① Age :- 25 yrs → PCOS
Late

Infertility

Obese
34 yrs ± oligo ± excessive hair growth.

D/D → PCOS
Cushing syndrome
Late onset adrenal hyperplasia
Obesity
Adrenal tumour
Androgen producing ovarian tumour
Hyperthyroidism
Drug → phenothiazine
cemetidine
Methyl dopa
✓Danazol
✓phenytoin

oligo only
- Hyperprolactinemia
- Tubercular endometritis

M/A → After application of GnRH there is upregulation of pituitary GnRH receptor resulting in initial surge of plasma gonadotropin level. This flare effect last for 1-3 wks. After 3 wks of continious use down regulation of pituitary GnRH receptor occure resulting ↓ FSH ↓ LH.

INTAKE - III

μPS, 3rd-13

Answer: 2.b) Role of GnRH analogue in gynaecological practice

GnRH analogues (agonists and antagonists) have been derived from GnRH decapeptide, but 100 times more potent and has increased half life.

Mode of action:

After application of this agent majority of GnRH receptors in the pituitary glands are occupied resulting an initial surge of plasma gonadotrophins levels. After initial stimulation, continued receptor occupancy downregulates pituitary gonadotrophin secretion.

Route of administration:

Not active orally.
It can be used I/M, S/C, intra nasally.

- Subcutaneous inj → Buserelin 200-400 μg daily
- → Goserelin (implant) 3.6 mg every 28 days
- → Leuprorelin 3.75 mg every 28 days

Uses of GnRH analogues in Gynaecology:

- Intranasal spray:
  - Buserelin 300-600 μg daily
  - Nafarelin 400-800 μg daily.
- I/M → leuprorelin.

1. In assisted reproductive therapy (ART):

It is the longest established gynaecological use.

Use of GnRH agonists, together with gonadotrophins prevent spontaneous LH surges and improves egg collection rate and subsequent fertilization and implantation.

In short protocol, no down regulation is induced and GnRH agonist and gonadotrophins are used parallel.

In long protocol, stimulation of ovary only starts after complete pituitary downregulation, results in higher pregnancy rates but more expensive and time consuming.

2. Ovulation induction in woman with anovulatory subfertility:

If woman with PCOS, do not respond to clomiphen, gonadotrophins, then GnRH analogue can be used.

3. In endometriosis: producing hypophysectomy → hypoestrogenic state → atrophy of ectopic endometrium.

~~Now well established~~.

Treatment is usually limited to 6 months.

To avoid hypo-oestrogenic symptom, add-back therapy with oestrogen. is given

INTAKE - III

4. In fibroid:

producing hypoestrogenic state → Uterine size decrease (30-64%) after 3 months of use of it.

So, it is used pre-operatively for the following reasons:

- Reduce intraoperative blood loss.
- Relief of symptom.
- Relief of anemia & reduce need for transfusion.
- May enable use of lower transverse incision.
- Reduction of tissue trauma at myomectomy.

5. Pre-cocious puberty:

It can be used if no cause can be found or when a cause cannot be removed.

6. Premenstrual syndrome:

This can be effectively treated by GnRH agonists.

Treatment should be limited to 6 months or less.

7. Hirsutism:

In idiopathic group, by suppressing the pituitary gonadal axis, the excess hair growth can be arrested with the use of GnRH analogue.

8. DUB:

Prior to endometrial resection, GnRH analogues are used to suppress the endometrial growth.

Hazards of GnRH analogues:

Hot flushes, vaginal dryness, dysparenia, headache, and depression(menopause like symptom). Acne, muscle pain, back pain, dry skin are also noted. Ostoeporosis is the threat if it used more than 6 months.

GJ trac - 2

Hirsutism

valval ca

Ovarian ca

DUB

fibroid

Ecto pic

Abortion

Menopause

Prolapse

fistula

Urinary incontinence

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NBVH → criteria
complication.

sacrospinous fixation.

- Breast
2nd degree hemorrhage.

FIGO
AGI
NYHA

Q:- ~~A~~ adolescent girl present with ~~hirsu~~
a) Cause responsible ~~for~~ problem
b) Evaluate her
c) Rx her.

FCPS July-13, 14

Hirsutism is one of the manifestation of hyperandrogenism & came problem to the young. Hirsutism is excessive growth of androg dependant terminal body hair in female like male pattern that worries the patient

Cause :-

1) Constitutional ——→ [• familial • Hormon level normal • ↑ end organ sensitivity • No effect on fertility]

2) Ovarian cause :-
   i) PCOS
   ii) Ovarian neoplasm →
      • Sertoli leydig cell tumour
      • Wilm cell tumour
      • lipoid cell tumour
   iii) Luteoma of pregnancy.

3) Adrenal cause :-
   • Late onset CAH
   • Adrenal tumour
   • Cushing syndrome.

Pituitary tumour :

- Secreting excess ACTH (cushing disease)
- Secreting excess growth hormone (acromegaly)

Exogenous (drug therapy) :-

- Androgen
- Anabolic
- OCP
- Danazol
- phenytoin
- synthetic progesterone.

) Idiopathic → 5-15%. → [young age isolation onset unassociated virilism, normal cycle]

History :-

Age :- • Early reproductive age → more likely PCOS

• Any age → Adrenal / ovarian tumour.

Menstrual history :-

- PCOS → Normal (50%)
  oligomenorrhea (30%)
  Amenorrhea (20%)
- CAH → primary amenorrhea.
- Androgen secreting tumour → Normal cycle with sudden irregular menstrual follow by amenorrhoea.

- Regular [illegible] excess hair on limbs & around lips →
  - constitutional
  - idiopathic variety

3) Symptome analysis :-

- Speed of progression →
  - Rapid onset → Androgen secreting tumour
    - Androgenic drug
  - Insidious onset → PCOS
    - idiopathic

- Weight gain
  Acne
  AN
  H/O subfertility
  ] PCOS

- Sign of virilism
  breast atrophy
  deepening of voice
  ↑ muscle bulk
  ] Androgen secreting tumor

- H/O lethargy, cold intolerance, constipation, wt gain] hypothyroidism associated hyperthecosis

4) Family history → (+)ve family history for excessive hairgrowth
PCOS
CAH.

· Drug history →
  · Danazol
  · OCP
  · Anabolic

Status of pg → pregnancy ± hirsutism → suspected luteoma of pg.

Examination :-

IE :-

special attention to differentiate hirsutism from virilism →

To determine severity of hirsutism

Ferriman Gallway grading :-

Rating → 0, 1, 2, 3, 4

0 → No growth of terminal hair

4 → Complete & heavy cover.

Location → 9 sites

· Upper lip
· Chin
· Chest
· Upper abdomen
· lower abdomen
· Upper back
· lower back
· Upper arm
· thigh.

Total score → 36

Interpretation →

Mild → score 8-15

Moderate → >15.

2) Hight, wight, BMI → Obesity → PCOS
Central obesity → Cushing syndrome.

3) Acral
AN
Alopecia
] PCOS

4) Sign of virilism →
Deepening of voice
Breast atrophy
↑ muscle bulk
Clitoromegaly
] Androgen secreting tumour

5) • facial plethora
• Centripetal obesity, & abnormal striae
• wasting of extremities
• fat deposition in supraclavicular area, in neck, face
] Cushing syndrome

6) Thyroid gland → Any thyroid disorder.

7) Breast → Breast Atrophy / Galactorrhoea.

Per abdominal → palpable mass in lower abdomen → Androgen secreting tumour.

Evil exam →

clitoromegaly
labial fusion
abnormal urethral course
] CAH.

Investigation

Aim → . To confirm diagnosis
. find out etiology
. for management purpose.

Screening test →

Serum testosterone → ↑ in PCOD
CAH
Androgen secreting tumour

> 200 ng/dl → Androgen secreting ovarian tumour.

2) DHEAS → ↑ in adrenal pathology
> 700 - 800 µg/dl → Adrenal tumour.

3) 17 OH progesterone →
> 800 ng/dl → Adrenal hyperplasia.

1. Directed test

a. LH : FSH → > 3:1 or > 2:1 → PCOD.
b. Prolactine → slight ↑ in PCOD.

INDEX

OBS-01

ME

Q:- 34 wks pregnancy ē H/O convulsion. How will you manage. FCPS July-16

All the pregnant woman ē convulsion considered as eclampsia untill other diagnosis is confirmed.

As this is a obstetric emergency patient should 1stly managed by immediate resucitation without any delay.

→ Shout for team approach

→ Asses pt by ABC approach → Check airway breathing & circulation → by {Look, listen, Feel.
circulation by pulse, BP, tem, U/O, level of conciousness

→ Maintain airway — by left lateral position.

→ If shallow breathing → O_2 inhalation ē mask 12L/min

→ If not breathing → Positive pressure ventilation by Ambu bag or endotracheal tube

- I/V access → I/V fluid by N/S or Hartman sol @ rate of 1ml/kg/hr or 80 ml/hr.

- Send blood for → Hb%, Grouping & Rh typing, LFT, RFT, coagulation profile.

→ Continious catheterization → maintain intake output chart.

→ Antibiotic → Inj Ceftriaxone 1gm IV 12 hrly.

→ Monitoring → Rise, BP, RR, reflex, FHR, Intake - output, Auscultate lung base | ½ hrly

After initial management relevant history from her relative & quick thorough examination.

possible causes :-

Eclampsia
Epilepsy
Meningitis
Encephalitis
Cerebral Malaria
Hypoglycemia
E. imbalance

History :-

① About convulsion :-

- No of fit → >10 fit
- Duration between of onset of fit & referral → late referral } poor prognosis
- coma in between fit

② History according to cause :-

Eclampsia :-

- Know PE & impending sign
- Tonic, clonic, generalized convulsion
- self limited

Epilepsy :-

- Tonic, clonic, generalize / petimal convulsion
- Convulsion before pg
- taking anti epileptic drug

Meningities / encephalities :-

- continious high fever
- Drowsiness
- stiff neck.

Cerebral malaria :-

- Intermittent fever + chills & rigor
- headache, joint & muscle pain
- H/O travel in malaria endemic zone.

Hypoglycemia :-

- known DM
- taking insulin.

- E imbalance :-
  H/O vomiting
  Diarrhoea.

~~H/O~~ present Obstetric history :-

- Age → 32 yrs extreme age → more related to Eclampsia
- Accurate dating by - LMP
  Early USG
- Any ANC → review all record
- Obs complication :-
  - polyhydroamnion
  - Multiple pg
  - ~~PE~~ APH
- Medical complication :-
  - HTN
  - DM
  - cardiac disease.
  - Thrombophilia

Past obstetric history :-

- Para → Multipara → More chance PE
  Elderly primi → of ~~PE~~, eclampsia
- Mode of delivery :- ~~Forc~~ forc
  → rx purpose.

Examination

GIE

① Assess level of conciousness by AVPU

② Anaemia → complicated malaria
Jaundice → malaria
HELLP

③ Pulse → ↑ tachycardia

④ BP → ↑
⑤ Oedema +ve | Associated ↑ eclampsia

⑥ temp → ↑↑ → malaria
meningitis
encephalitis

⑦ Opthalmoscopic examination :-
Retinal oedema
Altered vein & arterial ration | Eclampsi

⑧ Respiratory system →
pulmonary oedema may present → eclampsia

⑨ Nervous system :-
Neck rigidity → meningitis
patelar reflex → ↑↑ in eclampsia.
clonus ↑

~~Investigation~~ :-

Abdominal :-

- SFH → ↓ in eclampsia if associated with IUGR or oligo
  ↑ in GDM due to macrosomia poly.
- Assess fetal lie
  presentation
  position
  Liquor volume
  fetal size.
- FHR.

Investigation :- - To confirm dx
- for management purpose.

① Blood → - CBC & Hb%. → : asses anaemia
, rule out infection.

Hb% → ↓ → malaria
TC, DC, ESR → ↑↑ in meningitis encephalitis

- Fasting & 2hrs after 75gm glucose → confirm DM

PC → <1 lac/cmm
BT > 6min
CT > 7min
PT → ↑
APTT → ↑
Fibrinogen level <150mg/dl
FDP ↑
D-dimer ↑

If DIC

- S. electrolyte
- RFT → S. creatinine ↑, S. uric acid ↑
- LFT → S. bilirubin ↑, AST ↑, ALT ↑, LDH ↑
- coagulation profile

if eclampsia

- peripheral thick & thin film → malaria

- Urine :-
  - Urine for proteinuria 5gm → massive proteinuria
  - 24 hrs total urinary ~~total~~ protein
- EEG → to confirm type of epilepsy
- Examination of CSF → meningitis, Encephalitis.

For fetal assessment :-

- USG of P/P →
  - Gestational age
  - ~~Biometry~~ EFW, fetal Biometry
  - AFI
  - placental position
  - fetal lie, presentation
- CTG → for acute hypoxia
- BPP → ch. ~~ab~~ & ch. hypoxia due to ch. placental insufficiency,
- Colour doppler → UA, MCA, DV

⇒ other routine inv if not done.

General mx →

- Immediate general mx is alread done.
- then keep the pt in calm room e eclamptic position & emergency facilities
- Airway keep clear by O-P suction
- Inserting padded mouth gag to prevent torgue fall back
- Using bed side rail to prevent injury
- Inf vomiting → change posture 2 hrly
  → NG tube feeding 2 hrly by 250 ml
  → Care of eye & maintain oral hygiene.

Dr. Razia Perveen

- Medical disorder
- Antinatal assessment
- Less fetal movement
- IUD
- BOH + oligo
- Neonatology
- Drug
- operative

OBS - 2

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Heart Disease

(4)

Peripartum cardiomyopathy.

Peripartum Cardiomyopathy is one of the myocardial condition most commonly seen myocardial condition during pregnancy. Initially it was named postpartum cardiomyopathy but now it is all called peripartum cardiomyopathy because it appears at any time in the last month of pregnancy & up to 5 months after delivery. Peripartum cardiomyopathy is responsible for an elevated proportion of maternal death.

PPCM is a unique form of myocardiopathy, probably of viral origin or immunemediated.

Risk factors:

- Advanced maternal age
- Multiparity
- Multiple pregnancy
- obesity
- Black race

Clinical Findings:

① Majority of patients are 20-35 yrs old

② Present in 2nd & 3rd postpartum period months & weakness, shortness of breath, orthopnea cough, paroxysmal nocturnal dyspnea & palpitation.

Physical examination reveals:

tachycardia, arrhythmia, peripheral oedema & pulmonary rales.

The diagnosis is based on the following criteria:

1. Development of heart failure in the last month of pregnancy or upto 5 months postpartum.
2. Absence of an identifiable ~~heart disease~~ cause for heart failure.
3. Absence of recognizable heart disease before the last month of pregnancy.
4. Left ventricular dysfunction demonstrate by echocardiogram.

The ~~echocardiography~~ echocardiographic criteria for diagnosis of PPCM are as follow:

- Ejection fraction less than 45%.
- End diastolic dimension more than 2.7 cm/m^2

Investigation:

1. Chest x-ray: Enlarge heart & pulmonary vascular redistribution
2. Echo: Enlargement of all chamber of heart, predominantly left ventricle.

Rx

General mx :-

① Hospitalization in THC

② Counselling about · condition
· Rx
· prognosis

③ joint consultation of cardiologist

④ Bed rest & propped up position

⑤ O_2 inhalation

⑥ Salt & fluid restriction

⑦ Diuretics (to reduce preload) → Inj furosemide

⑧ Digitalization → ·5 mg I/V then
·25 mg orally
· improve contractility
· Relief symptom.

⑨ Anticoagulant therapy → Heparin 5000 unit S/C - BD

⑩ Vasodilator → Inj Hydralazine

⑪ B blocker.

⑫ Immunosuppressive therapy → if myocardial biopsy indicate myocarditis.

Obs mx :- · Termination of pg if untreated
· vaginal delivery preffered
· No contraindication of BF

Complication → · DVT
· CCF
· arrythmia

maternal mortality 20-50%.

5

Prognosis:

- Patients who have dilated hearts 6 months after the onset of symptoms have high mortality.
- Pts who have normal size heart 6 months after the initiation of therapy usually have good prognosis.
- When therapy is delayed more than 6 months from initiation of symptoms the prognosis is poor.

Recurrence:

- The risk of recurrence is approximately 21% in women who's left ventricular function return to ~~no~~ normal.
- Recurrence rate is 44% those who have persistent left ventricular failure.

Advice:

- Women ~~i~~ persistent ventricular dysfunction should be avoid pregnancy.

Effect of maternal HD or pregnancy →

Pregnancy outcome is compromised by the presence of cardiac disease. Fetal outcome is good in rheumatic heart disease.

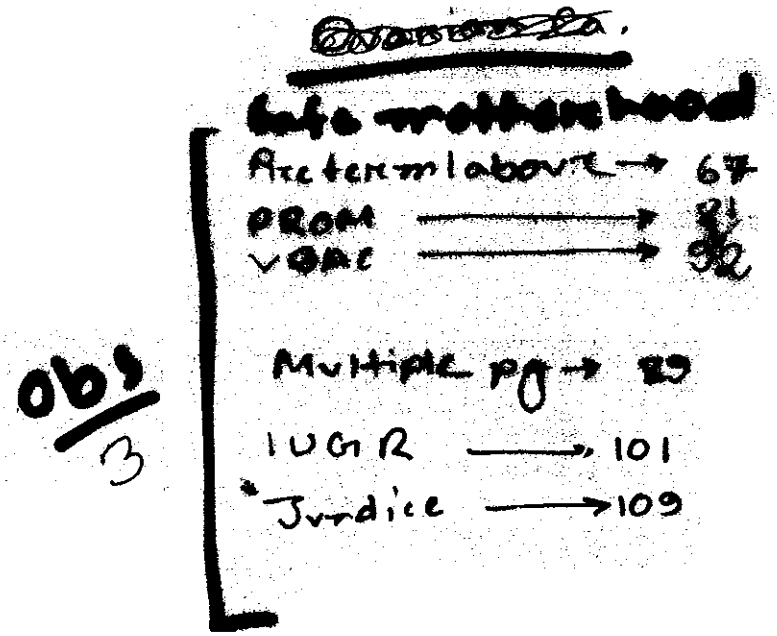
1. Preterm delivery
2. Prematurity } ↑ fetal morbidity
3. IUGR → due to inadequate uteroplacental circulation.
4. Congenital heart disease
   → If mother has congenital heart disease, there is ↑ incidence (4-5%)
5. Fetal death → (3-10%) → due to cyanotic heart disease
   Marfan's syndrome
   Functional impairment — class III & IV

① Easy fatigability, shortness of breath, orthopnoea, and pulmonary congestion → s/s of Lt sided heart failure.

① Weight gain, dependent oedema, tender hepatomegaly and ↑ed jugular venous pressure → Rt sided heart failure.

② Respiratory distress
· Haemoptysis
· Basal crepitation
· Gallop rhythm
· pulsus alternans

cardinal sign of LVF



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1

Q:- How can you minimize the risk of litigation in obs practice?

medicolegal problem in obstetric practice is rising both in developed & developing country. This is due to great expectation of society & progressive technological advancement.

There are certain area of legal threat in obstetrical practice :-

① Perinatal injury →
- Still birth
- Neonatal death
- Cerebral palsy
- After ~~assisted~~ breech delivery

② Maternal injury →
- trauma
- Episiotomy
- Forgotten gauze in vagina or abdomen
- Anesthetic hazard
- Death.

These problem may occur both in instrumental & operative procedure. Litigation issue arises due to system error, negligence.

malpractice, incompetence. Some measures can be taken to minimize this problem.

Pre procedure task :-

① Proper evaluation of case by history, examination, inv

② Counselling / explaining the procedure to pt & pt's attendant in clear understandable way.

③ Informed & written consent

④ Proper documentation of facts in pt's file properly clearly.

During procedure :-

① Strict adherence to established management protocol & any deviation must be documented with reason.

② Multidisciplinary input or consultation to other specialist when any problem arise

③ Careful record maintenance in Hospital.

post procedure task :-

① Develop a effective protocol & good chain of communication among medical staff to avoid any delay in dx & action.

② Post procedure counselling

③ Details should provide in prompt discharge ~~paper~~ paper.

Others :-

① Adequate training & supervision of juniors specially involved in labour ward pt. Senior staff also included.

② Regular audit & meeting should done to update the knowlage of staff

③ Finally, care & attention according to establish norm.

Dr. Razia

Obs & History

Part- I (Case)

1.	Perperium	Bronchial Asthma
2.	PROM → 10	S Anaemia
3.	APHV → 39	
4.	Rh (-) ve → 15	Incidence
5.	Multiple pg → 28	
6.	Post dateds — 46	Thallasecmia- 1-8%
7.	LEM/FDS LMF → 50 MUD → 52	B. Asthma- 3-5%
8.	IUGR	SLE-100-1000000
9.	PE → 100	DM-1-14%
10.	GDM → 78	GDM-7-8%
11.	Heart diseases → 121	Hyperemesis gravida- 0.5-1%
12.	Thyroid –Hypothyroid → 74	RPI-1%
13.	Thallassaemia	PE-5-10%
14.	RPL — 109	APH –pp- Prim-0.5%
15.	BOH 113	Multip-5%
16.	IUD	AP-Prims- 1%
17.	Pre C/S → 95	Militi- 2.5%
18.	UTI	Hypothy roidi-1%
19.	Hyperemesis → 69	Hyper-0.2-0.9%
20.	Hepatitis	TB- 1-2%
21.	SLE → 55	
D	Anencephaly – 114 Hydrocephalus – 117	380

Puerperium
2. PROM
3. APH
4. Rh (-)ve
5. Multiple pg
6. Post dated
7. LFM/FD
8. IUGR
9. PE
10. GDM
11. Heart disease
12. Thyroid — Hypothyroid
13. Thallassaemia
14. RPL
15. BOH
16. IUD
17. Pre c/s
18. UTI
19. Hyperemesis
20. Hepatitis
21. SLE

(A)

Bronchial Asthma
5 Anaemia

Incidence

Thallassemia → 3-8%.
B. Asthma → 3-5%.
SLE → 5/100-1000000
DM → 1-14%.
GDM → 7-8%.
Hyperemesis gravidarum → 0.5-1%.
RPL → 1%.
PE → 5-10%.
APH → PP → Prim - 0.5-1%.
Multip - 5%.
AP - Prim - 1%.
Multi - 2.5%.
Hypothyroidism → 1%.
Hyper → 0.2-0.9%.
TB → 1-2%.

3

Dr. Nadira Rahman

1-3-11

Puerperium

Mrs. Sheuli, age 30 yrs. para-2, housewife of a middle class family hailing from comilla got herself admitted into BSMMU on 16th February, 2011 at her 39 wks pregnancy with H/O previous 1 C/S. She had LUCS on 16th February,2011 and now she is complaining of slight lower abdominal pain.

Patient states that she was in regular ANC, her pregnancy was uneventful and she admitted at 39 weeks of pregnancy for elective caesarean section.

Her immediate post operative period was uneventful. She has no breast and urinary complaints, bowel discomfort. Lochial discharge is average with no foul smell. On the day of examination she was complaining of mild pain

over the wound area, dull in nature, not radiating or not associated with fever.

Regarding her obstetric history, she is married for 7 years, mother of two ~~normal alive~~ child ~~with no history of MR~~ or abortion, ALC-3 days; both delivered by LUCS. Her 1st LUCS was done due to CPD 6 yrs back.

Regarding menstrual hx

She is a regularly menstruating women with average flow and duration.

She is non-diabetic & normotensive. She gave no significant past medical or surgical illness of her own but her mother is a patient of DM. ~~She was duly immunized by 5 doses of TT before 1st conception.~~

With due consent and maintaining privacy, I examined her on 3rd POD and found ~~she was~~ her cooperative with average body built and nutrition. She was mildly anaemic, non ecteric,

Dr. Rajia

Part- II (Case)

Content:

1. Fistula → 1
2. RVF — 8
3. CPT — 8
4. Primary subfertility — 12
5. Endometriosis — 18
6. C. PID — 27
7. Prolapse — 37
8. Elongated CX — 42
9. Fibroid — 43
10. Adenomyosis — 53
11. DUB — 61
12. CIN — 67
13. Ca CX — 69
14. Endometrial ca — 75
15. Ovarian tumour — 80
16. vulval ca — 91
18. vagina — 96
19. PGTN — 98
20. Mullerian agenesis — 99
21. AIS — 102
22. Turner → 104
23. CAH
24. Cryptomenorrhoea.
25. Chronic cervicitis
26. PCO
27. Myomatous polyp
28. RPL
29. Abortion
30. Chronic ectopic

A

18/9/10 DR: AZIZA · SULTANA
ROLL N- 21

Mrs. Parveen, 26 years old, para-2+1(still born),a housewife from low socio-economic condition hailing from Laksam, Comilla got herself admitted into DMCH on 20th August 2010 with the complaints of

. Continuous dribbling of urine per vagina for last 12 years.

.No urge to pass urine for 12 years.

. Vulval itching for last 4-5 years.
10yrs

According to the patients statement she conceived immediately after her marriage at the age of 13 years. During her pregnancy she did not receive any antenatal check up. And she did not give any history of immunization. At term, labour pain started and she was attended by an untrained dai at home. Her labour was prolonged and difficult. After suffering for 2 days her

relatives brought her to Dhaka Medical College Hospital and diagnosed as a case of obstructed labour. Then a male stillborn baby was delivered by caesarean section.

She was catheterized for 14 days. But at the day of 11th POD she noticed continuous dribbling of urine per vagina though there was catheter in situ. Since then she had no urge to pass urine. After 14 days catheter was removed and she was discharged with advice for readmission after three months. But she did not come for further treatment. After one and half year she again conceived and when she started labour pain she was admitted a local private clinic and was done caesarean section. Catheter was done but dribbling is continued. Then during discharged from the hospital she referred to DMCH for further management. But she did not come. At last on 20th August 2010 she got herself admitted in DMCH for further management.

She was normotensive, nondiabetic.

Regarding her menstrual history menstruation is irregular in cycle with scanty flow for 8 years. due to hypothalamic inhibition

With due consent , I examined her on 5th September 2010. She was 4 feet 7 inch (138cm) tall and her weight was 36 kg, uriniferous smell was coming from her clothes. She was mildly anaemic, non-icteric, her pulse rate was 72beats/min.

BP-100/70 mm of Hg

Cardiorespiratory system revealed no abnormality.

Regarding her perabdominal examination – nothing abnormality detected.

Per vaginal examination;-

on **inspection** valve and perineum were found wet and mildly excoriated, urine was coming out through introitus.

7

DUB ——→ 1

2) Mulerian agenesis ——→ 3

- Infertility due to PCOS ——→ 6
- Infertility due to oligospermia ——→ 8
- Neonatal jaundice ——→ 10
- Infertility & endometriosis ——→ 12
- Functional ovarian cyst ——→ 13
- Benign ovarian tumour ——→ 15
- Borderline ovarian tumour ——→ 17
- MOT ——→ 18
- Molar pg ——→ 19
- Choriocarcinoma ——→ 23
- Urinary incontinence ——→ 27
- Myomectomy ——→ 29
- Ectopic pg ——→ 32
- Laparoscopy for infertility ——→ 34
- BLTL ——→ 35
- Ch. pelvic pain ——→ 36
- Ca Cx IB ——→ 39
- Ca Cx IIB ——→ 41

- Obstructed labour — 43
- placenta previa — 46
- Epilepsy — 49
- HIV — 53, 54
- peripartum hysterectomy — 52
- Ruptured ut — 57
- HD ——→ 59, 63
- Blighted ovum — 61
- Severe PE — 65

Never keep praying
how dark & hopeless it is
keep your faith.

1) আসসালামু আলাইকুম

2) মা, আপনার মাসিকের সময় অতিরিক্ত রক্তক্ষরণ হয় / আপনার ~~অনিয়ম~~ অনিয়মিত মাসিক হয় কিন্তু পরীক্ষা নিরীক্ষা করে কোন সুনির্দিষ্ট কারণ খুঁজে পাওয়া যায় না।

3) তবে ধারনা করা হয় যে আপনার H-P-O এর অসমঞ্জস্যতা এবং মাসিকের সময় জরায়ুর ঠিকমত কাজ করতে না পারা - ~~এর জন্য~~ এই সমস্যার জন্য দায়ী। রক্ত জমাট বাধার জন্য জরায়ুতে যেসকল উপাদান কাজ করে যেমন Prostaglandin - তার তারতম্যের জন্যও এমন সমস্যা হতে পারে -

4) Dx নিশ্চিত -এর জন্য কিছু পরীক্ষা ~~নিরা~~ নিরীক্ষা করা হবে। যেমন
- CBC
- হরমোন -
  - ১. TSH
  - ১. FSH, LH
  - ১. Prolactine.
- USG → কোন সমস্যা / জরায়ুর পুরুত্ব দেখার জন্য
- Endometrial sampling → জরায়ু থেকে ~~[illegible]~~ tissue সংগ্রহ করে পরীক্ষা করতে পাঠানো।

5) সাধারণত DUB-তে কোন অসুবিধা হতে পারে না।

~~চিকিৎসা~~

ও দিয়ানের- চিকিৎসা পদ্ধতি রয়েছে-

General চিকিৎসা

medical "

ও

অপারেশন।

General চিকিৎসা হলো →

1) মাসিকের- দিনগুলোতে আলাদা বিশ্রাম নিবেন

2) রক্তশূন্যতা পূরণের জন্য- প্রতিদিন খাবার, iron tablet খাবেন প্রয়োজনে রক্ত প্রদান করা লাগতে পারে।

মেডিকেল চিকিৎসা → Non hormonal → ~~Mefenamic acid~~ → মাসিকের দিনগুলোতে ~~Antifibrinolytic TNX~~ → অতিরিক্ত রক্তক্ষরণ কমাতে ও

হরমোন চিকিৎসা

প্রোজেস্টেরন জাতীয় হরমোন ১টি- কয়েন- দিনে ২২ দিন খাবেন- ৭দিন বন্ধ থাকবে। এভাবে ৩ মাস।

এছাড়া LNG-IUS- যা জরায়ুতে প্রতিস্থাপন করা হয় খুব কার্যকরী সেবন্ট মাসে আপনার রক্তক্ষরণ কমাবে ও জন্মনিয়ন্ত্রণে ভূমিকা রাখবে। ৫ বছর- কার্যকরী।

অন্যান্য- হরমোন - Danazol Mefipristone ব্যবহার করা যায়-

এছাড়া Non hormonal → PGI → Mefenamic acid Antifibrinolytic (TNX) → মাসিকের দিন গুলোতে ব্যবহার করা যায়।

40U17

আসসালামু আলাইকুম, আমি ডাঃ - - -

আপনার মাসিকের সময় অতিরিক্ত রক্তক্ষরণ হয় বা অনিয়মিত মাসিক হয়, কিন্তু পরীক্ষা নিরীক্ষা করে কোন সুনির্দিষ্ট কারণ খুঁজে পাওয়া যায় নাই তবে তখন ধারণা করা হয় মাসিকের সময় আপনার জরায়ু ঠিকমত কাজ করতে পারছে না। রক্তক্ষরণ বন্ধের জন্য জরায়ুর ভেতর উৎপাদন হয় এমন কিছু যেমন Prostaglandin সেগুলোর তারতম্যের জন্যও এমন সমস্যা হতে পারে।

Endometrial sample

সমস্যা নির্ধারণ করার জন্য আমরা আপনার জরায়ুর ভিতর থেকে কোষ/মাংস সংগ্রহ করে পরীক্ষা করতে পাঠাব। যদি সেখানে কোন সমস্যা না পাওয়া যায় তাহলে আমি আপনাকে হরমোন দিব। ***

প্রোজেস্টেরন জাতীয় এই হরমোন আপনাকে ... দিন খেতে হবে ৭ দিন বন্ধ রাখতে।

CBC, USG, TSH, RBS, LH, Prolac

USG → কোন সমস্যা / জরায়ুর

3 option

2

→ Greeting & self introduction —

⇒ আসসালামু আলাইকুম। আমি ডাঃ .... । আমি আপনার সাথে আপনার মেয়ের সমস্যা নিয়ে কথা বলব।

→ Regarding diagnosis =

মা, আপনি তো এসেছেন আপনার মেয়ের মাসিকের সময় অতিরিক্ত রক্ত ক্ষরণ হয়, এই সমস্যা নিয়ে তাই না?

→ Symptom analysis -

আপনার মেয়ের সমস্যা সম্পর্কিত কিছু তথ্য জানা প্রয়োজন -

01 — প্রথম মাসিক শুরু হওয়ার বয়স।
02 — কতদিন ধরে অতিরিক্ত রক্তক্ষরণ হচ্ছে?
03 — মাসিক Regular/Irregular. নিয়মিত/অনিয়মিত
04 — কতদিন পর পর মাসিক হয় এবং শেষ মাসিকের তারিখ।
05 — মাসিক শুরু হলে কতদিন ধরে রক্তক্ষরণ হয়?
06 — প্রতিদিন কয়টা করে তুলা/Pad ব্যবহার করতে হয়?
07 — মাসিকের সময় কোন চাকা রক্ত যায় কিনা?
08 — তার স্বাস্থ্য কি দিন দিন মোটা হচ্ছে?
09 — শরীরে অতিরিক্ত অবাঞ্ছিত লোম তৈরী হচ্ছে কি না?
10 — অতিরিক্ত ঠান্ডা বা গরম অনুভূত হয় কিনা?
11 — ছোটবেলা হতেই কোথাও কেটে গেলে রক্তক্ষরণ বন্ধ হতে দেরী হতো কিনা.
12 — অতিরিক্ত দুর্বল লাগে কিনা কিংবা পেটে কোন চাকা অনুভূত হয় কিনা।

→ Examination of the patient --

- ওজন, রক্ত স্বল্পতা / Anaemia।
- any bruise, echymosis.
- vital signs — pulse. BP. Temp. / Sex mark.
- any lump in abdomen.

→ Treatment option –

অন্য কোন সমস্যা না থাকলে চিকিৎসা বহুলাংশে নির্ভর করে রক্তে হিমোগ্লোবিনের এর পরিমাণের উপর। যেমন,–

Hb% যদি 10–12 gm/dl (Normal) হয় তাহলে শুধু মাত্র Iron tablet & vitamin supplement খাবে এবং সময়ের সাথে সাথে এটা ঠিক হয়ে যাবে।

Hb% যদি <10 gm/dl (anaemia) হয় তাহলে আমরা সাধারণত Iron & vitamin tablet এর সাথে হরমোনও দিয়ে থাকি। progesteron hormone ৩–৬ মাস খেতে হয়। প্রতি মাসে ২১ দিন ঔষধ খাবে (প্রতিদিন ১টা) এবং ৭ দিন বন্ধ রাখবে। এই সময় মাসিক হবে। ৩–৬ মাস পর আবার check-up করে দেখতে হবে। ~~তখন মাসিকে রক্তের পরিমাণ রাখতে হবে।~~ আপনি নিজে দায়িত্ব নিয়ে প্রতিদিন নির্দিষ্ট সময়ে আপনার বাচ্চাকে ঔষধ খাওয়াবেন।।

আর যদি আপনার বাচ্চার শরীরে রক্তের পরিমাণ খুব বেশী কমে যায় Hb% <6 gm/dl হয় তাহলে আপনার বাচ্চাকে হাসপাতালে ভর্তি হতে হবে এবং শরীরে রক্ত দিতে হবে। এই সময় অতিরিক্ত রক্তক্ষরণ বন্ধ করতে হরমোন ইনজেকশনের মাধ্যমেও দিতে হতে পারে (conjugated equine oestrogen)। বাচ্চা হাসপাতাল হতে ছুটি হয়ে গেলে ৩–৬ মাস মুখে হরমোন ট্যাবলেট খাবে (20–40mg 6–8 hrly) এবং ৩–৬ মাস পর আবার তাকে check-up এ আসতে হবে।

(2) conjugated equine oestrogen 20–40mg i/v every 6–8 hours.

এই সময় তাকে পুষ্টিকর খাবার, আয়রন supplement দাও।

→ **Prognosis :**

মা আপনাকে ধৈর্য ধরে চিকিৎসা চালিয়ে যেতে হবে। ২-৪ বছরের মধ্যে শরীরে হরমোন নিঃসরণ নিয়ন্ত্রণে আসে মাসিকও স্বাভাবিক হয়ে যায়।

→ Any quary about your problem –

→ Thank-you –.

1. forcep delivery - 1
2. vertome " - 3 3
3. forcep delivery after coming head of breech → 5
4. Assisted breech — 5
5. Lovset Petavrid's manuvair → 7
6. Malar flexion & shoulder traction → 8
7. IPV → 9
8. Internal bimanual compression → 10
9. Aortic compression → 11
10. Balcon catheter → 12
11. B-lynch suture → 14
12. Ut artery ligation → 15
13. Ut - ovarian " → 16
14. repair of cervical tear → 17
15. Ut inversion — 19
16. ECV — 20
17. Shoulder dystocia - 22
18. pelvimetry - 24
19. Neonatal resuscitation → 25
20. Active management of 3rd stage - 29.

1) MVA ——→ 31

2) IUCD ——→ 34

3) PPIUCD ——→ 36

4) Medorald → 37

5) Pap smear → 39

6) VIA test → 40

7) Vertical mattress - 42

8) Horizontal " → 43

9) Reef knot } 43

10) Surgeon knot

11) Rectus sheath repair → 44

12) Pelvic / Bimanual exam

1. forceps delivery

1) At first greet the pt & introduce myself

2) • Counsell the pt what I am going to do
• Explain the pt that → ~~the~~ delivery is prolonging & fetus is in distress so, I have to deliver the baby by forceps, she should co-operate me.

3) I will ensure the pre-requisite of forceps application has been full filled that is →
• Cervix full dialated
• Membrane is ruptured
• presentation is vertex
• ~~station~~ Rotation complete
• Station below zero
• & there is no CPD.

4) I will ensure the
• consent,
• evacuation of bladder
• Assistant, anaesthesiologist
neonatologist
• third person
• labour analgesia
• privacy
• Good light source,

5) I will check all my logistics —
- A pair of obstetric forceps
- wash kit
- Episiotomy kit.
- Equipment for baby resuscitation.

7) Bring the pt at edge of table & keep in lithotomy position.

8) Prepare myself surgically.

9) wash the valva & perineum, drape her

10) Do P/V exam to see the criteria is fullfilled

11) Assemble the forcep before application. Identify the left blad

12) Apply lubricate to forcep blade

13) Then hold the left blade by by left hand in per holding manner keeping the handle parallal to opposite inguinal ligament of patient.

14) Then insert two fingers of the rt hand into vagina by the side

of fetal head & introduce the left blade under guidance of right hand.

15) Ask my assistant to hold it horizontally.

16) Then insert rt blade in same manner.

17) Lock the forceps

18) When crowning occurs, give liberal episiotomy & infiltration ~~ep~~ & 1% lignocaine.

19) I will grip the handle keeping middle finger inbetween the blades & index & ring fingers on either side

20) I will give traction along & lateral contraction in a direction of horizontally backwards towards me then upwards & forwards towards mother's abdomen. In the meantime my assistant will give perineal guard.

21) In between contraction ask my assistant to check fetal heart rate.

22) After delivery of head I will unlock the blade, remove rt blade first then left blade.

23) Trunk of baby is delivered by lateral traction.

24) Hand over the baby to peditrician for resecitation.

25) Manage the 3rd stage actively

26) Explore the genital tract for any cervical or perineal tear.

27) Repair episiotomy in layers.

28) Wash vulva & perineum

29) Cover her & keep her in comfortable position

30) Assure her about condition

31) Thank her for co-operation

32) Unlock all instrument & put it in Chlorine sol.

33) Keep everything record

34) Keep her under observation

Vacuum extraction

1. Greet & introduce myself
2. I will counsell the pt → What I am going to do & explain her that the delivery is prolonging & fetus is in distress, so I have to deliver the baby by vacuum extraction & she should co-operate me.
3. I will ensure the pre-requisite of vacuum application has been full filled that is →
   - Cx full dialated
   - Membrane is ruptured
   - presentation vertex
   - station below 0 & there is no CPD
   - baby is term.
4. I will ensure →
   - consent of pt
   - Evacuation of bladder
   - An assistant, anesthesiologist neonatologist, third person.
   - labour analgesia
   - privacy
   - Good light source.
5. I will check all the logistics. →