Dr. Fida'a; Menstrual Cycle 23/3/21

- diff. btwn longest & shortest cycle is 9 days

- polymenorrhea → < 21 days
  oligomenorrhea → > 35 days
  menorrhagia → heavy period

- PCB → cervical cause while TMB usual cause → cervical or endometrial
  oligomenorrhea → always think PCOS

- Calculate ovulat^{n} day = # of cycle days − 14 = x
  peak progesterone = x + 7 ; then test for mid-luteal progesterone level for ovulat^{n}.

- Pressure symptoms → mass ???
  → most commonly fibroids
- PID → not a differential of dysmenorrhea / heavy bleeding
- papsmear test → screening for cervical cancer.
- high vaginal swab ≠ papsmear test
  → for infection → cervical
- in history: tamoxifen → estrogenic → endometrium
  → anti-estrogenic → breast
  bleeding disorder → young female vs older female → coagulopathy
  BMI is important for 2 reasons → obese women → ↑ed estrogen
- speculum → look for cervical only; not vaginal
- hormone producing hormonal tumor → young females
- Pipelle → bedside + no need for anesthesia

CLASSICAL Presentation

- 46 yr old woman has a 3 yr history of worsening HMB with regular cycles & dysmenorrhea: Top DDx → fibroids & adenomyosis
- 42 yr old woman presents with a 2yr hx of AUB. She's nulliparous with a history of PCOS; imp points? 1) age → anovulation 2) nulliparous → RF for e. cancer 3) PCOS → anovulation
  DDx: endometrial hyperplasia, fibroids, hypothyroid

'irregular + heavy'

- Ms. Green, 48 yr old, nulliparous, irregular MB. 'menometrorrhagia' with a variable cycle length of 24-48 days with a durat° of 4-12 days. Prior to this, her cycle had been regular. Sexually active → no dyspareunia / PCB. last smear → normal. No associated mood changes or hot sweats.

DDx: endometrial hyperplasia, ovulat° + always RULE OUT pregnancy in female ages.

- ① ② ⑤ ④ ⑥ ⑤
66 yr old, nulliparous woman, menopause at 55 yrs, complains of 2 week hx of vaginal bleeding. Prior to menopause → irregular menses. no estrogen replacement therapy. PMH is significant for DM controlled with an OHD.

BMI → 35 BP → 150/90 mmHg Temp → 37.2°C

physical exam → abdomen obesity / everything else is normal

- What do you call this bleeding? → PMB
- What is your main concern? → endometrial ca.
- RFs? → 1 → 6 are all RFs
- Investigat°? → TVS USS → (ET) > 4mm → BIOPSY!
  even if < 4 mm + RFs → BIOPSY!

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Obstetric H:

→ You're called to the labour ward to see a lady with heavy vaginal bleeding. She had a NVD 30 mins. ago. Q1: Diagnosis? Q2: How will you approach the patient?

A1: 1° postpartum hemorrhage

A2: quick history, call for help ①, ABC, 2 large bore canulas, Bloods for CBC, KFTs, LFTs, clotting profile (DIC), warm IV fluids → as cold will cause hypothermia, Cross match blood, feel the uterus + massage it, medicat^{n}: oxytocin, ergometrin (CI in eclampsia), syntometrin (prevent^{n} of hemorrhage, active management of 3rd stage), Carboprost/haema-bate (if failure move from ward → theatre), Misoprostol (PGE1 given rectally + due to long onset of action give initially). If all the past fail, move patient to theatre. With atony → balloon tamponade is 1st line, if fails → laparotomy:- B lynch suture, devascularizat^{n}, hysterectomy.

→ Nadia / 32 yr old / multigravida at 31 weeks present to the labour ward after an RTA. C/O : sudden onset of moderate vaginal bleeding for the last hour, intense constant uterine pain & frequent uterine contractions. Q_1: Initial impression? Q_2: approach? CTG → normal ; Maternal V/S : BP 125/80 , PR 90 bpm , RR 17/min , T 37.1°C , O_2 sat 98 % , Minimal bleeding that is resolving , soft abdomen. Q_3: management?

A_1 : placenta rupture

A_2 : quick hx , call for help , ABC , O_2 , 2 large canulas , IV fluid , blood cross-matching , examine abdomen to check for tenderness / scars (previous CS.) , FSH & check for fetal lie & presentation , fetal ♡ (CTG).

Can I check for dilation by digital examination? No , exclude placenta previa first as placenta previa & abruption may co-exist. Hence digital vaginal examination CI in all antepartum hemorrhage until placenta previa is excluded.

A_3 : admission + conservative Mx + steroids to stimulate fetal lung maturity + if Rh -ve we should perform kleihauer test & give anti-D.

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→ Mrs. Green, 30 yrs (G5P3+1), 32 weeks pregnant, 2nd pregnancy ended as an incomplete 1st trimester miscarriage + had surgical evacuation of retained products of conception. She had her last pregnancy by CS due to breech presentation. She presents with vaginal bleeding for 3 hrs before admission. Q_1: approach? Q_2: management?

O/E BP 120/70, PR 86, RR 17; Abdomen SFH = 31 cm, soft, non-tender, minimal bleeding seen, CTG normal, TA US shows minor placenta previa.

A_1: quick history; ↓ painful bleeding diagnostic? no but suggestive of abruption. Previous attacks? provoking factors? intercourse? trauma? uterine contractions? labour? low placenta? (Imp. for placenta previa). speculum to rule out area of hemorrhage

A_2: stable → admission + steroids + anti-D is indicated + observe fetal & Rate.

while vaginal digital examination is CI in ante-partum hemorrhage, speculum & PVS USS if not as it's done professionally.

→ 48 yr old delivered a 4-2 kg baby vaginally 30 mins. ago. She required an episiotomy. Continued to bleed & begins to feel unwell. Assess her. Q1: RFs? Q2 management?

A_1: age, macrosomic baby, episiotomy

A_2: episiotomy is the cause → repair

atony " " " → as previously said.

tranexamic acid → cheap, saving, IV slow infusion in PPH.

misoprostol in guidelines → last resource in real life initially.