

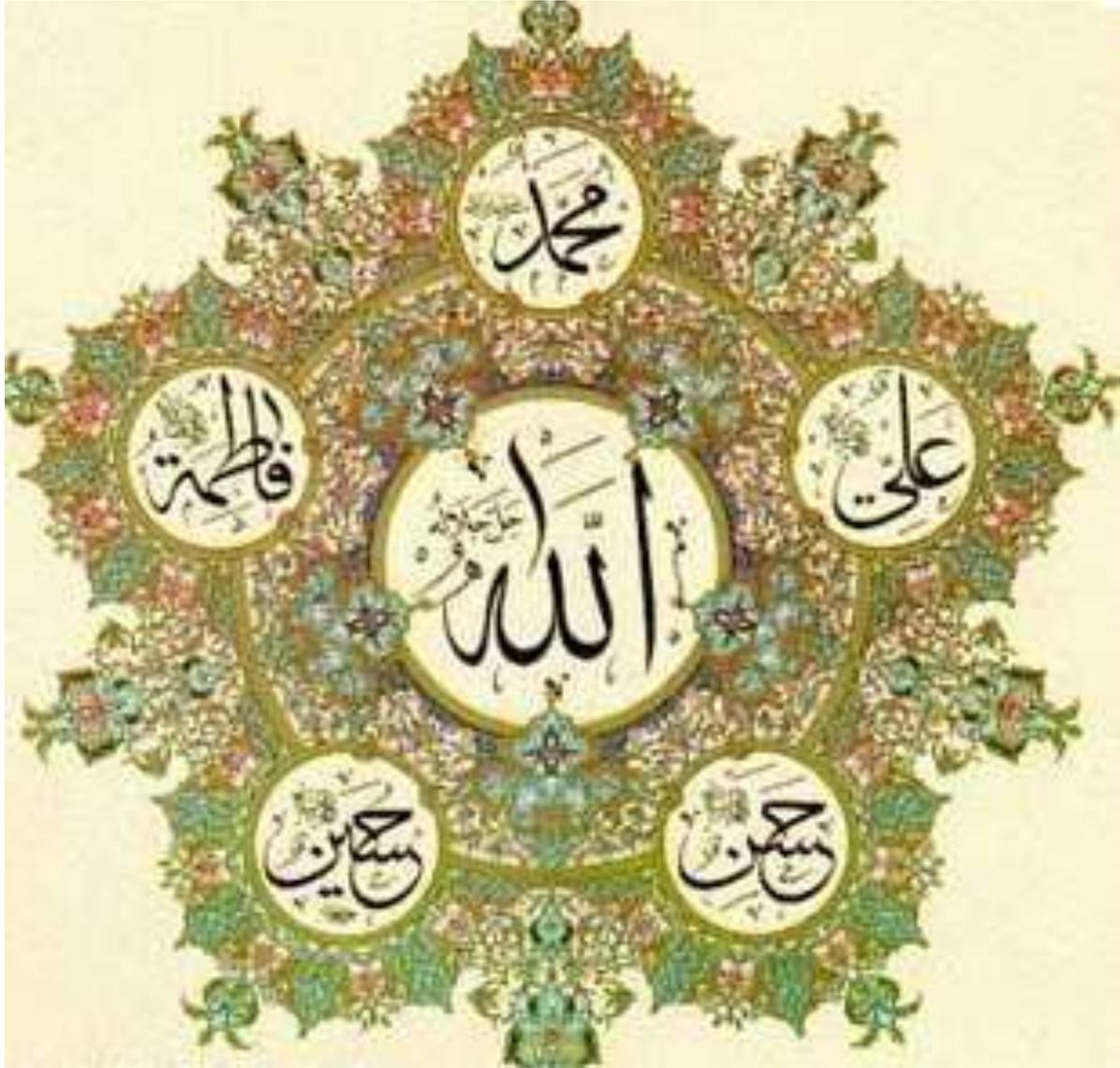
NUGGETS

OBSTETRICS AND GYNECOLOGY



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DEDICATED TO.....



MEDICAL DISORDERS IN PREGNANCY NUGGETS....

1) Diabetes can manifest in two ways: i) Patient already diabetic ii) Gestational diabetes (24-28 weeks) in 2-9% pregnancies

2) If a female is already diabetic :

i) Risks to baby: Antepartum: congenital (Neural tube defects, caudal regression; still-birth, miscarriages); macrosomia, IUGR.....

Intrapartum(Shoulder dystocia).....

Neonatal (Hypoglycemia, hypocalcemia, polycythemia, hyperbilirubinemia, RDS)

ii) Risk to mother: Antepartum(nutritional, PIH, pre-eclampsia, infections).....

Intrapartum(obstructed labor)..... postpartum(pph, hypoglycemia)

3) As gestational diabetes happens only in 24-28 weeks.... Complications include all the above mentioned but the CONGENITAL DISEASES are not associated b/c they will happen if hyperglycemia is in early pregnancy during the period of organogenesis;

4) Women with risk factors ; on 24-28 weeks pregnant should undergo screening tests for Gestational diabetes which include:..... If there is previous history of GDM; 1st test should be done on 16-18 weeks and 2ndly on 24-28 weeks

i) 1 hour 50g Oral glucose challenge test (OGCT)

ii) 2 hour 75g Oral glucose tolerance test (OGTT)

If any of the screening test is positive ie: >140mg/dl..... Then use CONFIRMATORY test... viz: 3 hour 100g Oral glucose tolerance test (OGTT)

5)Diabetes in 1st trimester risks baby for congenital abnormalities including CNS abnormalities and this risk of congenital abnormalities strongly correlates with maternal level of HbA1c. if HbA1c >10 % = 30% chance of congenital abnormalities.. so glycemic control is mandatory & target HbA1c should be <6.5% and glucose 3.5-5.5 mmol/L... Also due to risk of these congenital abnormalities ALWAYS GIVE A DIABETIC WOMEN HIGH DOSE FOLATE SUPPLEMENTS (5mg) and also screen for Congenital abnormalities.

6) Delivery of baby in diabetic women should not be delayed >39 weeks. i.e: deliver before 39 weeks. 50% ladies would undergo C-section b/c of shoulder dystocia/ CPD..... Also if there is vaginal candidiasis = Do c-section (not svd)

7) For glucose control during intra-partum period... Insulin infusion with 5%dextrose water is given.

8) Level of HbA1c strongly co-relates with the incidence of congenital abnormalities.

9) Thyroid binding globulins Normally increase during pregnancy so total t3 & t4 level increase but free t3 and free t4 levels are unchanged. So best test for thyroid disorder in pregnancy is FREE T-4.

10) Long acting THYROID STIMULATING ANTIBODIES in grave's disease can cross placenta after 20 weeks and can cause neonatal hyperthyroidism.... So measure thyroid hormones in cord blood of newborn.

11) For hyperthyroidism: Propylthiouracil in 1st trimester; Carbimazole in 2nd and 3rd trimester.

12) Propylthiouracil is highly protein bound so less chance to cross placenta

13) Cyanotic heart diseases are very high risk pregnancy in women with heart diseases.

14) Pregnancy is contra-indicated in a woman with EISENMENGER SYNDROME.

15) Women with Marfan syndrome have >50% mortality rate esp if aortic root is >4cm dilated. So serial Echocardiographic monitoring should be done in Marfan pregnant lady.

15) As cardiac output and plasma volume increase during pregnancy; so heart diseases are more evident during pregnancy and the most important is MITRAL STENOSIS..

16) For pregnant woman with M.S/heart disease give EPIDURAL ANALGESIA during labor; Forceps delivery is best; avoid c-section; Give endocarditis prophylaxis; Fluid restriction; oxygen inhalation; DO NOT GIVE ERGOMETRINE during 3rd stage of labor ; instead give slow infusion of syntocinon..... also after deliver : vigilantly monitor for PULMONARY EDEMA and PERI-PARTUM CARDIOMYOPATHY.

17) A woman in 3rd trimester with Itching and pruritis esp on palms; worse at night; Bilirubin and Bile salts elevated and liver enzymes mildly elevated = INTRAHEPATIC CHOLESTASIS OF PREGNANCY....it is due to Estrogen and very high recurrence rate in next pregnancy ; there is no risk to mother but child is having great risk of PRETERM LABOR AND STILLBIRTH..... Give ursodeoxycholic acid for pruritis and monitor fetal well being.

18) Most common anemia during pregnancy is NUTRITIONAL DEFICIENCY and most common nutrient deficiency is IRON.

19) Anemia = Hemoglobin <11g/dl....

20) Total iron requirement during pregnancy = 1200mg.....(placenta = 300mg; fetus=300mg; RBC=600mg))

21) Non-pregnant woman needs 2mg/day iron.

22) Pregnant: (2mg +)

1st trimester = 0.8 mg/day

2nd trimester = 4.4mg/day

3rd trimester = 7.7mg/day

23) Oral Feso4 is given during pregnancy ; s.e: diarrhea, constipation, cramps..... take oral iron with meals and Vitamin C aids in absorption.....

24) If can't tolerate orally or anemia >28 weeks = give: p/E::: iron(Dextran, Sucrose, sorbitol, Feric carboxymaltase).... Iron sorbitol is given i/m on buttock with Z-technique to prevent dark staining.

25) Response to iron therapy manifests 4-8 weeks after starting therapy so if u want to assess the response to therapy before 4 weeks..... Do RETICULOCYTE COUNT as reticulocytosis happens 7-10 days after iron supplement.

26) If anemia >36 weeks / SEVERE ANEMIA/ cardiac failure= we can't wait 4-8 weeks for effect of iron supplement = SO TRANSFUSE PCV. Or EXCHANGE TRANSFUSION

27) Folic acid deficiency esp in Multiple pregnancy; diabetic; and in women on anticonvulsants....For prophylaxis = 400ug (0.4mg)/ day is given = mainly combined with iron tabs.... Folic acid prophylaxis is given before pregnancy and continuing in 1st half of pregnancy.....but if lady has already folate deficiency = give high dose x10 times = 4000 ug (4mg)... and continue giving even four weeks after delivery..... similarly if a lady has previous history of neural tube defects = give same high dose folic acid.

28) Malaria also causes folic acid deficiency...and folic acid deficiency in turns lead to NTD, Megaloblastic anemia and ABRUPTIO PLACENTA.

29) Most common chronic disease in pregnancy is ASTHMA

30) Most common cause of jaundice in pregnancy is VIRAL HEPATITIS and esp Hep E is notorious in preg.

31)

LABOUR/OBS EMERGENCIES/ NUGGETS.....

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- 1) Most common cause of breech presentation is PREMATUREITY and the incidence of breech at term is 3%..... & the most common type of breech is FRANK (EXTENDED)
- 2) Footling breech (incomplete breech) can lead to Cord prolapse and Foot prolapse
- 3) External cephalic version should not be done <37 weeks and before doing ECV; give RhoGam to Rh-ve mother; empty the bladder; and do under USG guidance
- 4) If a lady has undergone a previous C-SECTION and now has breech = never do ECV.
- 5) A lady presenting with pain and some bleeding p/v after undergoing ECV = its ABRUPTION
- 6) Before doing vaginal delivery for breech = always rule out CPD... and baby weight should be <3.8kg
- 7) vAGINAL BREECH DELIVERY: Give epiziotomy..... Pinard manuevere (for legs)..... Loveset manuevere(for shoulder).....For head (Maurecci-smelli-veit manuevere; Burn marshell; Piper forcep)
- 8) For aftercoming head of breech.....i) If nape of neck not visible = Mauricei Smelli veit;..... ii) If nape of neck visible = Use Piper forcep)
- 9) Breech incidence = 3/100 Face: 1/500..... Brow= 1/2000....

10) Cervix dilated and on P/V baby NOSE, MOUTH, EYE FELT= Face presentation Presenting diameter is SUBMENTOBREGMATIC..... TWO TYPES (mento-anterior; mento-posterior)..... Mento-anterior can undergo vaginal delivery but for mento-posterior=do always c-section..... when u find face presentation = always rule out ANENCEPHLY, GOITER, NECK MASS OF BABY.....

Most cmn congntal abnor associated with FACE PRESENTATION = ANENCEPHALY

11) Cervix dilted and on P/V Baby NOSE, SUPRAORBITAL RIDGES, ANTERIOR FONTANELLE felt..... BROW PRESENTATION..... presenting diameter is MENTOVERTICAL..... Do always c-section

12) Episiotomy can be given MEDIAL or MEDIO-LATERAL..... everything is GOOD about MEDIAL but one thing is bad = it has high incidence of PERINEAL TEARS (3RD AND 4TH DEGREE)..... Everything is BAD about MEDIO-LATERAL but one thing is GOOD = Less chance of perineal tears. (so it is preferred despite of less healing , more bleeding etc)

13) Woman at term with regular uterine contractions; Cervix fully dilated and baby at 0 - +1 station .. No descent change in 3 hours PROLONGED 2ND STAGE OF LABOUR : = causes= problem with 3-P (Power, Passage, Pessenger)

14) Most common cause of prolonged 2nd stage is Secondary uterine inertia (power) b/c of Maternal dehydration/Ketosis/Epidural analgesia = Do rehydrate and give I/V Syntocinon

15) Problems with Passage and Pessenger include Occipito-posterior position (OP) ; Deep transverse arrest and Cephalopelvic disproportion...

16) for OP = do C/s or Instrumental delivery

17) For deep transverse arrest = Use killiand forcep or C-section

18) Cephalopelvic disproportion include many causes

i) Fetal = Shoulder dystocia, macrosomic baby, thyroid tumor, neck mass, cystic hygroma

ii) Maternal = short stature, vit d def, contracted pelvis.....

For all above C-SECTION IS PREFERRED... but Shoulder dystocia is managed differently....

19) Women delivering baby at 2nd stage..... head come out but shoulder not delivering with POSITIVE TURTLE SIGN = Shoulder dystocia..... manage by HELPER...

i) H: Call for Help

ii) E: Epiziotomy

iii) L: Legs elevate (McRobert manuevere)

iv) P: Pressure (suprapubic)

v) E: Enter the vagina for posterior shoulder rotation (Wood corkscrew)

vi) R:

Reach posterior shoulder and deliver

Return head into vagina for c-section (Zavanelli manuevere)

Rupture the clavicle of baby or Pubic symphysis of mother

20) CTG measures i) Baseline heart rate ii) Baseline variability iii) Accelerations iv) Decelerations iv) Uterine contractions

21) If CTG is showing 2 accelerations in 20-30 mins = it is REACTIVE CTG=normal

22) If CTG is showing decelerations = its abnormal =

i) Early decelerations = Head compression / CPD

ii) Late decelerations = Uteroplacental insufficiency/ Fetal hypoxia

iii) Variable/Sinusoidal = Cord compression/ Cord prolapse

23) A lady with known uterine fibroid/any abnormality; at term with regular uterine contractions; footling breech with umbilical cord protruding; CTG showing Variable decelerations = UMBILICAL CORD

PROLAPSE.....Rx... i) Move woman to all 4 with head down; Knee-chest position; Exaggerated Sims position ii) Fill the bladder with 500ml saline iii) Minimal cord handling and replace cord into vagina carefully iv) If cervix not fully dilated = immediate c-section v) If cervix dilated and head below 0 = Immediate forcep delivery....

As it is emergency like shoulder dystocia (so call for help/ iv line/ catheter bla bla to likhna he ha)..... dont wait kyunki 10 min tk prolapse rehy to brain damage hojata ha and 20 min k ander death hojati ha....after birth of baby.. Take cord blood sampling for ABGs

24) Induction of labor depends upon BISHOP SCORE..... total bishop score=13.....

25) If Bishop score >6 : i) ARM ii) Dilute synto infusion iii) Membrane Sweeping

26) If Bishop score <6 : i) Prostaglandin pessary (PGE2, F2a).... ii) Prostaglandin gel..... iii) Oral prostaglandin..... iv) Vaginal Misoprostol tab..... v) PGE2 administer via EXTRA-AMNIOTIC FOLLEY CATHETER

27) Most common indication for induction of labor is PROLONGED PREGNANCY..... other are: PROM, PRE-ECLAMPSIA, IUGR, DM, TWIN >38WK, ISOIMMUNIZATION, APH, maternal deterioration, Fetal death

28) Prostaglandin and Synto cause = Uterine hyperstimulation.... ARM lead to = cord prolapse and Abruption..

29) Max time of 2nd stage of labor = 2hours in Primi and 1 hour in Multi..... If epidural given = add 1 hour

30) Most common indication for c-section = Prior history of c section

31) Normal baby enters the pelvis at LEFT-OCCIPITO TRANSVERSE position and comes out at OCCIPITO-ANTERIOR POSITION with outcoming diameter= SUBOCCIPITOBREGMATIC = 9.5 cm..

32) In face presentation = SUB-MENTOBREGMATIC = 9.5 cm

33) In Brow presentation = Mentoverical = 13.5 cm (Largest skull diameter)

34) Android and Anthropoid pelvis give rise to PERSISTANT OCCIPITO-POSTERIOR POSITION = so prolong 2nd stage.....

35) The only indication for INTERNAL PODIALIC VERSION is delivery of 2nd twin after 1st..... e:g if 2nd twin has transverse lie and 1st has delivered = u can do INTERNAL PODIALIC VERSION...

36) Vaginal delivery should not be done in TRANSVERSE LIE..... the only indication of vaginal delivery is delivery of 2nd twin by internal podialic version

37) Placenta adherent to uterine wall = Accreta

38) Placenta invading into uterine wall/myometrium = Increta

39) Placenta invading through uterine wall = Percreta

40) Placenta with a separate portion connected to it with artery and vein = Succunuriate lobe of placenta

Small placenta constricted by amniotic ring = Circumvellate placenta

41) Placenta with umbilical cord attached at on edge = Battledore placenta

42) Largest fetal skull diamater = Mentoverical (13.5cm)

43) Smallest fetal skull diameter = Suboccipitobregmatic (9.5cm)

44) After Perineal tears; the most common position for vaginal tears is over ISCHIAL SPINE = so examine it after delivery

45) Perineal tears:

1st degree = Only vaginal skin/mucosa

2nd degree = Perineal muscles

3rd degree = anal sphincter (ext/int)

4th degree = anal/rectal mucosa

46) Pregnant with previous h/o C-section (esp classic c-section); abdominal pain with contractions and p/v bleeding 3rd trimester; Soft and tender abdomen; Loss of FHR = UTERINE RUPTURE = Do Surgery ; deliver baby and repair if young ; in old=hysterectomy

47) Pregnant with h/o trauma/ECV/PROM/HTN; abdominal pain and p/v bleeding 3rd trimester; Tense and tender abdomen = ABRUPTIO PLACENTAE= If mild (Expectant management: bed rest, iv, maternal and fetal monitoring).....If moderate to severe: i) Mother+fetus stable/>36 wek = Vaginal delivery by Induction ii) If not stable = immediate C-SECTION.....

COMPLICATIONS: A) MATERNAL: ARF, DIC, PPH, Rhesus sensitivity, recurrence, maternal mortality

B) FETAL: Perinatal mortality, Stillbirth, FGR, congenital malformation

48) Pregnant with h/o previous c-section; bright red vaginal bleeding; NO ABDOMINAL PAIN = PLACENTA PREVIA....Do NOT DO VAGINAL EXAMINATION..... i) If mild: Expectant: bed rest, tocolytics, serial ultrasound, Betamethasone for lung maturity)

ii) If mod t severe: C-SECTION.....if placenta is >2cm from cervical os = vaginal delivery can be done

49) Pregnant at 3rd trimester underwent ARM and after that PAINLESS vaginal bleeding ; CTG show fetal bradycardia = VASA PREVIA.....Do immediate c-section..... VASA PREVIA is associated with VELAMENTOUS INSERTION OF CORD/ SUCCENTURIATE LOBE OF PLACENTA

50) Woman with sudden onset of dyspnea, cyanosis and shock during labor = AMNIOTIC FLUID EMBOLISM.....maintain ABC.....poor prognosis

51) On vaginal examination you found TWO fetal bony prominence and ONE ORIFICE which are making a triangle = FACE PRESENTATION (2 malar eminence and 1 mouth)

52) On vaginal examination you found TWO fetal bony prominence and ONE ORIFICE which are making STRAIGHT LINE = FRANK BREECH (2 ischial tuberosities, one anus)

SHAFERVAR

Ideally a mother should attend the antenatal clinic 1/month for 7 months

2/month on 8th month

1/week in 9th month

But minimum 3...

1st: 20 week

2nd 32 week

3rd 36 week

SHAHRIYAR

ANTENATAL VISITS AND PRENATAL DIAGNOSIS NUGGETS.....

1) On Booking Visit do these investigations: (1st trimester tests)

CBC.....blood group.....urineanalysis for asymptomatic bactiuriaRubella screening.....Hepatitis B.....

HIV.....Syphilis.....Hemoglobinopathies (Thalasemia; Sca)

2) Normally : some parameters in blood decrease (Hematocrit, albumin, uric acid, creatinine, Hemoglobin)..... Some parameters increase (WBC, Clotting factors, ESR, gamma globulins, fibrinogen)..... RBC mass increases but their number remains constant... whereas PLATELETS remain constant : so decrease in platelet is indicative of Thrombocytopenia.....

3) Dating scan : 10-14 weeks = see for Nuchal translucency and look Crown Rump Length

4) Congenital anomaly scan: 18-20 weeks

5) Anti-RhD antibodies test and adminstor dose = 28 weeks..... (300ug)

6) Minimum 4ml of blood is required for significant Rh sensitization.....eg: if a Rh -ve woman conceives Rh+ve baby... due to any reason; if 4ml of blood gets enter into mother = She gets sensitized by making Anti-Rh antibodies IgG.

7) If mother RH-VE and father RH +VE = RhoGam at 28 weeks ;....; repeat 34 weeks (300ug)

8) If baby Rh+ve.....also give RhoGam after birth (300ug)

9) If a women is undergoing some procedures like Amniocentesis, CVS, ECV, Cordocentesis.....or she sustained trauma.....or ectopic pregnancy; abortion = also give RhoGam

10) visit schedule is: 10-14, 16, 18-20, 25, 28, 31, 34, 36, 38, 40, 41

11)

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Endometrial Malignancies NUGGETs.....

- 1) The most common cause of post-menopausal bleeding is ATROPHIC VAGINITIS and it is treated with TOPICAL ESTROGENS
- 2) other causes of postmenopausal bleeding : Endometrial hyperplasia, endometrial carcinoma, endometrial polyp, cervical ca, cervical polyp..
- 3) The gold standard for diagnosis of endometrial carcinoma = Hysteroscopy and Biopsy
- 4) Mean age for presentation of endometrial carcinoma= 54 years
- 5) Endometrial biopsy can be taken by : i) Hysteroscopic guidance ii) Pipelle iii) D&C
- 6) 1st use PIPPLE for taking endometrial biopsy but many postmenopausal women have cervical stenosis as well = so use DILATATION AND CURETTAGE for taking biopsy
- 7) For all stages of endometrial ca = TAH+BSO..... Stage2 onwards will need RADIOTHERAPY and LYMPH NODE DISSECTION AS WELL..... whereas for stage 3 and 4 = add chemo as well.
- 8) As estrogen replacement therapy is a risk factor for endometrial carcinoma so POST-MENUPASAL WOMEN SHOULD TAKE PROGESTERONE IN ADDITION TO ESTROGEN TO PREVENT THE UNOPPOSED ESTROGEN RESPONSE ON ENDOMETRIUM
- 9) Similarly POLYCYSTIC OVARIAN SYNDROME IS ALSO A RISK FACTOR FOR ENDOMETRIAL CARCINOMA = GIVE THEM PROGESTERONE
- 10) Normal thickness of endometrium = 4mm
- 11) Unopposed estrogen increases the risk for endometrial and ovarian carcinoma whereas COMBINED ORAL CONTRACEPTIVE PILLS reduce..
- 12) Simple and complex endometrial hyperplasia =Rx by Mirena IUCD, progesterone, medroxyprogesterone acetate Atypical hyperplasia = Rx by TAH
- 13) Radiotherapy is given in endometrial carcinoma to prevent recurrence BUT the most common site of recurrence = VAGINAL VALUT..... REMEMBR: radiotherapy does not increase survival

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INFERTILITY & PUBERTY NUGGETS.....

1) Failure to conceive after regular un-protected intercourse for 2 years in absence of any known reproductive pathology = INFERTILITY... 10-20% ppl will be facing this prblm

2) Whenever a couple comes with the workup of infertility = 1ST OF ALL DO SEMEN ANALYSIS.....
Before doing semen analysis make sure not to do intercourse for atleast 3 days.....

Normal parameters of semen analysis (v.v.v.v.imp) :

- i) Concentration : >2 crore/ ml
- ii) Morphology: >30%
- iii) Motility: >50%
- iv) pH: 7.2 - 7.8
- v) vol = >2ml

3) If Mild oligospermia = Do IUI (Intrauterine insemination) with washed MAN'S SPERMS via fine catheter = success rate 15-20%... during this procedure give female partner mild stimulation with FSH to mature 2-3 follicles and inseminate uterus..... IUI can also be used if there are antibodies to cervical mucus...

Scenario could be: A couple with male infertility; semen analysis shows concentration = 14 million/ml..... 25% motility.....23% morphology; all other things normal.....what is the 1st line therapy?? its IUI (intrauterine insemination)

4) if moderate to severe oligospermia = Do ICSI-IVF cycle

5) If AZOSPERMIA (no-sperms) = do SSR (SURGICAL SPERM RETRIVAL) ---->then do IVF..... if not successful = do AID (Artificial insemination by donor)

6) If a person has azospermia also investigate him for cystic fibrosis or congenital bilateral absence of vas deferenc

7) Whole process of spermatogenesis takes 74 days and head of epidydimitis stores upto 70% of sperms

8) Azospermia = no sperms

Necrospermia = immotile sperms

Teratospermia = Abnormal sperms

Asthenospermia = sperms with sluggish motility

Cryptospermia = sperms not coming out of testis/ obstructed

9) If semen analysis is normal = look for female factors and 1st check whether she is ovulating or not... = MID-LEUTEAL PROGESTERONE LEVEL is used to check whether ovulation is taking place or not. (Normal MLP = >30nmol/L)

10) Most common cause of AN-OVULATION = POLYCYSTIC OVARIAN SYNDROME.... other causes include:

- i) HORMONAL PROBLEMS: Hypothalamo-pituitary-ovarian dysfunction, Thyroid disorders, Hyperprolactinemia, tumors involving pituitary or hypothalamus, Ovary not working itself
- ii) Functional: BMI >29 or <19, premature cessation of ovulation, emotional stress

11) Treatment of ovulation depends upon cause:

- i) If ovary not working: Clomiphene citrate/ Letrozole/ Laproscopic ovarian drilling
- ii) If pituitary not working: HMG (Human menopausal gonadotropin containing FSH and LH)
- iii) If Hypothalamus not working: GnRH analogue

Besides these = For rapid induction of ovulation = give HCG === leads to ovulation after 38-40 hours of injection

12) If you are using In vitro fertilization (IVF) = you take sperm from male by doing testicular biopsy.... at the same time female is given HMG (to stimulate and produce multiple follicles)....> when follicles have been matured = we need rapid induction = so used HCG now to induce rapid ovulation and collect these eggs under ULTRASOUND GUIDANCE.....

13) Side effects of CLOMIPHENE CITRATE: Ovarian hyperstimulation syndrome; Twin pregnancy; Thinning of cervical mucus; Hotflushes; weight gain; osteoporosis

14) Note: Hot flushes and vasomotor are also the early symptoms of MENOPAUSE as well... and the only indication for HRT post-menopausally is these VASOMOTOR SYMPTOMS...

15) If in infertility workup... semen analysis is normal; ovulation is normal?? what to check further???.... there might be some problem with cervical mucus/ cervical mucus antibodies which may kill sperm..... this can be checked by POST-COITAL TEST / SIMMS-HUHNER TEST...

16) If semen analysis normal; ovulation normal; Cervical mucus normal...??? what to check further??? Might be some pathology with FALLOPIAN TUBES/Tubal blockade..... Do HYSTEROSALPINGIOGRAM.....

17) Tubal blockade may be due to PID or TB
PID: Chlamydia/gonorrhoea=may lead to pyosalpinx / hydrosalpinx
TB: Causes Beaded appearance and calcification of fallopian tubes

18) If Hysterosalpingiogram shows findings suggestive of tubal blockade you can do

- i) Laparoscopy ii) Ecovist iii) Rubin test
- iv) Hysteroscopy v) Salpingioscopy

Note: Dye present in HSG can also lead to spasm of proximal fallopian tube which is mis-interpreted as tubal blockade... so keep in mind while doing it

19) Gold standard from above 5 is LAPROSCOPY which is diagnostic as well as therapeutic

20) If there is tubal blockade you can use

- i) Tubal reconstructive surgery
- ii) IVF

21) So remember: IVF can be done if there is SEVERE OLIGOSPERMIA or if TUBUL BLOCKADE..... but remember: WHENEVER U R DOING IVF IN A FEMALE WITH TUBUL BLOCKADE AND SHE HAS HYDROSALPINX AS WELL= 1ST LIGATE THE FALLOPIAN TUBE AND THEN DO IVF b/c HYDROSALPINX LEADS TO FAILURE

22) Short luteal phase is due to Hyperprolactinimia = leads to INFERTILITY and SPONTANEOUS ABORTIONS.....treated by BROMOCRIPTINE.

23) 40% of infertile men have VARICOCELE.....VARICOCELE CAUSES OLIGOSPERMIA not AZOSPERMIA

24) Normal phases of puberty:

Thelarche (9.8 yr)-----> Adrenarche (10.5 y)-----> Menarche (12.8 y)

Of all these; ADRENARCHE is independant of estrogen; all other are estrogen dependant

25) If any puberty change happens <8 years of age = PRECOCIOUS PUBERTY...

26) Causes of PRECOCIOUS PUBERTY:

i) CNS TUMORS: do MRI

ii) McCune Albright syndrome = Cafe-leut spots, Polyostotic fibrous dysplasia of bones.... puberty is due to AROMATASE ENZYME which lleads to increased estrogen production by ovary...So Rx by aromatase inhibitor

iii) Granulosa cell tumor... Look for pelvic mass

CONTRACEPTIVES NUGGETS.....

- 1) The spermicidal agent used in Sponge and Gels for barrier contraception is NONOXYNOL-9
- 2) Diaphragm should be inserted 6 hours before intercourse and should be kept there 6 hours after intercourse..... if kept for long time... can lead to urinary retention
- 3) IUCD are indicated for women i) Who have atleast one child ii) Have normal menstrual cycle iii) No h/o of PID iv) In monogamous relationship
- 4) IUCD should never be used for NULLIPAROUS; woman with MULTIPLE SEX PARTNERS; H/O ECTOPIC PREGNANCY; H/O PID; GTD; immediate-postpartum or immediate-septic abortion
- 5) Mirena IUCD can be used for 5 years; have low failure rate than cu; causes hormonal side effects like acne, mastalgias, irregular periods
- 6) Cu-T can be used for 10 years; have high failure rate than mirena; no hormonal side effects; causes painful periods
- 7) Mirena can also be used for other purpose beside contraception eg HRT and aslo helps in prevention of HEAVY AND PAINFUL MENSES; but it does not controls menorrhagia caused by uterine fibroids
- 8) Other side effects of IUCD are: Bleeding; pain; PID; infection; spontaneous abortion; ectopic pregnancy; expulsion; dysmenorrhea
- 9) If estrogen component of combined oral contraceptive pills (COCP) is >50ug = it can lead to ARTERIAL AND VENOUS THROMBOSIS.
- 10) Side effects of COCP:
 - i) Mild: Nausea, mastalgia, migraine, weight gain
 - ii) Moderate: Breakthrough bleed, acne, hyperpigmentation
 - iii) Severe: Thromboembolism, Hypertension, DVT, Hepatic adenoma, Cholestasis, premature cessation of lactation, Atherogenesis.
- 11) As COCP can cause PREMATURE CESSAION OF LACTATION= they should never be used in LACTATING WOMEN.....BUT the contraceptive of choice in LACTATING WOMEN IS PROGESTERONE ONLY PILL (MINI-PILL).... although BREASTFEEDING IS NATURAL CONTRACEPTIVE but remember:: Breastfeeding prevents ovulation only for 1st 6 months.... usk baad beshak mother jitni dair tk feed kraye ovulation ho ge... so POP would be better choice to use for them....
- 12) Although failure rate of POP is high as compared to COCP ; but it is better contraceptive choice for i) Brestfeeding women ii) Old age (>40 years) iii) Patients with CVS risk factors eg smoker, diabetic
- 13) Progesteron only contraceptive methods include : POP, DMPA, Implanon, Mirena, pLAN-B (Levonogestrel)

14) Implanon contains 68mg Etonogesterel which is given sub-dermally after local anesthesia and gives effective contraception for 3 YEARS.

15) A couple having sexual intercourse and CONDOM BURSTS / UNPROTECTED unplanned sexual intercourse== What to do now?..... use EMERGENCY CONTRACEPTION (POST-COITAL CONTRACEPTION) which include

i) Mechanical (insert copper-T iucd within 5 days)

ii) Hormonal (PLAN B= Levonogestrel 0.75mg tab.... 1 goli abi and 1 goli 12 hours baadbut both tabs should be given if time frame is <72 hours)

iii) Mifepristone (RU-486)... 10mg SINGLE DOSE WITHIN 72 hours

16) Methods of terminal contraception include VASECTOMY in males and FEMALE STERILIZATION..

17) Methods of female sterilization include: Fallopian tube Clips, Rings, Tubul Ligation, Electro-cautry, Essure, Chemical Quinacrine....

18) All female methods of sterilization can be done by Laproscopy/Mini-laprotomy in general anesthesia but ESSURE and Quinacrine can be done under Local.

19) VASECTOMY can be done under LOCAL ANASTHESIA and include: Clips, Ligation, Excision, Sclerosing agents, Non-scalpal vasectomy

20) VASECTOMY is most effective mean of contraception b/c it has very low failure rate i.e 0.02/HWY..... but immediately after doing vasectomy= there are still sperm in the genital tract and those sperms get rid of the body after atleast 12 ejaculations so couple should use barrier or other methods for 3 months atleast after vasectomy.... and complete vasectomy is said if 2 CONSEUCTIVE SPECIMENS ARE FREE OF SPERMS....

21) The most common complication of vasectomy is HEMATOMA others are: i) Sperm granuloma ii) Anti-sperm antibodies iii) Failure after long time

LIVE LIKE MUHAMMAD (S.A.W.W) & ALI (A.S)

DIE LIKE HUSSAIN (A.S)

☺ **STAY BLESSED** ☺