

Uniformed Services University

Obstetrics and Gynecology

Core Clinical Clerkship



2011-2012

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
4301 JONES BRIDGE ROAD
BETHESDA, MD 20814

Third Year Medical Students:

Welcome to your third year Obstetrics and Gynecology Clinical Clerkship! Obstetrics and Gynecology is an exciting and unique field of medicine! In the span of one day, you may perform a surgery, deliver a baby, evaluate an elderly woman with ovarian cancer, and counsel a 15 year-old about prevention of pregnancy and sexually-transmitted infections. Obstetrics and gynecology offers breadth within the focus of women's health care. Over the next six weeks, you will experience many sides to women's health care that you may not have even known about.

The bulk of your clerkship will be made up of the clinical experiences you receive in obstetrics, gynecology, and ambulatory settings. The clerkship is designed with a **problem-based learning** approach. This means that the core concepts, and many of the objectives, are met by using sample patient cases for discussion with your peers and a preceptor each week. There are no traditional lectures other than those you may receive on grand rounds at various sites.

During the clerkship you will be required to maintain a "Clinical Encounter Card" to ensure you receive appropriate feedback from preceptors. You will also be required to complete and turn in 2 case write-ups; these cases require a written H&P and an oral presentation. These requirements will be reviewed in more detail at your orientation. Additionally, we have developed a curriculum through SAKAI, which will allow you to keep track of all of your assignments. You will be asked to write a prescription, an operative report, admission orders, and a delivery summary during your rotation on SAKAI. Please check your email frequently.

The final examination includes an Objective Structured Clinical Examination (OSCE). And the National Board of Medical Examiners (NBME) subject examination in OB/GYN. You must pass the NBME exam to pass this course. Please check your email weekly for any changes and/or updates regarding this rotation.

Obstetrics and gynecology is an exciting specialty, and I think you will find your rotation to be challenging, rewarding, and fulfilling. If you need to meet with me for any clerkship related issues, please do not hesitate to arrange an appointment or phone conference by contacting the department Clerkship Coordinator, Ms. Tanya Christian, at (301) 295-3777, or you can email me directly at laura.ramsay@usuhs.mil. We look forward to your upcoming rotation!

Sincerely,

Laura Ramsay, MD
LCDR MC USN
Assistant Professor
Director of Clinical Clerkships

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Link to interactive self-examination for multiple use during the rotation.

To access APGO uWise please go to the following link:

www.apgo.org click on elearn then click on uwise

The user name is: **usuhs**

The password is: **uwise146**

THIRD YEAR CLINICAL CLERKSHIP
Department of Obstetrics and Gynecology
F. Edward Hébert School of Medicine
Uniformed Services University of the Health Sciences

The six-week third year clinical clerkship in obstetrics and gynecology is conducted at the following six sites:

Fort Belvoir Community Hospital
Walter Reed National Military Medical Center
Tripler Army Medical Center
Washington Hospital Center
San Antonio Military Medical Center
Naval Medical Center Portsmouth

This introduction presents the policies and guidelines of the clerkship that have been established by the Department of Obstetrics and Gynecology at the Uniformed Services University of the Health Sciences. Information unique to each facility will be provided to you by the onsite clerkship coordinator at the beginning of your rotation.

Outline of Manual:

- I. Clerkship Components
 - a. Clinical Experience
 - b. Problem-Based Learning Sessions
 - c. Self-Directed Modules
 - d. Case Presentations
 - e. Clinical Encounter Cards
 - f. WebLog Entry
 - g. Objective Structured Clinical Examination
 - h. National Board of Medical Examiners Written Examination
- II. Instructional Objectives
- III. Assigned Reading Materials
- IV. Grading Policy
 - a. Student Performance Evaluation
 - b. Midterm Evaluation
 - c. Case Presentation Grading Form
- V. Attendance Policy
- VI. Student Evaluation of Clerkship
- VII. Suggested Resources
- VIII. Obstetric and Gynecologic History
- IX. Obstetric and Gynecologic Physical Examination
- X. Survival Tips
- XI. Sample Notes and Presentations
- XII. Glossary of Common Terms
- XIII. List of Common Acronyms

I. Clerkship Components:

The Obstetrics and Gynecology clerkship is composed of your clinical experience, problem-based learning sessions (PBLs), case presentations, clinical encounter cards, an objective structured clinical examination (OSCE), and a written examination from the National Board of Medical Examiners.

a. Clinical Experience

Your clinical experience will include obstetrics and gynecology, including surgery and ambulatory care. In some cases, you may receive a portion of your gynecology experience on a subspecialty team such as gynecologic oncology or reproductive endocrinology and infertility. During your clinical experience, the staff and residents that work with you will grade you on your **cognitive** and **noncognitive** academic performance.

The **cognitive** academic performance grade accounts for **20% of your final grade**, and is based on your performance on the wards, written histories and physical examination, progress notes, participation and knowledge during rounds and conferences, skill with oral case presentations, skill in performing technical procedures, and ability to analyze data, formulate appropriate problem lists (differential diagnosis), and make clinical judgments. It is also based on your use of texts and journals.

Noncognitive academic performance accounts for **30% of your final grade** and is based on your ability to appropriately relate to staff, peers, and patients, as well as your professional demeanor, maturity, and moral and ethical conduct. It is also based on the demonstration of commitment to, responsibility for, and involvement in clinical learning and patient care, including attendance, promptness, and availability for all assignments.

This information is acquired from evaluations completed by the residents, staff physicians, on-site clerkship coordinators, and nursing staff that you have worked with during your clinical experience.

b. Problem-Based Learning Sessions:

The Obstetrics and Gynecology clerkship teaches the core concepts by way of **problem-based learning (PBL)**. This has replaced the more traditional method of lectures. PBL involves a weekly interactive discussion between the students and a preceptor about various obstetric and gynecologic cases. The cases are designed to reflect the educational topics designated by the **Association of Professors of Gynecology and Obstetrics (APGO)**. You will typically cover 5 cases each week at your PBL session, and will also have self-directed case modules to review at your own pace.

These PBL cases are available in your clerkship manual and on our website (www.usuhs.mil) under ***“School of Medicine” – Department of Obstetrics and Gynecology – Medical Student Programs – MSIII clerkship – Problem-Based Learning Cases.***

The cases are matched to a chapter in your text for reading. In addition, a quiz is available for each PBL case and will be administered during the session. This is to aid you in self-evaluation so you will know how well you are preparing for the written examination. To prepare for these sessions, it is **essential** that you read the corresponding text chapter and the case, as well as any additional reading on the subject matter. The quiz grades are used by the site coordinators as part of your midrotation feedback so that you may develop strategies for preparation for the written examination. However, your **scores on the quizzes are not directly calculated in your final grade.**

c. Self-Directed Modules

Several self-directed modules are available for your review throughout the course at your leisure. These modules are important, as they review additional APGO Educational Topics not covered in the PBL sessions. In our clerkship manual, self-directed modules are referenced throughout the clerkship, but you may complete them whenever it works best for you. These modules are available on our website (www.usuhs.mil) under ***“School of Medicine” – Department of Obstetrics and Gynecology – Medical Student Programs – MSIII clerkship – Self-Directed Modules.***

d. Case Presentations

During your clerkship, you are required to write-up and present 2 patient cases that you have participated in during the clerkship. **One case must be an obstetrics case and one must be a gynecology case.** You will present the cases orally to an assigned preceptor(s) who will grade your performance and provide constructive feedback on your note-writing and oral presentation skills. These write-ups are intended to be thorough H&Ps, NOT abbreviated progress notes or focused clinic patient notes. It is **YOUR RESPONSIBILITY** to arrange these sessions with your assigned preceptor. Your site director can assist you with this process if needed. You should also pose a clinical question which prompts a literature search related to the case. It's also **YOUR RESPONSIBILITY** to bring the graded sheet to Dr. Ramsay on the day of your shelf exam if you will be taking the shelf at USUHS. Tripler and SATX students can give them to your site directors.

Your oral presentations and write-up account for **10% of your final clerkship grade.**

e. Clinical Encounter Cards

You are required to carry your Clinical Encounter Card with you at all times. These cards list a variety of clinical encounters which we expect you to have evaluated during your rotation. Upon completion of each individual encounter, have your preceptor sign the card and write observations and feedback. **The encounter card**

signature is only valid if actual feedback or comments are made by the preceptor. The purpose of this card is to ensure that we receive ample faculty and resident feedback on your performance so as to write an appropriate narrative summary. Your dedication to completion of this card is considered professional performance and is factored into your non-cognitive performance grade.

f. SAKAI Assignments

You will be assigned 4 separate web-based assignments through SAKAI, including writing a prescription, a delivery summary, an operative report, and a delivery summary. You are required to complete these and will be given feedback from Dr. Ramsay. However, this is formative only and will not be calculated into your final grade

g. Objective Structured Clinical Examination (OSCE)

This exam accounts for **10% of your final grade** and is designed to evaluate technical, problem-solving, interpersonal, and communication skills that are an integral part of providing care for patients. The skills are based on educational topics recommended by **APGO**. These skills are tested by use of standardized patients, models, and record or chart reviews. This exam is administered during the final week of the rotation.

h. National Board of Medical Examiners (NBME) Written Examination

This National Board of Medical Examiners (NBME) subject exam accounts for **30% of your final grade** and is a standardized, two-hour multiple-choice examination, which is used in the majority of clerkships throughout the country. This exam is administered during the last week of the rotation. It is not unheard of for students to receive very good clinical grades, but fail the exam. **DO NOT LET THIS HAPPEN TO YOU** by not studying the textbook.

II. Instructional Objectives:

The clinical clerkship in Obstetrics and Gynecology focuses on mastering the principles involved in addressing the health care needs of women. Since most medical students do not pursue a career in Obstetrics and Gynecology, the clerkship is structured to expose all students to a wide spectrum of female conditions, both normal and pathologic. With this experience, you will better understand the health issues unique to this patient population regardless of your chosen field of medicine

As third year medical students, you will actively participate in the evaluation and management of routine and complicated OB/GYN patients in both the inpatient and ambulatory care settings over the course of the six week clerkship experience. Under the direct supervision of resident and attending staff obstetrician-gynecologists, you will interact with patients and learn about their specific health problems.

The objectives for this clerkship are based on the recommendations of the **Undergraduate Medical Education Committee of the APGO 8th edition of *Medical Student Educational Objectives* published in 2004**. APGO suggests 267 educational topics that should be covered during your entire time in medical school; 126 are considered Priority 1 (Topics all medical students MUST learn and master) with the remaining 141 objectives considered Priority 2 (Topics students SHOULD be expected to learn). The complete publication may viewed and/or downloaded from the website www.apgo.org.

The third year clerkship at the Uniformed Services University has developed a list of educational objectives based on these “Educational Topics” by use of the PBLs, Self-Directed Modules, OSCE, and your clinical experience:

Approach to the Patient (APGO Educational Topics Unit 1):

1. History
2. Physical Examination
3. Pap Smear and Cultures
4. Diagnosis and Management Plan
5. Personal Interaction and Communication Skills
6. Preventive Care and Health Maintenance

Obstetrics (APGO Educational Topics Unit 2):

1. Maternal Fetal Physiology
2. Preconception Care
3. Antepartum Care
4. Intrapartum Care
5. Lactation
6. Ectopic Pregnancy

7. Spontaneous Abortion
8. Medical and Surgical Conditions of Pregnancy
9. Preeclampsia / Eclampsia
10. Isoimmunization
11. Third Trimester Bleeding
12. Preterm Labor
13. Rupture of Membranes
14. Anxiety and Depression
15. Postterm Pregnancy
16. Spontaneous Vaginal Delivery

Gynecology (APGO Educational Topics Unit 3):

1. Contraception and Sterilization
2. Vulvar and Vaginal Disease
3. Sexually Transmitted Infections and Urinary Tract Infection
4. Pelvic Relaxation and Urinary Incontinence
5. Endometriosis
6. Disorders of the Breast
7. Gynecologic Procedures – Counseling and Knowledge of

Reproductive Endocrinology and Infertility (APGO Educational Topics Unit 4):

1. Puberty
2. Amenorrhea
3. Normal and Abnormal Uterine Bleeding
4. Dysmenorrhea
5. Menopause
6. Infertility

Neoplasia (APGO Educational Topics Unit 5):

1. Cervical Disease and Neoplasia
2. Uterine Leiomyomas
3. Endometrial Carcinoma
4. Ovarian Neoplasms

Human Sexuality (APGO Educational Topics Unit 6):

1. Sexuality and Modes of Expression

Violence Against Women (APGO Educational Topics Unit 7):

1. Sexual Assault
2. Domestic Violence

The **APGO “Essential Elements”** listed below are the **mandatory** requirements for completing this clerkship. As you will notice, these are met through the PBL sessions and in a typical clerkship experience. If you are not experiencing one or more of the essential elements listed below, **it is your responsibility to notify your on-site clerkship coordinator or the clerkship director** so that we may arrange an alternate experience to meet these elements:

1. Clinical skills in the medical interview and physical exam
2. Collect and interpret a cervical cytology – first line disposition, limitations of cervical cytology
3. Thorough grounding in modern contraceptive technology
4. Differential diagnosis of the “acute abdomen” – pelvic infection, ectopic pregnancy, adnexal torsion, appendicitis, diverticulitis, renal calculi
5. Physiologic adjustments that accompany normal gestation, especially lab test results
6. Embryonic and fetal development – what does and does not affect it; what is and is not teratogenic.
7. Health and well-being of populations – social and health policy aspect of women’s health, ethical issues, sterilization, abortion, domestic violence, adolescent pregnancy, access to health care, etc.
8. Menstrual cycle, including menopause.
9. Infertility
10. Intrapartum Care
11. Breast health, including breastfeeding
12. Vaginal and vulvar disorders
13. Sexuality – patient and physician
14. Common problems in obstetrics
15. Screening for reproductive cancers

The following objectives specific to this clerkship are designed to meet the Uniformed Services University School of Medicine objectives as well as the above described APGO objectives.

The Gynecological Inpatient Experience:

1. Follow patients through the course of their hospital stays.
2. Participate in the surgical and medical management of the patient.
 - perform assessments and write progress notes
 - perform history and physical examinations that include a discussion of the patients' problems
 - present the patients' daily status to the team of faculty, residents, and fellow students on rounds

The Obstetrical Inpatient Experience:

1. Understand the principles of management of labor:
 - stages of normal labor
 - fetal assessment and monitoring techniques
 - pain management
2. Participate in vaginal deliveries:
 - fetopelvic anatomic relationships
 - spontaneous and assisted deliveries
 - pain management
 - episiotomy and laceration repair
3. Become familiar with complications in the labor and delivery process:
 - management of dysfunctional labor
 - indications for cesarean section delivery
 - peripartum or postpartum hemorrhage
 - neonatal resuscitation
4. Manage the postpartum patient in conjunction with the resident or staff; demonstrate knowledge of the following:
 - normal maternal physiologic changes of the postpartum period
 - normal postpartum patient care
 - appropriate postpartum patient counseling
5. Duties while on the Obstetric service will include patient assessment, written H&P's and progress notes, and presentation to the Obstetric team.

The Surgical Experience:

1. The student will be an active participant in the operating room.
2. The student will review normal and abnormal anatomic relations of the female pelvis.
3. The student will be exposed to gross pathology of disease processes in women.
4. The student will demonstrate basic surgical procedures:
 - assisting in surgical procedures
 - knot tying
 - suturing techniques
5. The student will understand the principles of surgical management:
 - indications for surgical vs. medical management of diseases and disorders
 - diagnosis and management of surgical complications

The Ambulatory Care Experience:

1. The student will participate in the outpatient management of the routine and complicated obstetrical patient.
 - take a focused obstetrical history
 - perform a focused obstetrical exam
 - perform the initial obstetrical history and physical examination
 - understand the rationale for each laboratory test ordered and the normal and abnormal values expected during pregnancy
2. The student will participate in the outpatient management of the routine and complicated gynecological patient.
 - Perform the annual female examination screening:
 - PAP smear and pelvic examination
 - breast examination
 - contraception and STD counseling
 - primary health care screening
 - Perform a focused problem gynecologic history and physical examination.
3. The student will understand the indications, risks, and contraindications for office procedures in OB/GYN
 - Colposcopy and cervical biopsy
 - Urogynecology
 - Amniocentesis
 - Pelvic ultrasonography
 - Antepartum fetal monitoring
 - Endometrial biopsy
 - Hysterosalpingography
 - Electrosurgical excision of cervix
 - Hysteroscopy

- Needle aspiration of breast mass
- Vulvar biopsy

Military and Women's Health Care:

The student will be exposed to balancing the active duty woman's health care needs with the military mission.

- Military profiles
- Convalescent leave

Psychosocial Aspects of Women's Health:

The student will understand the psychosocial aspects of women's health.

- Sexuality
- Abuse

III. Assigned Reading:

Hacker et al. Essentials of Obstetrics and Gynecology, 5th Edition has been issued to you and should be read on a regular basis throughout the duration of the clerkship. It is suggested that you coordinate your reading schedule with your specific PBL assignments and with the care of your patients to maximize the learning process and to aid in the retention of relevant information. This should be your primary study resource.

IV. Grading Policy:

Your final grade and written assessment at the conclusion of the clerkship will be based on the following components:

Cognitive Performance: 20%
Noncognitive Performance: 30%
Case Presentations: 10%
NBME Written Examination: 30%
OSCE Performance: 10%

FAILURE OF ANY ONE OF THESE ELEMENTS ALONE WILL RESULT IN A FAILING GRADE. REMEDIATION OF POOR PERFORMANCE FOR SITUATIONS NOT DETAILED ABOVE WILL BE AT THE DISCRETION OF THE DEPARTMENT CHAIR.

A grade of D- is required to pass the written exam. Failure of the exam will result in a grade of "Incomplete" for the clerkship. In order to pass the clerkship, the exam will need to be re-taken and passed (D- or better). Your final grade for the NBME exam portion of the grade will be the average of the initial exam and the re-take, and this averaged grade will still count for 30% of the final clerkship grade.

A grade of D- is also required to pass the OSCE. Similar to the policy for the NBME exam, failure of the OSCE will result in a grade of "Incomplete" for the clerkship. In order to pass the clerkship, the OSCE will need to be re-taken at one of the sites offering the OSCE and passed (D- or better). Your final grade for the OSCE portion of the grade will be the average of the initial OSCE and the re-take, and this averaged grade will still count for 10% of the final clerkship grade.

If a student fails to pass the repeat exam (either the NBME exam or the OSCE), the initial "Incomplete" grade will be converted to an "F" and remediation of the clerkship will be recommended in the following manner:

If the student's clinical performance was adequate, (C- or better on Cognitive AND Non-Cognitive assessments), the student will complete an additional 4-week ob/gyn clerkship. The student will need a satisfactory clinical performance as well retake the NBME exam or the OSCE as applicable. The passing grade for passing this exam will again be the same minimum required to pass the exam initially (D- or better).

If the student's clinical performance was **inadequate**, (< C- on either Cognitive OR Non-Cognitive assessments) the student must repeat the full MSIII 6-week core clinical clerkship, achieving adequate clinical performance, **AND** retake the NBME exam or the OSCE, as applicable, getting a passing grade (D- or better).

Failure of the standard remediation described above will be subject to remediation at the Department Chair's discretion and may involve repeating the NBME exam, OSCE, and/or other suitable methods of evaluation to include oral examination.

All grades and narrative descriptions of your performance will be discussed at a tele- and/or videoconference attended by the various site coordinators. This occurs approximately four weeks after your rotation is complete, to allow the final exam scores from the NBME to be returned prior to the teleconference. Your final grade and narrative evaluation are then sent to the Chairman and the Registrar's office approximately **6 weeks after the conclusion of your clerkship.**

If you have a question about your grade, please contact Ms. Tanya Christian at 295-3777 or tchristian@usuhs.mil. If you are unsuccessful in reaching Ms. Christian, please contact Dr. Laura Ramsay, the clerkship director, at laura.ramsay@usuhs.mil.

**OBSTETRICS AND GYNECOLOGY CLERKSHIP
CASE PRESENTATION GRADING FORM**

STUDENT NAME: _____

DATE: _____ **LOCATION:** _____

PRECEPTOR: _____

CASE TITLE: _____

TYPE OF CASE (circle one): **OBSTETRICS** **GYNECOLOGY**

ORAL PRESENTATION (please rate each component 1-5 ; 5=outstanding, 4=above average, 3= average, 2= below average but acceptable, 1=unacceptable)

Organization of the presentation _____

Flow of the presentation _____

Logical progression of the presentation _____

Proper scientific or medical terminology _____

Develops a differential diagnosis _____

SCORE FOR ORAL PRESENTATION _____

WRITTEN CASE (please rate each component 1-5; 5=outstanding, 4=above average, 3= average, 2= below average but acceptable, 1=unacceptable)

Thoroughness of the case write-up _____

Logical format of the write-up _____

Pertinent positives and negatives are included _____

Quality of clinical question generated by student _____

Uses literature search to answer question _____

SCORE FOR WRITTEN CASE _____

TOTAL SCORE (ORAL AND WRITTEN) _____

V. Attendance Policy:

You are expected to attend the following activities while on your clerkship:

1. On-site departmental lectures, seminars, rounds, or conferences specific for the particular aspect of the rotation. (For example, you would attend High-Risk OB Conference while assigned to the Obstetrics part of the rotation, but likely not while on the Gynecology service). Specific mandatory conferences will be further detailed by the on-site coordinators; when in doubt, ask the residents/staff you are working with for that particular aspect of the rotation.
2. PBL sessions
3. OSCE Examination
4. NBME Written Examination
5. All assigned clinics, rounds, ward work, and night call as outlined in the clerkship schedule, unless excused by the respective department chair, vice chair, or clerkship director.

If you are ill and cannot come to work, **it is your responsibility** to contact **YOUR SITE DIRECTOR** and notify him or her of your absence. Likewise, please contact the site coordinator and clerkship director if you need to miss an event due to an unavoidable scheduling conflict. **Please note that email is not an acceptable form of this notification; you must contact the site director, administrator, or clerkship coordinator or director via phone.**

The student who fails to attend mandatory sessions will be referred to the department Chair or his/her representative for counseling. A student who fails to respond to such counseling will be referred to the Assistant Dean for Clinical Sciences.

A student may not miss more than 3 days of the rotation without additional makeup time. This will be dealt with on a case by case basis.

VI. Student Evaluation of Clerkship:

It is our goal to provide for you the best possible experience. We actively solicit your evaluation of the teaching program. Faculty and housestaff are receptive at **any time** to your constructive suggestions for modifications of the curriculum. At the end of the clerkship, you will have an opportunity to prepare a formal critique of the program via the electronic evaluation system (<http://cim.usuhs.mil/surveyor>). In addition, if you desire, each of you will have an opportunity to speak with the respect clerkship director about the teaching program and about your plans for graduate medical education. Please contact Ms. Tanya Christian at 295-3777 to schedule this appointment with Dr. Ramsay.

The Chairperson of the Department of Obstetrics and Gynecology, USUHS, is interested in interviewing all students considering a career in obstetrics and gynecology. The Chair is available to answer any question you might have about the specialty and/or available graduate medical education programs. Please contact Ms. Tracy Smith at (301) 295-4390 to arrange this meeting with Dr. Zahn.

VII. Suggested Resources:

The following references may aid you in your clerkship and in the study of obstetrics and gynecology. They are recommended for your advanced reading and reference use:

Textbooks:

Beckmann et al. Obstetrics and Gynecology, 4th Edition, Williams and Wilkins, 2002.

Cunningham FG, MacDonald P, et al: Williams Obstetrics, 21st ed., Appleton & Lange, 2001.

Jones HW, Wentz AC and Burnett LS: Novak's Textbook of Gynecology, 12th Edition, Williams and Wilkins, 1996.

DiSaia P and Creasman W: Clinical Gynecologic Oncology, 6th Edition, Mosby Yearbook, 2001.

Speroff L, Glass RH and Kase NG: Clinical Gynecologic Endocrinology and Infertility, 6th ed., Williams and Wilkins 1999.

Gabbe SG, Niebyl JR and Simpson JL: Obstetrics: Normal and Problem Pregnancies, 4th ed., Churchill Livingstone Inc., 2002.

Journals:

Obstetrics and Gynecology ("Green Journal")

American Journal of Obstetrics and Gynecology ("Gray Journal")

Journal of Reproductive Medicine ("Purple Journal")

Websites:

Association of Professors of Gynecology and Obstetrics: www.apgo.org

American College of Obstetricians and Gynecologists: www.acog.com

VIII. Obstetric and Gynecologic History:

A thorough obstetric and gynecologic history is an important part of primary health care and preventive medicine for women, and should be a part of every woman's general medical history and physical examination. Certain questions must be asked of every woman, whereas other questions are specific to particular problems. To accomplish these objectives, optimal communication must be achieved between patient and physician.

In interviewing the female patient, the physician should document the following historical facts:

1. Gravity: Number of pregnancies

2. Parity: Number of births, not the actual number of children born (i.e., twins represents a single birth process). A more detailed description of each pregnancy is expressed with the following shorthand notation:

FPAL: "F"= full-term deliveries
 "P"= premature deliveries (20-36 6/7 weeks gestation)
 "A"= abortions, ectopics, losses (prior to 20 weeks gestation)
 "L"= living children

Example: A patient has been pregnant twice. The first pregnancy was full-term with delivery of a healthy infant. The second pregnancy was then complicated by the premature delivery of twins, both of who survived. This patient would be: G₂P₁₁₀₃. Fetal deaths (stillbirths) also qualify under parity.

For each pregnancy, the student should determine the following facts:

- a. Length of gestation
- b. Antenatal complications
- c. Length of labor
 - first stage
 - second stage
- d. Type of vaginal delivery
 - spontaneous
 - forceps
 - vacuum
- e. Laceration/Episiotomy
 - type
 - degree
- f. Type of Cesarean delivery
 - indication
 - type of uterine incision - request operative report
- g. Unusual postoperative complications
- h. Intrapartum complications, e.g., fetal distress
- i. Postpartum complications
- j. Neonatal complications

3. History of Abortion:

- Type of abortion
 - spontaneous
 - elective
 - therapeutic (Medically indicated)
- Length of gestation when abortion occurred

4. Age at Menarche

5. Description of Menstruation:

- length of cycle (days from beginning of one period to the beginning of the next)
- duration of flow
- amount of flow

6. History of Contraception:

- type (hormonal, barrier)
- reasons for discontinuing

7. History of Menstrual Irregularities:

- menorrhagia/metrorrhagia
- hypomenorrhea/oligomenorrhea
- intermenstrual bleeding
- postcoital bleeding
- dysmenorrhea

8. History of prior gynecologic disorders:

- bleeding irregularities
- pelvic infection
- abnormal cytology - date and result of latest Pap smear
- pelvic pain
- gynecologic neoplasm
- endometriosis
- infertility
- ectopic pregnancy

9. History of prior abdominopelvic surgery (especially gynecologic surgery)

10. History of bowel or bladder dysfunction

- incontinence
- difficulty voiding/stooling/evacuating

11. Symptoms of pelvic relaxation

- prolapse
 - pain/pressure/protrusion

12. History of hormone use (hormonal replacement)

- type
- dose
- complications/side-effects

13. Symptoms of sexual dysfunction:

- dyspareunia
- orgasmic dysfunction
- libido

IX. Obstetric and Gynecologic Examination:

An accurate examination compliments the history, provides additional information, and helps determine diagnosis and guide management. It also provides an opportunity to educate and reassure the patient.

1. Mental Status Examination: Evaluate mood, affect, behavior, and dress. Endogenous depression is commonly encountered in women, and the earliest manifestations of serious depressive illnesses are often overlooked due to inattention to this part of the evaluation. Postpartum depression is also a significant problem.

2. Blood Pressure: Note position of the patient and indicate in which arm the pressure is measured.

3. Breast Examination:

- size
- shape
- nipple – e.g. inverted, crusted, reddened
- presence of nodules - describe
 - location
 - size
 - shape
 - consistency
 - mobility
 - presence of overlying skin changes
- presence of galactorrhea - spontaneous or elicited by manual expression

4. Abdominal Examination:

- shape
- consistency
- bowel Sounds
- presence of “guarding” (voluntary)
- rigidity (involuntary)
- tenderness (direct or rebound)
- ascites
- hepatosplenomegaly
- presence of mass

5. Pelvic Examination:

- external genitalia
 - hair distribution
 - development of labia
 - clitoral size
- Bartholin’s gland (greater vestibular)
- urethra
- Skene’s glands (paraurethral)
- vagina

- general size (“gaping” or stenotic)
 - atrophy (dryness, “thin”, irritation”)
 - presence of rugae
 - color
 - visible lesions or discharge
 - palpable nodules
 - vaginal tumors may develop in the stroma or muscular wall of the vagina and because of their location, may be palpable but not visible.
 - Cystocele
 - Rectocele
 - Enterocele
 - vault prolapse
- cervix
 - shape of os (nulliparous or multiparous)
 - presence of lacerations
 - presence of lesions
 - prolapse (cervicouterine prolapse)
 - uterus
 - position in sagittal plane (anterior, midposition or posterior)
 - size
 - shape
 - consistency
 - symmetry
 - mobility
 - prolapse
 - adnexal structures
 - size
 - tenderness
 - presence of mass (character, size)
 - rectovaginal examination
 - cul-de-sac
 - uterosacral ligaments
 - intrinsic rectal lesions

5. Obstetric Examination:

- Fundal height
- Lie / Presentation of fetus
- Presence and rate of fetal heart tones
- Cervical examination (dilation, effacement, station, consistency, position) if applicable

X. Survival Tips for Obstetrics and Gynecology:

This clerkship offers a practical “hands-on” approach to learning. You **must take initiative** in establishing what you want to learn. Those students who have enjoyed this rotation the most are those who exhibit the greatest degree of **independence and assertiveness**. You must be an active participant on rounds, ask questions about concepts you don’t understand, and be aggressive in picking up patients as new admissions, doing their work-ups, and following them closely throughout their hospital stay. Alternatively, students who show no enthusiasm, simply “go through the motions” and have marginal interest may lose the opportunity to really experience what obstetrics and gynecology is all about.

Presentation of Patients

When you present patients, the best generally format is (which will differ slightly from resident to resident) is as follows:

Mrs. _____ is a _____ y/o G_P_____ at _____ wks gestation by (sure LMP and 1st/2nd trimester ultrasound) who presents with the chief complaint of _____, She reports (insert the answers to the FOUR QUESTIONS here – see Part B of this section)

Her prenatal course has been complicated by: 1. _____ 2. _____, etc.

Past OB history is significant for (dystocia, post-partum hemorrhage, preterm delivery, etc)

Past GYN history significant for (abnormal Pap, HSV, PID)

Her PMH is significant for _____.

Current medications include _____.

Her physical exam revealed _____ (non OB/GYN)

Pelvic exam:

Normal external female genitalia (NEFG)

Vulva/Vagina (without lesions, with fluid in vault, etc)

Cervix

Uterus (firm, tender, etc)

Adnexae (if appropriate; typically early pregnancy)

Assessment:

Plan:

Labor and Delivery

Most patients come to “the labor deck” for one of two complaints: ruptured membranes or because they believe they are in labor. There are only a few things that you absolutely **MUST** do for each of these, and if you know what those are, you’ll be several steps ahead of everyone else.

First of all **ALWAYS** ask these four questions to every pregnant woman who walks in:

1. Are you having any **BLEEDING**?

2. Are you having any CONTRACTIONS? (include time of onset/frequency/intensity)
3. Do you feel like you broke your WATER?
4. Have you felt your baby MOVING?

(These questions will save you from any embarrassment as they are the first things every OB resident you present to will ask you.)

Spontaneous Rupture of Membranes (SROM) check

This can be diagnosed most of the time by the history alone. The best stories are the ones that relate a sudden “large gush” of fluid that soaks their underwear or clothes. The less convincing stories will involved a “dribble of fluid” especially right after urination. Other questions you must ask (besides THE Four’s) are:

1. What time did you notice this?
2. What color was the fluid? (to r/o meconium)

A sterile speculum exam is performed with sterile gloves to rule out SROM (to limit the risk of infection if she is ruptured). The four things you use to diagnose SROM are:

1. “Pooling” of fluid in the vagina
2. Leakage of fluid with valsalva
3. Nitrazine paper
4. Ferning on a dried slide under the microscope

The pooling in the vagina is an obvious finding, as is the leakage of fluid with valsalva. The Nitrazine will turn blue with amniotic fluid because of the basic pH compared with the normal acidic vaginal pH (but this can be false positive with blood!) The ferning is very distinct and due to the estrogen content of the amniotic fluid.

On your exam, it is important to visualize the cervix if at all possible. You can use large Fox swab to clean out the fluid and then visually decided how dilated cervix is. If you cannot see the cervix, and you are sure the membranes are ruptured, DO NOT DO A VAGINAL EXAM TO CHECK! The right thing to do at this point is to use your visual exam of the amount of dilation. The reason for this is that with ruptured membranes, the risk of infection increases significantly with repeated exams. So, the patient will be admitted and when she become significantly uncomfortable, then an exam will be performed.

If your tests are negative and she is not ruptured, then you can go ahead and check the cervix and document that.

The last thing to do after you admit someone for SROM is to pull the ultrasound into the room and quickly ensure the baby is in the cephalic presentation. It is bad form to miss a breech because you couldn’t do a cervix check on admission!

Note: These people with SROM will be admitted, and the goal is that they will be delivered within 24 hrs to reduce their risk of infection. Additionally, ultrasound may be able to visualize the cervix and assess dilation if cervical dilation is difficult to assess via speculum exam. Almost all term pregnancies will go into labor on their own within a day of SROM, but we usually augment them with oxytocin if they aren't contracting.

Now, you probably won't actually go over everything listed in the presentation, especially for a simple labor check, but it is good to know in case you get asked the more in depth questions. Answer to most of the things can be obtained from both the patient and their OB record.

Labor check

These patients may have been in numerous times or they may be there for the first time. After asking your four questions, you can usually just go ahead and get a chaperon and do a cervical check. * (Important note: if they are complaining of any kind of "gush"/"leakage of fluid" you have to do a SROM check first!!!!)

The cervical check is relatively simple. You can check your measurements and get your bearing using a template by the labor board before you go in the room. Generally, one finger barely in is 1cm, two fingers on top of each other is 2 cm, and 2 finger side by side, is 3 cm.

You can think of effacement as the cervix is approximately 4 cm long, which would be 0% effaced, 3cm = 25%, 2cm = 50%, 1cm = 75%, and if the cervix is very thin the entire way around it is 100%, or completely effaced (don't worry, patients can be 100% effaced and only dilated to 3-4cm!).

Station is difficult to ascertain at times, but zero station is defined as the presenting part being at the level of the ischial spines. +1 is a cm below that and -1 is a cm above that. Further descent is defined by cm below the ischial spines.

Things to note on the exam:

- cervical dilation
- cervical position (posterior/anterior/mid)
- cervical effacement (0-100%)
- cephalic or breech presentation
- station of the infant
- anything unusual (do you feel cord, hands, feet?)

* Tricks for the exam: sometimes the cervix is WAY posterior and you can help yourself by having the patient put her hands under her hips, which will tilt the pelvis such that it is easier to palpate.

General Information: Obstetric Service

- Primiparas (first child) are generally required to stay 48 hrs after deliver (by pediatrics).
- Multiparas (>1 child) are generally allowed to leave 24 hrs after first feed of child
- All mothers can be allowed to stay 48 hrs after delivery, so that a multipara may stay that long if she desires.

Daily Responsibilities

Notes and discharge paper work should be done during rounds each day so that the patients can be discharged in a timely manner and that laboring patients don't have to sit in the hall in pain waiting for rooms. Patients will be discussed at work rounds and complicated patients (cesarean sections, preeclamptic, etc...) will be presented at attending rounds.

In the afternoon you need to check on your patients to ensure they are doing well. No note is needed at this time unless there is a significant change or a concern has developed.

XI. Sample Progress Notes:

Brief Op Note

Preop Dx:

Postop Dx:

Procedure(s): *(list all)*

Surgeon:

1st Assist:

2nd Assist:

Staff:

Anesthesia: *(type - eg. GETA, epidural, etc.)*

Specimens:

Findings: *(brief, but comprehensive - important to list all pertinent findings)*

Fluids: *(amount and type, such as crystalloid, etc.)*

EBL: _____ urine output:

Drains: *(such as Foley, NG tube, etc.)*

Complications:

Signature

Post Op Note

S: Pt is POD # _____ s/p _____ complicated by _____ complains of _____

Also address: Pain control, flatus, voiding/Foley, ambulating, and diet

O: VS: Tmax: _____ T current: _____ P _____ R _____ B/P _____

I/O: _____

Lungs: *(address rales, wheezes or rhonchi)*

Heart:

Abdomen: *(example: soft, non-distended, no bowel sounds)*

Incision: *(example: clean, dry intact)*

Extremities: *(example: non-tender no Homan's or edema)*

Pelvic: *(as appropriate)*

A: POD # _____ from _____ doing well

P: Diet _____

Activity _____

IV _____

Dressing _____

Meds _____

Labs/Studies _____

D/C Planning _____

Signature

Outpatient Note

28 year old G3 P1112 LMP: 2 June 2002 using Depo-Provera for contraception presents for annual well woman exam and Pap smear. No complaints.

Past OB/GYN Hx: (*address H/O STD's, PID, abnormal Paps, problems with contraceptive method, etc.*)

PMH:

PSH:

Meds:

Exam (*example*):

Breast: no masses, no galactorrhea

Abd: soft, NT, no masses

Pelvic:

-EFG: without lesion, nl BUS

-Vagina: no lesions

-Cervix: parous, no lesions

-Uterus: NSSC, RV

-Adnexa: no palpable masses

-RV: confirms, guaiac neg

A: Normal gyn exam

P. Pap done

Refill Depo-Provera

Counseling regarding: (*address appropriate items: risky behaviors, smoking, immunizations or other age-appropriate screening, etc*)

F/U one year or prn

Signature

Delivery Note:

Date: Time:

25 year-old G2P1001 progressed to C/C/+1 and pushed for delivery of a viable male infant in the OA position over a second degree laceration. Infant's head was delivered atraumatically, bulb suctioned at perineum, and shoulders and body delivered without difficulty. Active cry elicited. 3 vessel cord clamped and cut. Infant passed to awaiting pediatric team w/ active cry and good tone noted. Apgars were 9 and 9. Weight= 3450g. Time of birth = 0515. Normal appearing placenta delivered spontaneously, manual uterine massage provided good hemostasis. Second degree laceration repaired w/ 2-0 vicryl in standard fashion.

Signature

Postpartum Note:

PPD # _____:

____ y.o. G _ now P_____ who delivered by (method) at _____ weeks.

Prenatal/antepartum course complicated by _____.

Intrapartum course complicated by _____.

Today the patient notes: *(address nay complaints, postpartum events out of the ordinary)*

Tolerating_____ diet +/- nausea vomiting +/- flatus/BM

Pain control: *(address type, adequacy)*

Voiding/ Foley:

Infant status: *(particularly if in the NICU, or if a problem has arisen)*

Breast/ Bottle feeding:

VS: (Tm/Tc): BP: R: P:

I/O (MgSO4 and C-section patients):

Heart:

Lungs:

Abdomen: *(address fundal height, consistency and tenderness)*

Incision: *(as applicable)*

GU: *(address lochia, episiotomy/laceration)*

Extremities: *(Homan's sign/ edema/reflexes)*

Lab results: *(Hct, possible chemistries if pre-eclamptic patient)*

A/P: PPD # _____

Meds:

Labs:

Any additional plans

Contraceptive plans:

Signature

XII. Glossary of Common Terms:

Adenomyosis: Presence of endometrial tissue within the myometrium

Adnexae: The uterine appendages, including the fallopian tubes, ovaries and associated ligaments.

Adrenal hyperplasia: A congenital or acquired increase in the number of cells of the adrenal cortex, occurring bilaterally and resulting in excessive secretion of 17-ketosteroids with signs of virilization.

Amenorrhea: Absence or cessation of menstruation.

Primary: Failure of menarche to occur by the 16th year of life.

Secondary: Absence of menses for three or more months after menarche.

Amniocentesis: Aspiration of amniotic fluid, usually transabdominally, for diagnostic or therapeutic purposes.

Amniotic fluid: The fluid confined by the amnion.

Anemia, megaloblastic: Anemia with an excessive number of megaloblasts in circulation, caused primarily by deficiency of folic acid, vitamin B12 or both.

Anemia, iron deficiency: A deficiency of iron in the bloodstream, a more common cause of anemia in women.

Anorexia nervosa: Eating disorder characterized by altered body image and marked reduction in the intake of food, caused by psychogenic factors and leading to malnutrition and amenorrhea.

Anovulatory bleeding: Irregular uterine bleeding that occurs in the absence of ovulation.

Antepartum: Before labor or delivery.

Apgar score: A physical assessment of the newborn, usually performed at 1 and 5 minutes after birth, used to determine the need for resuscitation.

Ascites: An abnormal accumulation of fluid in the peritoneal cavity.

Atony, uterine: Loss of uterine muscular tonicity, which may result in failure of labor to progress or in postpartum hemorrhage.

Autonomy: In medicine, a patient's right to determine what health care she will accept.

Barr bodies: Sex chromatin masses on the nuclear membrane. The number of Barr bodies is one fewer than the number of X chromosomes in that cell.

Bartholin cyst: Cystic swelling of a Bartholin gland caused by obstruction of its duct.

Bartholin glands: A pair of glands located at the 4 o'clock and 8 o'clock positions on the vulvovaginal rim.

Basal body temperature: The oral temperature at rest, used for detection of ovulation.

Benign cystic teratoma: The most common germ cell tumor, consisting of mature elements of all three germ layers (often called dermoid cyst).

Biophysical profile: A physical assessment of the fetus, including ultrasound evaluation of fetal movement, breathing movements, fetal tone, amniotic fluid volume and electronic fetal heart monitoring.

Biphasic temperature curve: A graph showing a basal body temperature in the luteal phase that is 0.3-1.0 F higher than that of the follicular phase, which indicates that ovulation has occurred.

Blood flow, uteroplacental: The circulation by which the fetus exchanges nutrients and waste products with the mother.

Breakthrough bleeding: Endometrial bleeding that occurs at inappropriate times during the use of hormonal contraceptives.

Breech: The buttocks (often refers to a fetal presentation).

Cancer staging: The clinical and pathological evaluation of the extent and severity of cancer.

Carcinoma in situ: A neoplasm in which the tumor cells are confined by the basement membrane of the epithelium of origin.

Cesarean delivery: Birth of the fetus through incisions made in the abdomen and uterine wall.

Chloasma (mask of pregnancy): Irregular brownish patches of various sizes that may appear on the face during pregnancy or during the use of oral contraceptives.

Chorioamnionitis: Inflammation of the fetal membranes.

Choriocarcinoma: A malignant tumor composed of sheets of cellular and syncytial trophoblast.

Chorionic villus sampling: The transcervical or transabdominal sampling of the chorionic villi for cytogenetic evaluation of the fetus.

Climacteric: The period of life or the syndrome of endocrine, somatic and psychic changes that occur in a woman during the transition from the reproductive to the nonreproductive state.

Clomiphene: A synthetic nonsteroidal compound that stimulates the maturation of follicles and thereby ovulation as a result of its antiestrogenic effect on the hypothalamus.

Coitus interruptus: Withdrawal of the penis during coitus before ejaculation.

Colporrhaphy:

Anterior: A surgical procedure used to repair cystocele.

Posterior: A surgical procedure used to repair rectocele.

Colposcopy: Examination of the vagina and cervix by means of an instrument that provides low magnification.

Condyloma acuminatum: A benign, cauliflower-like growth on the genitalia, thought to be caused by human papillomavirus.

Cone biopsy: A cone of cervical tissue excised for histologic examination.

Contraception: Prevention of conception.

Cordocentesis (Percutaneous umbilical blood sampling, PUBS): A fetal assessment and therapeutic technique in which a needle is passed into an umbilical vessel and blood is sampled or treatment is given.

Corpus luteum: The cystic structure formed in the ovary at the site of a ruptured ovarian follicle.

Cul-de-sac: The pouch-like cavity (also called the Pouch of Douglas) between the rectum and the uterus, formed by a fold of peritoneum.

Culdacentesis: Needle aspiration of intraperitoneal fluid or blood through a puncture of the posterior vaginal fornix into the cul-de-sac.

Curettage: Scraping of the interior of a cavity or other surface with a curette.

Fractional: Separate curettage of the endometrium and the endocervix for diagnostic evaluation. Specimens are submitted separately for pathologic examination.

Suction: Endometrial curettage using a suction catheter.

Cushing syndrome: A symptom complex caused by hypersecretion of glucocorticoids, mineralocorticoids and sex hormones of the adrenal cortex.

Cystocele: Protrusion of the urinary bladder that creates a downward bulging of the anterior vaginal wall as a result of weakening of the pubocervical fascia.

Cystogram: A radiogram of the urinary bladder after the injection of a contrast medium.

Cystometry: Measurement of the function and capacity of the urinary bladder by pressure-volume studies, often used to diagnose hyperactive bladder.

Cystoscopy: Direct endoscopic inspection of the interior of the urinary bladder.

Decidua: Identifiable changes in the endometrium and other tissues in response to the hormonal effects of progesterone.

Dermoid cyst: See Benign cystic teratoma.

Dilation: The physiologic or instrumental opening of the cervix.

D immunoglobulin [RhO(D) immunoglobulin]: An immunoprotein that prevents D sensitization.

Disseminated intravascular coagulation (DIC, Consumptive coagulopathy): An intravascular coagulation abnormality originally described in the obstetric complications of abruptio placentae and intrauterine fetal demise.

Double set-up: The simultaneous availability of two sterile set-ups for either a vaginal or abdominal delivery.

Dysgerminoma: A malignant solid germ cell tumor of the ovary.

Dysmaturity: Intrauterine growth retardation leading to a small-for dates baby, associated with placental insufficiency.

Dysmenorrhea: Painful menstruation.

Dyspareunia: Difficult or painful intercourse.

Dystocia: Abnormal or difficult labor.

Dysuria: Painful urination.

Eclampsia. The convulsive form of preeclampsia eclampsia syndrome.

Ectopic pregnancy: A pregnancy located outside the uterine cavity.

Ectropion: The growth of the columnar epithelium of the endocervix onto the ectocervix.

Effacement: Thinning and shortening of the cervix.

Embryo: The conceptus from the blastocyst stage to the end of the 8th week.

Endometrial biopsy: The procedure of obtaining endometrial tissue for diagnostic purposes.

Endometriosis: The presence of endometrial implants outside the uterus.

Endoscopy: Instrumental visualization of the interior of a hollow viscus.

Enterocoele: A herniation of the small intestine into the cul-de-sac, usually accompanied by (and sometimes confused with) rectocoele.

Episiotomy: An incision made into the perineum at the time of vaginal delivery.

Estrogen replacement: The exogenous administration of estrogen or estrogenic substances to overcome a deficiency or absence of the natural hormone.

Estrogen, unopposed: The continuous and prolonged effect of estrogen on the endometrium, resulting from a lack of progesterone.

Eversion: See Ectropion.

Exenteration, pelvic: The removal of all pelvic viscera, including the urinary bladder, the rectum or both, usually in the setting of advanced cervical malignancy.

Fern (ferning): The microscopic pattern of sodium chloride crystals as seen in estrogen stimulated cervical mucus or amniotic fluid.

Fetal Testing (non-stress testing): Evaluation of the fetus by electronic fetal heart rate monitoring, when not in labor.

Fetus: The conceptus from 8 weeks until birth.

Fibrocystic changes (breast): Mammary changes characterized by fibrosis and formation of cysts in the fibrous stroma.

Foreplay: The preliminary stages of sexual relations in which the partners usually stimulate each other by kissing, touching and caressing.

Functional ovarian cyst: A physiologic cyst arising from the Graafian follicle or the corpus luteum.

Functioning ovarian tumor: A hormone-producing ovarian neoplasm.

Galactorrhea: The spontaneous flow of breast milk in the absence of a recent pregnancy.

Gender (sex) role: An individual's understanding and feeling of the activity and behavior appropriate to the male or female sex.

Gonadal agenesis: The congenital absence of ovarian tissue or its presence only as a rudimentary streak.

Gonadal dysgenesis: The congenitally defective development of the gonads.

Gonadotropin:

Human chorionic (hCG): A glycoprotein hormone that is produced by the syncytiotrophoblast and is immunologically similar to luteinizing hormone (LH).

Human menopausal (hMG): A preparation isolated from the urine of postmenopausal women, consisting primarily of follicle-stimulating hormone (FSH) with variable amounts of LH, used for ovulation induction.

Pituitary: An endocrine organ composed of the anterior gonadotropin secreting component and the posterior oxytocin secreting component.

Granulosa cell tumor: A feminizing, estrogen-producing ovarian tumor.

Gravida: A pregnant woman.

Gravidity: The pregnant state, or the total number of pregnancies a woman has had, including the current pregnancy.

Hemoperitoneum: Blood in the peritoneal cavity.

Hermaphrodite: A person who exhibits characteristics of both sexes.

A true hermaphrodite is characterized by the presence of both ovarian and testicular tissue.

Hirsutism: The development of various degrees of hair growth of male type and distribution in a woman.

Hormone therapy (HT): Estrogen and progestin replacement therapy.

Hot flushes (flashes): A vasomotor symptom characterized by transient hot sensations that involve chiefly the upper part of the thorax, neck and head, frequently followed by sweats, and associated with cessation or diminution in the ovarian secretion of estrogen.

Hydatidiform mole: A pathologic condition of pregnancy characterized by the hydropic degeneration of the chorionic villi and variable degrees of trophoblastic proliferation.

Hydramnios (polyhydramnios): Excessive amounts (more than 2 liters) of amniotic fluid at term.

Hyperplasia, endometrial: The abnormal proliferation of the endometrium with a marked increase in the number of glands or cystic dilation of glands. These changes may be related to prolonged unopposed estrogen stimulation.

Hypoestrogenism: A condition of subnormal estrogen production with resultant atrophy or failure of development of estrogen-dependent tissues.

Hypofibrinogenemia: A deficiency (usually < 100 mg%) of circulating fibrinogen that may be seen in conditions such as abruptio placentae, amniotic fluid embolism and fetal death in which the fibrinogen is consumed by disseminated intravascular coagulation.

Hypogonadism: The subnormal production of hormones by the gonads.

Hysterectomy:

Abdominal: The removal of the uterine corpus and cervix through an incision made in the abdominal wall.

Radical: The removal of the uterine corpus, cervix and parametrium, with dissection of the ureters; usually combined with pelvic lymphadenectomy.

Laparoscopic Assisted Vaginal Hysterectomy (LAVH): The combination of laparoscopy (pelviscopy) with vaginal surgery techniques to remove the uterus and, frequently, the adnexa.

Subtotal (supracervical): The removal of the uterine corpus, leaving the cervix in situ.

Total: The removal of the uterine corpus and cervix (without regard to tubes or ovaries).

Vaginal: The removal of the uterus through the vagina.

Hysterosalpingography: Roentgenography of the uterus and tubes after injection of radiopaque contrast medium through the cervix. It is useful in ascertaining irregularities of the uterine cavity and patency of the fallopian tubes.

Hysteroscopy: The transcervical endoscopic visualization of the endometrial cavity.

Hysterotomy: Surgical incision of the wall of the uterus.

Imperforate hymen: Failure of a lumen to develop at a point where the budding vagina arises from the urogenital sinus.

Impotence: The inability to achieve or sustain penile erection.

Infertility: The inability to achieve pregnancy with regular intercourse and no contraception within a stipulated period of time, often considered to be 1 year.

Intervillous space: The space in the placenta in which maternal blood bathes chorionic villi, allowing the exchange of materials between the fetal and maternal circulations.

Intraductal papilloma: A benign mammary tumor, often multiple, occurring predominantly in parous women at or shortly before menopause. It is typically located beneath the areola and is often associated with bleeding from the nipple.

Intrauterine device (IUD): A device inserted into the uterine cavity for contraception.

Intrauterine fetal demise (IUFD, stillbirth): Intrauterine death of a fetus. For purposes of vital statistics, a fetal death prior to 500 grams is usually classified as an abortus.

Intrauterine growth retardation (IUGR): See Dysmaturity.

Intromission: Introduction of the penis into the vagina.

Justice: Ensuring or maintaining what is considered to be just or fair according to predetermined criteria.

Karyotype: A photographic reproduction of the chromosomes of a cell in metaphase, arranged according to a standard classification.

Labor: The process of expulsion of the fetus from the uterus.

Induced: Labor that is initiated artificially.

Stimulated (augmented): Labor that is stimulated, usually with oxytocin.

Lactogen, human placental (hPL): A polypeptide hormone that is produced by the syncytiotrophoblast, is similar to prolactin and somatotropin from the pituitary, and is involved in carbohydrate metabolism by the mother and fetus.

Laparoscopy: The transabdominal endoscopic examination of the peritoneal cavity and its contents after inducing pneumoperitoneum.

Leiomyoma (fibroid): A benign tumor derived from smooth muscle.

Leiomyosarcoma: An uncommon malignant tumor of smooth muscle.

Leukoplakia: An imprecise clinical term usually referring to white lesions of the vulva.

Levator muscle: The muscular sheet, consisting of the iliococcygeus, pubococcygeus and puborectalis muscles, which forms most of the pelvic floor (pelvic diaphragm) and supports the pelvic viscera.

Libido: Sexual desire or urge.

Lie: The relationship of the long axis of the fetus to the long axis of the mother. Examples are longitudinal, transverse and oblique.

Ligament:

Cardinal: The dense connective tissue that represents the union of the base of the broad ligament to the supravaginal portion of the cervix and laterally to the sides of the pelvis. It is considered to be the primary support of the uterus.

Uterosacral: The peritoneal folds containing connective tissue, autonomic nerves and involuntary muscle arising on each side of the posterior wall of the uterus at about the level of the internal cervical os and passing backward toward the rectum, around which they extend to their insertion on the sacral wall. It is considered to play an important part in axial support of the uterus.

Ligation, tubal: The surgical or mechanical interruption of the continuity of the fallopian tubes for the purpose of permanent contraception.

LMP: Last menstrual period.

LNMP: Last normal menstrual period.

Mastitis: Inflammation of the breast.

Masturbation: Sexual stimulation by the manipulation of the genitals.

Maturation index: The ratio of parabasal to intermediate to superficial vaginal epithelial cells (eg. 0/20/80), which is an indication of estrogen effect.

Maturity: The condition of a fetus weighing 2,500 grams or more.

Membranes, premature rupture of (PROM): Rupture of the amniotic membranes before the onset of labor.

Menarche: The onset of the menses.

Menopause: The permanent cessation of the menses caused by ovarian failure or removal of the ovaries.

Menorrhagia: Excessive or prolonged uterine bleeding occurring at regular intervals.

Metaplasia: A reversible change in which one adult cell type is replaced by another cell type. The most common type of epithelial metaplasia is the replacement of columnar cells by stratified epithelium (squamous metaplasia).

Metrorrhagia: Uterine bleeding occurring at times other than the expected menses; for example, intermenstrual bleeding.

Mid pelvis: An imaginary plane that passes through the pelvis and is defined by three points: the inferior margin of the symphysis pubis and the tips of the ischial spines on either side. This plane usually includes the smallest dimensions of the pelvis.

Mortality: A fatal outcome.

Maternal: Death of the mother.

Fetal: Death of the conceptus between >500 grams and birth.

Stillbirth (intrauterine fetal demise): Death of a fetus before birth.

For purposes of perinatal vital statistics, the fetus must be over 20 weeks gestational age or over 500 grams in weight.

Neonatal: Death of the infant in the first 28 days of life.

Perinatal: Death of the fetus or neonate between 20 weeks of gestation and 28 days after birth. It is the sum of stillbirths and neonatal deaths.

Mosaicism: The presence in an individual of cells of different chromosomal constitutions.

Mucus, cervical: The secretion of the cervical mucous glands; its quality and quantity are influenced by estrogen and progesterone. Estrogen makes it abundant and clear (which is called spinnbarkeit) with a fern pattern on drying. Progesterone makes it scant, opaque and cellular without a fern pattern upon microscopic examination.

Neonatal: Referring to the first 28 days of life.

Nonstress test (NST): Evaluation of the fetus by electronic fetal heart monitoring, not in labor. Also known as fetal activity testing.

Oligomenorrhea: Infrequent menstruation.

Orgasm: The climax of sexual excitement.

Osteoporosis: Atrophy of bone caused by demineralization.

Ovulation, induction of: Stimulation of ovulation by artificial means.

Oxytocin: An octapeptide formed in the hypothalamus and stored in the posterior lobe of the pituitary. It has stimulant effects on the smooth muscle of the uterus and the mammary glands.

Papanicolaou smear (Pap smear): A cytologic smear of exfoliated cells (for example, from the cervix, endometrial cavity or vagina) used in the early detection of cancer or for evaluation of a patient's hormonal status.

Parity: The number of pregnancies of a particular woman in which the fetus is over 20 weeks gestation prior to delivery.

Pelvic floor: The floor or sling for the pelvic structures, located at the level of the pelvic outlet. The most important structures are the levator ani muscle and fascial sheaths.

Pelvic inflammatory disease (PID): An infection of the pelvic viscera, usually by ascending routes. The likely etiologic pathogens include: Neisseria gonorrhoeae, Chlamydia trachomatis, and other anaerobic and aerobic organisms.

Pelvic inlet: An imaginary plane passing through the pelvis that represents the upper boundary of the true pelvis. It is bounded posteriorly by the promontory and alae of the sacrum, laterally by the linea terminalis, and anteriorly by the horizontal rami of the pubic bones and the upper margin of the symphysis pubis.

Pelviscopic Surgery: Laparoscopic surgery using multiple small incisions, specialized instruments and techniques.

Percutaneous Umbilical Blood Sampling (PUBS): See cordocentesis.

Perinatal: Pertaining to the combination of fetal and neonatal periods, considered to begin after 20 weeks of gestation and to end 28 days after birth.

Perineorrhaphy: Plastic repair of the perineum.

Perineum: The pelvic floor and associated structures occupying the pelvic outlet.

Pessary: A device placed in the vagina or uterus to support the uterus.

Placenta previa: A condition in which the placenta is located in the lower portion of the uterus and covers part or all of the internal os.

PMP: Previous menstrual period.

Pneumoperitoneum: The presence of air in the peritoneal cavity.

Polycystic ovary syndrome (Stein-Leventhal syndrome): A syndrome of secondary oligomenorrhea and infertility associated with multiple follicle cysts of the ovary and failure to ovulate.

Polyhydramnios: See hydramnios.

Polymenorrhea: Cyclical uterine bleeding that is normal in amount, but occurs <24 days apart.

Position: The relationship of a designated point on the presenting part of the fetus to the maternal pelvis (example: left occiput anterior [LOA]).

Postmenopausal bleeding: Bleeding from the uterus, cervix or vagina that occurs after the menopause.

Postpartum: After delivery or childbirth.

Postterm pregnancy: Pregnancy prolonged beyond the end of the 42nd week of gestation.

Preeclampsia: A specific hypertensive disorder of pregnancy with the diagnosis made on the basis of hypertension with proteinuria. It usually occurs after the 20th week of pregnancy.

Prematurity: An infant born before 37 completed weeks (260 days) of pregnancy.

Premenstrual syndrome (PMS): A complex of symptoms occurring in the progesterational phase of the menstrual cycle.

Presentation: The portion of the body of the fetus that is coming first in the birth canal. Examples include vertex, breech and shoulder presentations.

Presenting part: The portion of the fetus that is felt through the cervix on vaginal examination. The presenting part determines the presentation.

Primigravida: A woman who is pregnant for the first time.

Prolapse:

Cord: A condition in which the umbilical cord precedes the presenting part of the fetus.

Uterine: Prolapse of the uterus, usually due to the loss of supporting structures. It is related to injuries of childbirth, advanced age or congenital weakness.

Pseudocyesis: False pregnancy, in which some of the signs and symptoms of pregnancy are present, although no conception has taken place.

Puberty: The period between the beginning of the development of secondary sexual characteristics and the completion of somatic growth.

Delayed: The lack of appearance of secondary sexual characteristics by age 14.

Precocious: The appearance of secondary sexual characteristics before 7.5 years of age.

Puerperium: The period after delivery in which the reproductive tract returns to its normal, nonpregnant condition, generally 6-8 weeks.

Quickening: The first perception by the mother of fetal movement, usually between the 16th and 20th week of gestation.

Rectocele: Protrusion of the rectum through the supporting structures of the posterior vaginal wall.

Reflux, tubal: The retrograde flow of uterine or tubal contents into the abdominal cavity.

Rhythm (periodic abstinence): A method of contraception in which coitus is avoided when ovulation is likely.

Salpingectomy: Surgical removal of fallopian tube.

Salpingoophorectomy: Surgical removal of a fallopian tube and ovary.

Schiller test: The application of a solution of iodine to the cervix. The iodine is taken up by the glycogen in normal vaginal epithelium, giving it a brown appearance. Areas lacking in glycogen are white or whitish yellow, as in leukoplakia or cancer. Although nonstaining areas are not diagnostic of cancer, they aid in choosing the spot to which a biopsy should be directed.

Secondary sexual characteristics: The physical changes that have occurred in response to endocrine changes during puberty.

Semen analysis: The evaluation of the components of semen, especially spermatozoa, as a means of evaluating male fertility.

Sexual dysfunction: Sexual disinterest, unresponsiveness or aversion.

Sexuality: The physiologic and psychologic expression of sexual behavior. The periods of infancy, adolescence, adulthood and the postclimacteric state each have characteristic manifestations of sexuality.

Sims-Huhner test (post coital test): A test for infertility in which cervical mucus is aspirated after coitus and examined for quality and presence or absence of infection. The motility, normality and number of sperm are noted.

Skene glands: The vestibular glands that open into and around the urethra.

Somatammotropin, chorionic: See Lactogen, human placental.

Sonography (ultrasonography, ultrasound): In obstetrics and gynecology, a diagnostic aid in which high-frequency sound waves are used to image pelvic structures in pregnant and non-pregnant patients.

Spinnbarkeit: The ability of the cervical mucus to be drawn out into a thread, characteristically greater in the preovulatory and ovulatory phases of the menstrual cycle.

Station: The location of the fetal presenting part (leading bony point) relative to the level of the ischial spines. Station +2 means the presenting part is 2 cm below the ischial spines. Station -1 means the presenting part is 1 cm above the ischial spines.

Sterility: The absolute inability to procreate.

Stress incontinence: The involuntary leakage of urine during an increase in intraabdominal pressure as a result of weakness of the supports of the internal vesical sphincter and bladder neck.

Striae gravidarum: Streaks or lines seen on the abdominal skin of a pregnant woman.

Supine hypotensive syndrome: A hypotensive syndrome often characterized by sweating, nausea and tachycardia. It occurs in some pregnant women in the supine position when the pregnant uterus obstructs venous return to the heart.

Teratogen: An agent or factor that produces physical defects in the developing embryo.

Testicular feminization: A syndrome of androgen insensitivity characterized by primary amenorrhea, a female phenotype, testes (abdominal or inguinal) instead of ovaries, the absence of a uterus and a male genotype.

Thecoma: A functioning ovarian tumor composed of theca cells.

Thelarche: The onset of development of breasts.

Trimester: A period of three months. The period of gestation is divided into three units of three calendar months each. Some important obstetric events may be conveniently categorized by trimesters.

Trophoblast: The epithelium of the chorion, including the covering of the placental villi. It comprises a cellular layer (cytotrophoblast) and syncytium (syncytiotrophoblast).

Tubercles, Montgomery: The enlarged sebaceous glands of the areolae of the mammary glands during late pregnancy and lactation.

Ultrasonography: See Sonography.

Ultrasound: See Sonography.

Urethrocele: Protrusion of the urethra through the supporting structure of the anterior wall.

Vacuum extraction: The use of a suction device placed on the infant's head to assist vaginal delivery.

Vasectomy: The surgical interruption of the ductus (vas) deferens for permanent contraception.

VBAC: Vaginal birth after cesarean delivery.

Viability: The condition of a fetus weighing 500 grams or more; the ability to live independently outside of the uterus.

Virilization: The development of masculine traits in a female.

Withdrawal bleeding: Uterine bleeding after the interruption of hormonal support of the endometrium.

XIII. Common Acronyms in Obstetrics and Gynecology:

OB Acronyms

NOB:	New OB Clinic or appointment
ROB:	Routine OB Clinic or appointment
COB:	Complicated OB Clinic or appointment
WIC:	Walk in clinic
L&D:	Labor Deck
MICC:	Maternal Infant Care center (NNMC 6 th Floor)
IVF:	In-Vitro fertilization
AP:	Antepartum
APT:	Antepartum Testing
NST:	non-stress test
AFI:	amniotic fluid index
BPP:	biophysical profile
BTMZ:	Beta-methasone
PTL:	pre-term labor
PIH:	Pregnancy-induced hypertension
HSV:	Herpes
GBBS or GBS:	Group B beta strep
CHORIO:	Chorioamnionitis
SROM:	Spontaneous rupture of membranes
AROM:	Artificial rupture of membranes
PROM:	Premature rupture of membranes
PPROM:	Preterm premature rupture of membranes
CL:	Clear amniotic fluid
Thick:	thick meconium
Thin:	thin meconium
AI:	amnioinfusion
FSE:	fetal scalp electrode
IUPC:	intrauterine pressure catheter
PIT:	Pitocin augmentation/induction
Mg	Magnesium IV infusion
CLE:	Continuous lumbar epidural
C/5/2:	cervix is completely effaced, dilated 5cm, with presenting part at -2 station
50/1-2/OOP:	cervix is 50% effaced, dilated 1-2 cm with presenting part of out of pelvis
BLT:	Ballottable (fetal presenting part is felt out easily dissociated from station)
L/C:	Cervix is long and closed (internal os closed)
PP:	Postpartum
PPD:	Postpartum day
POD:	post-operative day
IS:	Incentive spirometry
Tmax:	maximum temperature in the past 24 hours
Tc:	current temperature
UO:	Urine output

GYN Acronyms

AF/RF:	ante flexed/retroflexed
AV/RV:	anteverted/retroverted
BSO:	bilateral salpingo-oophorectomy
BUS:	Bartholin's glands, Skene's glands, urethra
BLT/F/C:	bilateral tubal ligation/fulgaration/cautery
CX:	cervix
DI:	detrusor instability ("bladder spasm")
EG or EFG:	external genitalia
ETOP/TAB/VIP:	elective abortion
G:	gravidy
H/O:	history of
HRT/ERT:	hormone/estrogen replacement therapy
IUD:	intrauterine device
IUI:	intrauterine insemination
LAVH:	laparoscopic assisted vaginal hysterectomy
LMP:	last menstrual period
MMR:	menometrorrhagia
NSSC:	normal size shape and consistency (usually used to describe the uterus)
OCP:	oral contraceptive pills
P:	parity
RV:	recto-vaginal
S/P:	status post
SA:	sexually active
SAB:	spontaneous abortion
SUI:	stress urinary incontinence
TAH:	total abdominal hysterectomy
TVH:	transvaginal hysterectomy
US:	ultrasound