OB/GYN SURVIVAL GUIDE
FOR THIRD YEAR MEDICAL STUDENTS

INTRODUCTION

This survival guide is designed to assist the third year medical students in Obstetrics and Gynecology on the wards. The information in this handout is subject to modification at any time and is not official policy. It is up to you to determine how much information you apply for your own benefit.

PRIORITIES

Medical students are required to attend all lectures/conferences scheduled for the students and residents (except Friday M&M conferences). These take precedence over any ward duties that you may be assigned to. Resident lectures include **Grand Rounds at Wednesday, 7:30 a.m.** Please notify the chief resident anytime you need to leave the wards and give an estimated time of return. If at QMC, then this includes QMC grand rounds Monday at 1:00 p.m., laparoscopic skills lab Wednesday at 12:30 p.m. and pathology conference Thursday at 1:00 p.m.

PATIENTS

There are four types of patients that you will meet based on the attending. The type of patient will affect both resident and student responsibilities with that patient:

KHS Patients (includes KKV/KPC). The Chief Resident serves as the attending for these patients. Every one of these patients should be followed by both a student and a lower level resident. These patients come first at all times before others. These are our patients and we should take full advantage of the possible learning experience from them.

University Staff/WCCHC Patients. One of the University of Hawaii Ob/Gyn staff serves as the attending for these patients. All of these patients should be followed by both a student and a lower resident. Also of HIGH priority!

Private Patients – Teaching Staff. These patients belong to private attendings in the community who have privileges at Kapiolani Medical Center. The residents assist in their care and you should try to follow as many of these patients as possible. There is a wealth of potential learning from all of the different voluntary teaching attendings! Take advantage of it. These patients, however, may request "NO Medical Students" or "NO Males". Please do not take it personally and respect the patient's choice and privacy.

Private Patients – Non-Teaching Staff. These patients are initially triaged by the residents; however, both the residents and the students are not allowed to be involved with the routine care of these patients. If care is transferred to the perinatologists, these patients are treated as teaching staff and should therefore have a resident and student following them.

ROTATIONS

Labor and Delivery – Monday thru Friday – Ob/Gyn Rounds at 6:45 a.m.

Sign Out. The residents sign out the board at 6:45 a.m. and 5:30 p.m. each Monday through Friday and at 6:45 a.m. on holidays and weekends. Students on L & D are required to attend the morning sign-out session. The attending of the week may require you to present your patients at sign outs in the morning. Sign out all complicated patients to the student on call at 5:00 p.m., prior to resident sign-outs.

Patient Assignment. After sign outs, you should divide up the board taking an equal number of patients to follow. The goal is to get a good idea of the progression of normal and abnormal labors. You should review the charts, meet each of your patients, and get a feel for what is going on in their management. As your patients near complete dilation, it's a good idea to help the nurse push with the patient.

Deliveries. Students should attend as many deliveries as possible. There should be a student on every UH delivery. There should also be a student scrubbed on every cesarean section (except non-teaching cases). Practice your knot tying and sewing skills and you may be allowed to sew the episiotomy repair or tie and sew during the c-section.

Workup / "Res evals" You are required to do a history and physical on all normal labor patients; do not work up preterm patients unless approved by the senior resident. You should perform the entire exam except for the pelvic exam prior to presentation to the uppermost level resident available. If the patient's amniotic sac is not ruptured, both you and the resident should do the vaginal exam. Nonetheless, both of you will go together to see the patient.

Follow-up. You are expected to follow all patients that you deliver (or were present for the delivery) until discharge. Round once (in a.m.) for vaginal deliveries and twice a day (in a.m. and p.m.) for complicated cases.

GYN Surgery

Rounds. Monday through Friday surgery usually begins at 7:30 a.m. except for Wednesday at 8:30 a.m. You are expected to round on all your Ob and Gyn patients before rounds. You should be ready to present your patient's history and physical for the surgeries of the morning. Check with the chief resident in regards to where you should meet each morning. The usual schedule is 6:30am in the cafeteria on Monday through Thursday (Wednesday in pathology). Friday has no formal rounds (just round on your patients separately).

Students are required to scrub in on a certain number of major and minor cases. The idea is to see a wide variety of cases to become familiar with different treatments available. We realize that the majority of you are not interested in becoming Ob/Gyns. Our goal is not to make you an Ob/Gyn, but rather to expose you to different types of procedures that you will be able to converse with an Ob/Gyn and your future patients in regards to gyn-related problems and procedures. It would be helpful in explaining what's involved with the procedure, the associated risks, and it's limitations. There should always be a student scrubbed in on UH Staff cases.

Patients are usually admitted at least 2 hrs before surgery. It is good form to attempt to meet the patient and review the indications in preop holding prior to scrubbing in the case.

KHS Clinic

The KHS Clinic begins at 8:30 a.m. Monday through Friday; however, you may be required to come in earlier for educational purposes as dictated by the Chief Resident. Students will see patients on their own, take a history and do a physical exam (except for the pelvic), formulate a plan and then formally present the case to the attending of the day or the resident following the patient. Students should also see as many office procedures as possible (i.e., colposcopy, biopsies, cryotherapy, Norplant insertions/removals, menstrual aspirations, etc.).

CALL

Call usually starts with sign out of the board. For the majority of the time, call will be spent in Labor and Delivery (please refer to the L & D part in this handout). You may also see ER patients with the resident, accompany the resident on floor calls or see high-risk patients on PSCU (please ask the resident to notify you of these patients/calls). Check with the senior-most in-house resident in regards to leaving the floor or on leaving after call.

PROGRESS NOTES

Students are required to round independently and write progress notes on all patients that they attended for delivery or surgery until the patient is discharged. The note should be in the chart prior to the start of your day (signing out the board, Gyn rounds, or starting clinic). All surgical or complex patients should be rounded on twice each day: in the morning as previously mentioned and again in the afternoon prior to going home or call. Uncomplicated NDS's only need to rounded on once in the morning. You are expected to do staple removals on postoperative patients – in general, transverse incision staples are removed on POD #3 ("staples removed and steri strips applied without diff, incision C/I/D") and vertical midline incision staples are removed on POD #4. If the patient is obese, diabetic, or her wound doesn't appear to be healing well, check with the resident on the case to see if staple removal should be delayed. It is always a good idea to review the resident/attending notes in the afternoon to see if anything was added or changed.

General Note Writing Tips:

Date and time all notes
Label all notes as POD# __ or PPD#__
If patient on antibiotics, label # of days on med (Gent day #__)
Check with team prior to writing major statements regarding diagnosis or plans.
Let the resident or attending discuss the case with the patient,
All notes should be in SOAP format.

The following are sample progress (SOAP) notes:
S – subjective, O – objective, A – assessment, P – plan

Postpartum Progess Note (Sample)

09/01/95 MS3 PN
0530 S: Patient without complaints. Breastfeeding going well.
Urinating and ambulating without difficulty. Vaginal bleeding minimal.
O: BP – 110/76 P=88 I/O:777/500 (8 hours)
Heart: RRR s/o murmur; normal S1S2
Lungs: CTA bilat
Breasts: non-tender
Abdomen: Soft, NT, ND. BS normoactive
Fundus – firm at umbilicus, non-tender
Lochia: moderate rubra
Extremities: no tenderness, 1 + LE edema
Labs: H/H 7.8/22.5
A – 1. PPD #1 S/P NSD. Stable.
2. Anemia secondary to postpartum hemorrhage, asymptomatic
3. Rh+/RI
4. BCM – desires Depo Provera before discharge.
P – 1. Routine PP care
2. Depo Provera prior to discharge
3. FeSO4 325 mg p.o. tid

R.U. Awake, MS3

Postoperative C-section Note (Sample)

09/01/95 MS3 Note
0530 S – Complaints/ambulating/adeq pain relief/void/PO intake/flatus/BM/Breastfeeding
O – VS Tm 103.2 P115 R30 BP: 122/65
I/O: 2800/800 (720 UOP/80 JP)
Heart: RRR in 80's with II/VI holoSM at 2nd ICS at LSB
Lungs: Bibasilar crackles
Abdomen: +guarding/-rebound. Soft/rigid. 1+tenderness. Distended.

Tympanitic. BS hypo-normo-/hyperactive.
Uterus: firm 2 fingerbreaths below umbilicus, mild fundal TTP.
Wound: C/I/D with staples. Erythema/discharge.
Lochia: mild rubra.
Extremities: tenderness. Edema.
LABS: CBC with diff?
A – 1. POD #1 S/P Primary LTCS for Breech Presentation.
2. Febrile morbidity
P – 1. Ambulate.
2. Check CBC with diff, UA from foley before dc'ed.

I.M. Sleepy, MS3

Usual Routine Post Operative Milestones:

POD #0 patient rests
POD #1 ambulate; dc foley cath;
Check on postop CBC result (compare to preop H/H)
if bowel sounds, advance to clear liquid diet (if not already on clears); if taking p.o.'s well, decrease i.v. to TKO, heplock or dc; p.o. pain meds (i.e., Tylox), stool softener (i.e., Pericolace), and gas pain relief (i.e., Mylicon) prn
POD #2 if flatus, advance to regular diet as tolerated; continue above (some may meet this on POD# 1)
POD #3 dc staples and apply steristrips (transverse skin incisions); dc to home

IV antibiotics usually continued until 24-48hrs afebrile.
Check culture results (x8569)
Path reports usually back in 2-3 days. (x8327)

Usual discharge from hospital:

C-section	3-4 days
NSVD	1-2 days
Minor GYN case	1 day
Major GYN case	3-5 days

ORDERS

For all of your rotations, orders are written using the eponym, A-D-C VAN DISSL. You are not expected to write orders but you can be very helpful in doing so especially when we are busy in L & D; you can write the orders while the resident writes the postoperative note and dictates the surgery. The more that you get used to doing this, the easier that it may be during your subinternships and resident years. If you do write orders, do so under the supervision of the resident and have them cosign the order sheet.

A admit/transfer to (floor/service)
D diagnosis
C condition
V vitals
A activity/allergies
N nursing (I/O, foley to gravity, T/C/DB q 1hr WA, venodyne boots, NGT, lines, etc.)
D diet
I i.v.
S special
L labs

POSTOPERATIVE NOTES

Like the orders, you are not expected to write postoperative notes, however, it may be useful to you in the future to get used to writing these. You can also prove to be helpful in those busy times if you're able to write these.

<u>MS3 Postoperative Note</u>
Preoperative Diagnosis:
Postoperative Diagnosis:
Procedure:
Surgeon:
Assistants:
Anesthesiologist:
Anesthesia:
Fluids:
EBL:
Complications:
Tissues:
Findings:

DELIVERY NOTE (Sample)

23yo G1P0 female delivered vigorous male infant over 2nd degree perineal laceration. Infant was bulb suctioned at perineum. No nuchal cord noted. Shoulders and body delivered without difficulty. Cord doubly clamped and cut. Infant to warmer where nursery was waiting. Spontaneous delivery of intact placenta with 3V cord. Uterus firm with massage and pitocin. Laceration repaired under local anesthesia with 3-0 chromic in usual running fashion. Cervix inspected and no lacerations noted. Vaginal bleeding minimal. EBL 350cc Patient tolerated procedure well and left in room to recover.

7 "W's" OF POSTOPERATIVE FEVER & POST PARTUM PATIENT

Wind	atelectasis
Water	urinary tract infection (UTI)
Walking	thrombophlebitis
Wound	obvious (I hope)
Wonder drugs	medications (especially antibiotics), street drugs
Womb	uterus – endomyometritis
Wow	breasts – mastitis or engorgement

ABBREVIATIONS

Ob/Gyn has a bizillion abbreviations. <u>MANY are not official terms/abbreviations and are not approved by KMCWC or QMC</u>. If it's not included in the following, feel free to ask…

AICU	adult intensive care unit
AMA	advanced maternal age
AMU	antepartum maternal unit (old name for PSCU)
AROM	artificial rupture of membranes
BPP	biophysical profile
BSO	bilateral salpingoophorectomy
BUFA	baby up for adoption
C/D/I	clean/dry/intact (incisions/sounds)
C/S	cesarean section
CPD	cephalopelvic disproportion
CVS	chorionic villous sampling
D & C	dilation and curettage
DIC	disseminated intravascular coagulopathy

EDC	estimated date of confinement
EGA	estimated gestational age
EFM	external fetal monitors
FAVD	forceps assisted vaginal delivery
FHT	fetal heart tones
FFNT	fundus firm, non-tender (postpartum)
GAC	Gentamicin/Ampicillin/Clindamycin
GDM	gestational diabetes mellitis
GUC	Gentamicin/Unasyn/Clindamycin
HELLP	hemolysis/elevated liver enzymes/low platelets
IFM	internal fetal monitors
ITOP	intentional termination of pregnancy
IUFD	intrauterine fetal demise
IUGR	intrauterine growth retardation
IUP	intrauterine pregnancy
IUPC	intrauterine pressure catheter
JW	Jehovah's Witness
LAVH	laparoscopic-assisted vaginal hysterectomy
LH	laparoscopic hysterectomy
LMP	last menstrual period
LTCS	low transverse cesarean section
MMG	mammogram
MSAFP	maternal serum alpha feto protein
NSD	normal spontaneous delivery
NSVD	normal spontaneous vaginal delivery
NST	non-stress test
PAV	pre admission visit
PIH	pregnancy induced hypertension
PPS	postpartum sterilization
PPROM	preterm premature spontaneous rupture of membranes
PROM	premature spontaneous rupture of membranes
PSCU	perinatal special care unit
PTL	preterm labor
RLTCS	repeat low transverse cesarean section
SHG	sonohysterography
SROM	spontaneous rupture of membranes
SSE	sterile speculum exam
SVD	spontaneous vaginal delivery
T & C	type and crossmatch
T & S	type and screen
TAH	total abdominal hysterectomy
TOLAC	trial of labor after cesarean
TP	teen pregnancy
TVH	total vaginal hysterectomy
UTI	urinary tract infection
VAVD	vacuum assisted vaginal delivery
VE	vaginal exam
VBAC	vaginal birth after cesarean