HISTORY & CLINICAL EXAMINATION IN OBSTETRICS

HISTORY IN OBSTETRIC

AN OBSTETRIC HISTORY SHOULD INCLUDE

.Current pregnancy details

Past obstetric history

Past gynecological history

Past medical and surgical history

Drug history and allergies

Family history-especially multiple pregnancy, diabetes, .hypertension, chromosome or congenital malformations

Social history

History of systemic review

Case summary

CURRENT PREGNANCY

*** Name**

*** Age**

*** Occupation**

*** Relationship status**

*** Blood group and RH**

*** Gravidity (i.e. number of pregnancies including the current one**

*** Parity (i.e. number of births beyond 24 weeks gestation)**

*** Miscasriage**

*** LMP**

*** EDD**

*** Gestational age**

Her husband

Name •

Age •

Occupation •

Blood group and rh •

*** The expected date of delivery (EDD) can be calculated from the last menstrual period (LMP) using Naegele's rule ((add 1 year and 7 days to the LMP and subtract 3 months**

*** not in Long cycles (oligomenorhoco) or add 7 days or 9 months of same year**

*** Irregular periods**

*** Relevant use of the combined oral contraceptive pill (COCP)**

GRAVIDITY AND PARITY EXPLAINED

The terminology used is gravida x, Para a+b •

X is the total number of pregnancies (including this one). •

*** A is the number of births beyond 24 weeks gestation**

*** B is the number of miscarriages or termination of .pregnancies before 24 weeks gestation**

Example

A woman who is pregnant for the 4th time with 1 normal delivery at term, 1 termination at 9 weeks and 1 miscarriage at 16 weeks would be gravida 4, Para 1+2

Chief complaint

History of present illness

HISTORY OF CURRENT PREGNANCY

Ist trimester

Second trimester

Third trimester

History of labor

HISTORY OF IST TRIMESTER

method of confirmation of pregnancy,LMP

General health (tiredness, malaise, and other non-specific

Symptoms)

Bleeding,pain.(Ectopic pregnancy, misscariage) Vaginal discharge

Hyperemesis

Urinary problems

Investigations(ultrasound,blood and urine test

drug history treatment

HISTORY OF SECOND & THIRD TRIMESTER

History of fetal movements (quickening)

Symptoms of anemia, Miscarriage, , Vaginal discharge, UTI, hyper emesis gravidarum , raginal bleeding

Ask for vaccination

- **Ocdema**
- **Paipitation**
- **Polyuria**
- **Fetal**
- **Anomaly scan**

Results of all antenatal blood tests-routine and specific

- **Results of anomaly and other scans (details of results can be cross checked with the notes).**

IF SHE IS POSTNATAL

- **Labor and delivery**
- **History of the postnatal period**

PAST OBSTETRIC HISTORY INCLUDES

- **Details of all previous pregnancies (including miscarriages and terminations**
- **Length of gestation.**
- **Date and place of delivery (raginal or cls)**
- **Onset of labor (including details of induction of labor).**

Mode of delivery •

Sex and birth weight •

Fetal and neonatal life •

Clear details of any complications or adverse outcomes such as shoulder dystocia, postpartum •

History often repeats itself, so previous antenatal, intrapartum, or postpartum complications should influence the management of this .pregnancy •

No.	Year And Date	Pregnancy Events	Labour Events	Methods Of Delivery	Puerperium	Baby Weight, Sex Condition At Birth, Duration Of Breast Feeding Immunization
1						
2						
3						

GYNAECOLOGICAL HISTORY

1- menarche age

2- Menstrual history

3- Method of contraception before conception

4- H.X of infertility

5- H.X of post coital bleeding

6- Cervical smear history

7- Coital problems

Past medical history

1- past medical history of chronic illnesses (H.T , D.M , chronic anaemia , Thyroid discase ..... etc

2- PMHX of infectious discase (Rubella, herpes , measles , HIV

3- PMHX of hospitalization

4- PMHX of blood transfusion

5- PMHX of allergy to drugs food and materials

Past surgical history

Past surgical HX of aperation (Indication, dusation and complications

FAMILY HISTORY

- **Any history of hereditary illnesses or congenital defects is important and is required to ensure adequate counseling and screening is offerer**
- **Familial disorders such as thrombophilia**
- **Previously affected pregnancies**
- **with any chromosomal or genetic disorder**
- **multiple gestations**
- **.Consanguinity**

Keywords Before Examination

*** Before examination, explain to the patient the need and the nature of the proposed examination**

.* Obtain a verbal consent

*** The examiner (either male or female) should be accompanied by another female**

*** Respect her privacy and examine in a private room**

Keywords Before Examination

***Expose only relevant parts of her anatomy for examination**

*** Ensure the patient is comfortable and warm**

*** Ask patient to empty the bladder**

*** Patient should lie in the dorsal position with thighs slightly flexed**

*** Stand right to her**

Keywords Before Examination

She is slightly rolled to the left side to prevent compression of the inferior vena cava by the enlarged uterus (inferior venacaval syndrome or supine hypotensive syndrome

Ask for any tender area before palpating the abdomen

Dorsal position/Supine position with thighs slightly flexed

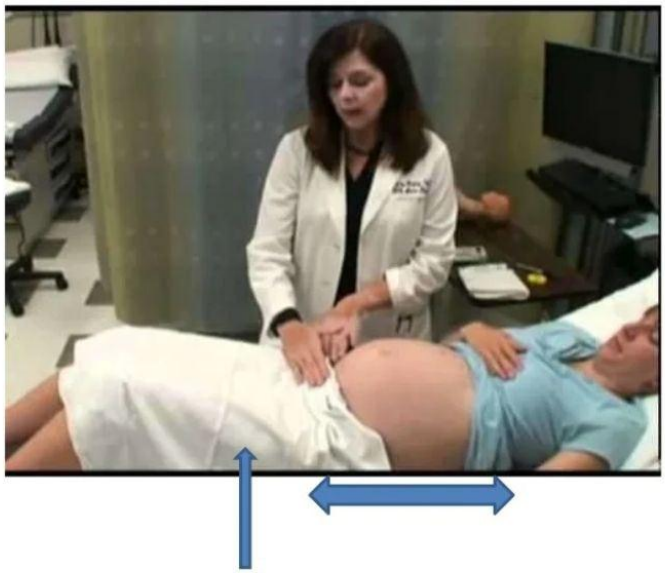


Fig. 7.7A: Position of the woman during obstetric examination

General Examination

VITAL DATA

NUTRITIONAL STATUS

HEIGHT

FACIAL FEATURE/EXPRESSION

SKIN

ICTERUS

LEGS

NECK

BREAST

General Examination

VITAL DATA :

1-Blood pressure

Record while she is in sitting and Semi-Recumbent (45 degrees) posture

Record in every visit

Usually unaffected or Slightly lower than normal due to SVR (SYSTEMIC VASCULAR RESISTANCE

If BP 140/90 mm Hg on 2 separate occasions 6 Hrs apart

Chronic Hypertension: if recorded before 20 weeks of pregnancy or may be persisted before pregnancy. With + family history

Gestational Hypertension if recorded after 20 weeks of pregnancy

2- Pulse rate: Slightly increased

3- Heart rate : Increased. Murmurs heard

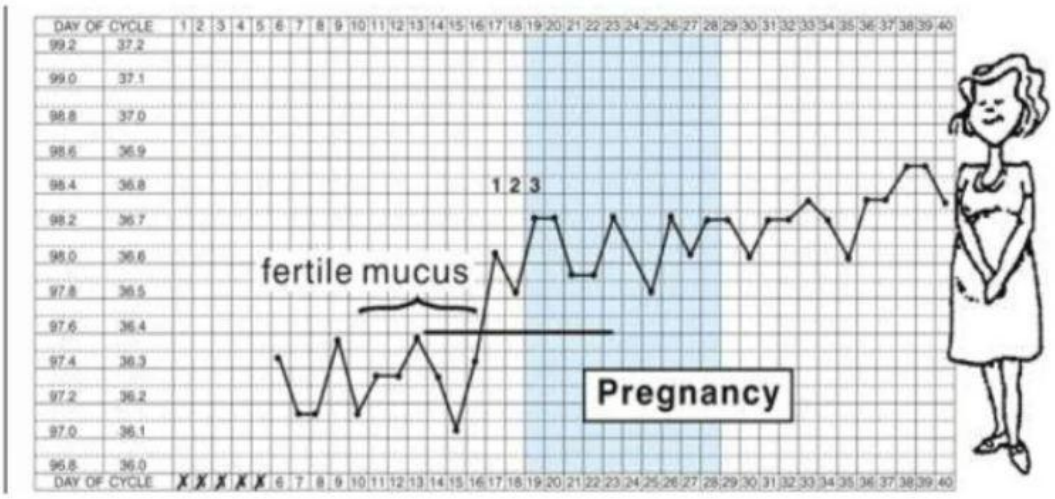
- normal- continuous hissing murmur- systolic type-also called mammary murmur- at left tricuspid area over 2nd and 3rd intercostal spaces

4- Respiratory rate: usually unaffected. feels shortness of breath with slight exertion due to elevated diaphragm

5- Temperature: may rise by 0.4 °F

i.e..98.6 °F to 99 °F •

Due to increased metabolic rat •



NUTRITIONAL STATUS

Nails- white spots in zinc deficiency, brittle nails in magnesium deficiency

Tongue- May be Large in iodine or niacin deficiency. May be pallor in Fe++ deficiency. Cyanotic in CHD. Site- dorsum of tongue

WEIGHT- The abnormal nutritional status can be described as obesity and emaciation

Check weight in every visit

Parameter-Body mass index BMI

Weight gain for a woman with normal BMI (20-26) is 11-16 kgs

Weight gain for a obese woman (BMI > 29) should be less than 7kgs

Weight gain for a under weight woman (BMI <19) is 18 kgs

Parameters helps in early intervention of preeclampsia (in obese) and IUGR of fetus (in under weight

HEIGHT

.Short stature women are mostly to suffer with small pelvis

May cause IUGR OF FETUS

FACIAL FEATURE/EXPRESSION

Some facial appearances are pathognomonic of disease

Here the patient may be having thyrotoxicosis

The appearance of the patient's face may also provide information regarding psychological makeup: is the person happy, sad, angry or anxious

SKIN: Extreme pigmentation around neck, face, forehead. Common in pregnancy

Palmar erythema - due to high estrogen

Hirsutism mild common, if more - Cushing syndrome

ICTERUS- Bulbar conjunctiva, under surface of tongue, Hard palate- to rule out any LIVER pathology

LEGS-EDEMA - common- physiological

other causes- Preeclampsia, Anemia, Cardiac Failure, Nephrotic Syndrome

NECK- Neck veins, Thyroid gland (diffuse enlargement common in pregnancy-50 % of cases), Lymph gland enlargement (any H/o of Kochs/other pathologies of lymph .(nodes

BREAST- Examination of breast is mandatory not only to note presence of pregnancy changes,but also to note the nipples/skin around areola

The breast changes are evident between 6-8 weeks

The nipple and the areola become more pigmented specially in dark women

Montgomery's tubercles are prominent

Thick yellowish secretion (colostrum) can be expressed as early as 12th week

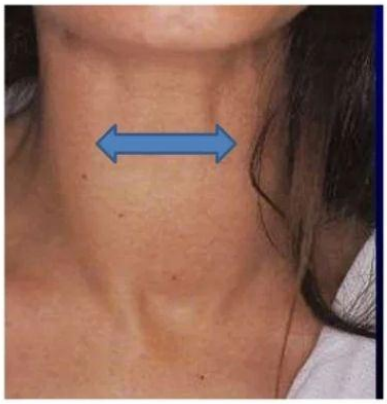
Breasts are enlarged with vascular engorgement evidenced by the delicate veins visible under the skin

Breast are changes are valuable only in primigravidae, as in multigravidae the breasts are enlarged and often contain milk for years

Purpose is to correct the abnormalities (cracks/fissures) early so that to make easy breast feeding more safely too infant after delivery

Neck

- Diffuse swelling
- common- 50 % cases of pregnancy



Abnormal swelling

BREAST

Normal in pregnancy

Abnormal in pregnancy

General Systemic Review

CNS

GIT

GENITALIA

URINARY SYSTEM

LOCOMOTORY SYSTEM

CNS: following finding are checked

sleeplessness, mental irritability due to some psychological - background

Any depression/psychosis -

Anaesthesia of the thighs due to compression of Lateral Cutaneous Nerve -

Carpel tunnel syndrome- median nerve compression in later months of pregnancy -

GIT

Gums-usually congested and spongy -

Esophageal reflux- due to relaxed sphincter by progesterone -

Constipation- due to atony -

Other signs of any disturbances should noted clearly

Chances of gall stones- due to raised cholesterol- advise USG USG if pain in Rt hypochondria -

ABDOMINAL EXAMINATION

Can be examined in three parts

INSPECTION

PALPATION

AUSCULTATION

INSPECTION

Size of the uterus -

If the length & breadth are both increased → multiple pregnancies, polyhydramnios

If the length is increased only large baby

Shape of the uterus -

Length should be larger than broad this indicates longitudinal lie. But if the uterus is low and broad indicates .transverse fetus lie

Pendulous abdomen- in primigravidae is sign of inlet contraction

INSPECTION

If there is lateral implantation of the placenta then the uterus enlargement enlargement will be asymmetrical- .piskacek's sign

Look for fetal movements -

More prominently seen in 3rd trimester / Less in) (oligohydramnios

Look for scars -

Herniations -

INSPECTION

- **CUTANEOUS SIGNS** - Linea nigra, Striae gravidarum, Striae albicans, Umbilicus flat or everted, Superficial veins.
- **SKIN CONDITIONS-** Ringworm/Scabies

LINEA NIGRA

EVERTED UMBILICUS

FETAL PARTS

STRIAE ALBICANS

PALPATION

Aim

Palpation of fetal parts

Active fetal movements

Height of the uterus (symphysis-fundal height

Gestational age

Foetal poles

Foetal lie

Presentation part- cephalic (head), breech,etc

Attitude

Level of engagement of presenting part

Uterine contractions

Estimate fetal weight

Any cephalo-pelvic disproportion Of the above parameters

To assess FETAL POLE, FETAL LIE, FETAL PRESENTING PART, ATTITUDE AND ENGAGEMENT OF FETAL HEAD- LEOPOLD'S MANOUEVRE IS FOLLOWED

1-Palpation of fetal parts

Distinctly felt after 20th week -

Usually done to estimate the pole/presenting part -

2- Active fetal movements

Gives positive evidence of pregnancy

Felt at intervals by placing the hand over the uterus as early as 20th week. Indicates live fetus

Intensity more in last trimester

3-Height of the uterus (Symphysis-Fundal Height

The distance from the symphysis pubis to the uterine fundus (top of the uterus)- size of the uterus directly related to the .size of the fetus

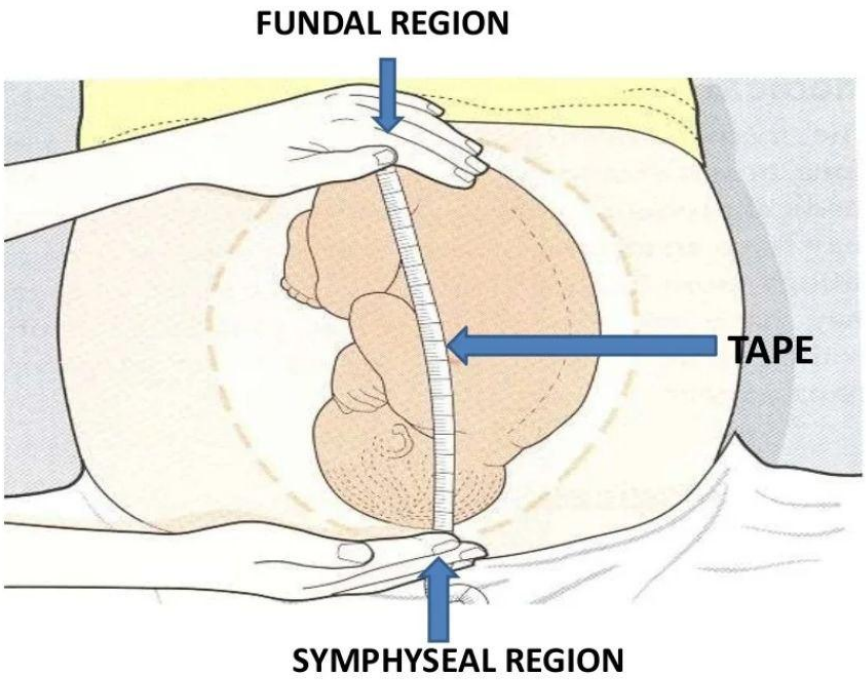
Technique

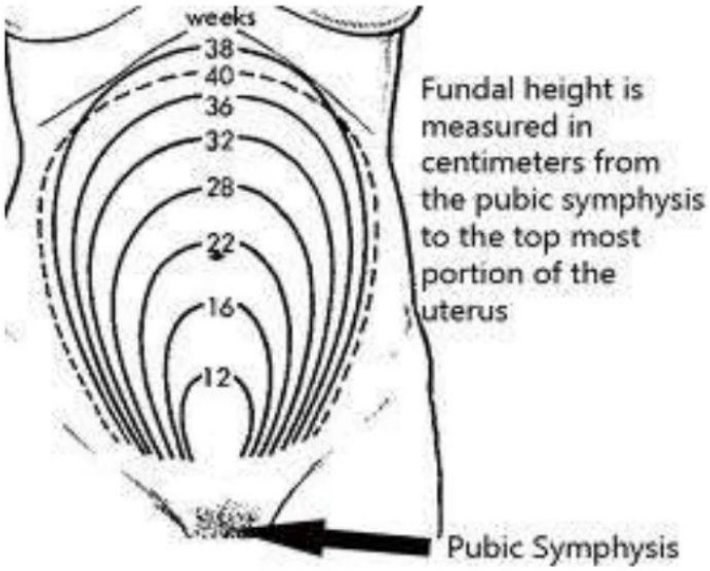
Place ulnar border of the left hand on the highest part of the .(uterus (fundus

Mark this point with a pen after obtaining her permission

The distance between the upper border of the symphysis pubis upto the marked point is measured by tape

This corresponds to gestational age


FUNDAL REGION
TAPE
SYMPHYSEAL REGION


weeks
38
40
36
32
28
22
16
12
Fundal height is measured in centimeters from the pubic symphysis to the top most portion of the uterus
Pubic Symphysis

4- Gestational age

The distance from the symphysis pubis to the uterine fundus (top of the uterus) corresponds to the gestational age/duration of pregnancy

After 24 weeks of pregnancy, the distance measured in cm normally corresponds to the period of gestation in weeks

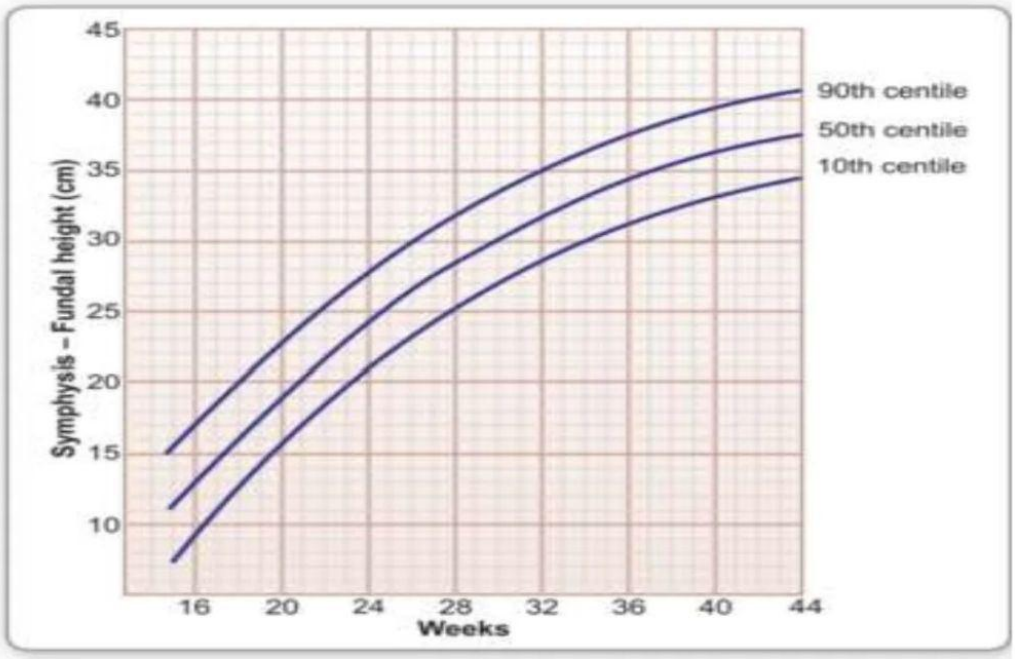


Fig. 11.1: Gestational age chart estimated from symphysis-fundal height

5-Fetal Pole, Lie, Presenting Part, Engagement And Attitude .Of Fetal Head are assessed by LEOPOLD'S MANOUEVRE

LEOPOLD'S MANOUEVRE: Done by four obstetric grips

1-Fundal grip - To assess fetal pole

2-Lateral grip - To assess fetal lie

3-Pawliks grip - To assess presenting part

4-Deep pelvic grip To assess engagement and attitude of fetal head

1-Fundal grip

Both hands placed over the fundus and the contents of the fundus determined

A hard smooth, round pole indicates a fetal head

Broad, soft and irregular mass suggestive of breechIn transverse lie no parts are palpated

2-Lateral Grip or umbilical grip

Move both hands in a downward direction from the fundus along the sides of the uterus to determine the "lie" of the fetus

Lie" is the relationship btw the longitudinal axis of the " fetus and the longitudinal axis of the mother

The "lie" is usually longitudinal, hence baby is lying length-wise in the same direction as mother's longitudinal axis

Lateral Grip

Other "lies" are

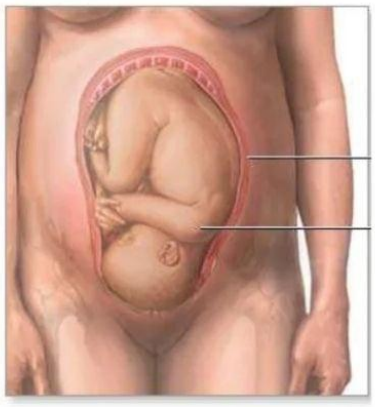
Transverse Lie: fetus lies longitudinal axis of mother and

across the

oblique lie: fetus lies at an oblique angle to the mother's .longitudinal axis

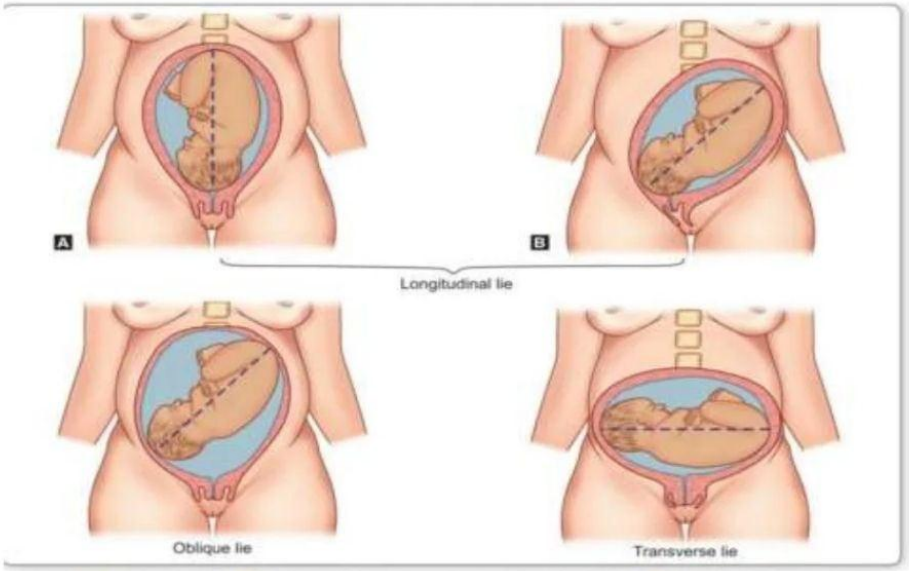
Can also determine which side the foetal back is situated by feeling the firm regular surface of the foetal back on one side and the irregular, lumpy surface as the foetal limbs on the other side

Longitudinal Lie



Transverse Lie

Fetus in transverse lie presentation



Figs 8.1A and B: Fetal lie. (B), the fetus seems to lie in oblique position in relation to the maternal spine but remains in ongitudinal lie in relation to uterine axis. Correction of the uterine obliquity rectifies apparent oblique lie of the fetus (A)

3-Pawliks grip: second pelvic grip

- **The thumb and four fingers of the right hand are placed over the lower pole of uterus keeping the ulnar border of palm on the upper border of the suprapubic area to .determine the presenting part**

Presenting part of fetus is the lowest most part of the fetus at the inlet of the pelvis

Presentation

Presenting part of fetus occupying the lower pole of uterus

.i.e

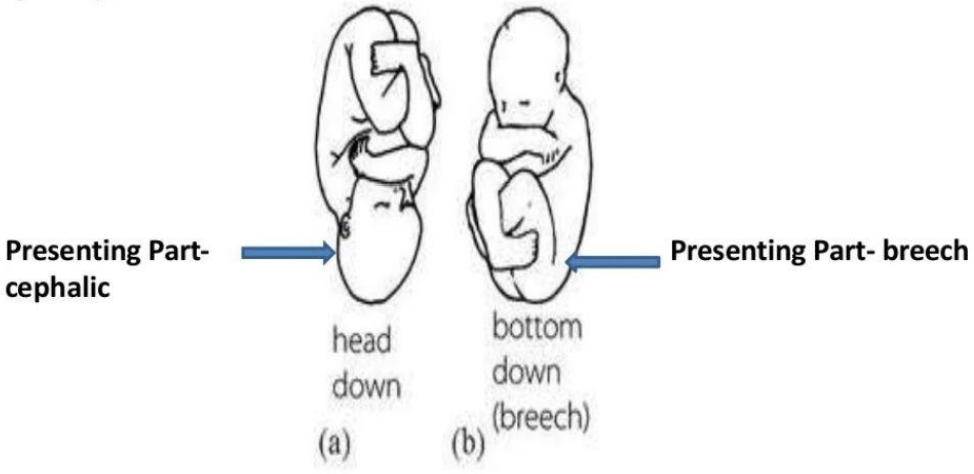
.Cephalic

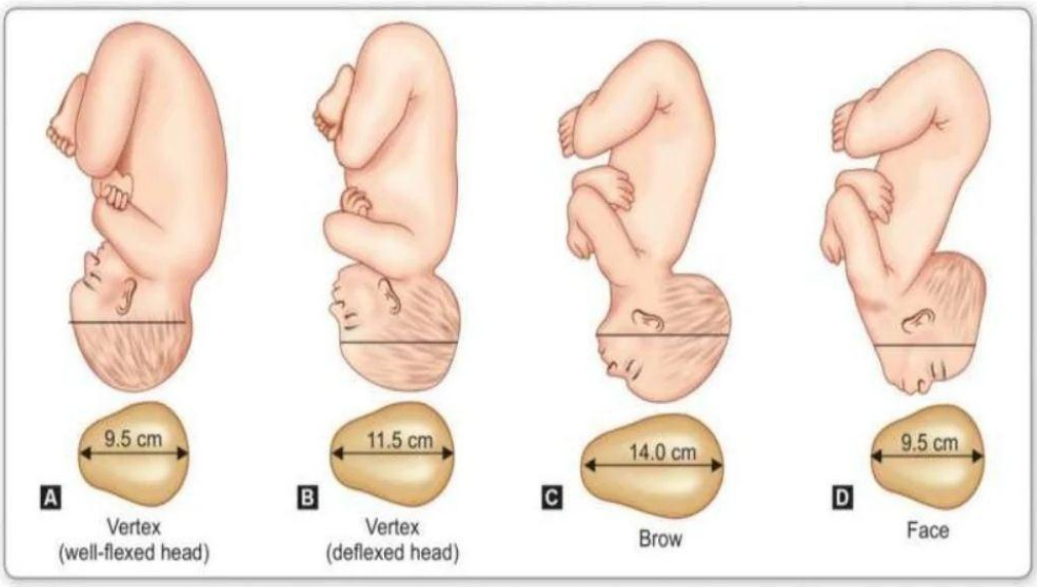
.Breech

Shoulder

Pawliks grip:

- In transverse lie, pawliks grip is empty.
- If not engaged the presenting part can be grasped and moved side to side.





Figs 8.2A to D: Varieties of cephalic presentations in different attitude

first pelvic grip=Deep pelvic grip:

Determines two points about the fetus

1-The attitude of the fetal head

2-Engagement of the fetal head

The attitude of the fetal head

The examiner turns around to face patients feet

Each hand placed on either side of the fetal trunk lower down

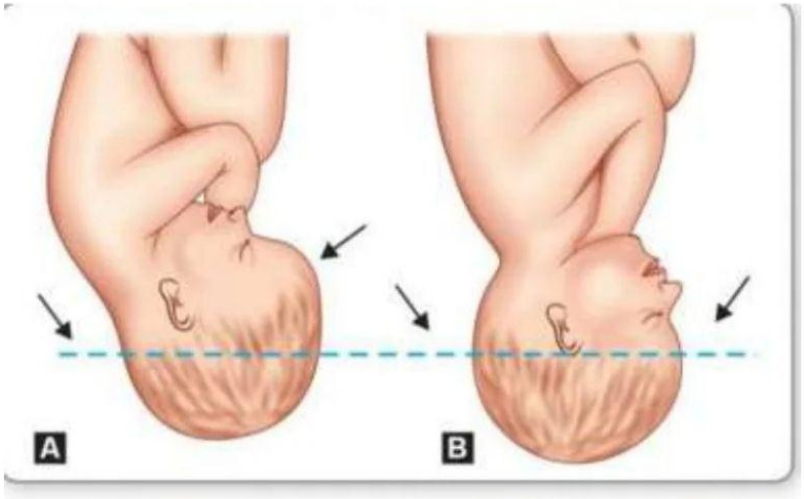
The hands moved downwards towards the fetal head

• Note made as to which hand first touches the fetal head (This point called cephalic prominence).
• Cephalic prominence helps determine the **attitude** (i.e. flexion, deflexed or extended) of fetal head.

If cephalic prominence (sinciput) is on the opposite side of (fetal back, fetal head is well flexed (Normal Position

If cephalic prominence (occiput) on the same side as fetal back, fetal head is extended (abnormal position

If examiners hands reach the fetal head equally on both sides (both sinciput and occiput), fetal head is deflexed Military position, indicating mal-position



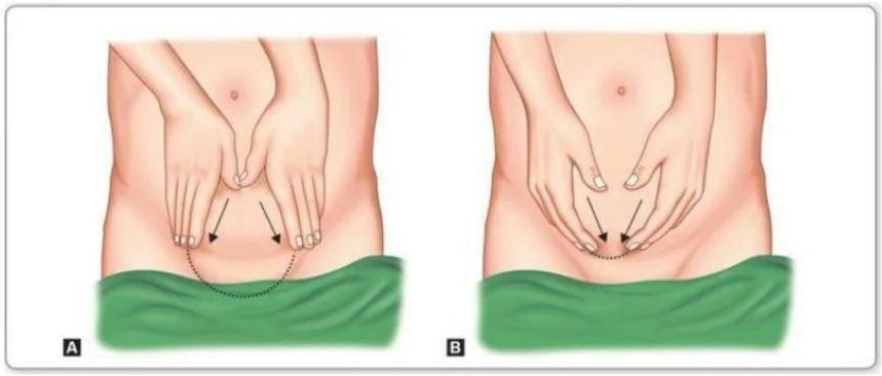
Figs 8.8A and B: Relative position of the sincipital and the occipital pole as felt in first pelvic grip: (A) Well flexed (B) Deflexed

Engagement of the fetal head

Engagement of the fetal head defined as having occurred - once the widest transverse diameter of the fetal head (bi-parietal diameter) has passed through the pelvic inlet into .the true pelvis

Procedure: Continue moving both hands down around the - fetal head, determine how far around the head you can get

Examiner should be able to palpate part of fetal head still in the lower abdomen (also called the 'false' pelvis but cannot palpate the part of fetal head in the true pelvis



Abdominal palpation to determine engagement of the head

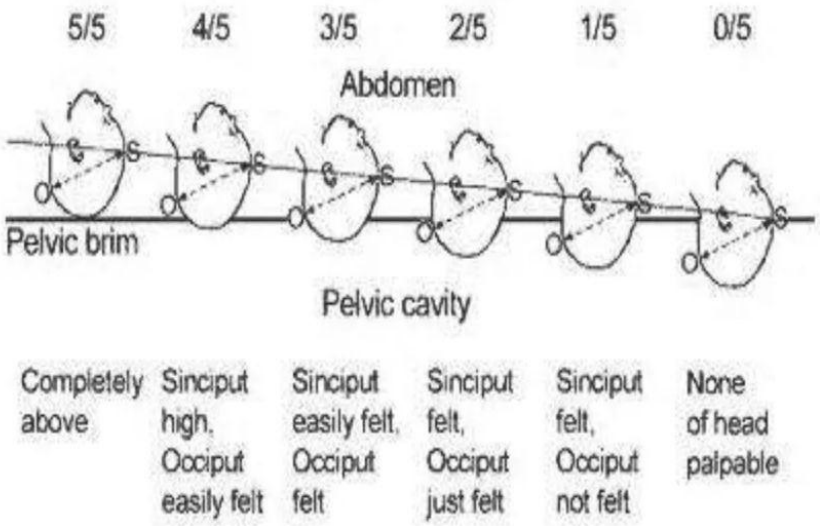
A- Divergence of fingers- **Engaged Head**

B- Convergence of fingers- **Not Engaged**

If you divide the fetal head into five-fifths, you estimate how many fifths of the fetal head can be felt

If 5,4 or 3 fifths can still be palpated, most of the head is still up, hence the widest part of the head has not engaged into the pelvis

If only 2,1 or 0 fifths of fetal head felt, the widest part of - the head has engaged into the pelvis



- Diagrammatic representation showing the difference between an engaged and a fixed head by use of egg cups and eggs.