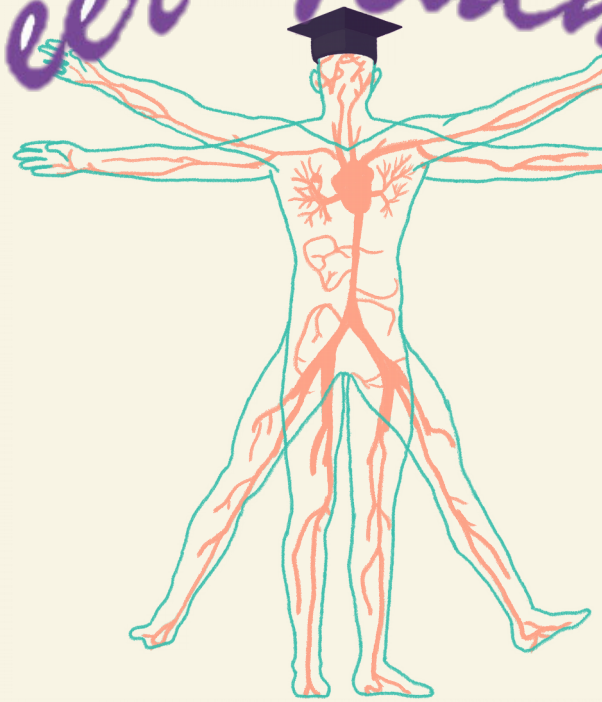
Peer Teaching



Society

2023/2024

Obstetrics & Gynaecology

Phase 3A Revision Session

Emily Finbow

16/11/2023 : 6pm

Aims and Objectives

- Case-based approach, range of o&g presentations
- Practice MCQs + SAQs

…it is impossible to cover all of o&g in one evening, I have picked a few areas!

Pre-Warnings

* For the purpose of this session, the words ‘women’ and ‘female’ will be used to describe people who are assigned female at birth / have female reproductive organs *

The topics I have picked should not be too triggering or sensitive but miscarriage / abortion / stillbirth / fertility problems may be discussed

Obstetrics and gynaecology

Presentations
Abdominal distension
Abdominal mass
Abnormal cervical smear result
Abnormal urinalysis
Acute abdominal pain
Acute and chronic pain management
Amenorrhoea
Bleeding antepartum
Bleeding postpartum
Breast tenderness/pain
Breathlessness
Chest pain
Complications of labour
Contraception request/advice
Difficulty with breast feeding
Fits/seizures
Headache
Hypertension
Hyperemesis
Intrauterine death
Jaundice
Labour
Loss of libido
Menopausal problems
Menstrual problems
Mental health problems in pregnancy or postpartum
Nipple discharge
Normal pregnancy and antenatal care
Painful sexual intercourse
Painful swollen leg
Pelvic mass
Pelvic pain
Pregnancy risk assessment
Pruritus
Reduced/change in fetal movements
Shock
Small for gestational age/ large for gestational age
Subfertility
Substance misuse
Unwanted pregnancy and termination
Urethral discharge and genital ulcers/warts
Urinary incontinence
Urinary symptoms
Vaginal discharge

Conditions
Anaemia
Atrophic vaginitis
Bacterial vaginosis
Cervical cancer
Cervical screening (HPV)
Chlamydia
Cord prolapse
Depression
Diabetes in pregnancy (gestational and pre-existing)
Ectopic pregnancy
Endometrial cancer
Endometriosis
Epilepsy
Essential or secondary hypertension
Fibroids
Gonorrhoea
Menopause
Obesity and pregnancy
Ovarian cancer
Pelvic inflammatory disease
Placenta praevia
Placental abruption
Postpartum haemorrhage
Pre-eclampsia, gestational hypertension
Sepsis
Substance use disorder
Syphilis
Termination of pregnancy
Trichomonas vaginalis
Urinary incontinence
Urinary tract infection
Varicella zoster
Vasa praevia
VTE in pregnancy and puerperium

https://www.gmc-uk.org/-/media/documents/mla-content-map-_pdf-85707770.pdf : pg 33

Today's Plan:

1. Acute abdo pain / pelvic pain
2. Cervical cancer + screening
3. Menopause
4. Hyperemesis
5. Bleeding antepartum
6. Cord prolapse

CASE 1: ACUTE PELVIC PAIN

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A 34-year-old woman presents with sudden-onset right lower abdominal pain and vomiting. She has a history of pelvic inflammatory disease (PID) treated three months ago. On examination, there is tenderness in the right lower quadrant, and pelvic ultrasound reveals an enlarged, oedematous right ovary.

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What is the most likely cause of her symptoms?

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B. Ovarian torsion
C. Tubo-ovarian abscess
D. Ruptured ovarian cyst
E. Mittelschmerz

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Sudden onset pain, history of PID + USS findings (+ lack of indication of pregnancy) is most indicative of ovarian torsion

Inflammation from PID can lead to adhesions + increased susceptibility to ovarian torsion

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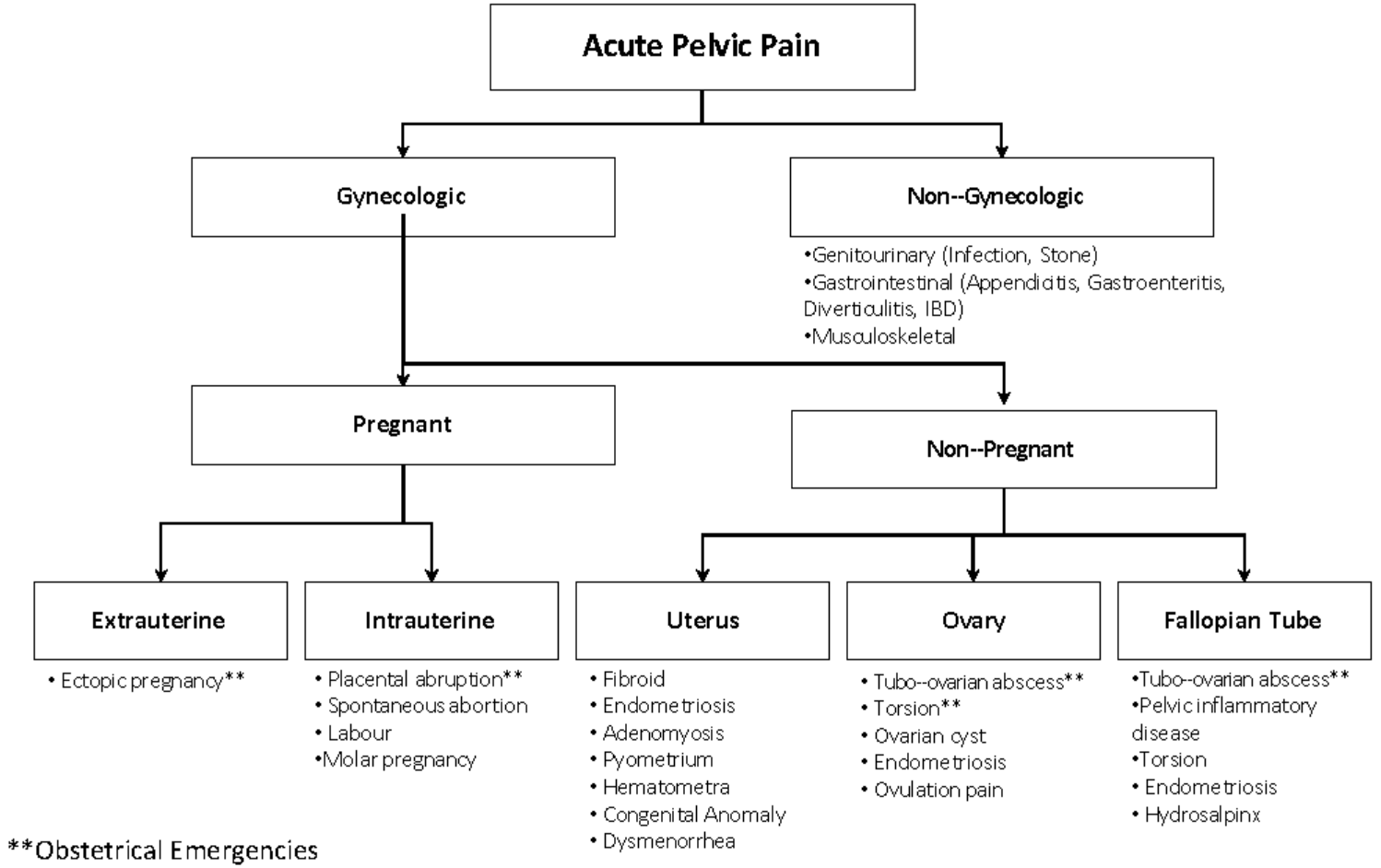
Ectopic pregnancy less likely in absence of pregnancy symptoms + recent history of PID

Tubo-ovarian abscess may present with pelvic pain, also often fever

Ruptured ovarian cyst would also present similarly, but USS findings more suggestive of torsion

Mittelschmerz (ovulation pain) is unlikely to present this acutely, nor show these USS findings

Acute Pelvic Pain



https://blackbook.ucalgary.ca/schemes/obstetrical-gynecological/acute-pelvic-pain/

CASE 2: CERVICAL CANCER + SCREENING

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Shannon, a 25 year old female has just attended her first cervical smear.

What is the aim of the cervical cancer screening programme? (2 marks)

How regularly are routine smears conducted? (2 marks)

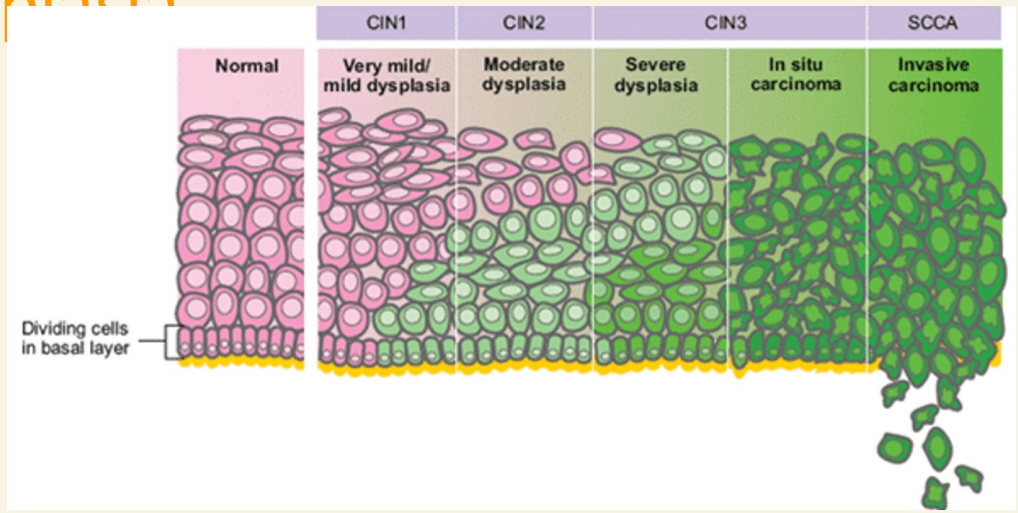
CASE 2: CERVICAL CANCER + SCREENING

Shannon, a 25 year old female has just attended her first cervical smear.

What is the aim of the cervical cancer screening programme? (2 marks)

Screen for HPV + abnormal cells indicative of pre-invasive (dyskaryosis) disease 'cervical intraepithelial neoplasia'

(NOT detecting cervical cancer)



CASE 2: CERVICAL CANCER + SCREENING

Shannon, a 25 year old female has just attended her first cervical smear.

How regularly are routine smears conducted? (2 marks)

Every 3 years in 25-49 year olds AND every 5 years in 50-64 year olds

CASE 2: CERVICAL CANCER + SCREENING

Shannon's results are available: **HPV detected, cytology normal.**

How should she be managed? (1 mark)

Aside from HPV, list 3 risk factors for the development of cervical cancer (3 marks)

Name one concerning finding on cervical examination that could suggest malignancy (1 mark)

CASE 2: CERVICAL CANCER + SCREENING

Shannon's results are available: **HPV detected, cytology normal.**

How should she be managed? (1 mark)

She should have a repeat screen at 12 months

CASE 2: CERVICAL CANCER + SCREENING

Aside from HPV, list 3 risk factors for the development of cervical cancer (3 marks)

Multiple sexual partners / younger age at first intercourse / non-attendance at smears / immunosuppression / oral contraceptives / higher parity / tobacco use / deprivation

CASE 2: CERVICAL CANCER + SCREENING

Name one concerning finding on cervical examination that could suggest malignancy (1 mark)

Ulceration

Visible mass

Inflammation

Bleeding

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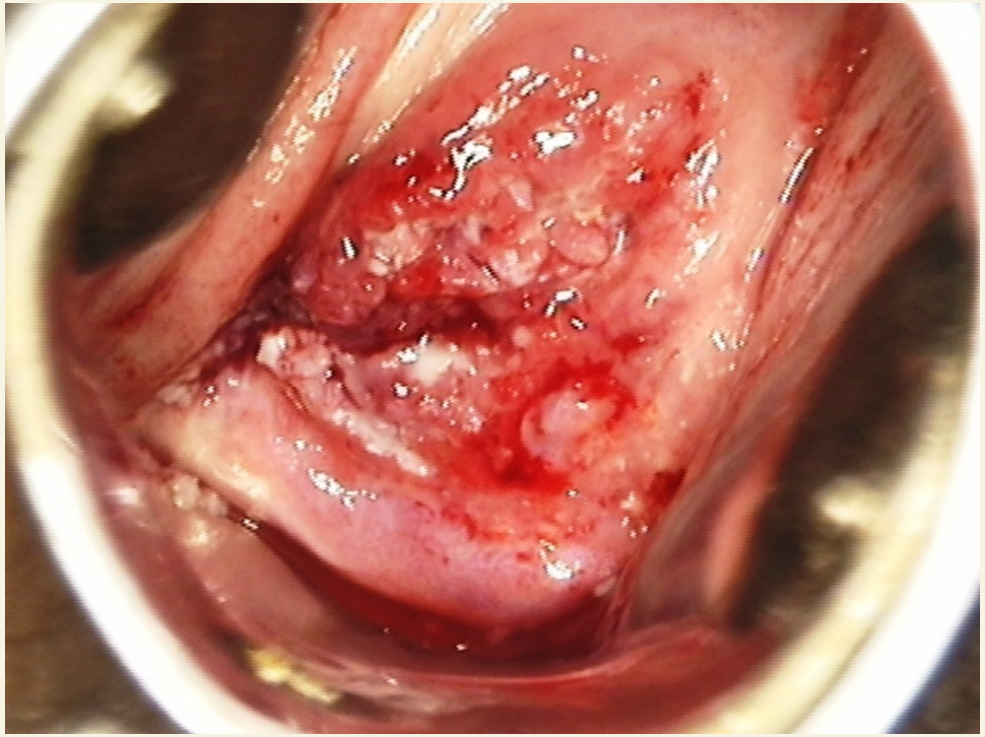

CASE 3: MENOPAUSE

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Sarah has come for a review with her GP regarding the menopause

What is the normal age range for menopause? (1 mark)

Name 2 common menopausal symptoms (2 marks)

When prescribing HRT, what is an important question to ask? (1 mark)

CASE 3: MENOPAUSE

Sarah has come for a review with her GP regarding menopausal symptoms

What is the normal age range for menopause? (1 mark)

Menopause usually occurs between 45 + 55 years of age, average = 51

(before this ‘early menopause’ or even POI)

CASE 3: MENOPAUSE

Sarah has come for a review with her GP regarding menopausal symptoms

Name 2 common menopausal symptoms (2 marks)

Vasomotor symptoms: hot flushes or night sweats / disturbed sleep or insomnia / low energy levels / low mood or anxiety / low libido / impaired memory or concentration or brain fog / joint aches / headaches / palpitations / vaginal dryness / urinary symptoms

CASE 3: MENOPAUSE

Sarah has come for a review with her GP regarding menopausal symptoms

When prescribing HRT, what is an important question to ask? (1 mark)

If she has a uterus / if she has had a hysterectomy

CASE 3: MENOPAUSE

Sarah is 49 and has been experiencing hot flushes, ‘brain fog’ and disturbed sleep. She had 2 children by Caesarean section over 2 decades ago. Other than this she has no PMH of note and takes no regular medication. Her BMI is 32. Her LMP was 13 months ago.

What should be prescribed? (3 marks)

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Hormone replacement therapy:

Oestrogen AND continuous combined progestogen (2 marks)

Transdermal (1 mark)

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Regimens	
Estrogen only	• Hysterectomised patients
Estrogen and progestogen	• If uterus is present
• Sequential/cyclical preparations	• Perimenopausal women
• Continuous combined	• Post menopausal women
• 3 monthly bleeds	• Perimenopausal women
Tibolone	

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03-BMS-TfC-HRT-Practical-Prescribing-02A-MAY2022.pdf (thebms.org.uk)

CASE 3: MENOPAUSE

Sarah has now been on HRT for 9 months and most of her previous symptoms have settled. Her only symptom currently is vaginal dryness, which is making intercourse difficult and painful.

How should her current treatment be amended? (2 marks)

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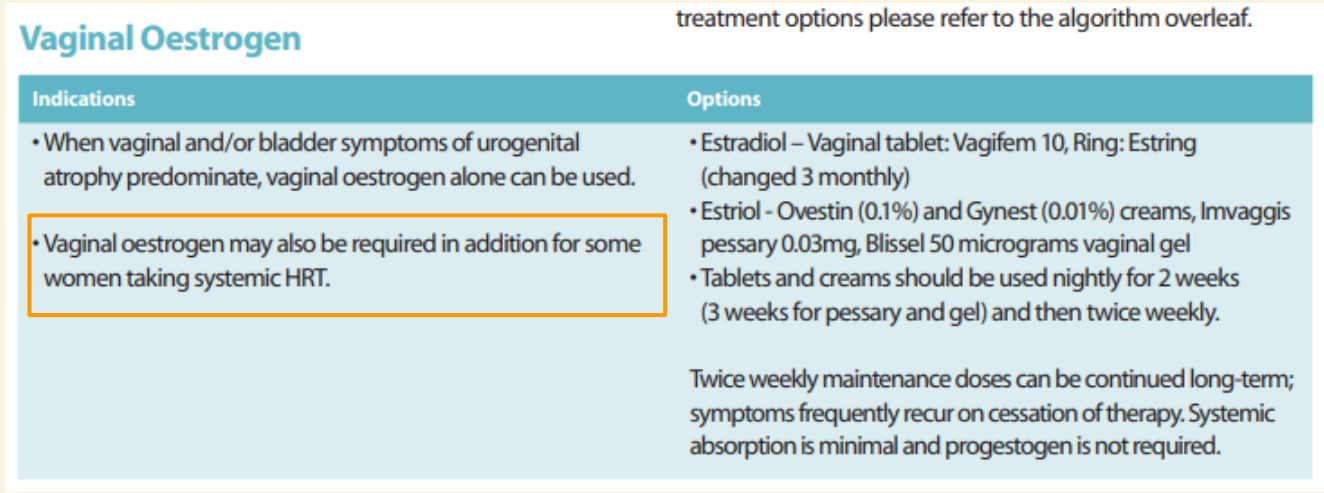
Sarah has now been on HRT for 9 months and most of her previous symptoms have settled. Her only symptom currently is vaginal dryness, which is making intercourse difficult and painful.

How should her current treatment be amended? (2 marks)

She can stay on current regimen (1 mark)

Add vaginal oestrogen (1 mark)



treatment options please refer to the algorithm overleaf.

Vaginal Oestrogen

Indications	Options
• When vaginal and/or bladder symptoms of urogenital atrophy predominate, vaginal oestrogen alone can be used.	• Estradiol – Vaginal tablet: Vagifem 10, Ring: Estring (changed 3 monthly) • Estriol - Ovestin (0.1%) and Gynest (0.01%) creams, Imvaggis pessary 0.03mg, Blissel 50 micrograms vaginal gel • Tablets and creams should be used nightly for 2 weeks (3 weeks for pessary and gel) and then twice weekly.
• Vaginal oestrogen may also be required in addition for some women taking systemic HRT.	Twice weekly maintenance doses can be continued long-term; symptoms frequently recur on cessation of therapy. Systemic absorption is minimal and progestogen is not required.

04-BMS-TfC-HRT-Guide-NOV2022-A.pdf (thebms.org.uk)

CASE 4: HYPEREMESIS

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Hayley is currently 9 weeks pregnant and is fed up because she has been experiencing daily nausea and vomiting for over a month now. At her last GP appointment for this she was given lifestyle advice and has made appropriate changes to her diet, to no relief.

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What is the most appropriate next step in management?

A. Tell her to increase ginger products in her diet
B. Prescribe ondansetron
C. Admission for IV fluids
D. Prescribe promethazine
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In mild-moderate N+V, lifestyle advice + diet modification should be offered first: ginger can be helpful

As this was not sufficient in controlling symptoms, medication is appropriate:

1st line: cyclizine or promethazine

2nd line: metoclopramide / ondansetron / domperidone

There is no indication of severe symptoms, dehydration or electrolyte abnormalities so admission to hospital is not necessary (yet)

- If oral antiemetics fail (first + second line) admission should be considered

CASE 5: ANTEPARTUM HAEMORRHAGE

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Betty is a 42 year old lady, who is 32 weeks pregnant with her second child. She is transported by ambulance in severe constant 9/10 abdominal pain, which came on suddenly, and heavy PV bleeding, for the last 25 minutes.

O/E her uterus is tense + tender

HR 132 bpm BP is 98/62

There is evidence of fetal distress on CTG monitoring.

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There is evidence of fetal distress on CTG monitoring.

What is the most likely diagnosis? (1 mark)

Name 2 risk factors for this condition (2 marks)

What would your top differential be if Betty was not experiencing any pain? (1 mark)

What immediate management does she require? (3 marks)

What is the definitive management (1 mark)

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What is the most likely diagnosis? (1 mark)

Placental abruption

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There is evidence of fetal distress on CTG monitoring.

Name 2 risk factors for this condition (2 marks)

Placental abruption in previous pregnancy (**)
Pre-eclampsia + other hypertensive disorders
Abnormal lie of baby eg transverse
Polyhydramnios
Abdominal trauma

Smoking
Cocaine use
Bleeding in first trimester
Underlying thrombophilias
Multiple pregnancy

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Placenta praevia

(Vasa praevia after ROM)

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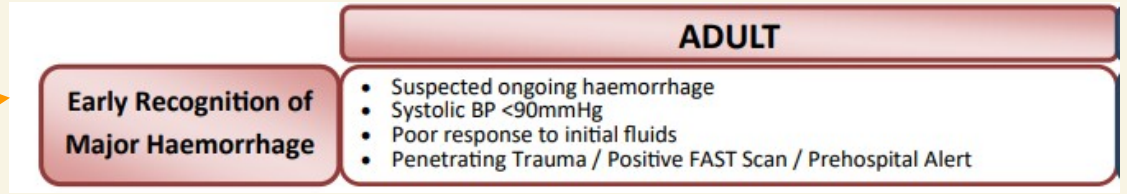
There is evidence of fetal distress on CTG monitoring.

What immediate management does she require? (3 marks)

Get senior help / 2222
A:Protect airway (may lose it with reduced levels of consciousness)
B: 15L of 100% oxygen through a non-rebreathe mask
C: Insert two large bore (14G) cannulas
Take bloods: group + save, FBC, clotting screen, U&E, LFT
Activate major haemorrhage protocol(?)
Give warmed fluids
Consider TXA
D: Monitor patient's GCS



(group O RhD negative blood)

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There is evidence of fetal distress on CTG monitoring.

What is the definitive management (1 mark)

Emergency Caesarean Section

(+ uterine repair or hysterectomy)

CASE 6: CORD PROLAPSE

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A 30-year-old woman, G2P1, at 38 weeks gestation, presents with a visible protrusion felt at the vaginal introitus. On examination, the umbilical cord is confirmed to have prolapsed beyond the presenting fetal part. Fetal heart rate monitoring reveals signs of distress.

CASE 6: CORD PROLAPSE

A 30-year-old woman, G2P1, at 38 weeks gestation, presents with a visible protrusion felt at the vaginal introitus. On examination, the umbilical cord is confirmed to have prolapsed beyond the presenting fetal part. Fetal heart rate monitoring reveals signs of distress.

What is the difference between occult and overt cord prolapse? (2 marks)
List 2 risk factors for the development of this condition (2 marks)
What position should she be moved into and why? (2 marks)
Under what circumstance would she be given terbutaline? (2 marks)

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Overt = complete: cord descends past presenting part + is lower than the presenting part

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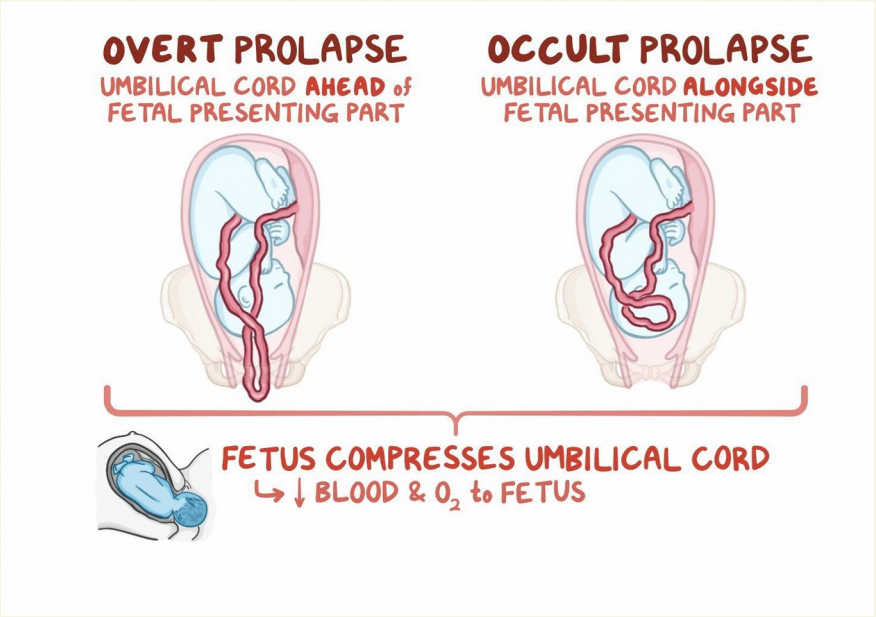

CASE 6: CORD PROLAPSE

A 30-year-old woman, G2P1, at 38 weeks gestation, presents with sudden-onset intense abdominal pain and a visible protrusion felt at the vaginal introitus. On examination, the umbilical cord is confirmed to have prolapsed beyond the presenting fetal part. Fetal heart rate monitoring reveals signs of distress.

List 2 risk factors for the development of this condition (2 marks)

Breech presentation / unstable lie / artificial rupture of membranes / polyhydramnios / prematurity

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What position should she be moved into and why? (2 marks)

Left lateral position (head down + pillow under left hip / knee to chest) = 1 mark

To relieve pressure off the cord from the presenting part = 1 mark

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Under what circumstance would she be given terbutaline? (2 marks)

If delivery/ theatre not imminently available = 2 marks

(terbutaline = tocolytic, will relax uterus + stop contractions, relieving pressure off the cord - essentially buy some time until transfer to theatre)

Conclusion

Opportunity to practice some SAQs + MCQs on a range of O&G presentations

RESOURCES

- Nice CKS summaries
- RCOG guidelines
- Patient Info - Professionals Section
- TeachMeObGyn
- Zero to Finals

RESOURCES

The Peer Teaching Society is not liable for false or misleading information…

Feedback

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THANK
YOU