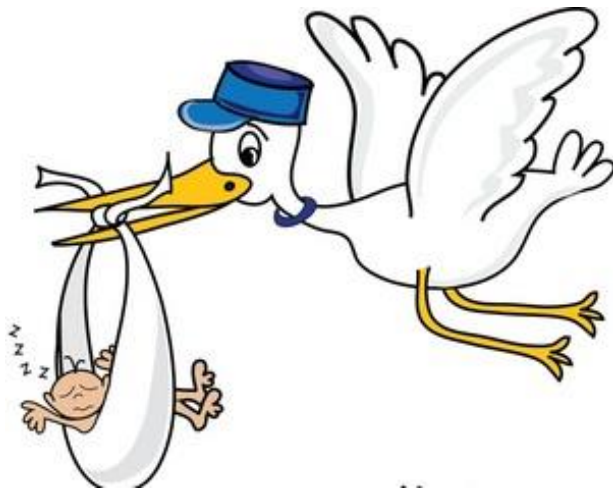


# LSU OBGYN

## Student Guide



Welcome to your OBGYN rotation!

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## COMMON ABBREVIATIONS

<p><b>1LTCS</b>- primary low transverse cesarean section</p> <p><b>AFI</b>- amniotic fluid index</p> <p><b>AROM</b>- artificial rupture of membranes</p> <p><b>BPP</b>- biophysical profile</p> <p><b>BSO</b>- bilateral salpingo-oophorectomy</p> <p><b>BTL</b>- bilateral tubal ligation</p> <p><b>CKC</b>- cold knife conization</p> <p><b>D&amp;C</b>- dilation and curettage</p> <p><b>EAB</b>- elective abortion</p> <p><b>EDC</b>- estimated date of confinement (due date)</p> <p><b>FAVD</b>- forceps assisted vaginal delivery</p> <p><b>FHT</b>- fetal heart tones</p> <p><b>FM</b>- fetal movement</p> <p><b>FTP</b>- failure to progress</p> <p><b>G #P#</b> noted as G2P1001</p> <p><b>G (Gravida)</b>- # times they've been pregnant</p> <p><b>P (Para)</b>- divided into TPAL</p> <p style="padding-left: 20px;"><b>T (Term)</b>- # full term births</p> <p style="padding-left: 20px;"><b>P (Preterm)</b>- # preterm deliveries (20- 36 6/7 weeks)</p> <p style="padding-left: 20px;"><b>A (Abortions)</b>- #spontaneous or elective abortions before 20 WGA</p> <p style="padding-left: 20px;"><b>L (Living)</b>- # children still alive</p> <p><b>GDM</b>- gestational diabetes mellitus</p> <p><b>Hystero</b>- uterus</p> <p><b>IUFD</b>- intrauterine fetal demise</p> <p><b>LAVH</b>- laparoscopic assisted vaginal hysterectomy</p> <p><b>LEEP</b>- loop electrocautery excision procedure</p> <p><b>LMP</b>- last menstrual period</p>	<p><b>LOF</b>- leakage of fluid</p> <p><b>NST</b>- nonstress test</p> <p><b>NSVD</b>- normal spontaneous vaginal delivery</p> <p><b>NT/NE</b>- non-tender/non-engorged (breast exam)</p> <p><b>PNC</b>- prenatal care</p> <p><b>POC</b>- products of conception</p> <p><b>PPROM</b>- preterm premature rupture of membranes</p> <p><b>PROM</b>- premature rupture of membranes</p> <p><b>PTL</b>- preterm labor</p> <p><b>RLTCS</b>- repeat low transverse cesarean section</p> <p><b>RTC</b>- return to clinic</p> <p><b>SAB</b>- spontaneous abortion</p> <p><b>SLIUP</b>- single live intrauterine pregnancy</p> <p><b>SROM</b>- spontaneous rupture of membranes</p> <p><b>TAH</b>- total abdominal hysterectomy</p> <p><b>TLH</b>- total laparoscopic hysterectomy</p> <p><b>TOA</b>- tubo-ovarian abscess</p> <p><b>TOLAC</b>- trial of labor after cesarean section</p> <p><b>TOD</b>- time of delivery</p> <p><b>TVH</b>- transvaginal hysterectomy</p> <p><b>US</b>- ultrasound</p> <p><b>VAVD</b>- vacuum assisted vaginal delivery</p> <p><b>VB</b>- vaginal bleeding</p> <p><b>VBAC</b>- vaginal birth after cesarean</p> <p><b>VFI</b>- viable female infant</p> <p><b>VMI</b>- viable male infant</p> <p><b>WGA</b>- weeks gestational age</p>
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## COMMON PRESCRIPTIONS

<p><b>Azithromycin</b> 1 gram Disp: 1 pill Sig: 1 po x 1 dose</p>	<p><b>Lortab</b> 7.5/500mg Disp: #30 (Thirty) Sig: 1-2 po q 4-6 hours prn pain No refill</p>
<p><b>Colace</b> 100mg (give to those on iron BID/TID) Disp: #60 Sig: 1 po BID prn constipation Refill x 6</p>	<p><b>MOM (Milk of magnesia)</b> 30mL Sig: 1 po q 6 hrs prn constipation</p>
<p><b>Ceftriaxone</b> 125mg Sig: 1 IM x 1 dose</p>	<p><b>Motrin 800mg &amp; Anaprox DS</b> Disp: #20 Sig: 1 po q 8 hours prn pain Refill x 1</p>
<p><b>Dulcolax suppository</b> 10mg Sig: 1 per rectum x 1 dose</p>	<p><b>Mylicon</b> 80mg Sig: 1 po q 6 hrs prn gas</p>
<p><b>Fergon</b> 325mg Disp: #30/60/90 Sig: 1 po daily/BID/TID Refill x 6</p>	<p><b>Percocet</b> 5/325mg Disp:#30 (Thirty) Sig: 1-2 po q 4-6 hours prn pain No refill</p>
<p><b>Flagyl</b> 500mg Disp: #14 Sig: 1 po BID x 7days</p>	<p><b>Prenatal vitamins</b> Disp: #30 Sig: 1 po daily Refill x 6</p>

# OBSTETRICS

***What is a normal morning like on OB?*** (Times/experiences may differ depending on location)

- You will round and write progress notes on post-partum patients. Residents will tell you when to have your notes finished. Be timely with your notes. The intern will see all of the patients after you. Please let the patient know that the resident will be following you.
- Always introduce yourself to the nurses. They can help you so much.
- Check the orders section every morning to see if something new has been ordered. Make sure you check labs every morning- f/u cultures, etc. Most attendings prefer the vitals to be listed in ranges.
- Begin working on discharge papers when you start seeing the patient. Your intern will let you know how to do discharge paperwork. Information required for discharge from labor and delivery include baby weight, type of delivery, APGARs, sex of infant.
- You will present your patient to staff. Ask your resident/staff if they want the full soap note presentation or the pertinent information. Know your patient and the topics about the patient. (For example, if your patient had chorioamnionitis, it is helpful to know the pathophysiology, the diagnosis, treatment, as these are common pimp questions on rounds).
- You will then be asked to follow a laboring patient. The team will divide the patients amongst the students. You should introduce yourself and come in for every cervical examination and intervention. You can be very helpful as a student to watch the fetal heart tracing. If your patient goes to a cesarean, you will go with them.
- You also may be asked to attend a scheduled cesarean section in the morning.
  
- Baton Rouge specifics:
  - Residents will want notes done by 6am, but you are not allowed to get to the hospital before 5 am and cannot go into a patient's room before 5:30. This leaves you rushed to see your patient(s), get the vitals and medicine records from the nurses, and write your note and have it in the chart in 30 minutes.
  - You can go on the computer in the residents lounge, and look up your patient before you see them, all the vitals/any new labs will be there. So basically, get there at 5 am, look up your patient on the computer and write down vitals and changes in meds, new labs, etc. so that when you go see your patient(s) and write your note, you'll already have that information.
- Touro specifics:
  - You will likely get to the hospital around 5:00. One student from your team can print an LSU OB list for your team in the computer in the call room. You will then round on your patients prior to the intern seeing them. It is helpful if you have vital ranges for your patients to give to the intern on your service. One option is to designate one student to be the "early" person each day. That student will



Helpful tips!

- show up at 5:00 and create a sheet with all the vitals for each postpartum patient (for both LSU and Touro) – this seemed to help out the interns a lot.
- Sign out is at 7:00. Have everything ready prior to that time. Following sign out, you will round with the attending on call.
  - Postpartum vitals can be found in Soarian (most likely) or Centricity. Ask your intern for the password to Centricity.
  - Maternal Fetal Medicine (MFM) curriculum: You will be primarily working with Dr. Stafford. She will ask you to see a patient and may ask you to prepare a short presentation pertinent to your patient. If time permits, you will round with the Dr. Stafford and the 2<sup>nd</sup> year MFM resident. You may also be asked to attend an MFM ultrasound clinic for a half day, where you will be exposed to advanced ultrasound.
    - Pyelonephritis- You will need to know how many hours the patient has been afebrile. Check for CVA tenderness every morning. Check the urine culture results every morning. She must be afebrile for 24 hours before going home.
    - DM control- Know her accuchecks each morning- ask the nurse if you don't see them in the chart. Have the resident discuss how we adjust insulin. Make sure she has a nutrition consult and diabetic teaching.
    - Rule out pre-eclampsia/ PreEclampsia- Ask the patient if she has a headache, vision changes, or RUQ pain each morning. Know her BP's. Check her 24 hour urine results. Know the results of all her labs (CBC, CMP, LDH, Uric Acid, UA).
    - PPRM: Know what day of antibiotics the patient is on. Always assess for fundal tenderness and temperature (as chorioamnionitis is a risk of PPRM). Ask about contractions.

## POST PARTUM ROUNDING

### ***What are good questions to ask a post-op/post-partum patient in the morning?***

- *How do you feel today? Any fevers or chills overnight? etc.*
- *Have you been up moving around (basically are you ambulating?)*
- *HAVE YOU PASSED GAS OR HAD A BOWEL MOVEMENT IF THEY HAD C-SECTION*
- *Are you having any vaginal bleeding (lochia)? If so, is it less than, equal to, or greater than your normal period?*
- *Dizzy? Fatigued? Lightheaded upon standing? Palpitations? Shortness of breath? (looking for s/s of anemia)*
- *Are you breast feeding?*
- *Are you having pain in your breasts? Are they engorged?*
- *What kind of birth control do you plan to use?*
- *Are you sore? Itching? Painful urination? Increased frequency? Blood in urine? (make sure to check before you see the patient if she had an episiotomy or if she still has a catheter)*
- *Headaches? Vision changes?*

- *On physical exam, extra things:*
  - *Feel for fundus of the uterus- and put on note: uterus is at the umbilicus, or how many centimeters below the umbilicus*
  - *Lochia (vaginal bleeding): Less than normal menses (Defer until you are with the resident)*
  - *Check for calf tenderness (DVT)*

### ***How do I manage a post-partum patient?***

- On C-section patients with pfannensteil incision (bikini cut), you can remove their bandage on POD#1 and remove staples on the day of discharge. Have someone show you how to do this. Apply benzoin and steri-strips. Counsel the patient that they may shower and use dove/dial antibacterial soap to clean it. It should heal within 2 weeks. They should keep it dry and clean. They may remove the steri-strips in the shower after 7 days.
- POD#1 orders for C-section patients (these will help you formulate a plan to present on rounds)
  1. Discontinue foley
  2. Activity: Ambulate TID with assistance; Patient may shower
  3. Diet: Advance as tolerated
  4. Heplock IV when tolerating po
  5. Discontinue IV/IM pain meds when tolerating po, then switch to po pain meds:
    - Percocet 5/325 mg 1 po q 4 hours prn pain level 1-5
    - Percocet 5/325 mg 2 po q 6 hours prn pain level 6-10
    - Motrin 800mg 1 po q 8 hours prn pain
    - MOM 30 ml po q 6 hours prn constipation
    - Mylicon 80mg po q 6 hours prn gas
    - May have Toradol 30 mg IV/IM q 6 hours prn pain (Max 4 doses)
- For 3<sup>rd</sup> and 4<sup>th</sup> degree tears we add:
  - Colace 100mg 1 po BID scheduled constipation
- If patient wants OCP's write prescription to start 6 weeks postpartum b/c increased risk of blood clots with estrogen component.
- If patient is breastfeeding, use micronor OCP's (6 weeks postpartum) or Depo provera (at discharge)- progesterone only.
- Please be on time for writing notes!
- Before entering the patient room, review type of delivery and hospital day. Go into the room and introduce yourself as a medical student. Ask if they had any problems overnight. Listen to their heart and lungs and abdomen. Check the fundus- it will be near or below the umbilicus (should be firm). Make sure breasts are not engorged.

### ***How do I present a patient on rounds?***

Patient presentations should be focused, in the format of an H&P and GOAL DIRECTED.

**HPI:** This is Postpartum/Post operative Day #1 for Ms. Jones who is s/p uncomplicated RLTCs/BTL (for h/o previous C/S\*2) or Spontaneous vaginal delivery. No complaints this AM. Endorses passing flatus. Tolerating regular diet vs. ice chips vs. clear liquids. Bottle-feeding. Ambulating without difficulty. Voiding independently vs. foley catheter in place.

**Vital Signs:** Tmax: 98.1 BP: 120-134/80-86 P: 78-94 R: 16 Uop (if catheter still in, prefer hourly output with > 30 cc/hr is adequate)

**Exam:** Gen-AO\*3; CV: RRR; Lungs: CTAB; Breast: Nontender/Non Engorged; Abd: Soft +BS; Incision: C/D/I (+staples or +steri-strips in place); Uterus: Firm/below the umbilicus; Lochia: moderate ; Ext: No clubbing/cyanosis/edema/calf tenderness.

**Labs:** Pre-delivery CBC and Postpartum CBC, Blood type, RPR, Rubella

**Assessment:** PP/postop day #1 for Ms Jones s/p RLTCs/BTL, doing well.

**Plan:** (Ask your intern for advice).

**Common post partum plans (vaginal delivery):**

- Continue PO pain control.
- Encourage ambulation.
- Encourage breast feeding.
- Anemia: Asymptomatic. Will discharge with PO iron.
- Contraception: Desires nexplanon placement.

**Common Post op plans (cesarean section):**

- Follow up post op CBC.
- Post op day 1 orders: Discontinue foley catheter. Advance diet as tolerated. Encourage ambulation.
- Encourage breast feeding.
- Contraception: \_\_\_\_\_.
- Disposition: Follow up in 1-2 weeks for incision check.

## TRIAGE

### *How do I evaluate a patient in triage/L&D?*

- Triage is our mini emergency room. OB triage is run by the intern and supervised by an upper level. Here we are trying to determine if the patient needs to be admitted or can go home.
- Follow the intern/resident initially to get oriented. If it is really busy, offer to start the H&P on the patient and then present to the intern/resident (see Triage H&P note). Do the physical exam but wait to do the vaginal exam with the intern/resident. **DO NOT write the following in your note:** chest pain (it may just be heartburn), SOB (most pregnant patients feel this way normally), weakness, dizziness or leg pain until you have spoken to the intern or resident first (this applies to all notes while on this rotation).

Helpful tips!



- **Important question for ALL obstetric patients (5 common questions):** vaginal bleeding? vaginal discharge? leakage of fluid? contractions- if so, how often? fetal movement?
- To learn cervical exams, grab a pair of gloves when the intern or resident checks the patient. It is best to teach you the cervical exam once the patient has an epidural.
- You can all help by trying to help gather supplies for the patient exam. Ask the resident/ intern or nurse for the location of the following:
  1. Culture swabs: Gonorrhea/Chlamydia culture, Group B strep culture
  2. Wet prep: Q-tips, slide, slide cover slip, and normal saline ampulle
  3. Sterile speculum
  4. Bed pan and chux pad
  5. Light

***What are the most common complaints presented at triage/L&D and how are they managed?***

1. **Rule out active labor in a full term patient (>37 wga):** This patient may only need a cervical check and monitoring to determine if they are in labor. If the cervical exam is 4cm dilated, they will likely get admitted.
  - a. **Specific questions to ask:** quality of pain, location, dysuria, nausea/vomiting?
2. **Rule out preterm labor (<37 weeks pregnant):** Most common cause is **infection**. This patient will need a cath UA, cultures and a wet prep- start collecting the supplies (as above). They may also perform a fetal fibronectin test.
  - a. **Specific questions to ask:** PTL in prior pregnancy, dysuria, substance abuse?
3. **Rule out rupture of membranes:** There are 3 test to confirm this: (1) pooling of fluid in vagina, (2) nitrazine test- test pH (amniotic fluid- blue), and (3) ferning test. You can help by collecting the supplies with an additional slide for the ferning test. If they are ruptured, they will be admitted.
  - a. **Specific questions to ask:** time of rupture, color of fluid, urinary incontinence, fevers, chills?
4. **Evaluation of elevated blood pressure:** The patient will need lab work (LFT's, CBC, CMP, LDH, Uric acid and UA (urine dip done first for protein)). We are working up the patient for pre-eclampsia. Check their DTR's on exam. This patient may require blood pressure management and magnesium sulfate for seizure prophylaxis. Read about this topic, eclampsia and HELLP syndrome!
  - a. **Specific questions to ask:** headache, vision changes, RUQ pain, shortness of breath, chest pain, h/o HTN or gestational hypertension, recent tobacco or drug use? Are they taking BP medications? If so, did they take them today?
5. **Evaluation of trauma in a pregnant patient:** This patient will need an US to rule out placenta previa and abruption, a speculum exam and monitoring for contractions as well as a CBC and type & screen.
  - a. **Specific questions to ask:** description of trauma, direct abdominal trauma, abuse, drug use?

6. **Evaluation of nausea and vomiting in pregnancy (rule out hyperemesis gravidarum):**  
Depending on the severity, the patient may need labs drawn- LFT's, CMP, Amylase, Lipase, UA (check for ketones), CBC- and will also have to tolerate p.o prior to discharge. Don't forget to consider other disorders of the GI tract: appendicitis, pancreatitis, hepatitis, cholecystitis, UTI, pyelonephritis or fatty liver of pregnancy.
  - a. **Specific questions to ask:** duration, abdominal pain, fever/chills, last time ate or drank something, weight loss.
  
7. **Evaluation of vaginal bleeding (rule out placenta previa/abruption):** Vaginal spotting is often caused by labor/PTL/ROM/ prior cervical exam/sex/STD. No matter what the cause, US will be done to evaluate for previa/abruption.
  - a. **Specific questions to ask:** onset, amount, last intercourse, trauma, prior C/S, drug or tobacco use, h/o prior abruption, Rh status, exam earlier that day?
  
8. **Decreased fetal movement:** The patient will get an NST and US for BPP if necessary. NST is a FHR tracing where we look for 2 accelerations of 15 beats above the baseline lasting for 15 seconds in 20 minutes- if so the baby is reactive (reassuring). A BPP is where we check the amniotic fluid index, the baby's tone, flexion/extension, breathing and NST. Each category gets 2 points and if 10/10, considered reassuring.
  - a. **Specific questions to ask:** accurate gestational age, trauma, contractions, bleeding?
  
9. **Fever:** The patient will need a cath UA to r/o pyelonephritis, CBC, and may need further workup depending on symptoms (CXR, etc.)

### ***How should I organize and write my note for a triage H&P?***

This format can be used for all H&P's in OBGYN.

**\*\*The hardest part of writing an H&P on an OB patient is to figure out how they are dated. Is it by LMP alone (no US), LMP consistent with an US (need documented US), or by US only and inconsistent with their LMP? Your intern/resident will help you to determine this. The patient usually does not know, but it will be in their chart if they have been seen in clinic or triage before.\*\***

Date/Time

**CC:** Contractions

**HPI:** 36 yo G3P2012 @ 39 6/7 WGA by LMP c/w 10 wk US presents with complaints of (Ctx, ROM, VB, decreased FM, dysuria, abd pain, trauma). Pt. denies vaginal bleeding, vaginal discharge, ROM, occ. ctx, positive fetal movement. Prenatal care with LSU (or other clinic).

**PMHx.** HTN/DM/Asthma (Any recent hospitalizations)? Any history of lung problems, heart problems, liver or kidney problems, or bleeding disorders?

**PSHx:** C/S? If gyn surgery, ask if it was laparoscopic or open, indication (especially in myomectomy)

**Meds:** PNV/Fe? Other meds, if so put dosage/frequency/etc.

**Allergies:** to meds? what reaction?

**POBHx:**

Year of delivery/NSVD or C-section or forceps (reason for c-section)/vacuum/weight/male or female/preterm or full term/complications/hospital  
(ex: 2003, 1LTCS for failure to progress, 6 lbs, Term, no complications)

**PGYNHx:** (1) Menarche/Time between cycles/Cycle duration

(2) Abnormal pap, if so when and did they ever have biopsies, cryotherapy (freezing) or surgery on their cervix (CKC/LEEP)? Were their follow-up pap smears normal?

(3) STD's, if so when and if treated? Make sure you name them all:

(GC/Chl/HIV/Herpes/Hepatitis/Trichomonas/Syphilis), LMP, sexual history

(ex: 12/28day/7days; no abnormal paps; h/o chlamydia this pregnancy- treated)

**SocHx:** Tob/EtOH/Drugs?

**FamHx:** health problems, birth defects, multiple births? Any family members with breast cancer, uterine cancer, ovarian cancer, or colon cancer? Age at diagnosis?

**Vital Signs:** pay attention to elevated BP

**Gen:** A&O x 3, NAD

**CV:** RRR (normal to hear flow murmur)

**Lungs:** CTAB

**Abd:** Gravid, NT, nl BS

**Ext:** No C/C/E (normal to have mild edema); DTR

**EFM** (external fetal monitor): baseline HR/accelerations?/decelerations?

**Toco:** ctx? if so, how frequent?

**Cvx:** Dilation/Effacement/Station (ex. 4/50%/0)

**Labs:** List all prenatal labs (Type & Screen, CBC, Sickle cell, HIV, Hep B, GC/Chl, Rubella, RPR, Group B strep, Urine culture, pap, O'Sullivan-1hr glucose)

**Ultrasound:** The intern/resident will do this. You can help fill out the report page.

**A/P:** 36yo G3P2012 with IUP @ 39 6/7 WGA with \_\_\_\_\_

You will formulate the plan with the intern/resident.

### ***How do I deliver a baby?***

1. Babies are coming out whether you are ready or not! Try to get dressed as fast as you can so that you can participate. Ask someone where to find boots, hat and mask with faceshield so that you aren't scrambling for it at the last minute (best to have these ready when the patient is ~ 8 cm).
2. Make sure that you put your sterile gloves and gown on the delivery table. Don't expect someone to get it for you.
3. Pick up the gown on the sterile field with your bare hands- the part of the gown that touches you is not sterile. Put your hands in the sleeves but not past the white cuffs. Pick up the right glove with our left hand (which is still covered by the gown), place the glove on the right hand. Now your right hand is sterile and you can put on the left glove. Have someone tie the back of your gown and help you turn. Now you're ready! (If this process is confusing, have someone go over it with you when nothing is going on.)
4. Place the bottom drape under the patient and leg drapes.
5. Place fingers at the head of the baby.
6. Instruct mom to push while contracting- i.e. be a cheerleader counting 1-10/breath 3 times during a contraction. Support the perineum with a raytek while the head crowns.

With your other hand, apply pressure so that the fetal head does not extend rapidly and cause trauma.

7. After the head delivers, the baby will reposition, meaning the head decides which way it will turn. Then check for a nuchal cord; if it is present the resident will help you maneuver accordingly.
8. Pancake the baby's head between your two hands. Once the head is out, continue with downward pressure to deliver the anterior shoulder.
9. Now deliver the posterior shoulder by elevating the head using both of your hands and lift upwards. The resident will be protecting the perineum as you do this. As the body delivers, use one hand to support the head and the other to guide the rest of the baby out.
10. Deliver the baby onto the mother's belly or your arm.
11. Congratulate the mom. Place two clamps on the cord and cut in between. You can let the father cut the cord.
12. You then collect cord blood by allowing blood to drain from the cord into a bucket.
13. Deliver the placenta by gentle traction downward on the cord with one hand and at the same time applying suprapubic pressure with the other hand. Continue to advance the clamp towards the perineum as you get more slack. Normal placental delivery can take up to 30 minutes. Don't pull too hard as you can avulse the cord or invert the uterus.
14. After the placenta is delivered, the resident or you will massage the uterus to ensure firmness and may sweep the uterus if necessary to remove clots.
15. The vagina/perineum is examined for tears and repaired by the resident if necessary. You can help by blotting or helping to provide exposure for the resident.
16. Next the patient is cleaned, the laps are counted and the sharps are disposed.

Common vaginal delivery pimp questions:

- What are the cardinal movements of labor?
- What are the patient's G\_P\_?
- What are the types of lacerations?
- What is the difference between occiput posterior/anterior and how can you tell?
- Etiology/definition of post partum hemorrhage.
- What are the signs of placental separation?
- Show me the maternal vs. fetal side of the placenta? How many umbilical arteries vs. veins are there? Which one goes to and away from the baby?

### ***What is my role as a student in a Cesarean section or tubal ligation procedure?***

A student scrubs in for C-section and tubal ligation. You will act as an assistant- help hold bladder blade and if you have practiced, help sew the skin. Just like with general surgery, have suture scissors in your hand when the resident is tying knots.

Common cesarean section pimp questions:

- What are layers of the abdominal wall?
- Blood supply to uterus?
- Be able to identify the round ligament vs. fallopian tube.

- Blood supply to abdominal wall.

## GYNECOLOGY/GYN ONCOLOGY

### *What should I do to prepare for a GYN surgery?*

- The day before surgery, talk to your resident about what cases are going to occur.
- Divide the surgeries between the students (1 surgery per student), and when you go home that night, learn your patient's history and recent labs (know H/H) (will be on the OR schedule)
- Learn what surgery you will be scrubbing in on. Review techniques and review anatomy (they always pimp on anatomy)
- If your surgery is first, pre-op the patient. Always introduce yourself to your patient prior to the surgery. 1 student there at a time (for your surgery) – usually the other students can study during the other surgeries.
- After your surgery, text the other student for next operation and they will come down and pre-op
- In the OR:
  - Know the residents' and staff glove size
    - Have the gloves pulled before they come to the OR
  - Help the residents set up the bed.
  - After helping set up, be the first to scrub unless told not to, they don't want to wait for the student to finish scrubbing so they can scrub.
  - Know everything about your patient
  - After the surgery, help with clean-up, always follow your patient into the recovery room.
- Certain days are assigned for reading time. Make sure to tell your residents you have assigned reading time that day. They don't know your schedule, so they may tell you to go to clinic after surgeries. Just inform them you have scheduled study hours and it shouldn't be a problem.



### *How do I manage a Gynecology/Gynecology Oncology patient?*

- These patients are much like C-section day #1 patients. Write the same orders on post op day #1 (in uncomplicated cases).
- Take off the bandage on POD#1 and take out staples on pfannensteil incisions (bikini) on POD#3.
- Be sure to ask all abdominal surgery patients about flatus and bowel movements daily.
- Read the patient's H&P and know this info as well as the indication for the surgery. Check the order section each time you open the chart to see if something new has been ordered and needs to be followed up.
- Write a PM note daily unless the resident has already written one.
- Reasons patients are admitted are s/p gyn surgeries, for anemia with menorrhagia to receive blood transfusion (will have CBC 6 hours after transfusion), r/o ectopic pregnancy, missed abortions for cytotec treatment and possible D&C, PID or TOA's, etc.

- When the patient is put to sleep in the OR, you should put on a pair of gloves and help position the patient. Then change your gloves and get ready to examine the patient under anesthesia. When the surgery is over, put on gloves again to help move the patient. Get patient stickers for the residents. The resident will fill out the operative report. You can help write orders and prescription (for those going home). Keep prescriptions on you at all times!

### ***How should I organize and write my post-op GYN note?***

#### **L3 Gyn Note (Post-op note)**

34yo G2P2 with uterine fibroids s/p TAH/BSO/Cysto POD#1. Pain relief adequate, no complaints, no flatus, no BM, tolerating ice chips, no ambulation yet. No N/V.

VS: Tmax Tcurrent BP P RR Urine output

Gen: A&Ox 3, NAD

CV: RRR

Lung: CTAB

Abd: Soft, NTND +BS (BS very important in post-op patient)

Incision: C/D/I (clean/dry/intact)- pull off bandage on POD#1

Ext: No C/C/E, No calf tenderness, SCD's in place

GU: Foley to gravity with clear urine

Labs: Pre-op CBC and Post-op CBC

A/P: 34yo G2P2 s/p TAH/BSO/Cysto POD#1- Doing well

1. Advance to POD#1 orders- good urine output
2. Encourage ambulation and incentive spirometry.

### ***What do routine post-op orders (Day #1) look like?***

#### **Routine Post op Day #1 Orders (for use after C/S, hysterectomy, major operations):**

1. Discontinue Foley
2. Activity: Ambulate TID with assistance; Patient may Shower
3. Diet: Advance as tolerated
4. Heplock IV when tolerating PO
5. Discontinue IV/IM pain meds when tolerating PO, then switch to PO pain meds:
  - Lortab 7.5/500mg 1 PO every 4 to 6hrs prn pain
  - Lortab 7.5/500mg 2 PO every 4 to 6hrs prn pain
  - \*\*also can use Percocet 5/325mg
  - Motrin 800mg 1 PO every 8hrs prn pain
  - MOM 30ml PO every 6hrs prn constipation
  - Mylicon 80mg PO every 6hrs prn gas
  - May have Toradol 30mg IV/IM every 6hrs prn pain (Max 4doses)
6. IS to bedside use 10x/hour while awake

### ***What are the most common causes of post-operative fever?***

Fever is defined as an increase in temperature  $\geq 100.4$  on 2 occasions at least 4hrs apart, excluding the 1<sup>st</sup> 24hrs OR temperature  $> 101.5$ .

-If a patient has a fever, the most likely cause is determined by the postoperative day (POD). Remember the **7W's: Wind, Water, Womb, Wound, Walking, Wonder Drugs, and Watermelons (Breast)** — useful tools when following post-op patients (i.e. C-section or Gyn surgery)

POD 1-2: **Wind (Atelectasis):** often causes fever secondary to inadequate deep breathing after surgery and incisional pain on deep breathing. Treated with Incentive Spirometry b/c deep breathing prevents atelectasis.

POD 3-5: **Water (Urinary tract infections):** secondary to Foley catheters.

**Womb (Uterus):** secondary to endometritis. Predisposing factors: C/S, prolonged labor, PROM, Chorio, Internal Monitors, Multiple vaginal exams, meconium, manual placenta extraction, anemia, poor nutrition.

**Watermelons (Breast):** Always check breasts during each exam. Keep breasts bound if not breast feeding.

POD 4-6: **Walking (Deep Venous Thrombosis):** due to venous stasis. Venous compression devices or low dose heparin reduce the incidence of venous thromboembolism. Early ambulation of the patient on POD#1 is the best way to prevent this complication.

POD 5-7: **Wound:** Most wound infections occur during this period, especially in obese patients. Preoperative antibiotics are important to prevent or reduce the risk of infection.

POD 7: **Wonder Drugs:** If all other sources of fever are ruled out after careful physical exam and laboratory evaluation. Check the meds that the patient is taking. Also, look at the temperature chart for characteristic spiking pattern. (CBC may show elevated eosinophils)

# CLINIC

*New Orleans Students: 5<sup>th</sup> floor of UMCNO, Area C  
Clinic starts at 8:00*

## **What is my role as a student in clinic?**

- You will see patients and present to your staff. DON'T CHART SHOP!! (pick up the first chart in the stack, don't go through the charts and pick one that interests you...they notice that and hate it!)
  - Always get a full history- but do it quickly!
- Follow a resident in clinic until you feel more comfortable seeing patients alone. But keep in mind that your initiative is noticed and appreciated by everyone on the team. Dive in, grab charts, and see patients without being asked. Don't expect someone to babysit you while you are at clinic! The more you put in, the more you will get out of your experience. Ask questions if you don't understand something, volunteer to grab prescriptions or paperwork off the printers, run them to patients, and go the extra mile.
- You can work up a patient: write the H&P and also do the physical exam except the pelvic and breast exam. You will need a chaperone for these exams.
- Hopefully after watching a pap smear the first couple of times, your resident will motion for you to perform one. Review how to hold the speculum and how to remove it to minimize discomfort for the patient. Ask your resident before entering a room if it would be okay for you to perform the speculum exam. Your interest and engagement matter, even if you are not looking for a career in OBGYN!
- OB Visit:
  - Questions to ask
    - Are you having any contractions?
    - Vaginal bleeding?
    - Leakage of fluid?
    - Fetal movements? (will be felt generally after ~ 18 weeks)
    - RUQ pain, headache, vision changes (s/s of pre-eclampsia)?
  - On physical, do fetal heart tones, and measure fundal height
  - Print out a chart of the labs/vaccinations/screening tests needed during each trimester visit (good one in blueprints) and carry it in your pocket
  - Jot down the patient's pertinent prenatal lab values/test results and make note of any testing they will need at the current visit in your plan for the patient.
  - In your assessment/plan, don't forget about important health maintenance items in addition to routine prenatal care. Mention things like recent abnormal pap smears, when their next pap is due, any abnormal labs and how to follow/treat them, postpartum birth control methods, and if they plan to breast or bottle feed.
  - Some people still use the pregnancy wheel - they have numerous apps for iPhone that calculate gestational age for you!



Helpful tips!



Helpful tips!



- GYN visit:
  - Investigate the patient's chief complaint similar to how you would in medicine (DOCCLARAPPP or OLDCARTS). If it is an annual well-woman exam, ask the patient if she has any recent concerns or questions for the doctor since she was last seen
  - If it is a repeat patient or annual exam, ask if there have been any new changes to her medical history, any recent hospitalizations or surgeries, and review her medication list
  - But always ask: Last menstrual period and methods of birth control

**What should I include in my prenatal clinic note?**

1. Locate the patient's chart in Epic (if at UMC clinic) and find the note from the patient's last visit to determine the Gs/Ps as well as gestational age. You can also read the last note to find out about the patient's specific issues or problems which will guide you in your interview and help to focus and streamline your assessment and presentation to interns/residents/staff. Then enter the room, introduce yourself and start your H&P.
2. Use the sample note below as a guide. The patient only needs a full H&P on the initial OB visit.
3. Labs: Know what we need at each visit.

**Table 4-3 Clinical Components of Routine Prenatal Care Visits**

	1st visit	15-20 week	24-28 week	29-41 week
Complete H&P	✓			
BP	✓	✓	✓	✓
Weight	✓	✓	✓	✓
Palpation/ovine exam	1st and any other visits if having contractions, bleeding, discharge, leaking, or at term			
Fundal Height	✓	✓	✓	✓
FHT	✓	✓	✓	✓
HR	✓	✓	✓	✓
Blood type & Rh	✓			
Antibody screen	✓			
Flag	✓			
Glucose screen			✓	
Lipid panel screen		✓		
Cystic fibrosis	✓			
TB screening	✓			
Urinalysis	✓	✓	✓	✓
Chlamydia culture	✓			
Gonorrhea test	✓			
Syphilis test	✓			✓
Genital culture	✓			✓
Chlamydia culture	✓			✓
HIV	✓			✓
CMV			✓	✓
Group B Strep				✓

*Handwritten note: Tdap 26-37 week*

\* Routine ultrasound is done at 18-20 weeks for fetal anatomy survey. For high risk pregnancy or unsure LMP, early US is recommended to accurately determine the gestational age.  
 \* Routine fetal movement counting is not recommended.  
 \* We need to judge fetal presentation before 36 weeks due to breeches and placenta.

4. Prenatal patients only need cervical checks at their initial visit and if they c/o pain or contractions and every visit from 37 weeks until delivery.

### **Sample Prenatal Note**

21 yo G3P2002 at 30 6/7 WGA by LMP c/w 12 wk US for OB visit. Pt. without complaints. +FM, no LOF, no VB, no Ctx.

VS: BP HR

Urine dipstick results- Protein/Glucose/Nitrite

FH (fundal height)- use tape measure (i.e. 30cm)

FHT- (fetal heart tones)- use Doppler (i.e. 140's)

A/P: 21 yo G3P2002 at 30 6/7 WGA by LMP c/w 12 wk US.

1. S = D (size equals dates)
2. Note anything from problem list and how it is being managed (i.e. GDM, CHTN)
3. h/o C/S x 2 for repeat C/S
4. Continue PNV and iron
5. Kick counts/ PTL or Labor precautions (the nurses will give patient instruction sheets).
6. Collected all prenatal labs today.
7. Given Flu Shot (or other indicated vaccinations).
8. RTC in \_\_\_ weeks (<28 WGA: 4 week appt., 28-37 WGA: 2 week appt., >37 WGA: 1 week appt till delivery)

### ***What should I include in my GYN clinic note?***

1. Read the nurses assessment at the top of the page. Then enter the room, introduce yourself and start your H&P.
2. Use the guide below to help you structure your interview/note. The best thing you can do to cull your history-taking skills is to practice asking questions in the order you want to present them (see below). While you will not be writing a note that will enter into the Epic/Soarian system or any legal documentation, it's great practice to write a note on every patient you see – it will allow you to organize your thoughts and sift through the information so that only the pertinent stuff is included in your presentation. Being able to write a quick and detailed note is a very important skill! Then read your note while you present – don't leave anything out.
3. Be sure to review Health Maintenance- pap smears, breast self awareness, mammograms, colonoscopy, fecal occult blood, calcium/Vit D supplementation, immunizations.
4. Many appointments are for annual exams- get these charts! You are able to do everything on these patients. Get a resident to help with your first few exams until you are comfortable.
5. For menstrual period complaints make sure you ask if they are regular or irregular, how many pads per day, how many days of bleeding, hormonal therapy use, any medicines used and if they worked. Any patient over 35 with menometrorrhagia (heavy periods and bleeding between periods) will likely require an EMB (endometrial biopsy) to rule out pathologic source. Always look to see if the patient has had an **ultrasound**, and what their **h/h** is most recently.

6. Ask about any new sexual partners since last visit, contraception (and history of contraceptive use including any adverse reactions or reasons for stopping), inquire about any desire for STI testing, or discuss future fertility plans if patient indicates she is planning on getting pregnant

#### **GYN H&P/Note Outline:**

- Chief Complaint
- History of Present Illness
- OB History → Number of pregnancies including miscarriages/abortions, when the baby was delivered, term/preterm, vaginal vs. C-section, and any pregnancy complications/infections/NICU stay
- GYN History → Age at menarche, regular periods, Last Pap smear, history of abnormal Pap, history of ovarian cysts, fibroids, or STIs (it helps to list them)
- Past Medical History → Including Hypertension, Diabetes, heart, lung, liver, kidney, or bleeding problems
- Past Surgical History → It is important to find out when and where any surgeries were done
- Medications
- Allergies
- Family History → HTN, DM, bleeding disorders, history of birth defects, history of breast, uterine, ovarian, or colon cancers
- Social History → EtOH, Tobacco products, illicit substances (“Or any other drugs that aren’t prescribed to you?” – keeps it judgment free)
- Vital signs, Physical Exam (see above)
- Assessment, Plan

## **PRECEPTOR**

### ***What should I expect from my Preceptor experience?***

- It is important to get in touch with your preceptor early in the rotation (DAY ONE OR TWO) to figure out what their schedule is like and how often you will meet them in their private clinic.
- Go in with an open mind. Each attending is different and will have different expectations. Once you have introduced yourself and feel comfortable with your preceptor, it is completely reasonable to politely ask them what expectations they have for you while on rotation. Will you be seeing your own patients and presenting, or will it be more like shadowing? Some of the clinics are very busy and you may not necessarily see patients independently every time.
- This experience is meant to show you the “private” side of OBGYN. Keep in mind that these patients are your preceptor’s private patients. They are not universally receptive to students being involved in their care. That being said, OBGYN clinic is a lot of fun and can be very gratifying with good doctor-patient relationships, and there will be some patients that enjoy and appreciate the fact that you are learning.
- **Preceptor is a great time to do a witnessed H&P.**
- Don’t be afraid to ask for feedback!



- Don't necessarily wait for the mid-course evaluation. If you ask early on, you have more time to make changes and benefit from your preceptor's guidance
- Being able to accept constructive criticism is a huge part of being a medical student (or resident or physician), and the more comfortable you are with receiving criticism, the better you will incorporate the advice of others and the better you will become as a student and future clinician

Ask lots of questions! OBGYN is a fun specialty with surgical to primary care experiences for all interests!

## LSUHSC Student's Guide to Pelvic Exam (rev. 1/2017 modified from APGO)

- Introduced himself/herself to the patient
- Verbalized to patient that she is in control and to openly express any discomfort
- Appeared relaxed and comfortable during the entire exam
- Performed exam with reasonable speed, using smooth, comfortable, gentle movements
- Used good verbal and non-verbal communications skills. Did not "talk down to patient", did not mumble, and did not avoid eye contact. In this process, conveyed respect for patient (did not use sexist, intimate, or suggestive terms.)
- During exam, was attentive to patient's need for comfort (moved pillow down, footrest placement, use of drape for patient modesty). Assessed if patient was comfortable regarding drapes, positioning, foot rest positioning, etc.

### Breast Exam

- While the patient is sitting up, inspected breasts with her 1) arms to the side, 2) arms raised, and 3) hands pressed to the hips.
- Placed the patient in supine position with one arm raised over her head & palpated all breast tissue including areola, tail of Spence, and axillary areas. This was performed bilaterally.
- (if history warrants) Assessed for nipple discharge.
- Asked patient if she practices self-breast awareness or examinations and, if necessary, the student provided instruction.

### External Genitalia exam

- Explained that the pelvic exam is next
- Attended to comfort of patient at the end of the table when beginning exam (assisting with pillow, helped patient into position on table, etc)
- Put on gloves, being careful not to touch anything except patient -including light source once the patient is touched
- Inspected the external genitalia
- Inspected clitoris, urethra/meatus
- (if history warrants) Checked hair distribution
- (if history warrants) Checked for cystourethrocele/rectocele
- Inspected perineum/anus

### **Speculum exam**

- Explained that speculum exam is next
- (if needed) Demonstrated speculum
- Gently separated the lower labia to allow insertion of speculum
- Inserted speculum correctly
  - a) plates closed
  - b) oblique position
  - c) downward pressure
  - d) open plates using thumb for control
  - e) lock plates
- Localized cervix with reasonable speed & inspected cervix
- Verbally described performing ectocervical pap smear (collect cells) and endocervical brush
- Unlocked speculum before removal while maintaining blades open until cervix is outside of blades (to avoid “pinched cervix”)
- Visualized vaginal walls while removing speculum
- During removal of speculum, kept blades partially closed & applied slight pressure posteriorly
- Allowed speculum to close completely as it was withdrawn and withdrew speculum smoothly without causing discomfort

### **Bimanual Exam**

- Succinctly explained procedure
- Used lubricant
- Inserted middle and forefinger into vagina using downward pressure & gently supinated
- Palpated cervix
- Palpated uterus & noted position (anteverted, retroverted, midplane), size & mobility
- Palpated right and left ovaries
- (if indicated) Performed rectal/ recto-vaginal exam
- Palpated for inguinal lymphadenopathy
- Verbalized entire exam to patient
- Completed exam with a closing statement
- Directed the patient to slide up first then sit up