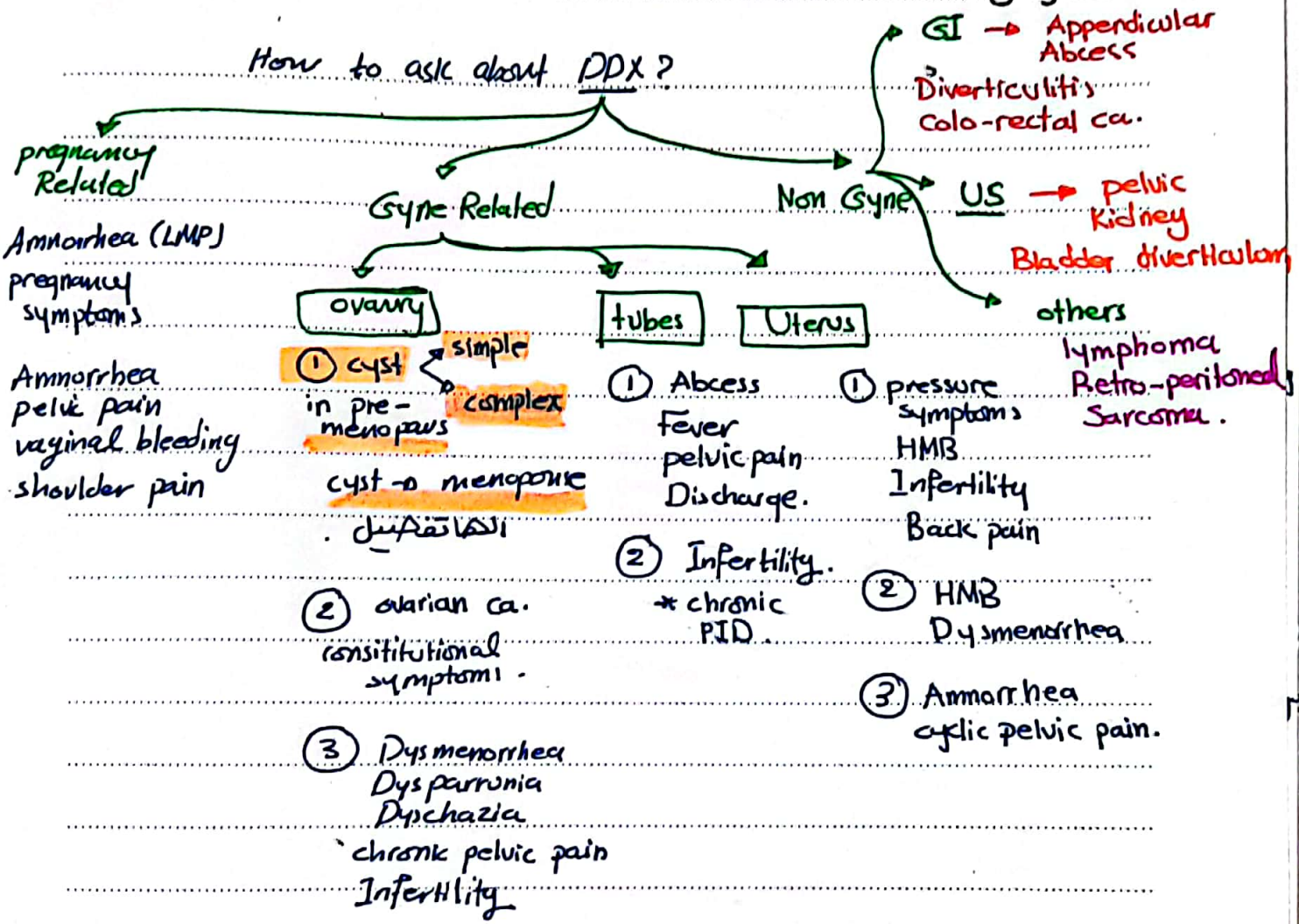
- **ovary**
  1. ovarian cyst (functional, Benign)
  2. Ovarian Ca
  3. Endometrioma
- **Tubes**
  1. TOA / TOC
  2. Hydrosalpinx / pyosalpinx
- **Uterus**
  1. fibriod
  2. Adeno-myosis
  3. Hematomytra.

Non-Gyne

* GI
* Urinary
* others.

الموضوع :

الـــدرس :



* medical Hx : Crhon's dz, liver/pancreatic dz/ hernias
  ca: colon, ovary, Breast, endometrial, cervical.
* Family Hx : same as medical
* Drug Hx : ?
* smoking / Alcohol !

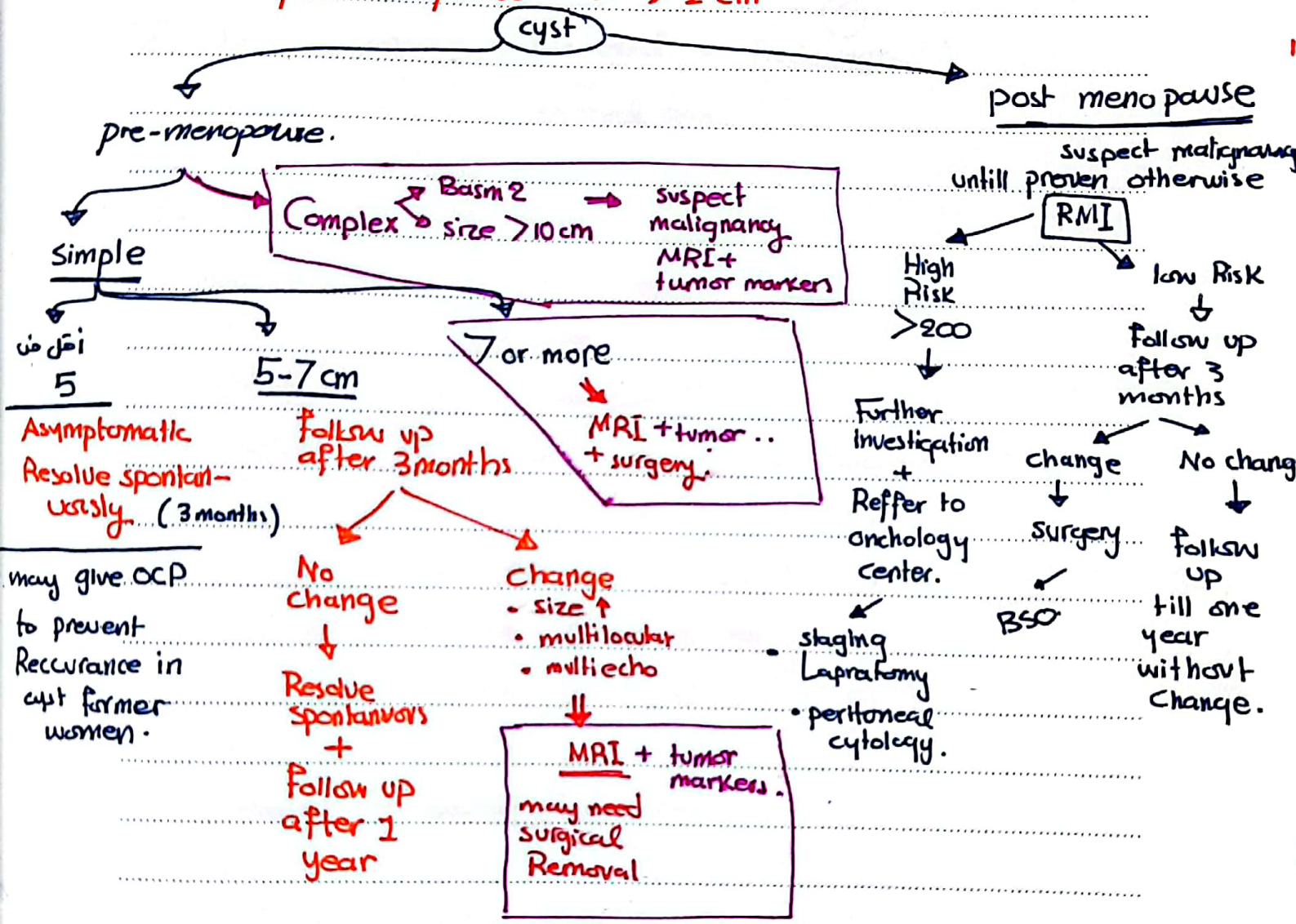
الموضوع :

الـــدرس :

Approach to ovarian cyst

① cyst in premenopause → >2cm (follicle <2m)

in post menopause → >1 cm



rs.

Drainage

omy.

الموضوع : .....

الـــدرس : .....

Exam of pelvic mass:

1. vitals + BMI
2. Abdominal exam full
3. pelvic (speculum + Bimanual + Recto vaginal (?))
   ↓
   Adnexal mass

Investigation In pelvic mass:

1. pregnancy test ⇒ R/O eclopic
2. CBC → ↑WBC (infection)
3. KFT & LFT + serum amaylase (?)
4. → confirm ovarian cause → US + Vascularity
   → Tumor markers

CA 125 + CEA, CA19.9, HCG, AFP, LDH, Inhibin

look for mets → Chest x-ray
CT pelvic & Abdomin.

Management → according to cause

TOA → Gonorrhea / chlamydia / Ecoli. / closed space (anaerobic)

1. Medical →

Broad — Gonorrhea — anerobic

Doxycline + Cefotetan + Metronidazole

Oral 100 mg / 12 hours for 2 days — 2 g IV — 500 mg IV / 8hours.

2. If not Respond to medical → surgical Drainage

or size > 8cm

Colpotomy.

Infertility

تشغلها حالة ادسكن ـ امي حنني couples نشأ
ازكم ما خلفوا ، سنو بدك أسئلك / سنو بدي أحكيلك / سنو markup

check the definition of Infertility:
Inability to concepe after 1 year of regular unprotected intercorse.

History

pt profile

① Age: if > 35 years ovaian reserve ↓ in count & quality

② occupation: exposure Radiation → affect male and female fertility

③ Gravida & para: to distinguish primary or secondary infertility.

* how long trying to get pregnant? Duration of Infertility

start asking about causes

female factors: ⑥

ovarian المشاكل من جوة لبرة

① symptoms of Hypothalamic dysfunction ↓FSH, ↓LH leads to anovulation
* low body weight BMI < 19.
* excessive excersise
* Anoroxia nervosa.
* stress.

② Hypothyroidism symptoms:
* cold intolerance
* wt gain
* constipation
* Fatigue
* Brady cardia
* impaired memory

كَتِلي:
حد مقعد في مكانه
ما بتحرك سنو بصير معه

6

③ Hyper-prolactenemia.
* Amnorrhea / Irregular cycles.
* Galactorrhea
* Visual distubance (if macroadenoma compress optic chiasma)

④ PCOS
* amnorrhea / oligomenorrhea → Irregular cycles.
* hirsutism / acne / balding
* obesity
* acanthosis negricans (why / most PCOS → obesity, ↑ leptin, ↑ insulin resistance) → skin hyperpigmentation, armpits & neck

⑤ premature ovarian insufficiency
* hot flushes
* vaginal dryness
* night sweating.

⑥ Drugs affect ovulation
* Antipsychotic
* NSAIDs

Tubal

فكرتي بده صار عنك Adhesion
بالتالي شو أسبابه

① PID symptoms,
* pain (lower abdominal)
* fever
* Dysuria

② Surgeries in abdomin or pelvis?

③ Hx of ectopic pregnancy?

④ endometriosis
* Dysmenorrhea
* Dysparynia
* Dyschazia.

⑤ Tubal ligation.

Uterine

① submucosal Fibroids (affect implantation)
* heavy / prolonged bleeding
* urinary Retention / constipation
* lower back pain

② Hx of Uterine abnormalities (septum)

③ Hx of D&C or evacuation → if agresive Induce Asherman syndrome (intrauterine adhesion)

cervix

① Infection (HPV) → vaginal discharge

② procedure → cone biopsy, cryosurgery

③ Trauma → Hx of truma / Instrumental deliveries.

Remember ② infections → HPV
→ STD (chlamydia, Gonorrhea)

④ STD → PID → tubal adhesion

Investigation

if she do any investigation? Results?
Laproscopy, Hysteroscopy, HSG, hormunal Inv. profile
pap smear

Male factor ③

آسئلة عن ماضيه ، أسئلة حاضره ، عن أكاج

الماضي

* testicular surgery (varicosele, Testicular Torsion, malignacy)
* Trauma
* infection (STD, Mumps)
* Hx of congenital defect
* Hx of sterilization
* undesended testes

* pregnancies with previous partners.

الحاضر

* if he has sexual dysfunction / what's the nature of it: change in libido
→ impotence
→ erectile dysfunction
premature ejaculation
pain during erection / ejaculation

Drugs : Sulfasalazine (affect sperm quality)
anabolic Steriods
Chemotherapy Cimitidine

Toxins : Hx of exposure to environmental toxins :
* Excessive heat
* Radiation
* chemicals : heavy metals
* smoking , Alcohol

Medical problems
* DM
* COPD
* RF
* HF
* hemochromatosis
* cystic fibrosis

Klienfilter syndrome
- Gynecomastia
- ↓ facial hair
- ↓ libido

sexual Hx
* How many times sexual intercoarse per week?
* at time of ovulation
* do you use lubricant (could be spermicidal)
* Difficulties in intercoarse
  - dyspareunia
  - impotence
  - vaginsmus

past obst
Any previous pregnancy? MOD ? complications?
(miscarriage, stillbith, live)
- Duration
- US finding.

past gyne
* monustral Hx
  - menarche (?)
  - Regular, amount , frequency. Length.
  - LMB
* IMB
* contraception

past Medical & surgical

Family Hx
of infertility or birth defects?

Social Hx
* smoking * Alcohol * caffience.
* living condition.

Physical exam
vitals + BMI
- <19 → Hypothalamic dysfunction
- >30 → longer time to concepe

Female exam

Breast exam :
- Breast development
- Galactorrhea

Abdomin :
- mass.

ovary
- PCOS signs → hirsitism / balding. acne
- ↑ prolactin → galactorrhea, visual field defect

tubes
- PID → pelvic tenderness
- surgeries → scars.

uterus → fibriod → pelvic mass, Irregular uterus.

cervix
- cervicitis → motion tenderness
- POI → atrophic cervix & vagina

- secondary sexual characteristics
- signs of androgen excess.
  1. Hypertrichosis
  2. Hirsitism / acne
  3. Deepening of voice
  4. ambigius genetalia

Male exam
- secondary sexual characteristics
- structure of external genitalia
- varicocele
- Inguinal hernia

Testes:
- absent / undescended
- mass
- tenderness → infection

Work up / Investigation

① **Semin fluid analysis**

* if abnormal ⇒ repeat it
* normal values : cp vv mm
  - Volume → 1.5 ml or more
  - vitality → 58% or more
  - motility → 40% or more
  - morphology → 4% or more (normal form)
  - concentration → 15 million or more
  - PH ⇒ 7.2 or more

② **Ovarian reserve**

1. Anti mullerian Hormone AMH
2. Antral follicle Count AFC

Ovulation

1. Hx of Regular cycles
2. Mid Luteal progestrone.

③ screen for **Rubella**

infection → severe malformation.

⇒ not vaccinated → give vaccine

get pregnant after 1 month

④ Screen for **chlamydia Trachomatis**

→ infection → adhesion → hydrosalpinx

vulvar swab.

⑤ **pap smear.**

⑥ **TSH** ⑦ **Prolactin** → Irregular cycles

⑧ Tubal patency & Anatomy of uterine Cavity :

1. **Hysterosalpingiography HSG**

   dye + x-ray.

   ↳ urografin or lipidol
2. **Hystero salpingo - contrast - sonography**

   contrast + US
3. **Laproscopy** → diagnostic
   - endometriosis
   - Adhesion
   - tubal patency

   Remember Methyline blue
   - Hydrosalpix.

   → therapeutic
   - Laproscopic ovarian Drilling
   - myomectomy
   - tubal surgery.
4. **Hysteroscopy** → if failed repeated IVF

   → therapeutic
   - Intrauterine septum

IUI

Indication

① couple unable to have vaginal intercourse

② HIV

don't offer

① unexplained infertility

② low seperm count or quality

③ mild endometriosis.

الفكرة : فرصة نجاح بالطبيعي أفضل من استخدام IUI

ICSI

① low number of sperm

② severe teratospermia

③ Failure of previous IVF

IVF

① Failure to concepe after **2 years** of Regular unprotected intercourse

② Failed 2 cycle of artificial Insemination (6 of them are IUI)

IVF complication

① side effect of medication ⇒ headache

② Mulliple pregnancy

③ ectopic pregnancy

④ **OHSS**

↳ high Risk → PCOS, low # of follicle, low BMI

APH

History

pt profile :-

Age (Advanced age → Risk factor for both P.P & PA)

Gravidity & Para
- Primigravide → PA
- Multiparous → PP

LMP (to calculate GA) multi ← 2 حسب تعريف الـ

Blood Group + Rh.

Analysis of bleeding

Duration, **Amount**, **Color**, previous episodes of bleeding
(Fresh → PP, Dark → PA)

Bleeding from other sites (PIH → Abruption, DIC)

* Is it Provoked by **Trauma** (PA)
* Is it Provoked by **PV exam** or **Intercourse** (PP)

Abdominal pain
- painful → PA, uterine Rupture — continuous / Localized وضع تحليل
- painless → PP, Vasa previa.

Labor pain on-off

Diffuse

Uterine Contraction
- PA may stimulate Labor to begin

Liquor passage ⇒ Analysis ← Amount, color, smell
Fever ?

Fetal Movement

Anemia symptoms :- Dizziness, LOC, SOB, palpitation, Oliguria.

previous US finding
- single / Multiple (Risk factor for PP, PA)
- position of placenta
- fetal malpresentation (associated with PP)
- Date by scan (?)

Drugs (anticoagulant)

Smoking (Risk factor for PP, PA)

Cocaine Use (potent VC → PA)

Family Hx ⇒ PP, PA, HTN, Bleeding disorder.

PP → تذكر placenta مابتلاقي سبب
PA
Multiple Gestation
↓
↑ HCG
↓
PIH
↓
Abruption

Going to DDX and its Risk factors.

Obstetric Causes (4)

1. continuous Localized pain
2. Dark or No Vaginal bleeding (concealed)
3. Uterine contraction

Placental Abruption

1. previous placental Abruption
2. Trauma / ECV (?)
3. chronic HTN or pre-eclampsia
4. polyhydramnious with sudden ROM.
5. Advanced age / PG / Multiple Gestation smoking / cocaine

placenta Previa

1. previous PP
2. previous Uterine scars : CS / Myomectomy / D&C
3. Advanced age / Multiparity
4. smoking / Multiple Gestation

Vasa Previa ⇒ need doppler US

1. Velamentous cord insertion (?)
2. Accessory placental Lobe (?)
3. Multiple Gestation
4. IVF.

Triad to diagnose
1. Rupture of Membrane
2. painless Vaginal bleeding
3. severe fetal distress / Bradycardia.

Uterine Rupture

1. previous Uterine Rupture
2. previous Uterine surgeries
3. Malpresentation / Macrosomia (overdistention)
4. Trauma.
   1. Abnormal CTG
   2. Loss of station
   3. Abdominal pain between contractions.
   4. Loss of uterine contraction.

Systemic Causes

Bleeding disorder (easy bruising, mucosal bleeding)

Local causes

Ask about previous pap smears (?)

1. Vaginal / cervical Laceration ⇒
2. Infection (vaginal / cervicitis) → Vaginal Discharge
3. Cervical ectropion.
   post coital bleeding / pain (Dyspareunia.
   excessive mucus discharge (normal color / odor)

After Hx → Next step → **physical exam**

① General Look + Vital signs + signs of anemia (pallor, ..)
(BP, RR, PR, Temp)
Heart Rate is more important than BP.
Because Hypotension of shock may be masked by Hypertension that cause Abruption

② Abdominal exam..
[1] Tenderness in uterus → yes → PA / No → PP
[2] Symphysis Fundal Height
Large for GA in concealed PA
[3] Leopolds manuvers.
نهم what's the presenting part ?
in PP → mostly non cephalic
what's the lie ? → mal presentian / PP
[4] Auscult fetal Heart Rate.

③ Speculum to exclude Local causes
& Assess the bleeding (Inspect pad)
I won't do PV unless doing US
& Localize position of placenta.

By this I finish exam going to **Investigation**

[1] US ① Localize placenta. & exclud PP
② Fetal Heart is present ?
③ Retroplacental Hematoma (concealed PA)
④ confirm GA / Liqor.

[2] CTG if > 26 weeks

Management

* Assess ABC
* Ressuscitation ?
* 2 IV Lines
* take Blood ⇒ CBC, Blood Grouping cross matching
KFT, LFT
fibrinogen concentration (DIC)
Kleihauer-Betke test (to decide amount of Anti D - RhΘ)
كيلي هاور
* Give Steriods
Give Anti-D if indicated.

لازم اجاوب سؤالين ؟

Am I going to terminate ?

yes if ① In Labor
② Maternal or fetal Jeopardy
- shock (Tachycardia ↓BP)
- Bradycardia
- Repetitive Late decelration

③ Term.
حالة من اثنين

No preterm + stable mother & fetus.
↳ conservative + steriods.

How to terminate ? السؤال اللي بعده

According to cause of APH

Placental Abruption
- emergent CS → maternal or fetal complication
- Vaginal delivery → stable term In Labor

Placenta previa
only CS
- emergent → maternal fetal complication
- elective → stable term.

Vasa previa → emergent CS.

Uterine Rupture → Uterine Repair / Hysterectomy.

Observe for PPH

Complications

maternal

فكري حالة انه فقدة دم كتير.

placental Abruption

1. Hypovolemic shock
2. Acute Renal Failure
3. DIC (remember PIH → DIC)
4. PPH
5. Anemia & Blood transfusion.

placental Previa

1. Abnormal placentation (placenta Acreta spectum)
2. PPH

Uterine Rupture

1. Maternal Death

Fetal → for PA + Vasa previa

1. IUGR
2. Hypoxia
3. IUFD
4. premature Delivery

Fetal

1. IUGR
2. Hypoxia
3. IUFD
4. premature delivery
5. Malpresentation

→ Fetal death.

* placenta previa low lying placenta after 28 weeks repeat US at 32 week to confirm dx

PROM = Pre-Labor Rupture of Membrane (term / not in Labor)

PPROM → Preterm prelabor ROM (preterm / not in Labor)

History

cc. Gush of fluid per Vagina or Discharge from Vagina.

Pt profile:
- Age (extremes are Risk factor of PROM)
- LMP, GA
- Gravida, para.

Analysis of cc.:
1. Gush of fluid followed by continuous drippling
2. Duration of this Leakage
3. Amount
4. color:
   - clear
   - blood stained → PROM with placental Abruption
   - Dark green → Meconium → so Fetal distress
   - yellow → urine ?
5. odor:
   - ammonia → urine
   - sweet → amniotic fluid.
6. previous episodes.

associated:
1. painful or painless Vaginal bleeding
   - painful → placental Abruption
   - painless → PP with PROM.
2. Sexual intercourse → Asending Infection Risk factor for PROM
3. Fetal movement
4. Uterine contraction (is she in Labor)
5. Urinary symptoms → ① DDx → urine incontinence; ② Asending infection is risk factor for PROM. (urgency, dysuria, fever, Incontinence)
6. Itching + Redness at Vulva

Risk factors of PROM

1. previous Hx of PROM, PTL
2. Over distension → Multiple gestation, polyhydraminous, Macrosomia
3. Asending Infection.
4. pregnancy Induced HTN → placental Abruption
5. Trauma
6. smoking / Intercourse / Age Extremes

DDx

1. PROM
2. Urine Incontinence
3. Vaginal Infection
4. Leukorrhea

Hx aid:
- smoking
- drugs
- Family Hx of PROM / PTL

PE

General Look
1. Vital signs, BMI (low / High wt → Risk factor for PROM)
   - Fever + Tachycardia (Asending infection as Risk factor chorioamnitis as complication)
2. Abdominal exam
   1. Abdominal tenderness → chorioamnionitis
   2. SFH → small for GA → oligohydraminous
   3. Leopold manuver → Lie, presenting part
      - Auscult Fetal Heart → Tachy → chorioamnionitis.
3. Speculum
   - (+) pooling in posterior fornix of Vagina
   - (+) cough test → fluid comes from vagina
   - Dilation of cervix
   - cord prolapse

   By looking not by PV

Don't Do PV → ↑ risk of Infection

Investigation

1. Nitrazine test ⇒ Amniotic fluid is Alkaline (تتحول الورقة للون ازرق)
   - false positive 15%
   - urine, Blood, semen ⇒ all are Alkaline
2. Ferning test → secretion on slide (تحت)
   - false positive 10%
   - could be infection not amniotic fluid
3. Amnisure
   - specific 100%.
   - Look for PAMG1 = placental alpha Microglobulin 1. (protein)
   - Insulin Growth factor Binding protein 1.
4. High Vaginal swab → Group B streptococcus
   - DDx = Bacterial Vaginosis. → Clindamycin
5. US ⇒ oligohydraminous (عليه حالات)
6. CTG

Management

Pre-term

1. Admission to hospital
2. Give Antibiotics (prophylactic)

   Erythromycin for 10 days
   500 mg 1*3 (oral)

3. Steriods

   Dexamethazone 12 mg x2
   12 hours apart
   (IM)

Between (24- 34+6)

time for steriod in PPROM.

حرف S
بنبه ع ٤

When to terminate?

1. As Reach 36 week
2. If Maternal or fetal complication
3. In Labor.

How to terminate ? IOL

term

more than 36 → PROM

بين
حنا وبين

Expectant ~~60%~~

wait for 24 hours

60% goes in spontaneous Delivery after PROM

Immediate IOL

- less hospitalization
- Less perinatal infection
- Less neonatal morbidity

Always Monitor for

Chorioamnionitis → preterm, term.

1. C-Reactive protein + WBC count
2. clinical ⇒ Abd. tenderness
   Fever
   Vaginal discharge
   Fatigue
   ↓ fetal movement
3. Fetal Tachycardia > 160.

Steriod

- ↓ Intraventricular Hemorrhage
- ↓ ROS
- ↓ Necrotizing enterocolitis
- ↓ NICU admission
- ↓ Neonatal death

No Recommendation for Repeating steriods
No Recommend to Tocolytics in PROM

PROM complication.

1. chorioamnionitis
2. cord prolapse
3. preterm Delivery
4. placental Abruption
5. Fetal Distress & Deformities (facial & skeletal)

Hyperemesis Gravidarum

excessive vomiting associated with : pic 5xp.

1. wt loss 5% (from the pre-pregnancy wt)
2. Dehydration
3. Electrolyte Imbalance
4. Ketosis. (in urine)

History

pt profile:
Age + parity → common in young + primi

c.c: excessive N&V

Analysis

1. Onset : HEG start in First trimester 5-6 weeks
   peak at 9 weeks
   end by 20 weeks.
2. How many times do you vomit
3. Is it related to food, medication, stress ? (Triggers)
   - Iron
   - opiods.

complication

1. Dehydration: Feeling thirsty. Dry eyes. Lips, mouth
   Headache
2. electrolyte imbalance
   - ↓ Na^+ → Lethargy, Headache, confusion, seizure
   - ↓ K^+ → muscle weakness, cardiac arrythmias.
3. Thyrotoxicosis (HCG mimic TSH → ↑ T3, T4)
   heat intolerance, tremors., sweating

Risk factors

* previous history of HEG
* Family Hx of HEG
* current Multiple pregnancy / GTD?
* pregnancy induced HTN ?

DDx

1. Neurological & psychological causes
   Migrane : throbbing like pain (beating)
   Eating disorder
2. GU system
   - Gastroenteritis : Abdominal pain, diarrhea
   - pancreatitis : pain radiate to back
   - Hepatitis : Jaundice, IV drug use
   - PUD : Heartburn.
3. GU system :
   - UTI or pylonephritis :
     Dysuria, Urgency, Frequency
     Fever, flank pain.
   - Kidney stones
     Loin pain.
4. Metabolic
   - DKA → Are you diabetic / take Insulin ?
   - Hyperthyroidism → Heat intolerance
     sweating
     tremors.

physical exam

* Vitals → Hypotension → Dehydration
  General → signs of Dehydration : sunken eyes.
  BMI → wt loss ?
  Abdominal → fundal Height → Large for GA
  if multiple pregnancy.
  Bimanual → Adnexal mass if molar.

Approach

1. Rule out other causes.
   (Multiple, Molar, GI, GU, Metabolic ..)
2. Decide if to treat pt as inpatient or outpt

How ?
- If can tolerate oral intake
- If improve with oral medication
- if No electrolyte imbalance

→ out pt.

how to manage out pt ?

1. Ginger
2. Vitamin B6 (pyridoxine)

Also:
* small frequent meals
* decrease fat
* ↑ carbs
* No water on empty stomach

How to manage Inpatient

Investigation

1. CBC → WBC → Infection
   → Hct → increased due to fluid loss
2. Electrolyte → ↓Na^+, ↓K^+ * TFT
3. Liver function test (↑ALT, AST if sever HEG)
4. UA → exclude UTI, No chloride in urine (loss HCL by vomiting)
5. Blood glucose → exclude DKA.
6. US → Viable ?
   → GA
   → Multiple
   → Molar.

Biochemical thyrotoxicosis By HEGS

Inpatient

1. Admission + NPO
2. IV Fluids → Normal saline
   - 1 Liter every 8 hours
   - Maintence
3. correct electrolyte
   Add KCl to normal saline
   maintainece 20-40 mEq / L of normal saline
   Deficit ?
4. Thiamine (Vit B1) → to prevent Wernicke's encephalopathy
   - ▲ Ataxia
   - Confusion
   - Opthalmoplegia.
5. Antiemetics (IV)

First line — Histamine 1 antagonist: Cyclizine
50 mg / 8 hours.

Second line — Dopamine antagonist: Metoclopramide
10 mg / 8 hours
5 days maximum ← Extrapyramidal side effect.

Domperidone
60 mg / 8 hours.

third line — Serotonine antagonist: Ondansetron
8 mg / 12 hours
or Corticosteriods

* you can combine drugs if no improvement

Last line — Termination.

6. prophylaxis of VTE
7. treat co-existing GERD → PPI / H2 Antagonist

---

* Don't give dextrose → glucose oxidation consume more thiamine.

Complication of Hyper-emesis.

fetal

1. IUGR / small for GA.
2. preterm Delivery

Maternal

1. Hyponatremia
2. Hypokalemia — loss Cl^- — loss H^+
3. Hypochloremic metabolic Alkalosis
4. Thiamine deficiency → Werneick's encephalopathy
5. Thyrotoxicosis
6. Mallory - weiss tear of esophagus.
7. VTE

puerperal pyrexia

temperture 38° or more after 24 h of delivery persist till end of perperm..

C.C ⇒ Fever, generalized weakness or offensive vaginal discharge.

لما حدن تكون بفترة puerperum مشوزي حالة دشالتي .

History

pt: Age, Gravida, para

C.C documented fever? By which route? How much?

Looking for source of infection By Hx · منهوف اللغت

1. Respiratory Tract Infection / chest infection
   chest pain, cough, SOB
2. Breast engorgement or Mastitis
   mastalgia (pain), swelling, nipple discharge trauma.
3. Wound infection (weither CS or episiotomy)
   pain at site of wound, discharge, redness.
4. peurperal sepsis ⇒ Foul smelling discharge
   Lower abdominal pain (endometritis)

   Risk factors of peurperal sepsis
   - prolonged Labor
   - prolonged PROM
   - Instrumental delivery / tears
   - Retained products of conception → was placenta complete?
5. Urinary tract infection:
   Dysuria, Urgency, Frequency.
6. Deep Venous thrombosis.
   painfull swollen calf?
7. systemic Risk factor
   Anemia, DM, ↓ immunity → steroids / chemotherapy / immuno-compromised.
   Ask about
   - wound packing for abcess
   - wait closure By secondary Intention ⇐

PE

منهوف اللغت

1. General:
   Vitals → Fever / Tachycardia
   Dehydration: sunken eyes
2. chest exam ⇒ Auscult basal crepitation
3. Breast exam ⇒ tenderness, swelling, discharge
4. Abdominal exam
   - tenderness → endometritis of peurperal sepsis / UTI
   - if wound → inflammation around it
5. PV → jumping sign if peurpral sepsis → parametritis.
6. Lower limb exam. → tenderness / swelling white?

Investigation

1. CBC → ↑WBC, CRP, ESR } General.
2. Blood culture + senseftivity
3. chest X-ray + sputum culture منهوف اللغت
4. US → Looking for Retained products of conception → that causes puerperal sepsis.
   - wound swab
5. High Vaginal swab
6. UA + urine cultore + senseitivity.
7. Doppler US (DVT)

Management

According to cause.

1. wound infection → admission
   * wound discharge swab → culture + senseitivity
   * drainage / cleaning
   * IV antibiotics / Broad spectrum / may add topical
   * IV analgesics.
   * IV antipyretics.

peurperal sepsis

* Admission

IV (fluids, analgesics, antipyretics)

IV antibiotics → broad spectrum.

- gentamycin ⊖
- ⊕ cephalosporins

anerobics - Metronidazole

→ if develop

- septic thrombophlebitis

→ IV hepain 10 days.

→ Immobilization

- Retained product

→ ergometrine

→ D&C

Mastitis

→ oral cloxacillin

→ can breast feed ✓

→ do Breast US to exclude Abcess. (if not respond

Chronic DM

تأثير الحمل على DM
مضبوط

* effect of pregnancy on DM
1. Increase Insulin Requirement
   (pregnancy → Human placental lactogen
   → cortisol
   → progestrone
   → Insulinase enzyme
   النتيجة انسولين قليل فيحتاج.
2. Deterioration in Diabetic Retinopathy, Neuropathy, Nephro.
3. DKA ↑
4. Hypoglycemia → بسبب الانسولين الزايد

effect of DM on [1] Mother (Pregnant) العكس عكسي

1. ↑ miscarriage / ↑ PTL / ↑ PROM
2. ↑ pre-eclampsia
3. ↑ Infection → vaginal candidiasis, UTI, wound infection
4. ↑ CS

[2] fetus

1. congenital anomalies. → VSD, NTD (sacral agenesis)
2. Macrosomia & poly hydrominous
3. polycythemia & Hyperbillirubinemia
4. IUFD

Preconception Counseling / Booking visit.

1. HBA1c → should be < 6.5 to get pregnant
   > 8 → (CI) → ↑ congenital anomalies
2. Monitor Glucose Reading at home
   (4) times daily → fasting, 2 hours after meals
   مش كل يوم كل اسبوعين
3. Modify ANC visit to become closer.
4. Screen or follow up for expected complication: (multiple specialists)
   - Retinopathy / nephropathy
   - HTN & CVD
   - Thyroid (Hypo)
   - Hypoglycemia → Fainting ?

مهم

5. counsel about possible complication
   - congenital anomalies, Macrosomic
   - Miscarriage / PTL / PROM / CS
   - pre-eclampsia
   → Do Detailed anomaly scan + US + Assessment of fetal wellbeing
6. Diet: ↓ carbohydrate
   ↑ Fibers.
   Small snack between meals
   exercise, ↓ wt.
7. Medication.
   - stop teratogenic medication
   (Both Insulin & metformin → Category B not teratogenic)
   - High dose of folic acid 4 mg / day
   - continue on metformin (if was on it)
   - can switch to insulin during pregnancy if > 200 mg/dL.
   * half to half (short acting + intermediate acting)

Target Blood Glucose
Fasting < 5 mmol/L
2 hours < 7 mmol/L

↑ isulin dose → 0.6 * weight (first trimester) → 0.7 * wt (second) → 0.8 * wt (third).
→ can breasfeed with Insulin or metformin -
→ after delivery → go back to Pre-pregnancy dose.

Contraindication of pregnancy with chronic DM
- HbA1c > 8
- Ischemic Heart dz
- Untreated proliferative Retinopathy
- Severe Renal Impairement
  creatinine > 250 mmol/L.

Examination
- vitals → BP ↑ & BMI
- Fundoscopy by opthalmolgist
- thyriod exam (enlarged ?)
- chest ascultation (cardiac and lung)
- check sensation / tremor / hypo - hyper Reflexia.

+ US → FHR

Labs
- HBA1c
- GFR / Creatinine (KFT) / Urine albumin/Creatine Ration (pre-eclampsia / proteinuria)
- TSH / LFT

Gestational DM ..

onset 24-28 weeks / due to anti-insulin Hormones

نفس اللي فوق بس أشمل.

Risk factors for GDM

1. previous GDM
2. Age > 25
3. BMI > 25
4. Family Hx of DM in First degree Relative
5. previous Macrosomic ≥ 4 kg
6. previous polyhydraminous.

سيزيد خطر GDM.

Maternal complication

1. Increase Risk of DM type 2 (40-60%) within 10-15 years
2. ↑ risk of Hypertensive disorder
3. ↑ risk of CS & Instrumental delivery

السكري يسبب ضغط

Fetal complication

1. Macrosomia > 4 kg
2. ↑CS, Instrumental & Birth Trauma
3. Neonatal Hypoglycemia, polycythemia Hyperbilirubinemia
4. ↑ risk of DM type 2 & obesity in life.

Brachial plexus injury ↑ clavicular fracture.

No Risk for congenital anomalies as organogenesis occurs at first 12 weeks

In Booking Visit

1. Assess if pt high risk for GDM
   - Age > 25 BMI > 25.
   - ethinicity → Asian + Indian
   - previous GDM
     Macrosomic babies > 4kg
     polyhydraminous.
     IUFD
     Recurrent miscarriages.
   - Family Hx of DM in First degree Relatives.
   - current pre-eclampsia or HTN
     PCOS (↓ insulin sensitivity)
     recurrent vaginal candidiasis.
2. symptoms → polyuria, polydypsia, polyphagia
3. Known Case of DM? which type? For How long?
4. Last Blood glucose Reading?
   Last HbA1c reading?
5. Monitoring ④ Medication.
   Any complication

نفس قبل chronic.

6. Drug Hx (teratogenic medication).
7. smoking. ⑥ medical / surgical Hx. (CS)

physical exam

1. vitals ↑BP, BMI, FHR
2. Abdomin → polyhydraminous
   Fundal Height → LGA
   muffeled heart sound
   abdomin → tense + Larg Area
3. persepeculum → discharge → ↑ infection
   premature → PPTL.
   opening of cervical os

* if high risk → screening in booking visit and (24-28) weeks
* if low Risk → 24-28 weeks.

Screening

1 hour → Oral Glucose intollerance test 50 gm

140 mg/dL or more → positive → Go to Diagnostic

If negative nothing to do.

Diagnostic test

1. One step approach → Fasting women + 75 gm 2H OGTT

Fasting Glucose	≥92	≥5.1
1 hour	≥180	
2 hour	≥153 mg/dL	≥11.1 mmol/L

to make dignosis → At least one reading (+)

2. two step approach → Not fasting women.

First step: 50g 1H OGTT

if 140 or more → positive go to second step.

Second step: 100g 3H OGTT

Fasting Glucose	≥95
1hour	≥180
2hour	≥155
3 hour	≥140 mg/dL.

to make diagnosis → At least 2 or more.

Mx

Goal → Fasting Blood glucose < 6 mmol/L

if Fasting Blood Glucose 6.1 – 6.9

Impaired fasting Glucose.

* Diet modification & exercise
  Daily monitoring (4 times Reading)
* Metformin → still not controlled 6.1 – 6.9
  and → No complication.

Once ① Fasting Blood Glucose 7 or more
② Any complication

* start Insulin.

Adjust insulin dose

1 trimester	0.6 * wt
2 trimester	0.7 * wt
3 trimester	0.8 * wt.

Management

* Diet modification & excersice always important
  Medication
* Councel the pt about GDM complication on Mother, Fetus, Neonate
* Monitor Glucose Reading at home 4 times daily.
* Regular follow up:
  US → evaluate fetal development
  CTG → every week → after 32 weeks.
  UA → proteinuria ?
  KFT (?)

~~* if low risk → spontanous labor → 38-40~~

* if uncotrolled or complication → need to terminate pregnancy (after giving steriod) — Delivery

Induction of labor at 38 weeks

CS
- >4.5 kg
- primi
- previous shoulder dystocia.

Intrapartum Mx

* continuous CG
* sugar reading → every hours → and put in Sliding scale of Insulin.
  - was not on insulin → give only sliding scale
  - was on insulin → Goal (4–7) mmol/dL
    - give insulin & dextrose to achieve goal

post partum

* stop medication.
* sugar reading 3 days → Goal 5–9 mmol/L
* follow up for 3 month (?)
  → Repeat OGTT & HbA1c