OB/GYN Clerkship Orientation Guide

Welcome to your OB/GYN Clerkship! We're excited to have you here. We think this is the very best specialty of all and we want to share our love of this field with you during your time with us. This packet includes some information we think you will find helpful on your rotation, including a brief overview of our expectations of you during this rotation, sample notes, and highlights of clinical information with which we expect you to become familiar. We suggest that you use create a packet of index cards that you can carry with you on your rotation for quick reference.

OB/GYN is an often unpredictable field of medicine. Some days will be crazy and others slow. Use your down time wisely for studying. You are expected to do independent reading regarding the topics that you encounter. If you need direction, we can suggest areas where you should focus. We are here to help you learn, but much of your learning will come from your interactions with the patients and from your observation of the team as they manage the patients.

If there is anything that you feel would be a useful addition to this compilation, please let us know. We hope you find these notes helpful.

Good Luck and Enjoy!

Notes on Notes:
All notes should be titled with your POSITION, TYPE of note, and your SERVICE for easy identification.
All notes must be DATED and TIMED.
All notes should be SIGNED
You are not permitted to use templates.

Obstetrics

Your L&D rotation is divided into 24 hr shifts divided amongst the other students on L&D. Sub interns are expected to round on antepartum patients and M3s (from the overnight shift) are expected to round on postpartum patients PRIOR TO SIGNOUT every morning, by 6am. Sign-out begins at 7:00 am every day but Wednesday in the resident education room, 246, on labor and delivery. PM sign-out occurs at 6:00 pm M, T, Th, F and 7:00 pm on Wednesdays. All students are expected to be on time for sign-out. You should sign-out your patients to the team that comes on after you. When you transition from one service to another, you are also responsible for passing on expectations and patient information to the next team.

L&D

Triage

Patients who present for triage should first be evaluated by the medical student. Be on the lookout for new patients. Once the nurse is finished checking in patient, you may go see them, get their history, and perform physical exam (*except for pelvic*). **After you have seen the patient, present them to the resident** (usually the junior resident on the service). See attached OB Triage H&P note. It is helpful to look through the patient's medical record prior to seeing them. Their prenatal record can be found under the **episodes tab** under chart review. Beware that the method of dating on these forms is often not correct. Radiology ultrasounds can be found under radiology, but **MFM ultrasounds are scanned in under the media tab**.

Labor Patients

You should divide the labor patients among the medical students present. **Only one student should see each patient**. Labor patients should have progress notes written **every 4 hours in latent labor** and **every 2 hours in active labor**. You are responsible for having notes written on your patients- we will not remind you. Once your note is written, please let your residents know and one will review it with you *if time permits*.

Deliveries

You may only attend a delivery if you have met the patient prior to the beginning of pushing. You will need to pull gloves for yourself (and sometimes a gown) to place on the delivery table. These are usually located inside the cabinet of the delivery table (or above the scrub sink at Gottlieb). Surgical caps, boots, and masks are located in drawers next to the nurses' station (or in the room next to the OR at Gottlieb). GET DRESSED FAST. We can't wait for you to get your gloves on, so if you're not ready, you're going to miss it. Afterward, you can help by taking the instruments back to the dirty utility room. A student should also scrub for every cesarean section. Again, make sure to meet the patient first. You should write the delivery note afterward. The resident will sign it.

Antepartum Patients

Progress notes should be written **every 4 hours** which review the strip, and if hospitalization is for a maternal medical indication, include a physical exam.

Magnesium Sulfate Notes

Notes should be written every 4 hours. Patients on magnesium need special monitoring for magnesium toxicity, respiratory depression, pulmonary edema, renal failure, neurologic irritation, worsening blood pressure, or signs of fetal distress. Note should include **s/sx of pre-eclampsia, vitals (including O2 sats), UOP, physical exam including reflexes, and recent labs.**

Postpartum

Postpartum patients would have progress note every day. **Patient's who deliver between Midnight and 6 am are not rounded on until the next day.**

Antepartum

These patients usually include women with preterm premature rupture of membranes, preterm labor, placenta previa, pre-eclampsia, or medical complications of or during pregnancy. They offer an opportunity to learn about more in-depth disease processes related to pregnancy. Please try to see antepartum patient's in addition to postpartum patients. However, understand that the prolonged hospitalization of these women can be very stressful, so be sensitive to their needs and requests. Progress note should include questions about **fetal movement, LOF, vaginal bleeding, s/sx of pre-eclampsia, sx of DVT or PE**. Vitals should include **fetal heart tones**, which are measured every shift. Objective portion of note should include general, cardiac, pulmonary, abdomen, extremities and any new lab or ultrasound results.

The Sign-out

This is an electronic document that we keep with information regarding all of the patients on the service. It is a vital aspect in our communication with each other. Your residents may ask you to assist with keeping the sign-out updated. When you see a new patient, they should be added to the list. Just follow the form of the other patients on the list. Bold means currently pregnant.

Labor and Delivery Pearls:

ANTENATAL TESTING- ***KNOW THESE DEFINITIONS!!!!!***

Definitions of Fetal Heart Rate Patterns	
Pattern	**Definition**
Baseline	• The mean FHR rounded to increments of 5 bpm during a 10 min segment • Must be for a minimum of 2 min in any 10-min segment
Baseline variability	• Fluctuations in the FHR of two cycles per min or greater • Quantitated as the amplitude of peak-to-trough in beats per min o Absent—amplitude range undetectable o Minimal—amplitude range detectable but ≤ 5 bpm o Moderate (normal)—amplitude range 6–25 bpm o Marked—amplitude range > 25 bpm
Acceleration	• Increase in the FHR from the most recently calculated baseline • Duration defined as the time from initial change in FHR from the baseline to the return to the baseline • 32 weeks and beyond: acme of ≥ 15 bpm above baseline, duration of ≥ 15 sec but < 2 min • Before 32 weeks: 10 beats per min or more above baseline, duration ≥ 10 sec but < 2 min • Prolonged acceleration: ≥ 2 min but < 10 min • If an acceleration lasts 10 min or longer, it is a baseline change
Bradycardia	• Baseline FHR < 110 bpm
Early deceleration	• Associated with a uterine contraction, gradual (onset to nadir 30 sec or more) decrease with return to baseline • Nadir of the deceleration occurs at the SAME TIME as the peak of the contraction
Late deceleration	• Associated with a uterine contraction, gradual (onset to nadir 30 sec or more) decrease with return to baseline • Onset, nadir, and recovery occur AFTER THE BEGINNING, PEAK, AND END of the contraction, respectively
Tachycardia	• Baseline FHR > 160 beats per min
Variable deceleration	• Abrupt (onset to nadir less than 30 sec) decrease in the FHR below the baseline • The decrease in FHR is ≥ 15 bpm, with a duration of ≥ 15 sec but < 2 min
Prolonged deceleration	• Visually apparent decrease in the FHR below the baseline • Deceleration is 15 beats per min or more, lasting 2 min or more but less than 10 min from onset to return to baseline

Nonstress Test (NST)

- Reactive: 2 or more accelerations occur in 20 minutes
- Nonreactive: no accelerations noted over 40 minutes

Contraction Stress Test:

- Pitocin or Nipple stimulation applied until 3 contractions in 10 minutes
- Positive (nonreassuring): late decelerations following 50 percent or more of the contractions
- Negative (reassuring): no late or significant variable decelerations
- Equivocal-suspicious pattern: intermittent late or significant variable decelerations
- Equivocal-hyperstimulatory: decelerations with contractions more frequent than q 2 minutes or lasting > 90 seconds.
- Unsatisfactory test: tracing is uninterruptable or contractions are fewer than three in 10 minutes.

Biophysical Profile:

- 2 pts for each of the following in 30 minute period:
  - NST
  - fetal breathing (≥ 1 episode of breathing lasting ≥ 30 sec)
  - fetal movement (≥ 3 discrete body or limb movements)
  - fetal tone (≥ 1 episode of extension of extremity with return to flexion or opening or closing of hand)
  - AFI (single vertical pocket > 2cm)
- Interpretation
  - 8-10 Reassuring
  - 6 Equivocal- deliver if mature, if not, administer steroids and repeat in 24 hrs
  - 4 or less→ deliver unless extremely preterm
- Modified BPP- NST + AFI

LABOR

Phases of Labor

First: Onset of labor to complete dilatation

Second: Complete dilatation to delivery

Third: Delivery of infant to delivery of placenta

Normal Labor Progress:

		Nulligravida	Multiparous	Therapy
Prolonged Latent		> 20 hrs	> 14 hrs	Rest, pitocin
Protraction	Dilation	< 1.2 cm/hr	< 1.5 cm/hr	AROM, pitocin
	Descent	< 1 cm/hr	< 2 cm/hr	Pitocin
Arrest	Dilation	> 2 hrs	> 2 hrs	AROM, pitocin, c-section
	Descent	> 2 hrs	> 1 hrs	Vacuum, forceps, c-section
	With epidural	*> 3 hrs*	*> 2 hrs*	

	Nulligravida		Multiparous	
	Avg.	Limit (95%)	Avg.	Limit (95 %)
Active phase	4.9 hrs		3.2 hrs	
2nd Stage	50 min	2hr *(3 with epidural)*	20 min	1 hr *(2 with epidural)*
Total	9 hrs	18.5	6 hrs	13.5

Fetal Lie- axis of the fetus. Longitudinal, Transverse, or Oblique.
Presentation- the fetal part at the cervix. Cephalic, breech, shoulder
Attitude- flexed or extended
Position- named for occiput, sacrum, or mentum in relation to maternal pelvis

Leopold's Maneuver

1. Feel top of uterus- Identification of the fetal pole in the fundus
2. Hands on either side of uterus- Location of back and small parts
3. Lower uterine segment between thumb and first finger- determines engagement
4. Fingers pointed toward patient's feet to determine position

Cardinal Movements of Labor

1. Engagement- biparietal diameter has passed pelvic inlet, 0 station.
2. Descent- often begins with engagement in multips
3. Flexion- from resistant forces of pelvic walls, pelvic floor, etc., brings shorter AP diameter into pelvis
4. Internal rotation- fetus faces maternal spine
5. Extension- head extends under pubic bone
6. External rotation/ restitution
7. Expulsion- delivery of body

Diagnosis of Membrane Rupture

1. Pooling
2. + Nitrazine with pH > 6.5 (dark blue).
- Amniotic fluid pH= 7.0-7.5 (normal vaginal pH 3.5-4.5)
- False + with blood, semen, or BV
3. Ferning- due to NaCl, proteins, and carbs
4. AFI

Perineal Lacerations:

1. fourchette, perineal skin, and vaginal mucosa
2. involves fascia and muscles of perineal body
3. involves anal sphincter
4. involves rectal mucosa

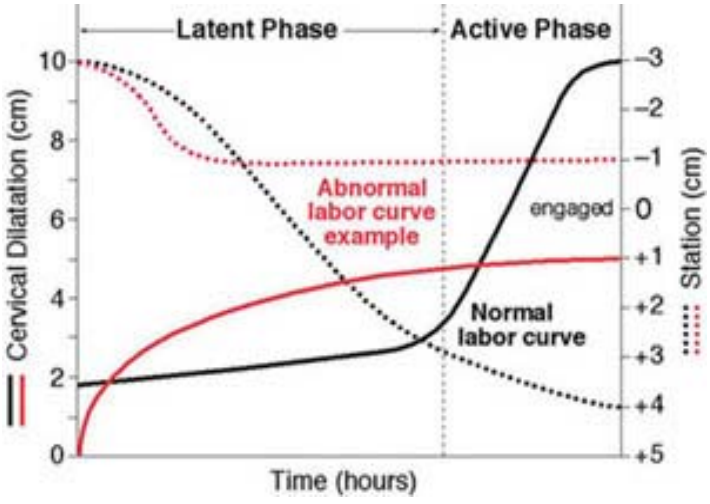
Etiology of Post Partum Hemorrhage

1. Atony
2. Retained Placenta
3. Lacerations
4. Uterine inversion

Medical Agents for Postpartum Hemorrhage

Oxytocin
Methergine (Ergonovine and Methylergonovine)-CI in HTN
Hemabate (Carboprost Prostaglandin F2a)- CI in asthma
Cytotec (Misoprostol)- 1000mcg rectally

Friedman curve:



INDUCTION OF LABOR

Bishop Score- To determine if cervical ripening is needed. *Calculate this for all Inductions*

	Dilation	Effacement	Station	Consistency	Position
0	Closed	0-30	-3	Firm	Posterior
1	1-2	40-50	-2	Medium	Mid
2	3-4	60-70	-1	Soft	Anterior
3	≥ 5	> 80	+1, +2		

Modified Bishop Score: Add one point for preeclampsia, and each prior vaginal delivery, Deduct one point for postdates, nulliparity, preterm or prolonged PROM

0-4: 45-50% failure
5-9: 10% failure
10-13: 0% failure
> 8: Probability of vaginal delivery similar to spontaneous labor

Cervical Ripening Agents

- Cervidil- (Prostaglandin E2/dinoprostone) One 10 mg Insert q 12 hrs, max 3 doses (Also available as Prepidil gel)
- Cytotec- (Prostaglandin E1/Misoprostol) 25 mcg (1/4 of 100 mcg pill) vaginally q 4 hrs
- Transcervical Catheter
- Extra-amniotic saline infusion (EASI)
- Hygroscopic dilators
- Oxytocin

"Hyperstimulation"

- Uterine Tetany: Single ctx > 2
- Tachysystole: more than 5 ctx in 10 minutes or 7 ctx in 15 minutes
- Correction of Tachysystole or uterine tetany with resulting FHR tracings:
  - Decrease or discontinue uterine stimulant
  - IV fluids
  - Maternal repositioning
  - Maternal oxygen
  - Consider Terbutaline if persists

Tocolytics

Medication	Mechanism of Action
Magnesium Sulfate	Decreases calcium needed for uterine contraction
Indomethicin (Indocin)	Cyclooxygenase inhibitor
Nifedipine (Procardia)	Calcium Channel Blocker
Terbutaline (Brethine)	Betamimetic
Atosiban (Antocin)	Pitocin antagonist

Pre Term Labor

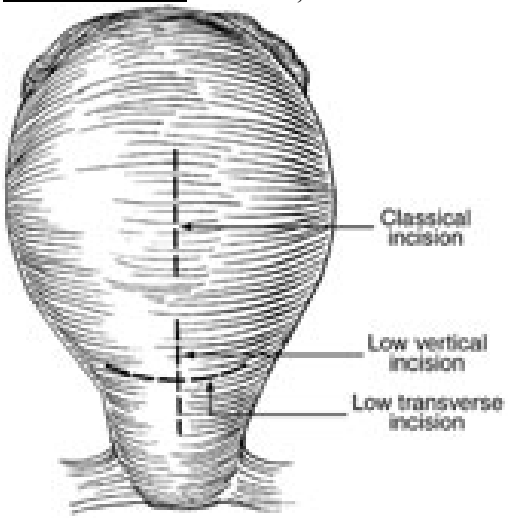
Steroids for Fetal Lung Maturity (FLM)
Betamethasone 12mg IM q 25 hrs x 2 doses
Dexamethasone 6 mg IM q 12 hrs x 4 doses
Tocolytic Medication to allow administration of steroids
Fetal Fibronectin (FFN)

- Used between 24 and 32 weeks to determine probability of PTL
- High negative predictive value
- Nothing per Vagina for prior 24 hrs
- Blood and Semen interfere with results→ false +

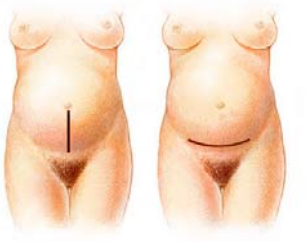
Incisions

There are different types of skin and uterine incisions, and one has nothing to do with the other. Only women with prior low transverse uterine incisions can attempt VBAC. (Rupture rate < 1%)

Uterine Incisions: Classical, Low Vertical or Low Transverse



Skin Incisions: Midline Vertical vs Pfannenstiel



Medical Student Labor and Delivery H&P

CC: Leakage of Fluid, contractions, vaginal bleeding, abdominal pain, etc
HPI: 27 yo AA G6P2123 @ 37-5 by LMP consistent with 1st TMUS (or by US alone) presents for _____. Patient reports +/- FM, no LOF, VB, or contractions. +/- HA, vision changes, RUQ pain. Pregnancy complicated by _____. Prenatal care @ _____.
LMP: _____
EDC: _____
OB Hx: G6P2123
(Year; Term or Preterm, if preterm-why; Vaginal or Cesarean, type of cesarean and why; male of female; Weight; complications. If SAB or EAB, note GA and if D&C performed)

1. 2001- 41w NSVD (or FAVD or VAVD or VBAC), M, 7lb 6oz, no complications
2. 2003- 36w 1LTCS, PPROM, NRFHT, F, 6lb 2oz, chorioamnionitis
3. 2005- 1TM SAB with D&C
4. 2005- 39w VBAC, F, 7lb 12oz, pre-eclampsia
5. 2007- 6w medical EAB
6. Current, GDM-A1

GYN Hx: h/o STDs, abnormal paps, etc
PMH: Asthma, cHTN, etc
PSH: D&C 2005, 1LTCS 2003, appendectomy 1985
Meds: PNV
Allergies: PCN- rash (always NOTE reaction)
Family Hx: Mother-DM, Father- HTN. +/- birth defects, mental retardation, bleeding or clotting disorders
Social Hx: +/- tobacco, EtOH, drugs. Living situation. Occupation. Feels safe? +/- Depression
ROS:
Gen: +/- Fever/chills
HEENT: vision changes, sore throat, rhinorrhea
CV: paplitations, chest pain
Pulm: SOB, prolonged cough
GI: abdominal pain, nausea, vomiting, diarrhea, constipation
GU: dysuria, hematuria, frequency, abnormal vaginal discharge
MS: joint pain, swelling
Neuro: severe headache, weakness
Heme: h/o anemia or blood clots
Psych: depression or anxiety
Physical Exam:
VS: BP 125/80, HR 72, RR 18, O2 Sat 99%
FHT *(baby's vitals):* Baseline, variability (absent, min, moderate, marked), accels?, decels (state type-early, late, variable)
Toco: q 5 minutes (or 2 in 1 hr, or none)
Gen: A/O, NAD or appears uncomfortable, etc
CV: RRR, + SEM
Pum: CTA B
Abd: gravid, NT, Fundal Height= 38cm. EFW= 7lbs. Leopolds= cephalic
Ext: no edema, calves non-tender
Neuro: DTRs 2+, no clonus *(needed if any concern about pre-eclampsia)*
SSE: no bleeding or pooling, Cervix visually dilated to 2-3 cm
SVE: 3cm/50%/-1

Wet Prep: - yeast, clue cells, or trich. Nitrazine and Ferning negative
Urine Dip: negative
PNL: O+/Ab-/HIV-/HepB-/RPR NR/RI/CF-/GC-/CT-/Hgb 13.2/Pap NIL/1 hr 72/GBS-
Level II US: EFW 3250g (40%), cephalic, 3VC, posterior placenta, normal anatomy, BPP 8/8, normal dopplers

A/P: 27 yo G6P2123 @ 37-5 by LMP c/w 1TMUS in labor, with SROM, PTL, etc

- FWB reassuring. Class I FHT
- Admit to L&D
- NPO, IVF
- Etc.

Your Name, MS3

MS3 Labor Progress Note

S: Patient comfortable after epidural
O: BP 113/65, HR 82, RR 18, T 97.8
FHT: 150, moderate variability, + accelerations, no decelerations
Toco: q 3 minutes, MVUs 120
SVE: 4/50/-1
Pitocin @ 6 mU/minute
A/P: 30 yo G2P1001 @ 38-4w, Labor

- FWB reassuring. Category I FHT
- Protracted labor- augmentation with Pitocin
- GBS +, continue pitocin
- Anticipate vaginal delivery

Your Name, MS3

MS3 Mag Note

S: + FM. Denies HA, vision changes, RUQ pain.
O: VS: 150/96, 90, 18, 97.5, O2 98% on NC
I/O: 4hr-600/500mL. Urine protein 3+
FHT: 150, moderate variability, + accelerations, variable decelerations to 120 lasting 20 seconds
Toco: q 3 minutes, MVUs 120
Gen: a/o, NAD
CV: RRR
Pulm: CTA B
Abd: gravid, NT, no epigastric or RUQ tenderness
Ext: 2+ edema, calves non-tender, SCDs in place.
Neuro: DTRs 3+, no clonus
SVE: 1/50/-3
Labs: Recent HELLP labs- CBC, LDH, Uric Acid, AST, ALT
A/P: 19 yo G1 @ 37-0. IOL for mild pre-eclampsia

- FWB reassuring. Category II tracing
- IOL with cervidil
- Magnesium for seizure prophylaxis- no s/sx of toxicity
- UOP appropriate
- BP stable. Hydralazine (or Labetolol) for BP > 160/110
- HELLP labs negative

Your Name, MS3

Post-Delivery Note

Pre-op Dx: 32 yo G3P2002 @ 39-6, PPROM, Induction of labor with Pitocin
Post-op: same, delivered, liveborn M/F infant, 2nd degree perineal laceration
Procedure: Normal Spontaneous vaginal delivery, repair of perineal laceration (or Primary or repeat low tranverse cesarean section, or classical cesarean)
Surgeon: Dr. Attending
Assistants: Dr. Resident, PGY3; You, MS3
Anesthesia: epidural and local (or spinal, or general)
Findings: liveborn M/F infant in LOA/ROA/OP position, apgars 8/9, 3340g, placenta delivered intact, 3VC, no cervical or vaginal lacerations, 2nd degree perineal laceration (If cesarean, note normal appearing tubes and ovaries or excessive scar tissue, etc)
EBL: 300 mL
Specimins: placenta
Complications: none
Condition: Stable In LDR

Your Name, MS3

MS3 Post Partum Note

S: 26 yo G3P3003 PPD#1 s/p NSVD (or POD#2 s/p 1LTCS, VBAC, FAVD, etc). Pain controlled. Tolerating general diet. No nausea or emesis. + Flatus/BM. Voiding without difficulty. Ambulating without dizziness. Denies CP, SOB, calf pain. Lochia =/</> menses. +/- Depression. Breast/Bottle Feeding. Baby boy/girl in room/nursery/NICU. Desires circumsicion for infant.

O: VS: 120/89, 90, 18, 97.5 I/O: 24 hr-2350/2300mL. 8hr-1234/980mL (cesarean only)
Gen: a/o, NAD
CV: RRR
Pulm: CTA B
Abd: soft, appropriately tender, + BS, fundus firm below umbilicus (incision c/d/I with staples in place for cesarean)
Ext: calves NT, no edema
Labs: Hgb 12.3→ 10.2 (Cesarean section only). Blood type: A neg. Rubella non-immune
A/P: 26 yo G3P3003 PPD#1 s/p NSVD (rLTCS, 1LTCS, VBAC, VAVD, FAVD)

- Pain controlled with Motrin and Darvocet (Norco, T#3, Toradol)
- Advance diet to general (clears, full liquid, etc) as tolerated (cesarean sections)
- Urine output appropriate. Discontinue foley catheter (cesarean sections)
- Encourage ambulation and IS (cesarean section)
- SCDs for DVT prophylasix (cesarean section)
- Colace for constipation. Simethicone for gas
- Iron for post-op anemia. MVI if breast feeding
- Rubella Non-immune- MMR prior to discharge
- Rh negative. Rhogam prior to discharge
- Circ for baby boy
- Dispo: floor. Home tomorrow

Your Name, MS3

Routine Postpartum Care Orders- Vaginal Delivery

- General diet immediately post delivery
- Colace for constipation
- Motrin 600 mg q 6 hrs and Darvocet N 100 1-2 q 6 hrs prn pain
- Discharge PPD#1-2
- Discharge Instructions: nothing per vagina x 6 weeks (no intercourse, tampons, douching). f/u 6 weeks

Routine Postpartum Care Orders- cesarean

- SCDs for DVT prophylaxis
- IS 10 times per hour while awake
- NPO x ice for 6 hrs postop, then advance to clear.
- Bedrest x 6 hrs then OOBTC
- PCA if no Doramorph in Epidural (Gottlieb only) or if under General Anesthesia
- Toradol 30 mg IV q 6 hrs x 24 hrs
- POD#1: discontinue foley, advance diet to general if + BS and no n/v, remove dressing, ambulate TID, d/c PCA and advance to PO meds if applicable, patient may shower
- Staples out POD#3 for phannenstiel incision, PD#7 for midline (generally, always ASK first)
- Discharge POD#2 or 3
- Discharge Instructions: Cesarean section: nothing per vagina x 6 weeks, showers only x 2 weeks, no driving x 2 weeks, no heavy lifting x 6 weeks, f/u 2 weeks and 6 weeks

Commonly Used Postpartum Meds:

Motrin 600 mg po q 6 hours PRN pain
Darvocet N-100 mg 1-2 tab q 6 hrs PRN pain (contains 650 tylenol PER TAB)
Norco 5/325 1-2 tabs q 4 hours PRN pain (contains 325 mg tylenol per tab)
Colace 100 mg po BID prn constipation
Senokot-S 1 tab BD prn constipation (Gottlieb)
Simethicone 80 gm 1 tab po four times daily for gas pain
Toradol 30 mg IV q 6 hours PRN pain (NSAID- do not give if also giving Motrin)

Postpartum Visit

- Cesarean sections- 2 weeks and 6 weeks
- Vaginal deliveries- 6 weeks
- Document using regular soap note. Special attention to **9 "Bs": Breast, Belly, Bottom, Bleeding, Bladder, Bowels, Birth control, blues and baby**. Pap and breast exam performed.
- 2 hr glucose tolerance for all gestational diabetics

PRENATAL CARE

1st Prenatal Visit:

- Counseling on diet, exercise, weight gain, OTC meds, environmental exposure, travel, frequency or visits, ED precautions
- Routine Labs: CBC, Type and Screen, GC/CT probe, Hep B, RPR, Rubella Titer, UA and Culture, Hgb Electrophoresis if AA
- Pap smear if not done in past year
- Breast Exam
- Cystic Fibrosis Screening- optional
- HIV- opt out screening has best results
- Ultrasound for dating if uncertain LMP

11- 14 wks: First Trimester screen *optional*
14-25 wks (usually 15-22): Quad test
18-22 wks: Anatomy US
24 wks: Rhogam for Rh Negative Patients
35wks: GBS culture

Visits q 4 weeks until 28 weeks
Q 2 weeks from 28 to 35 weeks
Weekly after 35 weeks until delivery

Prenatal Visit Progress Note
S: + FM. No LOF, VB, ctx.
O: BP 115/60, Wt 132 lbs
Urine dip- trace protein
FH: 32 cm
FHT: 145
Ext: no edema
A/P: 25 yo G2P1001 @ 32-4 by LMP c/w 1TUS

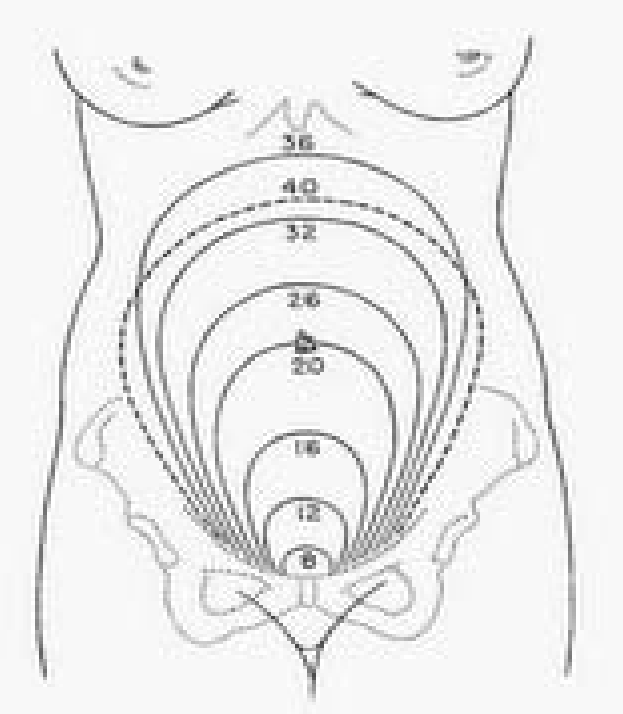
- PNL: O-/Ab-/HIV-/HepB-/RPR NR/RNI/CF-/GC-/CT-/Hgb 13.2/Pap NIL/1 hr 72
- Rh negative- s/p Rhogam at 28 weeks
- ROB 2 weeks

Your Name, MS3

Determination of Gestational Age:

1) FHT present by fetoscope > 20 weeks, or by doppler > 30 weeks
2) 36 weeks since + urine pregnancy test by reputable lab
3) US CRL @ 6-12 weeks c/w EGA > 39 weeks
4) US @ 13-20 weeks c/w GA > 39 weeks, consistent with history and physical exam

Fundal Height
Measurement in centimeters from pubic symphysis to top of fundus. After 20 weeks, should correlate with gestational age in weeks +/- 2 cm.



WELL WOMAN EXAM

- **6 "Bs": Bleeding, Breast, Bowel, Bladder, Birth Control, Blues**
- Sample GYN history:
    - Menses: LMP- _____. Menarche @ 14, cycle 28 days, 4 days flow, no severe dysmenorrheal. Age of Menopause if applicable and if any intermenstrual bleeding
    - Paps: no abnormal paps, last pap 2008- NIL
    - STDs: chlamydia at 16, treated
    - Sexual Activity: active with male partners only, 1 current partner, monogomous x 10 years, 4 partners in lifetime
    - Contraception: Condoms, OCPs, IUD, BTL, etc.
- Routine Health Maintanence: Mammogram, Colonoscopy, Dexa Scans, Lipid, Thyroid, DM, Immunizations, Calcium supplementation, Seatbelt usage
- Gardisil Vaccine for
    - Women 9-26
    - 3 shots at 0, 2, and 6 months
    - Covers types 6, 11, 16, 18 (prevents 70% cervical cancers and 90% genital warts)

ELECTRIC ROTATION SPECIFICS

WEDNESDAY

- Rounding on Wednesdays is different for each service. Please check with your residents if they would like you to round prior to PCC.
- Be at Patient Care Conference (PCC) at 7:00. BE ON TIME and BE QUIET. This is a formal conference and is very stressful for the residents. Interruptions are VERY distracting.
- After each resident's presentation, a student question will be asked. If you know the answer, volunteer it. Otherwise, someone will be called on.

MATERNAL FETAL MEDICINE

Clinic

- Clinic located at Loyola Outpatient Center, 2nd Floor
- Schedule located in EPIC @ LOC MATERNAL FETAL MEDICINE
- Hours usually Tuesdays 8-5pm and Thursdays 8-12pm
- Clinic responsibilities include seeing pts with fellows and writing a progress note, once comfortable, student may see patients alone and present to attending before writing a note.
- Look up pts prior to clinic to read about pts presenting problem
- Key Topics: Diabetes, HTN, and Infections in pregnancy, Preterm Delivery, Genetic Diseases, IUGR

Conference

- Tuesday morning at 7:30am in Chairman's conference room in main hospital on 1st floor.
- Table rounds for hospitalized antepartum patients, some housekeeping, occasional fellow lectures

History/Physical Exam

- Basic Exam Skills to be performed on OB Office Visits
    - History (including DETAILED OB and Gyne History)
        - PIH/Preeclampsia: HA/vision changes/epigastric pain/edema
        - Routine Antepartum: FM/LOF/VB/VD/CTX
        - Family History- review birth defects, mental retardation, other genetic diseases
    - CV/PULM Exam
    - Abdominal Exam
    - Uterus Fundal Measurement
    - Fetal Heart Tones with Doppler
    - Extremity Exam for edema
    - Spec exam/pap smear if indicated- Resident or attending to perform with you

Gottlieb

- Gottlieb runs slightly differently than Loyola. The main differences involve note writing rotation "assignments," and the computer system
- Although you may be assigned to "OB" or "GYN" at Gottlieb, because of the weeknight call schedule, you may be asked to scrub a c-section or a gyn case even though you aren't on that "service." This is more like real life, doing both together
- Documentation: Some notes at Gottlieb are hand-written and some are typed into Epic. Patient's of Loyola attendings (Dr. Graziano, Dr. Massey, Dr. Wagner, and Dr. Deighan) are all written in EPIC. **The electronic notes then need to be printed and placed in the patient chart.** This is especially important for patients in units other than L&D, because all notes automatically print in L&D. Non-Loyola attending patient notes are written in the charts. Daily notes are placed under progress note tab, H&Ps and Dictation summaries under another tab, and procedure notes under another. There is an H&P form for non-Loyola patients. DO NOT USE THIS FORM. As with templates, this is counterproductive for the educational process and we would prefer you write your own H&P.
- Patient information: Labs, Vitals, Ins and Outs are located in the Meditech System. You should be given a username and password before starting the rotation. After logging in, press 1, then 4 to get to the patient lists, which can be searched by name, location, provider, etc.
- OR schedule: also located in Meditech. Press 1, then 1, then enter the date you would like to review. This can be tricky to review because the surgeries are listed by attending username (first four initials or last name then first initial of first).
- Signout: Located on Toughbook in L&D in Awad Documents folder. It's called THE REAL GOTTLIEB SIGNOUT.
- The Board: Most labor wards have one of these. Please keep this updated with new information throughout the day.

GYNECOLOGY Rotations

OR Expectations- *for all services (there may be some minor variations)*

- There should be a medical student at all cases when possible. Sub-Is are responsible for assigning cases. If no Sub-I, decide among your fellow rotation-mates who will attend which cases.
- You should read about the type of case you will be performing and review relevant anatomy prior to the OR
- Know your patient. Be familiar with the patient history and know why they are undergoing the procedure
- Be near patient in pre-op area and page resident (to OR number) when patient is going back
- Help wheel patient to OR and move them to OR table. You may also help by placing SCDs and helping to position patient.
- Write patient name, procedure, allergies, Hgb and BMI on white board in OR
- Write your name and position on white board
- Introduce yourself to scrub nurse and circulating nurse. Pull gloves and gown (if needed) for yourself
- Ask the scrub nurse if you can place the foley catheter.
- After case, retrieve bed and help move patient back to PACU
- Write Operative Note and review with resident
- For outpatient cases, you can help by gathering the three documents that we need to complete from the chart- H&P for, H&P Validation, and Consent. We will fill out the validation and the consent. Please complete the H&P form (this is a BRIEF H&P). We will review it with you and cosign it.

Benign Gyn

- Patient List under "Shared Patient Lists"- "Benign GYN
- Rounding every weekday except Wednesdays is usually between 5:30 and 6:00am. Your resident will tell you exactly what time each day, as it will vary based on number of patients on the service. Please pre-round and have notes completed by that time.
- GYN Teaching rounds occur at 6:30 every weekday except Wednesday in the back room of the cafeteria. You should review the topic ahead of time so you are prepared to answer questions. Teaching rounds are structured as follows:
  - Mon: Attending lectures on assigned topic
  - Tues: Case discussion led by residents/attending
  - Weds: no Gyn Rounds
  - Thurs: Review of article or Practice Bulletin on theme for the week
  - Fri: Student presentations

  After teaching rounds, the GYN team will round with the attendings. You will be expected to present patients you rounded on.
- Mondays are primarily OR days.
- Tuesday morning is Dr. Summers's problem GYN clinic beginning at 8:00 and usually last until 4:00 pm
- Wednesday afternoon is Colposcopy clinic every other week
- Thursday there are sometimes cases, but not always
- Fridays are primarily ambulatory surgery cases. Please look up these cases prior to Friday.
- In House and ED consults are the responsibility of the GYN Service. You may be asked to see the patient ahead of the resident. Consult notes are detailed H&Ps similar to OB Triage notes. Make sure to get a detailed Gyn history. See WWE.
- Key Topics: Ectopic Pregnancy, Hyperemesis, Abnormal Uterine Bleeding, Fibroids, Endometriosis

GynOnc

- There is no "Shared Patient List" for this service. You may create a list with Dr. Smith and Dr. Potkul's Patients.
- Rounding every weekday except Wednesdays is usually between 5:30 and 6:00am. Your resident will tell you exactly what time each day, as it will vary based on number of patients on the service. Please pre-round and have notes completed by that time.
- Monday: Dr. Potkul has OR Cases
- Tuesday: Dr. Potkul has clinic all day, Dr. Smith has clinic in AM
- Wednesday: Dr. Potkul has outpatient cases beginning around 12:30. Arrive as soon as possible after educational events
- Thursday: Dr. Potkul in OR
- Friday: Dr. Potkul clinic in AM and Dr. Smith in ambulatory cases in AM. New patient clinic in afternoon- MS3s do not attend
- Dr. Potkul's Clinic: Breifly review chat to determine what patient has and what treatment they have undergone. Introduce yourself to patient and ask if they are having any problems. BE BRIEF. You should spend no more than 5 minutes on this process. Present patient to Dr. Potkul, then see the patient with him. Do not see new patients. The residents will see them.
- You do not attend Dr. Smith's clinic
- Key Topics: anatomy, cancer staging, tumor markers, bowel obstruction, neutropenic fever, types of hysterectomies.

UroGyn

PLEASE REVIEW THE CLERKSHIP GOALS FROM THE UROGYNECOLOGY DEPARTMENT REGARDING THIS ROTATION

General Schedule:

~6:00-7:00 am: Rounds with residents and fellows. ***Time changes daily***.

7:00am - 5:00pm: Rounds with attending, OR cases, clinic, etc. **Please ask the residents which days you should be going to the OR.** All other days, go to clinic. In General, one student will go to the OR, the other will go to clinic. There is no OR on Wednesdays. Tuesdays BOTH students will go to the OR.

~5:30pm: afternoon rounds with residents or fellows, postop notes.

Patient Lists:

Under "Patient Lists" in Epic, open "Shared Patient Lists" and look for "Urogyne". These are the in-patients for your service.

Rounds: You will typically meet for rounds in the Women's Health on the second floor or 4 Tower. The exact time will be determined by the fellows each day. **Make sure to ask your resident what time you will be rounding the next morning before you go home.** It is expected that you will **arrive before rounds to review vital signs, labs and I/Os for the patients, and update this information on the signout.** The signout report is found in EPIC under shared list, pick Urogyne. You can update the report by clicking on Signout Report when the patient list is up. The fellows like to have the preop baseline vitals signs on the signout, so do NOT delete these. Just add urine output (24 hr, 8 hr, hourly and voiding trial results) and any pertinent lab values. **You should have copies printed for the fellows and residents in time for rounds (approximately 10 copies).** You residents may also have a specific format they'd like to follow, so ask the first day.

Clinic: Located on the 3rd floor of the Loyola Outpatient Center (west side of the LOC). Coats and bags are typically left at the nurses work area, although it can get crowded there at times.

Monday - Kenton
Tuesday - no clinic
Wednesday - Fitzgerald
Thursday – Brubaker AM, Fitzgerald PM
Friday - Mueller

Arrive 10-15 min before the first patient. For Kenton's clinic on Monday, she often has several patient's scheduled for 8am, so she would like everyone there 15-20 min early. You will not see patients on your own in clinic. You should go in with the nurse to room the patients. They will show you how to perform straight catheterization and bladder scans for post-void residuals. You should then accompany the resident or fellow to see that patient. It can be very busy in clinic and the fellow or resident will not stop each time to invite you to follow them, so pay attention to who needs to be seen and ask if you can come in.

There is whiteboard map of the clinic with magnets for the nurses, attendings, residents, students, and numbers for the order of patients. You should familiarize yourself with the system and move your magnet to your corresponding location.

OR Days:

Monday - Fitzgerald
Tuesday - Kenton and Brubaker (sometimes Mueller or FitzGerald will also have a case)
Thursday – Mueller
Friday – Misc. Ambulatory cases in ASC

For all OR patients, you should look over each patient's history, know indications for surgery and review pertinent topics. Essentially all of the Urogyn cases are performed in the main OR, even if the patient will be going home the same day.

Meet the patient in pre-op and introduce yourself. Either you or the resident need to get the antibiotics from the OR Pharmacy prior to surgery. The Pharmacy window is located across from OR 18 - ask your resident or fellow which antibiotic the patient will need (usually 2g cefoxitin). You just need to ask for the antibiotic and give them the patient's name, OR number, and a patient sticker. In the OR, write up the patient's history on the whiteboard, including the patient's name, age, diagnosis, planned procedure, PMH, PSH, Allergies, POP-Q, and preop labs in addition to the names of the attending, fellow, resident and your name. It is best to do this while the patient is in preop, so that you can do other things to help out when the patient is in the room.

You should stay with the patient in pre-op and accompany them to the OR. Once the patient is in the room, help with positioning, taking the bed out, positioning the patient, getting SCDs on, and clipping the patient if needed. You will scrub into cases and assist. After the case, Help get the patient off of the table and to post op. Write a brief operative note and review with resident.

GRID meeting: Weekly planning meeting on **Wednesday afternoons at 2pm**. Held on the 4th floor room just right out of the elevators in the Medical School. This meeting is to go over upcoming cases. There is usually a topic presented as well. It is important to go, although it is understood that sometimes you will have other teaching obligations, resident clinic, etc.

Key Topics: Stress, Urge, Mixed and Overflow incontinence; Pelvic Organ Prolapse

Generic Operative Note

Service: GYN/UroGYN/GYN Onc
Pre-op Dx: Menorrhagia, ovarina mass, uterine prolapse, etc
Post-op: same, delivered, liveborn M/F infant, 2nd degree perineal laceration
Procedure: Total abdominal Hysterectomy, bilateral salpingo-oophorectomy, Lysis of adhesions
Surgeon: Dr. Attending
Assistants: Dr. Resident, PGY3; You, MS3
Anesthesia: epidural and local (or spinal, or general)
Findings: liveborn M/F infant in LOA/ROA/OP position, apgars 8/9, 3340g, placenta delivered intact, 3VC, no cervical or vaginal lacerations, 2nd degree perineal laceration (If cesarean, note normal appearing tubes and ovaries or excessive scar tissue, etc)
EBL: 300 mL
Specimens: placenta
Complications: none
Condition: Stable in LDR

Your Name, MS3

MS3 Post Operative Progress Note

S: 26 yo female POD#1 s/p TAH, BSO. Pain controlled. Tolerating clear liquid diet. No nausea or emesis. + Flatus/BM. Voiding without difficulty *(unless catheter in place).* Ambulating without dizziness. Denies fever, chills, CP, SOB, calf pain. +/- vaginal bleeding
O: VS: 120/89, 90, 18, 97.5
I/O: 24 hr-2350/2300mL. 8hr-1234/980mL (cesarean only)
Gen: a/o, NAD
CV: RRR
Pulm: CTA B
Abd: soft, appropriately tender, + BS, incision c/d/I with staples
Ext: calves NT, no edema
Labs: *(only include most recent labs)*
Hgb 12.3→ 10.2
A/P: 26 yo POD#2 s/p TAH, BSO

- Pain controlled with Motrin and Norco (PCA, T#3, Toradol)
- Advance diet to general (clears, full liquid, etc) as tolerated
- Urine output appropriate. Discontinue foley catheter
- Post op Hgb appropriate (or Iron or PRBCs as appropriate for acute blood loss anemia)
- Encourage ambulation and IS
- SCDs for DVT prophylasix (sometines Heparin- especially on Onc)
- Colace for constipation. Simethicone for gas
- *Don't forget to mention chronic medical conditions and what we are doing for them*
- Dispo: floor.

Your Name, MS3

Key to commonly used abbreviations:

AGC= Atypical glanular cells
AOL= augmentation of labor
AROM= artificial rupture of membranes
ASCUS= atypical squamous cells of undetermined significance
BMTZ= Betamethasone, given to promote fetal lung maturity
BME= Bimanual exam
BPP= biophysical profile
BSO= bilateral salpingo-oophorectomy
EAB= Elective abortion (also sometimes called therapeutic abortion, or TAB)
EDC= estimated date of confinement (due date)
EFW= Estimated fetal weight
EMB= Endometrial Biopsy
FHT= Fetal heart tracing
FFN= Fetal Fibronectin
FLM= Fetal Lung maturity
FM= Fetal Movement
FAVD= Forceps assisted vaginal delivery
FWB= Fetal well-being
FSE= fetal scalp electrode
G3P1011: G=Times Pregnant. P=TPAL→Term (>37w), Preterm (20-37w), Abortions (<20w), Living
Note: Multiples= ONE pregnancy, ONE delivery, MULTIPLE living, if applicable
GDM= gestational diabetes. Document type by White classifications
IOL= induction of labor
IUPC= intrauterine Pressure catheter
LDR= labor, delivery, and recovery room
LOA= lysis of adhesions
LOF= leakage of fluid
LTCS= low transverse cesarean section
MVU= Montevideo Units
NRFHT= Non-reassuring FHT
NST= Non-stress test
PROM= premature rupture of membranes (prior to labor)
PPROM= PRETERM premature rupture of membranes (<37wks)
PTL= Preterm labor
PTD= Preterm delivery
SAB= spontaneous abortion, before 20 weeks
SROM= Spontaneous rupture of membranes
SCH: supracervical hysterectomy
SSE= Sterile speculum exam
SVE= Sterile vaginal exam (digital exam)
TAH= total abdominal hysterectomy- means uterus and cervix, does NOT include ovaries
TVH= total vaginal hysterectomy
VAVD= vacuum assisted vaginal delivery
VB= Vaginal bleeding
VBAC= vaginal birth after cesarean
VTE= venous thromboembolism
VTOL= vaginal trial of labor

Important Numbers

Residents		**Loyola**	
Michael Awad	92449	L&D	63961
Ben Barenberg	91899	2 Women's Health	69567
Vance Broach	92275	Female Resident Call Room	66620
Danielle Burkett	92631	Male Resident Call Room	62629
Lyndsey Day	92670	Resident Office	65236
Megan DeJong	91884	Admitting	63848
Garrett Fitzgerald	92618	Central Scheduling	68563
Jill Gadzinski	92375	EPIC Help	7EPIC
Gretchen Garbe	92370	ER	68705
Joanna Horwitz	91107	Fast Track ER	69090
Stella Huang	91900	HELP desk	62160
Vanessa Kennedy	91186	**Gottlieb**	
Maike Liebermann	92273	Birth Center	4910
Darby Murphy	91180	2 West (Postpartum)	4912
Colleen Rivard	10274	Med Student Call Room	3418
Jordan Sheran	92427	Resident Call Room	3388
		Attending Call Room	3446
		Emergency Room	4975
		OR	2221