433 Teams

OBSTETRICS & GYNECOLOGY

HISTORY TAKING & PHYSICAL EXAMINATION OB/GYN

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Objectives:

Not Given

Color index:

Lecture . Book . 432 Team Work

OBSTETRIC HISTORY

- General information
- History of current pregnancy
- Past Obstetric history
- Gynecological history
- Enquiry about other systems:
- Past medical and surgical history
- Psychiatric history
- Family history
- Social history
- Drug history
- Allergies
- Summary

OBSTETRIC HISTORY

- **General information:**

- **Name**
- **Age**
- **Presenting complaint** (patients words not medical words)or reason for attending.
- **Gravidity**
  - ➡The total numbers of pregnancies regardless of how they ended.
- **Parity**
  - ➡number of live births at any gestation or stillbirths after 24 weeks of gestation.
- **Gestation (GA)**
- **LMP** (last menstrual period)
- **EDD** "Expected date of delivery" (Naegele's rule)
  - Is to add 9 months and 7 days to the first day of the last normal menstrual period example:
  - o LMP: July 20, 2008
    o EDC: April 27,2009
    o This Is in Gregorian date but if it is in Hijri add 18 days instead of 7 days. o Average cycle is 28 days and it can be from 21 to 35 days.
    o If it is21 = add one day, 28 = add 7 days, 35 = add 14 days.

OBSTETRIC HISTORY

- **History of current pregnancy:**
  - Dates as calculated from ultrasound.
  - Single /multiple (chorionicity).
  - Detailed of presenting problem.
  - Have there been any other problems in this pregnancy ?
  - Has there been any bleeding , contractions or loss of fluid vaginally ?
- **Past Obstetric history:**

1. Date of delivery (or pregnancy termination)

2. Location of delivery (or pregnancy termination)

3. Duration of gestation (recorded in weeks). When correlated with birth weight, this information allows an assessment of fetal growth patterns. The gestational age of any spontaneous abortion is of importance in any subsequent pregnancy.

4. Type of delivery (or method of terminating pregnancy). This information is important for planning the method of delivery in the present pregnancy.

5. Duration of labor (recorded in hours). This may alert the physician to the possibility of an unusually long or short labor.

6. Type of anesthesia. Any complications of anesthesia should be noted.

OBSTETRIC HISTORY

- **Past Obstetric history (Cont.):**

7**. Maternal complications**. Urinary tract infections, vaginal bleeding, hypertension, and postpartum complications may be repetitive; such knowledge is helpful in anticipating and preventing problems with the present pregnancy.

8. **Newborn weight** (in grams or pounds and ounces). This information may give indications of gestational diabetes, fetal growth problems, shoulder dystocia, or cephalopelvic disproportion

9**. Newborn gender**. This may provide insight into patient and family expectations and may indicate certain genetic risk factors.

10**. Fetal and neonatal complications.** Inquiry should be made as to whether the baby had any problems after it was born, whether the baby breathed and cried right away, and whether the baby left the hospital with the mother.

OBSTETRIC HISTORY

- **Gynecological history :**

- **Periods:** regularity.
- Contraceptive history, Oral contraceptives taken during early pregnancy have been associated with birth defects, and retained intrauterine devices (IUDs) can cause early pregnancy loss, infection, and premature delivery.
- Previous infections and their treatment.
- When was the last cervical smear? Was it normal? Have there ever been any that were abnormal? If yes, what treatment has been undertaken?
- Previous gynecological surgery?

- **Past medical and surgical history:**

- Relevant medical problems and drugs, In addition to common disorders, such as diabetes mellitus, hypertension, and renal disease, which are known to affect pregnancy outcome.
- Any previous operations; type of anesthetic used, any complications. Each surgical procedure should be recorded chronologically, including date, hospital, surgeon, and complications. Trauma must also be listed (e.g., a fractured pelvis may result in diminished pelvic capacity).

OBSTETRIC HISTORY

- **Psychiatric history :**
  - Post partum blues or depression.
  - Depression unrelated to pregnancy.
  - Major psychiatric illness .
- **Family history :**
  - Diabetes ,hypertension, thromboembolic disease , genetic problems, psychiatric problems …
- **Social history:**
  - Smoking, Alcohol use, illegal drug used
  - exposure to domesticated animals particularly cats (which carry a risk for toxoplasmosis).
  - Exposure to solvents (carbon tetrachloride) or insulators (polychlorobromine compounds).
  - Marital status
  - Occupation
  - SEXUAL HISTORY The health of, and current relationship with, the husband or partner(s) may provide insight into the present complaints. Inquiry should be made regarding any pain (dyspareunia), bleeding, or dysuria associated with sexual intercourse. Sexual satisfaction should be discussed tactfully.
- **Drug history**
- **Allergies**
- **Summary**

OBSTETRICS PHYSICAL EXAMINATION

- General examination
- Abdominal examination
- Lower limb examination
- Pelvic examination

OBSTETRICS PHYSICAL EXAMINATION

- **General examination:**

- Weight
- Height
- BMI ➡ (weight (kg) /Height (m^2)
- Vital signs (blood pressure , pulse , respiratory rate , temperature)
- Cardiovascular examination (routine auscultation for maternal heart sounds in asymptomatic women with no cardiac history is unnecessary).
- Breast examination (Formal breast examination is not necessary, self examination is as reliable as a general physician examination in detecting breast masses.)

Don't forget WIPE, ABCDE and VITAL SIGNS

OBSTETRICS PHYSICAL EXAMINATION

- **Abdominal examination:**
- **General instruction:**

✓ You should be on the right side of the patient to facilitate the movement of the right arm.

✓ Examination done by the palm of the hand rather than the tips of the fingers with warm hands (except in some maneuvers).

✓ Engage the patient in conversation to decrease the rigidity of the abdominal wall.

✓ Examine the inguinal canal and inguinal lymph nodes.

✓ Position and exposure:

- The patient lies flat with slightly raised head on a pillow.
- Her knees drown up to decrease rigidity of the abdominal wall.

✓ The abdomen is divided into 9 quadrants by two vertical lines(mid clavicular plain which extends from mid clavicular to the mid inguinal) and two horizontal lines the upper horizontal line (transpyloric plain at the level of the first lumber vertebra bisects the distance between the umbilicus and xiphisternum) the lower horizontal line (inter-crestal plane extend between the highest points on the iliac crest).

OBSTETRICS PHYSICAL EXAMINATION

- **Abdominal examination (Cont.):**

➢ **Ask about areas of tenderness before start the examination.**

➢ **INSPECTION:**

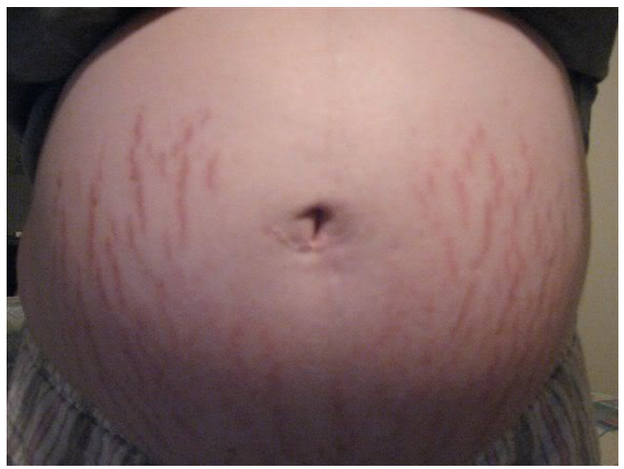
1. **Abdominal contour:** asymmetry?
2. **Respiratory movements.**
3. **Look for fetal movement**
4. **Abdominal skin:**

- scars of previous operation (CS,hysterotomy)
- pigmentation
- cutaneous signs of pregnancy ➡linea nigra,

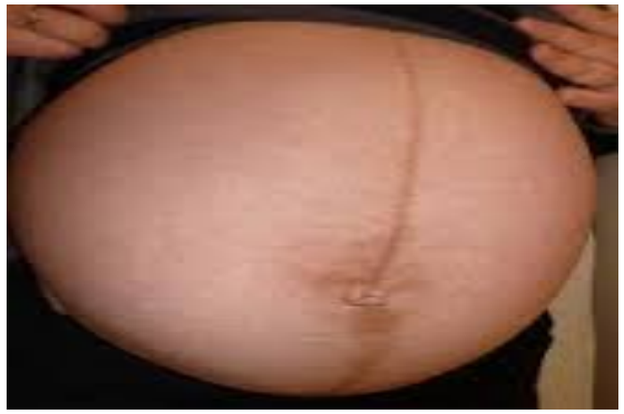
striae:] rubra (redish), albicans(white)[, gravidarum.

5. **Umbilicus:**

- Site, shape (inverted ,flat ,everted),discharge , discoloration, swelling , nodule.



striae



Linea Nigra

OBSTETRICS PHYSICAL EXAMINATION

- **Abdominal examination (Cont.):**

6. Hair distribution:

- Feminine (trisngular with horizonal upper border)
- Masculine distribution (extension of the pubic hair towrds the umbilicus).

7. hernial orifices:

- cough impulse : ask patient to cough and look at the hernial orifices(umblical,paraumbilical,inguinal,incisonal).

8. divarication of the recti .

- **Causes of abdominal enlargement (7F&ovarian tumor):**

(fetus, false pregnancy, flatus, fat, full bladder, fluid, fibroid, ovarian tumor)

OBSTETRICS PHYSICAL EXAMINATION

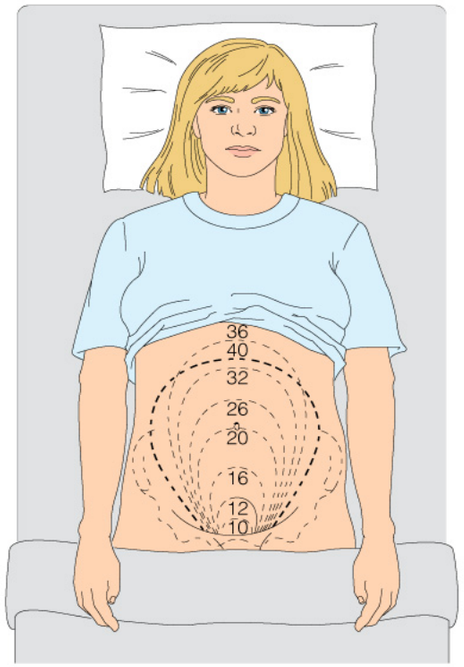
- **Abdominal examination (Cont.):**

➢ **PALPATION:**

- Uterine size ➡symphysis **fundal height (Level)** in cm = GA in wks

-at 12-14 wks ➡just palpable

-20-22 wks ➡at the umbilicus



(palpation done by the ulnar border of the left hand from the xiphisternum downward to feel the first resistence which is the fundus)

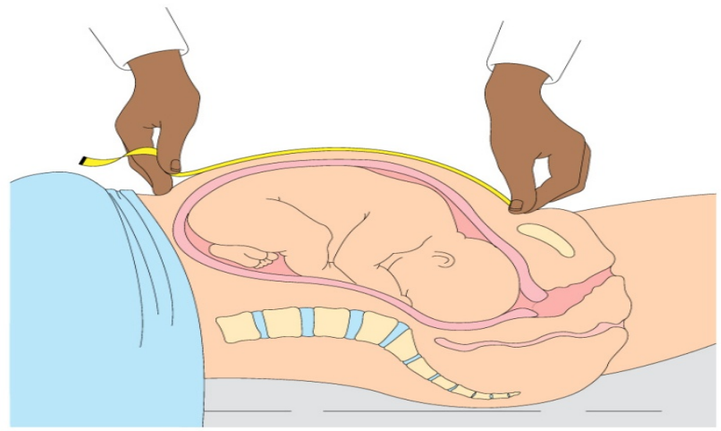
1. Superficial palpation:

By using the flat of the hand gently looking for tenderness or rigidity.

2. Deep palpation:

a-palpation abdominal organs (liver,spleen ,kidney)

b-palpation of pregnant uterus:



- because of asymmetric implantation of the ovum,

one cornu of the uterus may enlarge slightly **(Piskaçek sign).**

- Uterine consistency becomes softer, and it may be possible to palpate or to compress the connection between the cervix and fundus. This change is referred to as **Hegar sign.**

OBSTETRICS PHYSICAL EXAMINATION

- **Abdominal examination (Cont.):**
- **LEOPOLD MANEUVERS:**
  - **The first maneuver (fundal grip):** involves palpating the fundus to determine which part of the fetus occupies the fundus.
    - **Maneuver**:
      by grasping the fundus of the uterus by the palms of the 2 hands with your fingers quite close together.
  - **The second maneuver(Lateral grip)**: involves palpating the either side of the abdomen to determine on which side the fetal back lies.
    - First method :

      One hand used to support the uterus and the level of the umbilicus, other hand is used to palpate the other side of the uterus from above downwards in three lines (paramedian, midclavicular, midaxillary).
    - Second method:

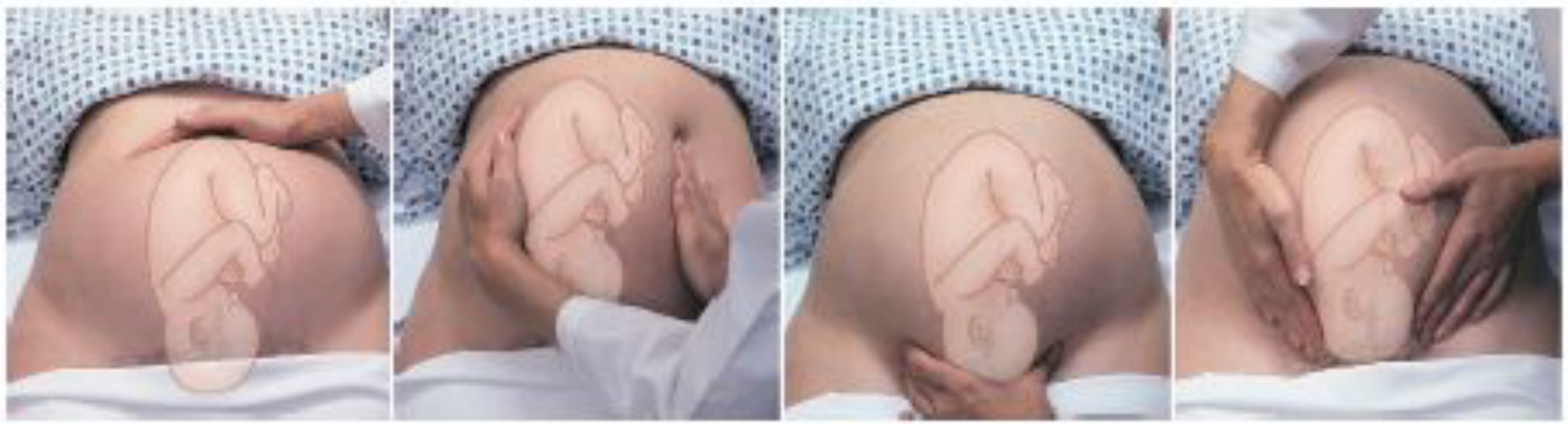
      Two hands are laid site by side at the level of the umbilicus and palpate the structure underneath them ,one hand supports and the other palpate the uterus and compare.

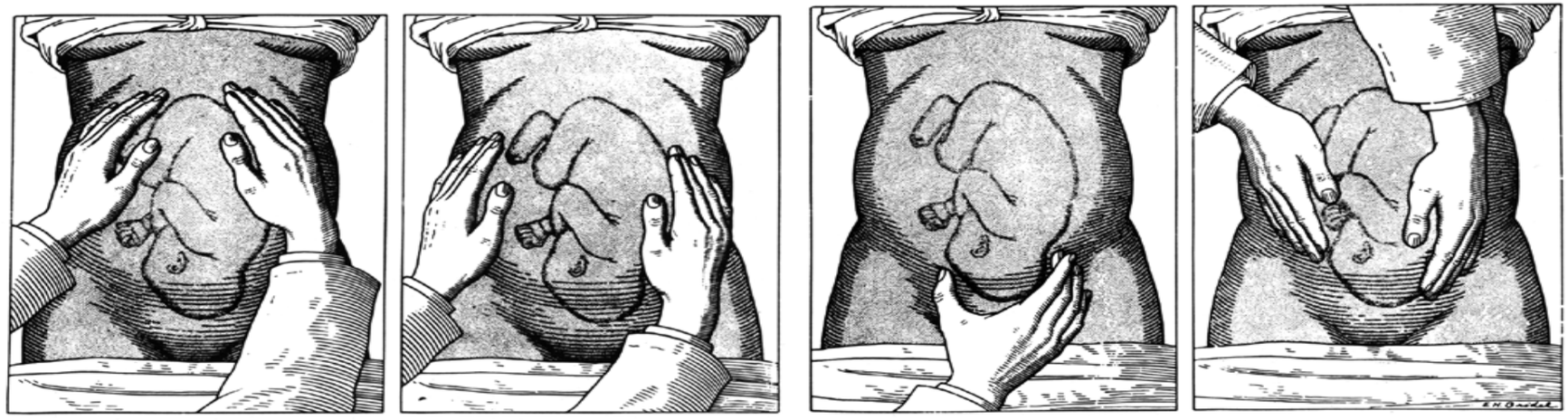
OBSTETRICS PHYSICAL EXAMINATION

- **Abdominal examination (Cont.):**
- **LEOPOLD MANEUVERS:**
  - **The third maneuver (Pawlick's grip) :** involves grasping the presenting part between the thumb and third finger just above the pubic symphysis to determine what fetal part is lying above the pelvic inlet or lower abdomen.
    1. By sitting beside the patient while she is supine with flexed hip and knee
    2. Try to catch the lower uterine segment by the right hand which the palm resting on the symphysis pubis
    3. the thumb is parallel to the right inguinal ligament and the other four fingers is parallel to the left inguinal ligament
    4. Try to feel the presented part between the thumb and other 4 fingers
  - **The fourth maneuver(Pelvic grip):** involves palpating for the brow and the occiput of the fetus determine the fetal position when the fetus is in a vertex presentation.
    1. now you turn your face towards the patient 's feet.
    2. The two hands are placed flat on both sides of the lower part of the abdomen and push there downward towards the pelvis and feel the sides of the presenting part by your fingers

OBSTETRICS PHYSICAL EXAMINATION

- **Abdominal examination (Cont.):**
- **LEOPOLD MANEUVERS:**



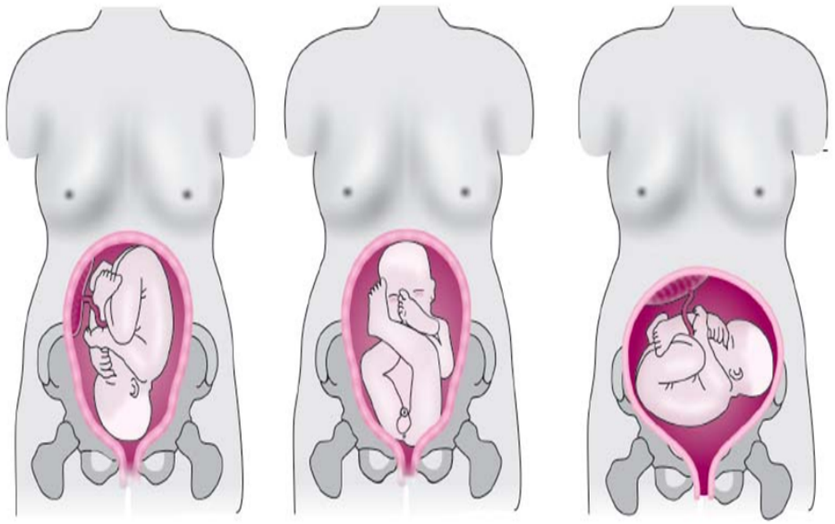


OBSTETRICS PHYSICAL EXAMINATION

- **Abdominal examination:**

FETAL LIE, PRESENTATION AND ENGAGEMENT:

- Lie of the fetus ➡longitudinal axis of the uterus to the longitudinal axis of the fetus (e.g longitudinal, transverse, oblique).
- Presentation ➡the part of the fetus that overlays the pelvic brim (e.g, vertex, breech, shoulder).
- Engagement : occurred when the widest part of the presenting part has passed successfully through the pelvic inlet.



Longitudinal lie
Vertex presentation

Longitudinal lie
Breech presentation

Transverse lie
shoulder presentation

OBSTETRICS PHYSICAL EXAMINATION

- **Abdominal examination:**

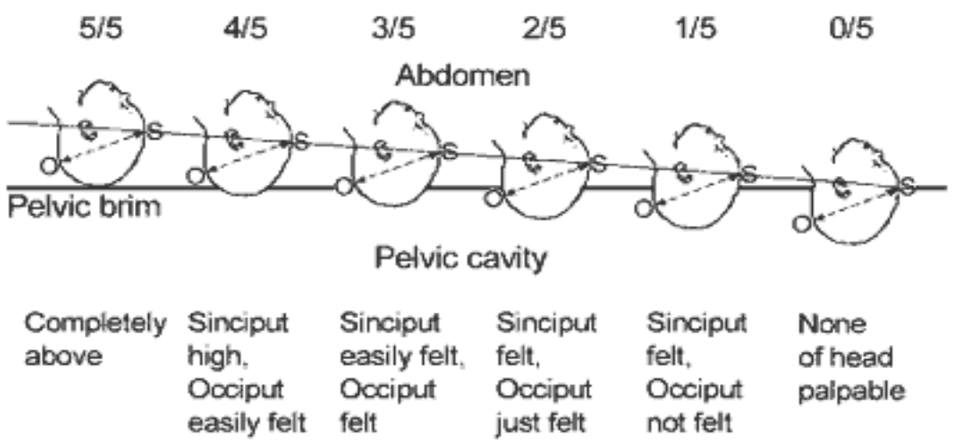
DESCENT OF THE FETAL HEAD:

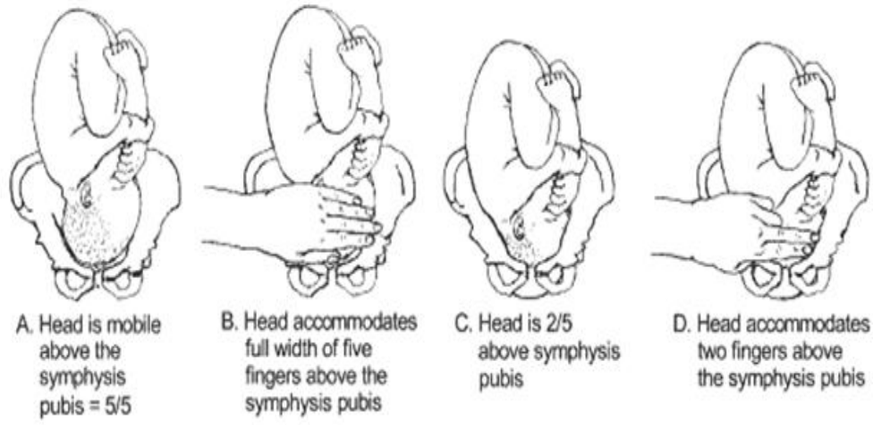
- Assessed abdominally,
- Using the rule of fifth to assess the engagement

→ Assess how much of the head is still felt per abdomen

- When only 2/5 or less of the fetal head palpated above the level of symphysis pubis, this implies the head is engaged.

› The vertex has passed or is at the level of ischial





A. Head is mobile above the symphysis pubis = 5/5

B. Head accommodates full width of five fingers above the symphysis pubis

C. Head is 2/5 above symphysis pubis

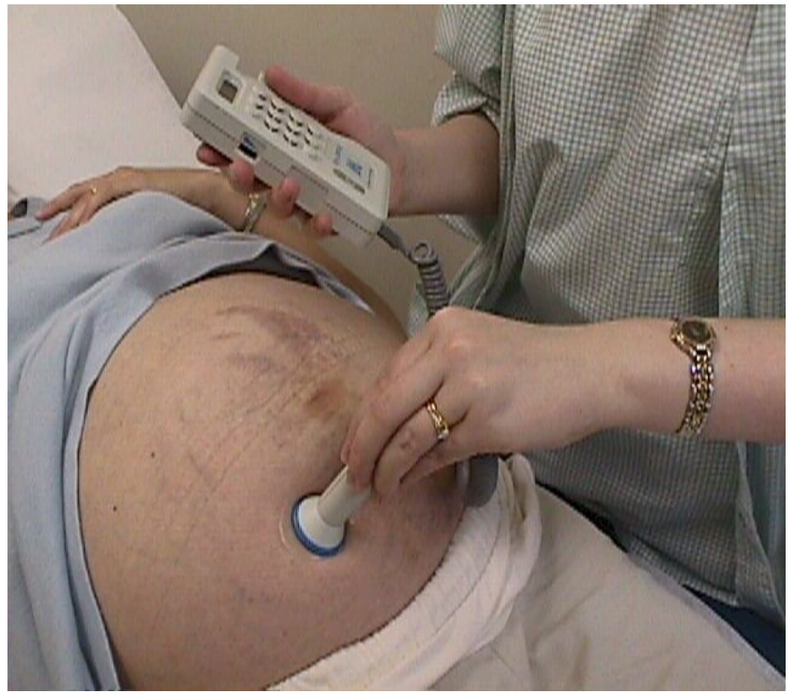
D. Head accommodates two fingers above the symphysis pubis

OBSTETRICS PHYSICAL EXAMINATION

- **Abdominal examination:**

➢ **Auscultation:**

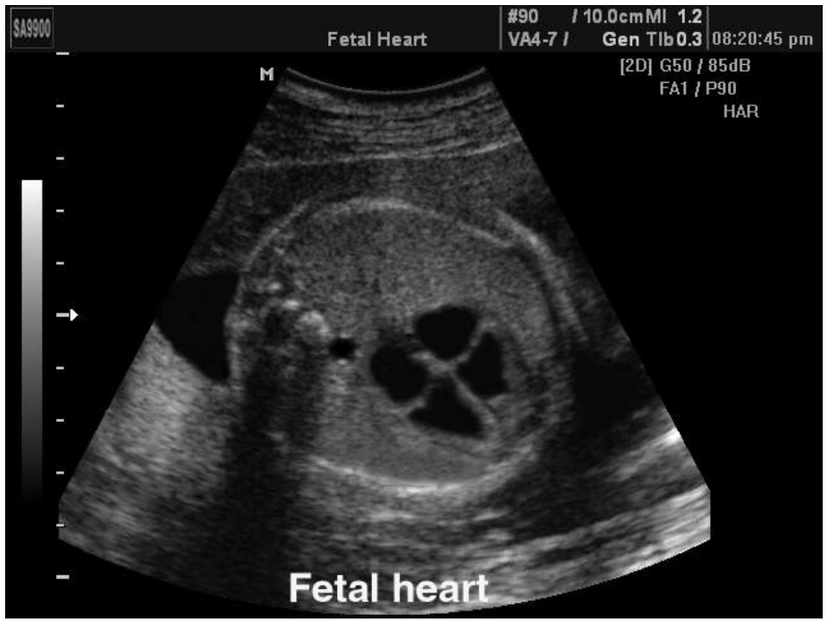
Listening for the fetal heart beat.



- **Lower limbs examination:**

➢ Swelling (edema).

➢ Varicosities.



OBSTETRICS PHYSICAL EXAMINATION

- **Pelvic examination:**
- *Routine pelvic examination is not necessary.*
- *Circumstances in which a vaginal examination is necessary (in most cases a speculum examination is all that is needed), these include :*

❑ Excessive or offensive discharge

❑ Vaginal bleeding (in the known absence of a placenta previa).

❑ To perform a cervical screen

❑ To confirm potential rupture of membrane

- The dark discoloration of the vulva and vaginal walls is known as **Chadwick sign.**

OBSTETRICS PHYSICAL EXAMINATION

- **Pelvic examination:**

➢ A digital examination may be performed:

➢ when an assessment of the cervix is required .

This can provide information about the consistency and effacement of the cervix that is not obtainable from a speculum examination (Modified Bishop score).

Score	Cervical Dilation	Cervical Effacement	Station of Baby	Cervical Posi-tion	Cervical Consistency
0	closed	0-30%	-3	posterior	firm
1	1-2cm	40-50%	-2	mid-line	moderately firm
2	3-4cm	60-70%	-1,0	anterior	soft (ripe)
3	5+ cm	80+%	+1, +2		

Add 1 point to overall score for pre-eclampsia and for each prior vaginal delivery.

Subtract 1 point off overall score do postdate pregnancy, no prior births, premature or prolonged rupture of membranes (water breaking).

A score of 5 or less is said to be "unfavorable." Unfavorable scoring shows mother is a candidate for cervical ripening prior to induction. A score of 6 or higher would indicate that the cervix is ripe and induction would have a higher probability of being successful. A score of 9 or higher indicates a very high probability of induction being successful.

OBSTETRICS PHYSICAL EXAMINATION

- **Pelvic examination:**

➢ **The contraindication to digital examination are :**

❑ Known placenta previa or vaginal bleeding when the placental site is unknown and the presenting part unengaged

❑ Prelabor rupture of the membranes (increased risk of ascending infection).

GYNECOLOGIC HISTORY

- General information
- History of present complaint (e.g,pelvic pain, vaginal discharge).
- Menstrual history
- Previous gynecological history
- Previous obstetrics history
- Enquiry about other systems
- Past medical and surgical history
- Psychiatric history
- Family history
- Social history
- Drug history
- Allergies
- Summary

GYNECOLOGIC HISTORY

- **General information:**

➢ **Name**

➢ **age**

➢ **Main complaints**

- **History of present complaint:**

➢ The detailed questions relating to each complaint.

- **Pelvic pain:**

➢ Site of pain , its nature and severity

➢ Any thing that aggravates or relieves the pain-specifically enquire about relationship to menstrual cycle and intercourse

➢ Does the pain radiate anywhere or is it associated with bowel or bladder function

➢ The common gynecologic causes of acute lower abdominal pain are salpingo-oophoritis with peritoneal inflammation, torsion and infarction of an ovarian cyst, endometriosis, or rupture of an ectopic pregnancy. Chronic lower abdominal pain is generally associated with endometriosis, chronic pelvic inflammatory disease, or large pelvic tumors. It may also be the first symptom of ovarian cancer.

GYNECOLOGIC HISTORY

- **Vaginal discharge:**

- Amount, colour, odour, presence of blood.
- Relationship to menstrual cycle.
- Any history of sexually transmitted disease or recent tests.
- Any vaginal dryness.
- Vaginal bleeding before the age of 9 years and after the age of 52 years is cause for concern and requires investigation. It is important to ensure that she is not bleeding from uterine cancer or from exogenous estrogens. Prolongation of menses beyond 7 days or bleeding between menses may connote abnormal ovarian function, uterine myomata, or endometriosis.

GYNECOLOGIC HISTORY

- **Menstrual history:**

- Age of menarche
- Usual duration of each period and length of cycle.
- First day of the last period.
- Pattern of the bleeding : regular or irregular and length of the cycle.
- Amount of blood loss : more or less than usual, number of sanitary towels or tampons used , passage of clots or flooding.
- Any intermenstrual or postcoital bleeding.
- Any pain relating to the period, its severity and timing of onset.
- Any medication taken during the period.
- Midcycle pain *(mittelschmerz)* and a midcycle increase in vaginal secretions are usually indicative of ovulatory cycles.

GYNECOLOGIC HISTORY

- **Previous gynecological history :**

- Previous treatment and surgery.
- Date of the last cervical smear and any previous abnormalities.
- Sexual active , difficulties or pain during intercourse.
- The type of contraception used and any problem with it.
- Menopause:(Date of last period ,any post menopausal bleeding ,any menopausal symptoms).

- **Previous obstetrics history:**

- Outcome & details of previous pregnancies

- **Enquiry about other systems:**

- (e.g, Appetite, weight loss/gain, bowel function, bladder function).
- A review of all other organ systems should be under- taken. Habits (tobacco, alcohol, other substance abuse), medications, usual weight with recent changes, and loss of height (osteoporosis) are important parts of the systemic review.

GYNECOLOGIC HISTORY

- **Past medical & surgical history**
- **Psychiatric history**
- **Family history**
- **Social history:**

➢ **Sexual history:** The health of, and current relationship with, the husband or partner(s) may provide insight into the present complaints. Inquiry should be made regarding any pain (dyspareunia), bleeding, or dysuria associated with sexual intercourse. Sexual satisfaction should be discussed tactfully.

- **Drug history**
- **Allergies**
- **Summary**

GYNECOLOGIC PHYSICAL EXAMINATION

- General examination
- Abdominal examination
- Pelvic examination
- Rectal examination

GYNECOLOGIC PHYSICAL EXAMINATION

- **General exam :**

- Height
- Weight , BMI
- Vital signs
- Hands , mucous membrane
- Evidence of **supraclavicular lymphadenopathy**, oral lesions, webbing of the neck, or **goiter** may be pertinent to the gynecologic assessment.
- Chest (CVS ,Respiratory) :The presence of a pleural effusion may be indicative of a disseminated malignancy, particularly ovarian cancer.
- Breast

GYNECOLOGIC PHYSICAL EXAMINATION

- **Abdominal exam:**

1. **Inspection:** distension, masses, surgical scars, hernia.
2. **Palpation:** guarding , tenderness, masses.
3. **Percussion:** useful if free fluid is suspected.
4. **Auscultation:** not specifically useful for the gynecological examination, in case of acute abdomen with bowel obstruction or postoperative patient with ileus (listening of bowel sounds).

- **Pelvic examination:**

➢ **Inspection:**

- External genitalia and surrounding skin.

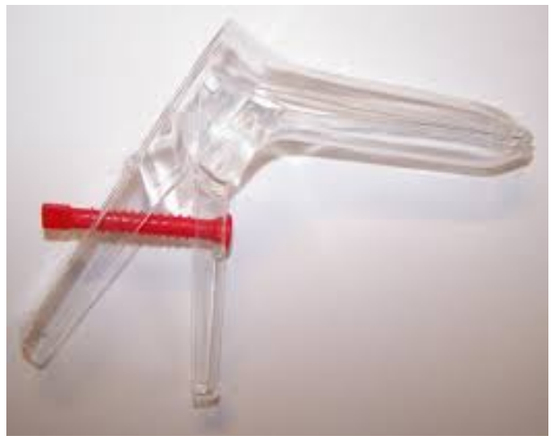
➢ **Speculum (bivalve , Or Cusco):**

- Inspect the vaginal walls and the cervix.
- Samples and PAP smear.

SPECULUM EXAMINATION – Note that speculum in illustration is not a Cusco....

Inspect the cervix:

- Type of cervical os- small round dimple (nulliparous os) or os in the shape of a smile (multiparous os)
- Colour- normally pink, may be a redder area around the os, known as cervical ectropion, or tinged blue if pregnant, red in cervicitis
- Secretions/ discharge - observe colour (eg cervical mucus if ovulating, blood if menstruating)
- Presence of growths/ tumours- usually cauliflower-like and friable, i.e. bleeds on touch (indicates malignancy)
- Ulcerations, scars and retention cysts (Nabothian follicles)
- The cervical smear/"Pap" smear is taken at this stage



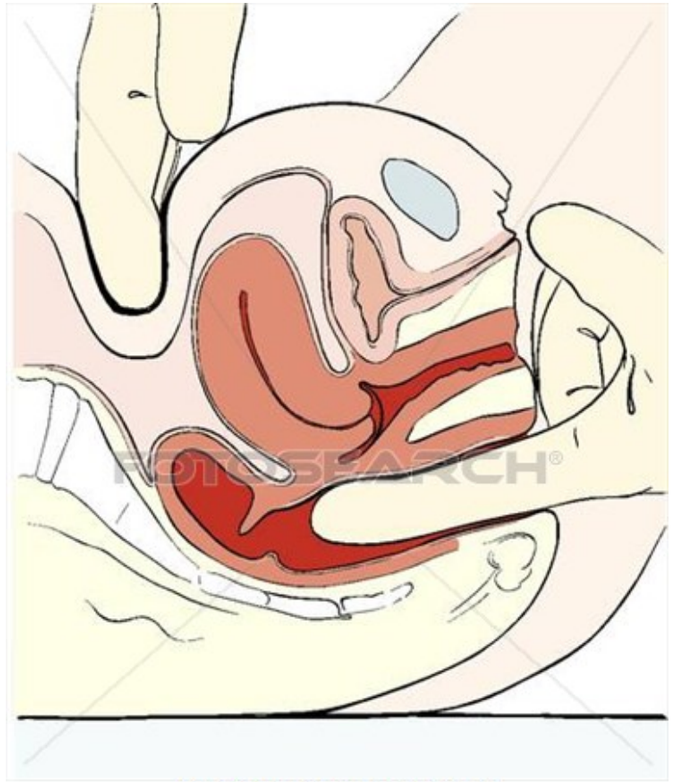
GYNECOLOGIC PHYSICAL EXAMINATION

- **Pelvic examination (Cont.):**

➢ The patient is asked to bear down **(Valsalva maneuver)** or to cough to demonstrate any stress incontinence.

➢ **Bimanual examination (picture):**

- Provides information about the uterus and adnexa.
- The urinary bladder should be empty
- The **pouch of Douglas** is also carefully assessed for nodularity or tenderness.



- **Rectal examination:**

➢ Used as alternative to a vaginal examination in children and in adults who are not sexually active.

➢ A rectovaginal examination is helpful in evaluating masses in the cul-de-sac, the rectovaginal septum, or adnexa. It is essential in evaluating the parametrium in patients with cervical cancer.

Thank You

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