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ODESA NATIONAL MEDICAL UNIVERSITY

Department of Obstetrics and Gynaecology

APPROVED

Vice-rector for scientific and pedagogical work

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METHODOLOGICAL RECOMMENDATIONS FOR MEDICAL PRACTICE "OBSTETRICS AND GYNECOLOGY"

(THE MAIN DUTIES AND PROFESSIONAL ACTIONS OF A DOCTOR OF WOMEN'S CONSULTATION)

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TOPIC 1
" Medical techniques in obstetrical practice".

Purpose: to master the correct implementation of practical skills during the examination of pregnant women. Identify from complaints, anamnesis, data of subjective, objective and special methods of examination the signs and features that are needed to establish the final diagnosis, evaluate them. Formulate deontological principles of communication with pregnant women.

Basic concepts (list of questions): anatomy and physiology of female genital organs in pregnant women. Peculiarities of performance of practical skills in pregnant women. Carrying out pelviometry. Leopold's techniques. Auscultation of the fetus. Determination of the expected date of delivery and the weight of the fetus. Apgar scale. Deontological principles of communication with pregnant women during practical skills.

Basic concepts for the lesson:

1.Scheme of examination of pregnant women

2. Carrying out pelviometry

3. External obstetric examination (Leopold's techniques)

4.Determination of the expected date of delivery and the weight of the fetus

5. Carrying out auscultation of the fetus

6. Evaluation of a newborn child according to the Apgar scale

Plan:

1. **Knowledge control.**

1.A 17-year-old woman in labor was hospitalized in the maternity ward with active labor. During the internal obstetric examination, a diagonal conjugate was determined. Specify its normal value.

A. 11-12 cm

B. +12.5-13 cm

C. 10-11 cm

D. 20-21 cm

E. 30-31 cm

2. Pregnant A., 30 years old, has the dimensions of the pelvis: 26-28-30-20 cm. The diagonal conjugate is 12.5 cm. The circumference of the carpal joint is 15 cm. Determine the true (obstetric) conjugate?

A. +11 cm

B. 28 cm

C. 12 cm

D. 25 cm

E. 13 cm

3. When measuring the size of the pelvis, it is established that the size of the pelvis is 26-29-31-21 cm. Determine the true conjugate.

A. +12 cm

B. 9 cm

C. 10 cm

D. 13 cm

E. 10.5 cm

4. During the external obstetric examination, it was established: the shape of the uterus is elongated in the transverse direction, the gestation period is 40 weeks, the head is palpated on the left side of the uterus, the pelvic end of the fetus is palpated on the right, the anterior part is absent above the entrance to the small pelvis. The heartbeat of the fetus is most distinctly heard on navel level. What is the position and position of the fetus?

A. +Transverse position, I position

B. Longitudinal position, II position, cephalic presentation

C. Transverse position, II position

D. Oblique position, II position

E. Longitudinal position, I position, pelvic presentation

2. **Discussion of theoretical questions.**

Algorithms for performing practical skills

Measurement and assessment of the size of the female pelvis.

1) greet the patient;

2) identify the patient (name, age);

3) inform the patient about the necessity of conducting the study;

4) explain to the patient how the study is conducted;

5) obtain permission to conduct research;

6) wash hands;

7) put on inspection gloves;

8) pick up a tazometer;

9) place the tasomer buttons on the front-upper spines of the iliac bones (indicate the normative indicator of D. spinarum = 25-26 cm);

10) move the buttons of the tazomer to the most distant places of the crests of the iliac bones (specify the standard indicator of D. cristarum = 28-29 cm);

11) install tasomer buttons on the large trochanters of the femurs (indicate the normative indicator of D. trochanterica = 30-31 cm);

12) lay the patient on her left side with the left leg bent at the knee joint; measure the distance from the upper edge of the symphysis to the suprasacral fossa (indicate the normative indicator of C. externa = 20-21 cm);

13) during the internal obstetric examination, measure the distance from the lower edge of the symphysis to the sacral promontory (indicate the normative indicator of C. diagonalis = 12.5-13 cm);

14) inform the patient about the results of the study;

15) thank the patient;

16) remove inspection gloves;

17) wash your hands.

External obstetric examination, vdetermining the topography of the fetus in the uterus

1) greet the patient;

2) identify the patient (name, age);

3) inform the patient about the necessity of conducting the study;

4) explain to the patient how the study is conducted;

5) obtain permission to conduct research;

6) wash hands;

7) put on inspection gloves;

8) by palpating the abdomen with the ribs of both palms, determine the level of the location of the bottom of the uterus and the part of the fetus located in the bottom of the uterus;

9) put your palms on the left and right part of the front wall of the uterus;

10) alternately palpate the front wall with the fingers of the corresponding hand, simultaneously fixing the opposite side with the palm of the other;

11) determine the position, position and type of the fetus;

12) place the hand on the upper edge of the pubic arch, cover the anterior part of the fetus;

13) determine the presentation of the fetus;

14) turn your back to the patient's head, place your palms on the front wall of the uterus;

15) move the palms from top to bottom and from the outside to the middle, trying to bring the fingers under the anterior part of the fetus;

16) determine the location of the anterior part of the fetus;

17) give a complete answer: position, position, type and presentation of the fetus;

18) thank the patient;

19) remove inspection gloves;

20) wash your hands.

Carrying out auscultation of the fetus, interpretation of CTG

1) greet the patient;

2) identify the patient (name, age);

3) inform the patient about the necessity of conducting the study;

4) explain to the patient how the study is conducted;

5) obtain permission to conduct research;

6) wash hands;

7) put on inspection gloves;

8) determine the location of the fetus in the uterus (visually on the phantom) - position, presentation, position, type of fetus;

9) determine and describe the location of the point for auscultation (on the phantom), attach a stethoscope;

10) calculate (on the phantom) the heart rate of the fetus (determine the heart rate of the fetus in 6 seconds, multiply the result by 10);

11) evaluate the obtained (on the phantom) fetal heart rate result (normal, tachycardia, bradycardia);

12) evaluate the results of CTG:

- variant of the norm
- pronounced tachycardia
- pronounced bradycardia
- monotonous rhythm
- late decelerations

13) thank the patient;

14) remove inspection gloves;

15) wash your hands.

Determination of the expected date of delivery and the weight of the fetus

1) greet the patient;

2) identify the patient (name, age);

3) inform the patient about the necessity of conducting the study;

4) explain to the patient how the study is conducted;

5) obtain permission to conduct research;

6) wash hands;

7) put on inspection gloves;

8) determine the expected date of delivery based on the data on the last menstruation, using the Nagele formula: add 7 days to the date of the first day of the last menstruation and subtract 3 months from the result;

9) palpate the middle of the upper-outer edge of the symphysis with your fingers and press the zero mark of the centimeter tape to it;

10) unfold the centimeter tape so that it is located along the middle line of the abdomen;

11) find the bottom of the uterus with the edge of the palm, by gently pressing on the abdomen, moving in the direction from the symphysis to the xiphoid process;

12) determine and remember the number corresponding to the height of the bottom of the uterus above the pubis on the edge of the palm that presses the centimeter tape;

13) place a centimeter tape around the abdomen in front at the level of the navel, behind - at the level of the lumbar region, mark the result obtained;

14) calculate the expected weight of the fetus using Jordania's method by multiplying: LW × VDM ± 200 gr.

15) inform the patient about the results of the study;

16) thank the patient;

17) remove inspection gloves;

18) wash your hands.

Evaluation of a newborn baby according to the Apgar scale

1) greet the patient;

2) identify the patient (name, age);

3) inform the patient about the necessity of conducting the study;

4) explain to the patient how the study is conducted;

5) obtain permission to conduct research;

6) wash hands;

7) put on inspection gloves;

8) evaluate the skin color of the newborn:

- pink - 2 points
- acrocyanosis - 1 point
- generalized pallor of the skin or generalized cyanosis - 0 points

9) assess the newborn's breathing:

- respiratory movements in full volume, loud cry - 2 points
- respiratory movements are irregular with the involvement of auxiliary muscles, the cry is weak - 1 point
- absence of respiratory movements - 0 points

10) estimate heart rate:

- more than 100 blows in 1 minute - 2 points
- less than 100 blows in 1 minute - 1 point

- absence of heartbeat - 0 points

11) assess muscle tone:

- active movements of the newborn in full - 2 points
- reduced tone - 1 point
- lack of movement, atony - 0 points

12) evaluate reflex reactions:

- reaction in the form of movements, coughing, sneezing, loud shouting - 2 points
- weak reaction (grimaces) - 1 point
- absence of any reactions - 0 points

13) determine the total number of points on the Apgar scale

14) determine the condition of the newborn (satisfactory, moderate, severe)

15) thank the patient;

16) remove inspection gloves;

17) wash your hands.

3.Formation of professional skills and practical abilities.

1. When measuring the pelvis, it was established that the diagonal conjugate is equal to 12 cm. The radius of the carpal joint is 14 cm.

What is the true conjugate equal to?

2.A pregnant woman applied to the housing complex to register her pregnancy. During the internal obstetric examination, the midwife managed to measure the distance between the tip of the sacrum and the lower edge of the pubic symphysis (conjugata diagonalis). After removing the right hand from the vagina, the midwife measured this distance with a tape measure.

What is this size?

3.A 32-year-old woman in labor came to the maternity hospital with complaints of cramp-like pain for 2 hours. It was found that the woman has a reduced diagonal conjugate.

With which examination was the result obtained?

4.A 29-year-old woman applied to a women's consultation regarding registration for pregnancy. During the vaginal examination, the diagonal conjugate, equal to 12.5 cm, was measured.

What measurement is necessary for a more accurate determination of the obstetric conjugate?

TOPIC 2

" Family planning counselling, selection of a postpartum contraception method."

Purpose: learn how to collect obstetric and gynecological anamnesis from a woman after childbirth. Learn the patient's examination plan before choosing a contraceptive method. Familiarize yourself with the main types of family planning activities in the postpartum period. Master family planning counseling. Learn how to select a modern method of postpartum contraception.

Basic concepts (list of questions): counseling on family planning: directions, advantages, counseling process. General overview of contraceptive methods: MLA, barrier methods and spermicides, IUD, COC, vaginal ring, contraceptive patch. Fertility recognition methods, voluntary surgical sterilization, emergency contraception. Assessment of the patient. An examination is necessary, which is carried out in a planned manner before making a decision on the use of a particular method of contraception. Family planning for people living with HIV.

Basic concepts for the lesson:

1. The main tasks of family planning, in particular in the postpartum period.
2. Clinical course of the postpartum period, concepts of early and late postpartum period.
3. The concept of breastfeeding.
4. Method of lactational amenorrhea (MLA).
5. Use of barrier methods of contraception and spermicides in the postpartum period.
6. Appointment of IUD in the postpartum period.
7. Purely progestin contraceptives for women after childbirth.
8. Voluntary surgical sterilization of women after childbirth.

Plan:

1. **Knowledge control.**

1. A 32-year-old woman with one child and infrequent (1-2 sexual contacts in two months) sexual relations with one sexual partner should be recommended:

A.Coitus interruptus (withdrawal)

B. Surgical sterilization

C.+ Condom

D.Natural method

E.Hormonal contraception

2. A woman, 23 years old, has no children. What method of contraception should she not use?

A.+Surgical

B. COC

C. IUD

D.Condoms

E.Natural family planning

3. A 28-year-old married woman with one sexual partner, suffering from chronic thrombophlebitis of the veins of the lower extremities, mother of one child, needs:

A. Oral contraceptives

B. Surgical sterilization

C.+ IUD

D. Implants

E. Spermicides

4.A 30-year-old patient complains of infertility for three years. In the history - ectopic pregnancy (operative treatment - salpingectomy on the left one year ago) and right ovarian cyst (operative treatment - adnexectomy on the right two years ago). The man was examined, no pathology was found. What fertility treatment tactics should be advised to this married couple?

A.+ In vitro fertilization

B. Laparoscopy

C. Hysteroscopy

D. Hydrotubation

E. Artificial insemination with donor sperm

2. **Discussion of theoretical questions.**

Clinical course of the postpartum period, concepts of early and late postpartum period

The postpartum period begins immediately after childbirth and lasts for 56 days. During this time, the organs of the woman's reproductive system return to the state that existed before pregnancy.

The postpartum period is divided into early and late.

The early postpartum period begins with the expulsion of the litter and lasts 2 hours. During this period, the woman in labor is in the delivery room under the supervision of a doctor, which is associated with the occurrence of complications, primarily bleeding. This period is very important and should be considered as a period of rapid adaptation of a woman's body after a heavy load during pregnancy and childbirth.

The late postpartum period begins 2 hours after childbirth and lasts for 56 days. During this period, there is an involution of all organs and systems that have changed in connection with pregnancy and childbirth. An exception is the mammary glands, the function of which is activated precisely in the postpartum period.

It should be noted that the appointment of any method or means of contraception, as a rule, becomes relevant after the end of 56 days after childbirth, because in most cases, due to social circumstances that are acceptable in society, the spouses have a period of postpartum abstinence (abstinence).

Breastfeeding concept

The most physiological, natural way of feeding newborns is breastfeeding.

Breastfeeding improves the course of the adaptive process, promotes local and general immunity, the formation of the physiological microflora of the intestines, and reduces the risk of early infection in newborns.

Feeding of the newborn is carried out at his request.

The method of lactational amenorrhea

The method of lactational amenorrhea (MLA) is the use of breastfeeding as a method of preventing pregnancy. It is based on the physiological effect of suppressing ovulation due to breastfeeding.

The duration of anovulation varies from 4 to 24 months after childbirth, although in some women ovulation resumes in the second month of the postpartum period. Data from scientific studies show that even after the return of menstruation-like secretions, the frequency of pregnancy in women who breastfeed is lower than among women who have stopped breastfeeding.

Physiological infertility develops during lactation. The frequency and duration of breastfeeding determine the duration of anovulatory infertility due to a decrease in the pulsatile release of gonadotropin-releasing hormone (GHG), which, in turn, leads to suppression of the secretion of luteinizing hormone (LH), which is necessary for normal ovarian activity. Previous studies have shown that during breastfeeding, the content of opioids in the hypothalamus, which affect the release of GTRH, decreases.

Prolactin production depends on the frequency and duration of breastfeeding. Breast sucking in newborns causes two reflexes that stimulate milk secretion:

Prolactin reflex: nerve impulses from the peri-mammary areas of the skin are transmitted to the vagus nerve, and then to the hypothalamus, where neuropeptides stimulate the production of prolactin in the pituitary gland, which leads to the secretion of milk and to anovulation;

Milk ejection reflex: impulses from the peri-mammary zone reach the posterior lobe of the pituitary gland, where oxytocin is secreted in response, causing contraction of the mammary gland and secretion of milk.

Although the benefits of breastfeeding for the health of the child are well known, the use of lactational amenorrhea as a method of family planning was determined not so long ago. An international group of scientists gathered in 1988 at the Center for Research and Conferences in Bellagio (Italy) reviewed the scientific data regarding the effect of breastfeeding on fertility.

The team concluded that women who are not using contraception but are fully or almost exclusively breastfeeding and who are amenorrhoeic have a very low risk (less than 2%) of becoming pregnant in the first six months after giving birth. The conclusions formulated by this group became known as the Bellagio Consensus.

The Consensus has become the scientific basis for determining the conditions under which breastfeeding can be safely used to plan birth intervals. Rules were developed for the use of lactational amenorrhea as a method of family planning. These rules include three conditions that must be met in order to ensure protection against unwanted pregnancy:

1. Exclusive breastfeeding;
2. Amenorrhea;
3. No more than 6 months have passed since childbirth

MLA provides protection against pregnancy by more than 98% during the first 6 months after childbirth if the above conditions are met.

Contraceptive advantages:

- Effective (1-2 pregnancies per 100 women in the first 6 months of use)
- Immediate effectiveness
- Not related to sexual intercourse
- Absence of systemic side effects
- There is no need for special medical observation
- Do not refill the contraceptive supply
- No money is required

Advantages are non-contraceptive (for the child):

- Passive immunization
- The best source of nutrients
- Reducing contact with infectious organisms in water, other milk or baby food, as well as with kitchen utensils

Disadvantages:

- Depends on the woman (requires compliance with the rules of breastfeeding).
- It can be difficult to perform due to social circumstances.
- It is highly effective only until menstruation resumes or for no more than 6 months.
- Does not protect against sexually transmitted diseases (including HIV/AIDS).

Who can use MLA:

Women who exclusively breastfeed at least 6 times a day, who have been less than 6 months postpartum and whose menstruation has not yet resumed.

Who should not use MLA:

Women who have resumed menstruation.

Women who do not exclusively breastfeed.

Women, if the child is 6 months or older.

How to use this method (MLA):

Feed the child from both breasts at her request approximately 6-10 times a day.

Feed the baby at least once at night (the interval between two feedings should not exceed 6 hours).

The child may not want to eat 6-10 times a day or may sleep through the night. These are normal phenomena, but if any of them occurs, the effectiveness of breastfeeding as a method of contraception is reduced.

Resumption of menstruation means that the reproductive function has been restored and the woman must immediately start protection (if she has no reproductive intentions).

If menstruation has resumed, the woman needs to start using another contraceptive method, if she is no longer exclusively breastfeeding or the child is 6 months old.

If a woman or her partner is at risk of contracting an STD, including the AIDS virus, barrier methods of contraception (condoms) should be used together with MLA.

Barrier methods of contraception and spermicides

Barrier methods of contraception can be defined as preventing unwanted pregnancy by preventing sperm from entering the vagina or cervix by chemical or mechanical means or a combination of both.

Despite the fact that there are now a number of more effective methods of contraception, the use of condoms remains very important, given that they are the only contraceptive method that can prevent the transmission of HIV and STDs.

It is the use of condoms as a means of preventing unwanted pregnancy that allows men to be actively involved in family planning and careful treatment of women.

When condoms are used correctly, their contraceptive effect is very high, "contraceptive failures" amount to 12.5%.

Mechanism of action:

They prevent sperm from entering the female reproductive tract.

Prevent the transmission of microorganisms (including STDs and HIV) from one partner to another (latex and vinyl only).

Contraceptive advantages:

- Immediate effectiveness
- Do not affect breastfeeding

- Can be used as an insurance method together with other contraceptives
- There is no health risk associated with the use of the method
- There are no systemic side effects
- Widely available (in pharmacies and in non-medical institutions)
- Sold without a prescription
- It is not necessary to conduct a medical examination before starting use
- Inexpensive method

Non-contraceptive benefits:

- Contribute to the involvement of the husband in family planning
- A single method of family planning that provides protection against STDs, HIV (only latex, vinyl)
- May help reduce the risk of developing cervical cancer
- Can be used in the treatment of immunological forms of infertility (within 3-6 months) to prevent sperm antigens from entering the vagina.
- Can be used in case of development of allergic reactions to seminal fluid and/or spermatozoa in a woman.

Disadvantages:

- Average effectiveness (2-12 pregnancies per 100 women during the first year of use)
- Contraceptive effectiveness depends on the couple's willingness to follow the instructions
- Can reduce the sensitivity of the penis
- Disposing of used condoms can be a problem
- Users must have appropriate storage conditions
- It is necessary to have a sufficient supply of condoms before intercourse
- Constant availability is required
- Both the condom itself and the spermicide can cause irritation in men and women

Who cannot use condoms:

- Couples where the woman's pregnancy is a serious danger to her health
- Couples in which one or both partners are allergic to the material from which condoms are made
- Couples who need a highly effective method of contraception
- Couples who want to use a method that does not involve sexual intercourse
- Couples who do not want to constantly and correctly use condoms during every sexual act

Spermicides

The mechanism of action - they cause the destruction of the membrane of spermatozoa, which reduces their mobility and ability to fertilize an egg.

Modern spermicides usually include two components: sperm-damaging chemicals and a base (carrier).

Spermicides, which are used in almost all currently available spermicides, are surfactants - surface-active substances that destroy the cell membranes of spermatozoa. An exception is the drug A-qen-53, sold in Europe, in which an enzyme inhibitor is used as an active spermicidal substance.

The role of the carrier included in spermicides is to ensure the dispersion of the chemical agent in the vagina by enveloping the cervix and holding it in place so that every sperm does not escape contact with the spermicidal ingredient. Occurs in the form ofaerosols, pastes, gels (cream), vaginal foam tablets, soluble suppositories, vaginal foam suppositories.

Contraceptive advantages:

- Immediate effectiveness
- Do not affect breastfeeding
- Can be used as an insurance method together with other contraceptives
- There is no health risk associated with the use of the method
- There are no systemic side effects
- Widely available
- Sold without a prescription
- It is not necessary to conduct a medical examination before starting use.

Non-contraceptive benefits:

- Contribute to the involvement of the husband in family planning
- Some protection against STDs, HIV

Disadvantages:

- Average effectiveness (3-21 pregnancies per 100 women during the first year of use)
- Contraceptive effectiveness depends on the woman's willingness to follow the instructions
- A woman should enter a contraceptive 10-15 minutes before the start of sexual intercourse
- Each injection is effective only for 1-2 hours
- Users must have appropriate storage conditions
- It is necessary to have a sufficient supply before intercourse
- Constant availability is required

Who can use spermicides:

Breastfeeding mothers who need contraception.

Women who do not want or cannot use hormonal methods of contraception, IUD.

Women who want protection against STDs and HIV whose partners do not agree to use condoms.

Couples who need a temporary method of contraception while waiting for another method.

Couples who do not have frequent sexual intercourse.

Who should not use spermicides:

Women whose age or number of births in the anamnesis, or health problems make pregnancy extremely dangerous.

Women who experience difficulties with this method.

Women who are allergic to spermicides.

Women with genital and other anomalies.

Couples who need a highly effective method of contraception.

Couples who do not want to follow the instructions and use spermicide with every sexual act.

Intrauterine devices (IUDs)

IUD are isolated, which have copper, silver, gold, as well as a progestin component.

Mechanism of action:

Affect the ability of spermatozoa to pass through the uterine cavity (which contain metal).

They affect the reproductive process before the egg reaches the empty uterus (which contain metal).

Thicken cervical mucus (progestins).

Change the state of the endometrium (progestins).

Contraceptive advantages:

- High efficiency (0.5-1.0 pregnancies per 100 women during the first year of use)
- Immediate effectiveness
- Long period of action
- The method is not related to sexual intercourse
- The method does not affect breastfeeding
- Immediate return of fertility after removal of IUD
- Few side effects
- In addition to a visit to the doctor after the introduction of the IUD, a woman should consult a doctor only in case of problems
- The patient does not need to have anything in reserve
- Relatively inexpensive method
- Only progestin IUDs reduce menstrual pain and menstrual bleeding

Disadvantages:

- Before introduction, it is necessary to conduct a gynecological examination and an examination for STDs is recommended;
- It is mandatory to have a trained medical worker for the introduction and removal of medical equipment;
- A woman should check the threads of IUD after menstruation, if they were accompanied by pain, cramps, or smearing bloody discharge;
- The woman herself cannot stop using the method (depends on the health worker);
- Spontaneous expulsion of IUD is possible;

- May increase the risk of ectopic pregnancy and STD development in women who are at risk of STDs
- IUDs do not protect against STDs, HIV, if one of the partners is at risk of infection with these diseases, condoms must be used together with IUDs.

Who can use IUD:

Nursing mothers who need contraception;

Women of any reproductive age;

Women with any number of births in history;

Women who wish to have highly effective and long-term protection against pregnancy;

Women who have previously successfully used IUDs;

Postpartum women who are not breastfeeding;

Women who have a low risk of STD infection;

Women who do not want or cannot use hormonal methods;

Women who can forget about the need for daily pill use.

Who should not use IUD:

Pregnant women (established or suspected pregnancy);

Women with unclear vaginal bleeding;

Women with genital tract infection;

Women with congenital anomalies of the uterus and uterine tumors;

Women with heart valve disease in the active phase;

Women diagnosed with trophoblastic tumor, pelvic tuberculosis, genital cancer.

When it is necessary to enter IUD:

On any day of the menstrual cycle, if there is a strong certainty that the woman is not pregnant;

From the first to the seventh day of the menstrual cycle;

After childbirth (immediately after in the first 48 hours or after 4-6 weeks - only IUD with metal; after 6 months, if the woman uses MLA and there is certainty that the woman is not pregnant).

Pure progestin pills

Use of hormonal drugs only with contentprogestagen allows a woman after childbirth to have a reliable means of contraception without interrupting breastfeeding. Such drugs do not affect the quality and quantity of breast milk and the health of the child (after 6 months). If the child is less than 6 months old, progestin can negatively affect the normal growth of the child.

As a progestin are used:

Levonorgestrel

Norethindrone

Norgestrel

Linestrenol

Mechanism of action:

Thicken cervical mucus, preventing the penetration of spermatozoa;

They change the endometrium, complicating implantation;

Reduce the movement of spermatozoa in the upper genital tract (fallopian tubes);

Suppress ovulation.

Contraceptive advantages:

- Effective if taken at the same time every day;
- Immediate effectiveness;
- Gynecological examination is not required;
- The method is not related to sexual intercourse;
- The method does not affect breastfeeding;
- Immediate return of fertility after cessation of use;
- Few side effects;
- The method is convenient and easy to use;
- Do not contain estrogen.

Non-contraceptive benefits:

- May reduce menstrual pain and bleeding;
- Can help reduce anemia;
- Reduce the risk of developing endometrial cancer, the risk of developing benign tumors of the mammary gland.

Disadvantages:

Causes irregular bleeding/spotting in the early stages in almost all women;

Some weight gain or loss is possible;

Constant motivation is required for daily use;

Must be used at the same time every day;

It is necessary to be able to replenish the supply of contraceptives;

Effectiveness may decrease with simultaneous use of some anticonvulsant or antituberculosis drugs (rifampicin);

The method does not protect against STDs, HIV.

Who can use:

Women of any reproductive age;

Women with any number of births in history;

Women who wish to have effective protection against pregnancy;

Nursing mothers in need of contraception;

Postpartum women who are not breastfeeding;

Women who smoke and have blood coagulation disorders;

Women who do not want to use or for whom estrogen-containing contraceptives are not recommended.

Who should not use:

Pregnant women (established or suspected pregnancy);

Women with unclear vaginal bleeding;

Women who cannot tolerate any changes in the nature of menstrual bleeding;

Women who use anticonvulsant or antituberculosis drugs;

Women who cannot remember to take pills at the same time every day.

Combined oral contraceptives

Not recommended for nursing women in the first 6-8 weeks after childbirth;

Postpone the use of COCs until weaning begins;

If a woman is not breastfeeding, COCs can be used 3 weeks after childbirth;

The use of COCs in the first 6 months after childbirth reduces the amount of breast milk and can negatively affect the normal growth of the child (this effect continues for 6 months);

In the first 3 weeks after childbirth, COCs slightly increase the risk of increased blood clot formation due to their estrogen content.

Remark:

COCs are the least acceptable methods for nursing mothers;

3 weeks after childbirth, the risk of increased blood clots disappears;

COCs can be used by women who had preeclampsia during pregnancy, provided that the woman has normal blood pressure and is healthy before using contraceptives.

Voluntary surgical sterilization

There are no medical conditions under which sterilization would be absolutely unacceptable for the patient. There may be conditions or circumstances that dictate the need to observe some precautions or postpone the procedure to correct the woman's condition.

The procedure of surgical sterilization is a tubal occlusion – a surgical blockage of the passage of the tubes in order to prevent the fusion of sperm and egg, i.e. fertilization. Tubal occlusion is a method of permanent cessation of female reproductive function. When the fallopian tubes are blocked (by tying and cutting them or using staples, rings or electrocoagulation), fertilization of the egg becomes impossible.

Methods:

Mini-laparotomy (postpartum, interval)

Laparoscopy

Postpartum mini-laparotomy

The operation can be performed in the delivery unit or operating room in the first two days after delivery. It is performed through a small transverse incision (1.5-3 cm) below the navel,

because in the postpartum period the uterus and fallopian tubes are located high in the abdominal cavity. The operation can be performed under local anesthesia with the use of sedatives and analgesics.

After childbirth, you can use Filshi clamps (clips), which are placed on the fallopian tubes at a distance of about 1-2 cm from the uterus.

Complications may be associated with anesthesia and the development of postoperative inflammatory diseases of the pelvic organs. This complication can be minimized by a thorough examination of the woman in order to identify contraindications to sterilization (postpartum bleeding, infectious diseases and inflammatory processes). The operation should be performed carefully to avoid injury to the intestine, the ligation of the tubes should be reliable to prevent bleeding. The operation is not recommended to be performed later than 48 hours after childbirth due to the risk of ascending infection when it is performed later.

If a mini-laparotomy cannot be performed after delivery, then the operation can be performed after 6 weeks.

Interval mini-laparotomy

It is carried out after full involution of the uterus 6 weeks after childbirth or on any day of the menstrual cycle, if there is certainty that the woman is not pregnant.

The technique of the operation is slightly different: the incision is made above the pubis, a metal uterus lifter is used to bring the uterus and tubes closer to the incision. Sterilization is performed by the Pomeroy or Parkland method.

Laparoscopy

During laparoscopic sterilization, rings, clamps or electrocoagulation are most often used. The operation is performed in a special operating room, the frequency of complications is low.

Advantages of tubal occlusion:

- High efficiency (0.2-4 pregnancies during the first year of use);
- Immediate effectiveness;
- Permanent method;
- Does not affect breastfeeding;
- Suitable for women for whose health pregnancy is a serious danger;
- A simple surgical procedure that is usually performed under local anesthesia;
- No side effects;
- Does not change sexual function - does not affect ovarian function

Disadvantages:

The method is irreversible;

The patient may later regret her decision;

Short-term discomfort/pain after surgery;

Does not protect against STDs, HIV

It should not be carried out in the postpartum period, as well as in women who have STDs, STDs.

General provisions that apply to all women:

The patient has the right to change her decision at any time before the start of the procedure;

The patient cannot be induced by any means to consent to voluntary sterilization;

The patient must write a statement or sign a standard form of voluntary consent to the procedure before the operation begins;

The husband's consent is not a mandatory condition.

Who can use tubal occlusion:

Women of reproductive age;

Women with any number of births in history;

Women who are sure that they have achieved the desired number of children;

Women who want to use a reliable method of contraception;

Women for whose health pregnancy is a serious threat;

Women after childbirth and abortion who do not suffer from STDs, STDs.

Who cannot use tubal occlusion:

Pregnant women (existing or suspected pregnancy);

Women with unexplained vaginal bleeding;

Women with acute pelvic or systemic infection;

Women who cannot tolerate surgical interventions;

Women who are unsure of their future fertility intentions;

Women who did not give voluntary informed consent to the procedure.

3.Formation of professional skills and practical abilities.

1.20-year-old unmarried N. came to the clinic for an abortion. The gestation period is 10 weeks. The menstrual cycle is not regular. During communication, it turned out that she does not know about methods of contraception. She is a student and does not want to have children in the near future.

What methods of contraception are the most accepted for her?

2. A 28-year-old woman came to the doctor for follow-up a week after the abortion. She had three births and one abortion. Has three living children. Feeling good at the moment. All children are healthy, the youngest is 4 years old.

What method of contraception can be recommended?

3. A 35-year-old patient came to consult on what can be done to get pregnant. In the past, she underwent two operations for an ectopic pregnancy, both fallopian tubes were removed during the operations.

Diagnosis? What possible methods should be used for this patient?

4.The patient is 25 years old, has a history of 1 childbirth, 5 induced abortions. Does not get pregnant for 1 year.

Diagnosis?Assign examination methods.

TOPIC 3

"Oncoprophylaxis of gynecological diseases"

Purpose: to teach how to conduct a screening examination of women who turn to a specialist for the purpose of early diagnosis of diseases of the female reproductive system. Assess the patient's condition , draw up an examination plan using modern diagnostic methods, analyze laboratory and instrumental examination data for benign and precancerous diseases of the female reproductive system and determine a preliminary diagnosis; determine management tactics (principles of primary prevention, monitoring, and surgical interventions and conservative treatment, as well as rehabilitation measures) in the treatment of precancerous and malignant diseases of the female reproductive system.

Basic concepts (list of questions): active identification and treatment of patients not only with early stages of malignant tumors, but also with pre-cancerous and benign tumors has an important contribution to solving the problem of prevention of the spread of malignant tumors of the genital organs .

Precancerous diseases of external genital organs. Precancerous diseases of the cervix: classification. Hyperplastic processes of the endometrium: etiology, pathogenesis, classification, modern diagnostic methods, management tactics and principles of treatment. Prevention of precancerous diseases of the female genital organs.

Basic concepts for the lesson:

1.Classification of precancerous diseases of the cervix.

2.Prevention of precancerous diseases of the female genital organs

3.Etiopathogenetic factors causing the development of cervical pathology. Papillomavirus infection.

4.Precancerous diseases of the cervix: etiology, clinic, diagnosis, treatment

5.Methods of diagnosis of precancerous diseases of the cervix.

6.Treatment tactics for precancerous diseases of the cervix, indications for radical treatment methods.

7.Vaccination against HPV infection

8.The concept of "hyperplastic processes of the endometrium" as a factor in the development of AMC in different age periods.

9.WHO histological classification of hyperplastic endometrial processes.

Additional methods of diagnosis of endometrial hyperplastic processes.

Plan:

1. **Knowledge control.**

1. A 24-year-old patient turned to a gynecologist with complaints about the appearance of growths in the area of the genitals. After examining the patient, the doctor found on the labia majora and minora papilla-like growths, reminiscent of cauliflower, of a soft consistency, painless, non-erosive. The patient was referred to a dermatologist for consultation. What is the most likely diagnosis?

A. +Acuminate condylomas

B. Wide condylomas

C. Vegetative pemphigus

D. Granulomatous candidiasis

E. Papillomatosis

step 2017

2. After 10 years of menopause, a 58-year-old patient started profuse uterine bleeding. In the course of bimanual examination and examination with the help of mirrors, apart from abundant bloody discharge, no other pathology was detected. What disease can be assumed?

A. Cancer of the uterine body

B. Schroeder's hemorrhagic metropathy

C. Incomplete abortion

D. Myoma of the uterus

E. +Violation of the menstrual cycle of a climacteric nature

3. In a 36-year-old patient, a neck deformity was detected during a preventive examination in mirrors

uterus with old postpartum tears. During colposcopic examination on the back lip

revealed fields of dysplasia. What should be done to clarify the diagnosis?

A. +Biopsy of the cervix

B. Diagnostic scraping

C. Cystoscopy, irigoscopy

D. Bacteriological examination of secretions

E. Ultrasound of the pelvic organs

4. A 54-year-old woman came to the gynecologist with complaints of vaginal bleeding for 1 month The last menstruation was 5 years ago. No pathology was found during the gynecological examination.

Your actions:

A. +Fractional diagnostic scraping of the walls of the uterine cavity

B. Colposcopy

C. Ultrasound

D. Take a swab for cytological examination

E. Prescribe symptomatic therapy

2. **Discussion of theoretical questions.**

Precancerous diseases Precancerous diseases of the cervix	Dysplasia of the cervical epithelium - focal or single or multiple pathological processes in which hyperplasia, proliferation, violation of differentiation, maturation and rejection of epithelial cells that do not go beyond the basement membrane are noted.
Ectopia of the cervix	displacement of the cylindrical epithelium on the displacement of the cylindrical epithelium on the vaginal portion of the cervix.
Polyp of the cervical canal	this is a focal proliferation of the connective tissue of the endocervix, covered with a cylindrical epithelium and protruding into the lumen of the cervical canal or beyond it and are connective tissue growths covered with epithelium. Cervical papilloma is a form of lesion of the cervix covered with epithelium.
Cervical papilloma	the form of the lesion of the cervix and is characterized by focal growths of the stroma and multilayered epithelium with keratinization. In their

	viral infections and chlamydia play a certain role in its occurrence
Candyloma of the cervix	abnormal growths of multi-layered flat epithelium according to the type of acanthosis (immersion of keratinized epithelial islands in the underlying tissue between the connective tissue papillae) with elongated papillae.
Erosive ectropion	inversion of the mucous membrane of the cervix, characterized by the presence of pseudoerosion and cicatricial deformation of the cervix
Dysplasia of the epithelium of the cervix (cervical intraepithelial neoplasia, CIN, cervical intraepithelial neoplasia, CIN	characterized by pronounced proliferation of atypical epithelium of the cervix with a violation of its stratification without involvement of the stroma and surface epithelium in the process, a pathological process of keratinization of the surface layers of a multilayered fold
Leukoplakia	The basis of the development of leukoplakia are histological changes: hyperkeratosis, parakeratosis, acanthosis. who the epithelium of the cervix
Endometrial hyperplasia	non-physiological proliferation of the endometrium, which is accompanied by a structural rearrangement of its iron and, to a lesser extent, stromal components
Atypical hyperplasia of the endometrium	gns of cytological atypia: it has signs of cellular and nuclear polymorphism along with disorganization of the epithelium of the endometrial glands. A benign neoplasm that rises above the surface of the endometrium to form a nodular form consisting of endometrial glands and stroma.

There is an effective prevention of RSHM timely detection and treatment of background and precancerous diseases, in particular dysplasia (cervical intraepithelial neoplasia (CIN) or squamous intraepithelial lesion of the cervix. For the last 10 years, the number of cervical dysplasias in young women under the age of 30 has increased, the number of patients with initial forms of cervical

cancer at the age of 33-43 has increased , mortality from cervical cancer has increased in the age range of 25-49 years.

The human papilloma virus (HPV) is a risk factor for the development of cervical cancer. The most carcinogenic strains are HPV types 16 and 18, which cause 7 3.5 % of cases of RSHM. Persisting in cells for years epithelium of the cervix, HPV leads to mutations, development dysplasia and malignancy.

Diseases of the cervix are classified into background, precancerous conditions (dysplasia), preinvasive and invasive cervical cancer.

Risk factors for the development of cervical dysplasia :

• Early onset of sexual life (14-17 years), when the epithelium of the cervix is immature and easily exposed to oncogenic influences.

• Frequent change of sexual partners.

• Sexually transmitted diseases. Bacterial infections (conditionally pathogenic and pathogenic microflora). Viral infections (HPV, HSV) c associations with CMV, chlamydia as a factor in STDs (papillomavirus, trichomoniasis, chlamydia, ureaplasmosis, gonorrhea, etc.).

• Smoking..

Traumatic damage to the cervix (after childbirth, abortions, surgical interventions on the cervix)

• Genetic factor

• Hormonal disorders

Comprehensive examination of patients with pathology of the cervix

Diagnostic methods	
Basic examination methods	**Additional examination methods (if indicated)**
Collection of anamnestic data	Bacterioscopic and bacteriological
Examination of the cervix mirrors	Virological
Cytological research	Hormonal
Colposcopy	Colpocytological
Bimanual vaginal examination	Sonography of the pelvic organs

Morphological study targeted biopsy material	

Examination of the cervix with abnormal cellular morphology of the Papanicolaou smear includes the following methods:

- simple and extended colposcopy;
- biopsy of the cervix;
- scraping of the mucous membrane of the cervical canal (endocervical curettage);
- targeted and cone-shaped biopsy of the cervix

A simple colposcopy is an examination of the cervix after removal of its surface without the use of medication.

Extended colposcopy is performed after applying 3% acetic acid solution or 2% Lugol's solution to the pelvic part of the cervix. After treatment with 3% solution of acetic acid, the unchanged epithelium changes to a pale color, when applying 2% Lugol's solution (Schiller's test), the surface of the vaginal part of the cervix is uniformly colored in a dark brown color

Targeted biopsy : Material is collected under the control of colposcopy

Ovarian tumors take the second place among neoplasms of female genital organs - 8-11% Benign - 85%, of which cysts - 35% Ovarian cancer takes the 3rd place among gynecological tumors pOvarian tumors take the second place

Among neoplasms of the female genital organs – 8-11% . Benign - 85%, of which cysts - 35%. Ovarian cancer ranks 3rd among gynecological tumors after cancer of the body and cervix, and 7th in the structure of the overall oncological incidence after cancer of the body and cervix, and 7th in the structure of the overall oncological incidence.

Complaints (discomfort, pain in the lower abdomen and lower back, menstrual disorders and reproductive functions, etc.) History of illness and life (transferred
children's infections, frequent tonsillitis, chronic tonsillitis, menstrual, generative,
sexual functions, heredity, etc.) General physical examination
Gynecological recto-vaginal examination, by which it is established
presence and localization of the pathological process, shape, size of the uterus and
appendages, their consistency, mobility, tenderness during palpation, anatomical
topographic relationships of pelvic organs, etc
imaging methods transabdominal ultrasound, transvaginal ultrasound, pelvic organs, CT, MRI, pelvic organs.
The use of tumor markers for the diagnosis of tumor processes of the pelvic organs.

Oncomarker SA125 . Increased in more than 80% of all patients
from RY. Increase in benign gynecological diseases, endometriosis,

malignant tumors of other localization, healthy women of reproductive age.

Tumor marker NO4 Secretory protein 4 of the epididymis, acidic glycoprotein
Belongs to the family of proteinase inhibitors and is expressed in normal epithelium
reproductive organs, upper respiratory tract and pancreas.
Increased production was detected at RY and endometrium, rarely - in the widespread form
lung adenocarcinoma.

Tumor marker NO4 With benign gynecological diseases, endometriosis increase level is not observed .

3.Formation of professional skills and practical abilities.

1.A 32-year-old patient complains of pulling pain in the lower abdomen, smearing brown discharge before menstruation and abundant discharge during the cycle. During bimanual examination, the uterus is slightly enlarged, more in the isthmus region, painful during excursion, round shape. Appendages on both sides without features. Preliminary diagnosis - internal endometriosis. During ultrasound, there is an echo-positive structure 1.5x1.0 in the cavity. The most informative for diagnosis and treatment tactics in this case?

2. A 45-year-old patient complains of watery vaginal discharge and contact bleeding. The last oncological examination was 5 years ago, erosion of the cervix was detected, and treatment with fat tampons was carried out. In the mirrors: the cervix is hypertrophied, growths are noted on both lips of the cervix, which bleed when touched. Vaginal: the body of the uterus is slightly enlarged, mobile, painless, appendages are not defined. Vaults of the vagina, parameters - free. Which of the methods is the most valuable for confirming the diagnosis?

3. A 48-year-old patient came to the gynecological department with complaints of bleeding from the genital tract. From the anamnesis: menstruation since the age of 14, established immediately (4-5 days after 28 days), moderate, painless. For the last 2 years, the intervals between periods have been 2-3 months. 15 days ago, after a 2-month absence of menstruation, uterine bleeding began, which continues to this day.

Upon admission: skin and visible mucus pale, pulse 76 beats. in min., blood pressure - 110/80 mm Hg. st., hemoglobin - 100g/l.

The abdomen is soft, painless on palpation. No pathology was detected from the internal genital organs.

Make a diagnosis? What should be the doctor's tactics?

TOPIC 4

" Management of physiological pregnancy. "

Purpose: is to gain basic knowledge about anatomical, physiological and biochemical changes during pregnancy, be familiar with the physiologic adaptations associated with a normal pregnancy, be able to differentiate between certain signs and symptoms that can be common to both disease processes and to physiologic adaptations of pregnancy, obtain knowledge about methods of obstetrical examination, appropriate prenatal counseling and supervision in order to provide successful obstetric outcome.

Basic concepts (list of questions): fertilization and development of a fertilized egg. Placenta, its structure and function. Critical periods of embryo and fetal development. Influence of harmful factors on the embryo and fetus. Physiological changes in a woman's body during pregnancy. Hygiene and nutrition of a pregnant woman. Methods of examination of pregnant women: diagnosis of early and late pregnancy. Orientation of baby in the uterus. Management of physiological pregnancy. Laboratory diagnosis of HIV infection. Counseling in the context of HIV infection. The concept of counseling and its ethical principles. Counseling skills. Determination of maternity leave date and date of birth. Assessment of fetal wellbeing. Biophysical profile of the fetus. CTG. Perinatal protection of the fetus. Ultrasound in pregnancy.

Basic concepts for the lesson:

1.Fundamentals of reproduction: gametogenesis, ovulation, fertilization, implantation.
2.Principal events in embryonic and fetal development.
3.Development, structure and function of the placenta and fetal membranes.
4.Genital tract changes during pregnancy, endocrinology of pregnancy.
5.Duration of pregnancy, presumptive, probable and definitive symptoms of pregnancy, chronological appearance of specific signs and symptoms of pregnancy.
6.Signs of previous child birth.
7.Methods of estimation of gestational age and due date of labor.
8.Methods of estimation of fetal weight.
9.Obstetrics terminology: lie, presentation, position and attitude of the fetus in the uterus.
10.Methods of obstetrical abdominal examination: inspection, palpation, auscultation.
11.Assessment of fetal wellbeing: biophysical profile of the fetus, CTG.
12.Ultrasound in pregnancy.

Plan:

1. **Knowledge control.**

1. Worldwide, which of the following is the most common problem during pregnancy?

A. diabetes

B. preeclampsia

C. heart disease

D.+ urinary tract infection (UTI)

E. iron-deficiency anemia

2. A patient presents with a positive pregnancy test, the exact date of the start of her last normal menses, and the date of her luteinizing hormone (LH) surge from a urine kit. Her expected date of delivery can most correctly be calculated by which of the following?

A. adding 254 to the date of the start of the last menstrual period (LMP)

B. counting 10 lunar months from the time of ovulation

C.+ counting 280 from the first day of the LMP

D. counting 40 weeks from the last day of the LMP

E. adding 256 to the date of the elevated urinary LH when detected by home testing

3. A friend mentions to you she just had a positive pregnancy test and wonders if you can tell her when she is likely due. The LMP was June 30. Her expected date of labor is approximately which of the following?

A. March 23

B.+ April 7

C. March 28

D. April 23

E. March 7

4. A patient presents to your clinic complaining of nausea and vomiting. She is currently ingesting combined oral contraceptive pills (OCP) and has used them for over a year. When you tell her she has a positive pregnancy test, she reports that her last bleeding on the OCPs was 8 weeks ago. In such a situation, determination of the most accurate estimated date of delivery can then be made by which of the following?

A. eliciting when breast tenderness or morning sickness began

B. assessing uterine size by physical examination

C. counting 280 days from the first positive serum pregnancy test

D. asking the patient when she first felt pregnant

E.+ obtaining fetal biometry by ultrasound prior to 20 weeks' gestation

2. **Discussion of theoretical questions.**

Gestational age is about 280 days calculated from the first day of the last normal menstrual period (LMP). Accurate LMP is the most reliable parameter for estimation of gestational age. But in significant number of cases (20–30%), the patients either fail to remember the LMP or report inaccurately. The matter becomes complicated when the conception occurs during lactation amenorrhea or soon following withdrawal of contraceptive pills (ovulation may be delayed for 4–6 weeks) or in cases with bleeding in early part of pregnancy. The following parameters either singly or in combination are useful in predicting the gestational age with fair degree of accuracy.

PATIENT'S STATEMENT

— Date of fruitful coitus: If the patient can remember the date of the single fruitful coitus with certainty, it is quite reliable to predict the expected date of delivery with accuracy of 50% within 7 days on either side. 266 days are to be added to the date of the single fruitful coitus to calculate the expected date.

— Naegele's formula: Provided the periods are regular, it is very useful and commonly practiced means to calculate the expected date. Its prediction range is about 50% with 7 days on either side of EDD. If the interval of cycles is longer, the extra days are to be added and if the interval is shorter, the lesser days are to be subtracted to get the EDD.

Practical skill
Calculation of the expected date of delivery (EDD) This is done according to Naegele's formula (1812) by adding 9 calendar months and 7 days to the first day of the last normal (28 day cycle) period. Alternatively, one can count back 3 calendar months from the first day of the last period and then add 7 days to get the expected date of delivery; the former method is commonly employed. Example: The patient had her first day of last menstrual period on 1st January. By adding 9 calendar months it comes to 1st October and then add 7 days, i.e. 8th October, which becomes the expected date of delivery. For IVF pregnancy date of LMP is 14 days prior to date of embryo transfers (266 days).

— Date of quickening: A rough idea about the probable date of delivery can be deduced by adding 20 weeks in primigravidae and 22 weeks in multiparae to the date of quickening.

PREVIOUS RECORDS: The required weeks are to be added to make it 40 weeks.

— Size of the uterus prior to 12 weeks more precisely corresponds with the period of amenorrhea.

— Height of the uterus above the symphysis pubis in relation to the landmarks on the abdominal wall.

— Auscultation of FHR at the earliest by 18–20 weeks using ordinary stethoscope and that using Doppler principle at 10th week. Palpation of fetal parts at the earliest by 20th week.

— Recording of positive pregnancy test using immunological principle at first missed period by earliest.

— Ultrasonographic findings at the earliest are: (a) Gestation sac — at 5 weeks. (b) Measurement of crown rump length (CRL) detected at 7 weeks, approximates 10 mm; at 10 weeks – 34 mm (CRL in cm + 6.5 = weeks of pregnancy). Crown — Rump Length (CRL) is most accurate. (Variation ± 5 days). Second trimester by BPD, HC, AC and FL measurement. Most accurate when done between 12 and 20 weeks (variation ± 8 days). Third trimester — Less reliable, variation ± 16 days.

— Lightening: Following the appearance of the features suggestive of lightening, the labor is likely to commence within 3 weeks.

ESTIMATION OF FETAL WEIGHT

- Height of the uterus above the symphysis pubis in centimeters multiplied by abdomen circumference measured on the level of umbilicus in either case gives the weight of the fetus in grams. Example — Height of the uterus above the symphysis pubis = 34 cm and the abdomen circumference = 95 cm. The weight of the fetus will be 34 × 95 = 3230 g. However, the approximate size of the fetus is modified by the amount of liquor amnii and thickness of the abdominal wall.
- Sonography: Fetal weight has been estimated by combining a number of biometric data, e.g. BPD, HC, AC and FL. Tables (Hadlock, Shepard) are currently in use (computer software). Estimated fetal weight likely to be within 10 percent of actual weight.

METHODS OF OBSTETRICAL EXAMINATION

ABDOMINAL EXAMINATION: A thorough and systemic abdominal examination beyond 28 weeks of pregnancy can reasonably diagnose the lie, presentation, position and the attitude of the fetus. It is not unlikely that the lie and presentation of the fetus might change, specially in association with excess liquor amnii and hence periodic checkup is essential.

Practical skill

Abdominal examination

Preliminaries: Verbal consent for examination is taken. The patient is asked to evacuate the bladder. She is then made to lie in dorsal position with the thighs slightly flexed. Abdomen is fully exposed. The examiner stands on the right side of the patient.

Fig.1: Position of the woman during obstetric examination

Inspection: To note (1) whether the uterine ovoid is longitudinal or transverse or oblique (2) contour of the uterus—fundal notching, convex or flattened anterior wall, cylindrical or spherical shape (3) undue enlargement of the uterus (4) skin condition of abdomen for evidence of ringworm or scabies and (5) any incisional scar mark on the abdomen.

Palpation: *Symphysis fundal height (SFH)*: The uterus is to be centralized if it is deviated. The upper border of the fundus is located by the ulnar border of the left hand and this point is marked. The distance between the upper border of the symphysis pubis upto the marked point is measured by a tape in centimeter. After 24 weeks, the SFH measured in cm corresponds to the number of weeks up to 36 weeks. A variation of ± 2 cm is accepted as normal.

Fig. 2: Symphysis fundal height (SFH)

There are conditions where the height of the uterus may not correspond with the period of amenorrhea. The conditions where the height of the uterus is more than the period of amenorrhea are: (1) mistaken date of the last menstrual period (2) twins (3) polyhydramnios (4) big baby (5) pelvic tumors— ovarian or fibroid (6) hydatidiform mole and (7) concealed accidental hemorrhage.

The condition where the height of the uterus is less than the period of amenorrhea are: (1) mistaken date of the last menstrual period (2) scanty liquor amnii (3) fetal growth retardation and (4) intrauterine fetal death.

Practical skill

Obstetric grips (Leopold maneuvers)

Palpation should be conducted with utmost gentleness. Clumsy and purposeless palpation is not only uninformative but may cause undue uterine irritability. During Braxton-Hicks contraction or uterine contraction in labor, palpation should be suspended.

Fundal grip (First Leopold): The palpation is done facing the patient's face. The whole of the fundal area is palpated using both hands laid flat on it to find out which pole of the fetus is lying in the fundus: (a) broad, soft and irregular mass suggestive of breech, or (b) smooth, hard and globular mass suggestive of head. In transverse lie, neither of the fetal poles are palpated in the fundal area.

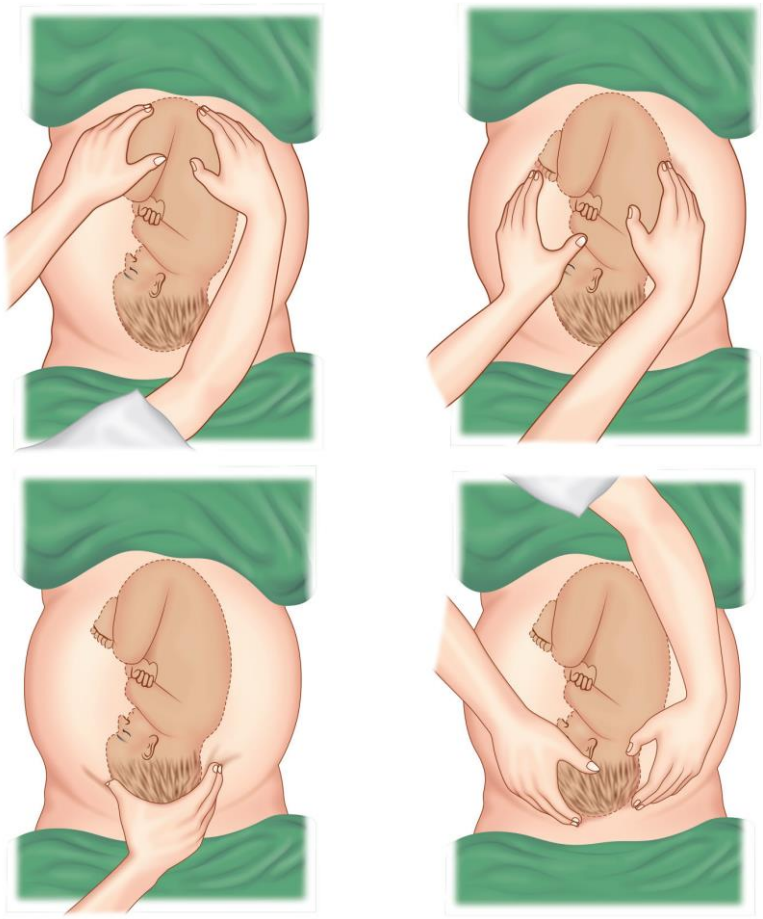
Lateral or umbilical grip (Second Leopold): The palpation is done facing the patient's face. The hands are to be placed flat on either side of the umbilicus to palpate one after the other, the sides and front of the uterus to find out the position of the back, limbs and the anterior shoulder. The back is suggested by smooth curved and resistant feel. The 'limb side' is comparatively empty and there are small knob like irregular parts. After the identification of the back, it is essential to note its position whether placed anteriorly or towards the flank or placed transversely. Similarly, the disposition of the small parts, whether placed to one side or placed anteriorly occupying both the sides, is to be noted. The position of the anterior shoulder is to be sought for. It forms a well marked prominence in the lower part of the uterus above the head. It may be placed near the midline or well away from the midline.

Pawlik's grip (Third Leopold): The examination is done facing towards the patient's face. The overstretched thumb and four fingers of the right hand are placed over the lower pole of the uterus keeping the ulnar border of the palm on the upper border of the symphysis pubis. When the fingers and the thumb are approximated, the presenting part is grasped distinctly (if not engaged) and also the mobility from side to side is tested. In transverse lie, Pawlik's grip is empty.

Pelvic grip (Fourth Leopold): The examination is done facing the patient's feet. Four fingers of both the hands are placed on either side of the midline in the lower pole of the uterus and parallel to the inguinal ligament. The fingers are pressed downwards and backwards in a manner of approximation of finger tips to palpate the part occupying the lower pole of the uterus (presentation). If it is head, the characteristics to note are: (1) precise presenting area (2) attitude and (3) engagement.

To ascertain the presenting part, the greater mass of the head (cephalic prominence) is carefully palpated and its relation to the limbs and back is noted. The attitude of the head is inferred by noting the relative position of the sincipital and occipital poles. The engagement is ascertained noting the presence or absence of the sincipital and occipital poles or whether there is convergence or divergence of the finger tips during palpation. This pelvic grip using both the hands is favored as it is most comfortable for the woman and gives most information.

A B



C D

Fig.3: Obstetric grips (Leopold maneuvers): (A) Fundal grip (first Leopold); (B) Lateral grip (second Leopold); (C) Pawlik's grip (third Leopold); (D) Pelvic grip (fourth Leopold)

Practical skill

Auscultation

Auscultation of distinct fetal heart sounds (FHS) not only helps in the diagnosis of a live baby but its location of maximum intensity can resolve doubt about the presentation of the fetus. The fetal heart sounds are best audible through the back (left scapular region) in vertex and breech presentation where the convex portion of the back is in contact with the uterine wall. However, in face presentation, the heart sounds are heard through the fetal chest.

As a rule, the maximum intensity of the FHS is below the umbilicus in cephalic presentation and around the umbilicus in breech. In different positions of the vertex, the location of the FHS depends on the position of the back and the degree of descent of the head. In occipitoanterior position, the FHS is located in the middle of the spinoumbilical line of the same side. In occipitolateral position, it is heard more laterally and in occipitoposterior position, well back towards the mother's flank on the same side.

INTERNAL EXAMINATION: The diagnosis of the presentation and position of the fetus may not be accurate by internal examination during pregnancy when the cervix remains closed. However, during labor, accurate information may be obtained by palpation of the sagittal suture and fontanelles through the open cervix. Stress for strict aseptic precautions during vaginal examination needs no emphasis.

ULTRASONOGRAPHY: The diagnosis of the lie, presentation and position may be difficult in the presence of marked obesity, irritable uterus, excessive liquor amnii and deeply engaged head, especially in primigravidae. Ultrasonography can locate the head and the body.

❖ Practical skill

Vaginal examination

Time: Vaginal examination is done in the antenatal clinic when the patient attends the clinic for the first time before 12 weeks. It is done (1) to diagnose the pregnancy (2) to corroborate the size of the uterus with the period of amenorrhea and (3) to exclude any pelvic pathology. Internal examination is, however, omitted in cases with previous history of abortion, occasional vaginal bleeding in present pregnancy. Ultrasound examination has replaced routine internal examination. It is more informative and without any known adverse effect.

Procedures: Vaginal examination is done in the antenatal clinic. The patient must empty her bladder

prior to examination and is placed in the dorsal position with the thighs flexed along with the buttocks placed on the footend of the table. Hands are washed with soap and a sterile glove is put on the examining hand (usually right).

Steps:

Inspection: By separating the labia—using the left two fingers (thumb and index), the character of the vaginal discharge, if any, is noted. Presence of cystocele or uterine prolapse or rectocele is to be

elicited.

Speculum examination: This should be done prior to bimanual examination especially when the smear for exfoliative cytology or vaginal swab is to be taken. A bivalve speculum is used. The cervix and the vault of the vagina are inspected with the help of good light source placed behind. Cervical smear for exfoliative cytology or a vaginal swab from the upper vagina, in presence of discharge, may be taken.

Bimanual: Two fingers (index and middle) of the right hand are introduced deep into the vagina while separating the labia by left hand. The left hand is now placed suprapubically. Gentle and systematic examination are to be done to note:

(1) Cervix: Consistency, direction and any pathology.

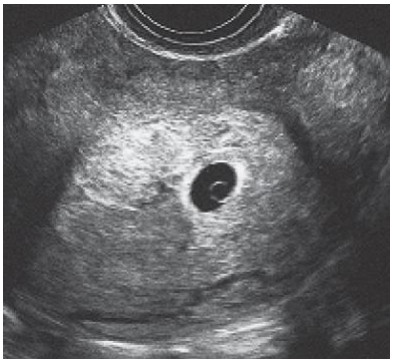
(2) Uterus: Size, shape, position and consistency. Early pregnancy is the best time to correlate accurately uterine size and duration of gestation.

(3) Adnexae: Any mass felt through the fornix. If the introitus is narrow, one finger may be introduced for examination. No attempt should be made to assess the pelvis at this stage.

3.Formation of professional skills and practical abilities.

1. A woman is referred from the general practitioner for pregnancy dating. She had a positive pregnancy test 3 days ago after she realized that she had missed a period. In the past she had had regular cycles bleeding for 5 days every 28 days. However, she had been taking the combined oral contraceptive pill (COCP) for the last 6 years and stopped only 10 weeks ago. She had a withdrawal bleed at the end of the last packet, followed by an apparently normal period 5 weeks later. She has had no other irregular bleeding or any abdominal pain. She has had regular intercourse throughout the time since she stopped her COCP and is pleased now to be pregnant.

Transvaginal ultrasound findings are shown in Fig.



How can pregnancies be dated and what is the approximate gestational age for this pregnancy?

2. A 22-year-old primigravida is seen in your office at 28 weeks' gestation for a routine prenatal visit. Her pregnancy has been uneventful to date. She expresses her concern about several moles on

her back, which have been enlarging over the past several weeks and for increasing difficulty with constipation. She also relates less energy to complete her job-related responsibilities at work and feels it may be related to the 18-lb weight gain she has experienced since becoming pregnant. She also has noted some gradual shortness of breath over the past 4 to 6 weeks especially when she climbs the three flights of stairs to her office at work. She wears contact lenses and relates that her visual acuity is not as good as before she became pregnant.

Physical examination reveals her height to be 162 cm, her weight to be 68 kg, and her blood pressure to be 90/60 mm Hg. She has several pigmented nevi over her shoulders and back. She has a darkened line on her skin from her xiphoid process to her symphysis. Examination of her heart reveals a 2/6 systolic ejection murmur heard best over the second left intercostal space. Her lungs are clear to auscultation and percussion.

Abdominal examination reveals a 28 cm fundal height with normal bowel sounds, and she has trace pretibial pitting edema. Laboratory values reveal a hemoglobin level of 120 g/L and a platelet count of 125000/mm3. Urinalysis reveals no nitrites or leukocyte esterase, 2+ glucose, and no albuminuria. Fasting glucose level was 4,2 mmol/L.

Does this patient have any metabolic or physiologic changes not associated with a normal pregnancy?

TOPIC 5

" Pharmacotherapy during pregnancy for extragenital diseases. "

Purpose: to acquaint students with higher education with the development of scientific views on perinatal protection of the fetus, data on the physiological course of pregnancy, to learn the main issues of pharmacotherapy, pharmacokinetics and pharmacodynamics of drugs during pregnancy.

Basic concepts (list of questions): in the process of teaching the material, the ability to diagnose the early stages of pregnancy, observe the physiological course of pregnancy and the properties of using pharmacological drugs for various forms of disorders is formed.

Basic concepts for the lesson:

1. The ability to provide the family therapist with a timely diagnosis of extragenital pathology.

2. Possibilities at the current stage in meeting the physiological needs of the fetus in basic nutrients and energy .

3. Meeting the needs of a pregnant woman in basic nutrients and energy to preserve her health and the health of the fetus.

4. Ensuring a woman's comfortable well-being, good mood and high activity at all stages of pregnancy.

5 . The maximum variety of women's diets with the inclusion of all food groups in them.

6. Restriction of products with high sensitizing activity .

7. Maximum consideration of women's individual needs.

8. Wide use of specialized food products enriched with protein, essential fatty acids, vitamins, and mineral salts .

9. Intensity of uteroplacental blood circulation.

10. The ability of the drug to ionize and dissolve in lipids, the degree of binding to plasma proteins.

Plan:

1. **Knowledge control.**

1. A 22-year-old first-time pregnant woman was admitted to the maternity ward with premature discharge of amniotic fluid. With the diagnosis: Pregnancy I, 18-19 weeks. Cramps are weak, the opening of the cervix is 2 cm. Which of the drugs should be prescribed to strengthen labor activity?

A. Folliculin.

B. Oxytocin 5 units intramuscularly.

C. +Oxytocin 5 units intravenously in 400 ml of physical. solution

D. Methylergometrine. D

E. Desaminooxytocin.

2. Pregnant for 20 years, came to the maternity ward with a diagnosis: pregnancy 36-37 weeks n . Childbirth I. I position, front view, main presentation. Placental insufficiency. Fetal growth retardation syndrome. Which of the drugs is the most effective in treatment?

A. +Actovegin.

B. Ascorbic acid.

C. Papaverine hydrochloride.

D. Ginipral.

E. Aloe extract liquid

3 . Pregnant for 27 years, came to the hospital with a diagnosis: pregnancy 9 weeks n . Threatening spontaneous abortion. What medicinal substance is the drug of choice?

A. +Dufaston.

B. Ginipral.

C. Papaverine hydrochloride.

D. Dexamethasone.

E. Oxytocin

4. Childbirth 30 years old, in the late postpartum period the temperature rose to 38°C. The diagnosis was established: postpartum metroendometritis. Which of the antibacterial drugs is the most acceptable?

A. +Ceftriaxone.

V. Augmentin.

C. Ampicillin.

D. Metronidazole.

E. Penicillin

2. **Discussion of theoretical questions.**

Most women during pregnancy take one or more medicines (on average four), not including vitamins and iron preparations.

The use of various medications during pregnancy is a very important issue, because prescribing a potentially dangerous drug to a pregnant woman can harm the future child, and it is also important because the presence of many drugs with contraindications for use during pregnancy significantly limits the possibilities of high-quality comprehensive treatment during this period.

The question of admissibility of certain drugs acquires special relevance and practical importance in the clinic of extragenital pathology of pregnant women. Pharmacological preparations can have a negative effect on the tone of the uterus, uteroplacental blood circulation and the balance of numerous hormonal factors that ensure the course of pregnancy. However, the central problem of drug therapy for pregnant women is the possible effect of drugs on the fetus - teratogenic, embryotoxic, fetotoxic.

Physiological changes that lead to a change in the concentration of medical drugs in the blood compared to the level of the achievable concentration in non-pregnant women are as follows:

- increase in intravascular volume;
- increase in glomerular filtration rate; a decrease in the level of blood plasma proteins, which leads to a decrease in the connection of the drug with blood proteins and an increase in the clearance of the drug;

- thinning of the membrane that separates the fetus from the mother, which leads to an increase in the transplacental diffusion capacity, as a result of which the ability of drugs to penetrate through the placenta increases;
- a decrease in the motor activity of the gastrointestinal tract, which is accompanied by a delay in the absorption of drugs when they are taken internally;
- acceleration of the destruction of drugs in the liver.

The following risk categories for the use of drugs during pregnancy, developed by the American Food and Drug Administration (FDA - Food) , are widely used all over the world and Drug Administration):

A - drugs that were taken by a large number of pregnant women and women of childbearing age without any evidence of their influence on the frequency of development of congenital malformations or harmful effects on the fetus;

B – drugs that were used by a limited number of pregnant women and women of childbearing age without any evidence of their influence on the frequency of development of congenital malformations or harmful effects on the fetus. At the same time, no increase in the frequency of damage to the fetus was found in animal studies, or such evidence was obtained, but the proven dependence of the obtained results on the use of drugs was not determined;

C – drugs that have demonstrated teratogenic or embryotoxic effects in animal studies. There are suspicions that they may cause a negative adverse effect on the fetus or newborn (due to pharmacological properties), but such that they do not cause the development of congenital anomalies. No controlled studies have been conducted on humans;

O - drugs that cause or are suspected of causing congenital anomalies or irreversible damage to the fetus. The risk to the fetus should be weighed against the potential benefit from the use of the medicinal product.

X is a drug with a high risk of developing congenital anomalies or permanent damage to the fetus, as there is evidence of their teratogenic or embryotoxic effect in both animals and humans. They should not be used during pregnancy.

Medicines can be divided into three groups:

- LPs that do not penetrate the placenta, therefore do not cause a negative effect on the fetus;
- LPs that penetrate the placenta, but do not cause a negative effect on the fetus;
- LPs that penetrate the placenta and accumulate in the tissues of the fetus, and have a negative effect on the fetus.

The influence of medicinal substances on **the central nervous** system of the fetus is of particular importance. The embryotoxic effects of drugs are more pronounced, the shorter the period of intrauterine development of the fetus and the greater the pharmacological activity and dose of the drug.

The distribution of the drug in the body is influenced by numerous factors: changes in hemodynamics, the volume of circulating blood, the amount of adipose tissue in the body, and the protein composition of the blood. Hemodynamic changes are caused by an increase in the volume of plasma during pregnancy (by 30-40%), extracellular fluid (by 5-8 l) and an increase in the number of erythrocytes by 18-20%. An increase in the amount of fat in the body during pregnancy (on average by 3-4 kg) is important for fat-soluble drugs that accumulate in this tissue.

Teratogenesis includes the concept of the development of not only organic, but also functional anomalies in a newborn. After the end of the embryogenesis period, you can no longer be wary of malformations.

Today, such critical periods in the life of the embryo are distinguished,

1. From the moment of conception to 11 days.
2. 11 days to 3 weeks, when organogenesis begins in the fetus. moment of neural tube closure).
3. Between 4 and 9 weeks, when the danger of fetal growth retardation persists, but the teratogenic effect is practically no longer manifested.
4. The fertile period (from the 9th week to the birth of the child), when postnatal dysfunctions and various behavioral abnormalities may occur.

LP , the use of which is contraindicated during pregnancy .

Antibacterial agent and drug : _ _

-antibiotics tetracycline of the new series - violation of the formation of bone tissue in the fetus and have hepatotoxicity properties;

- chloramphene and col (levom and cet and n) - risk inhibition of bone marrow function and the possibility of the development of " c i rogo syndrome in newborns " ;

- fluoride and nolon - act on muscle joints and cartilage _ in feathers and growth in the fetus and newborn ;

- co-trimoxazole (b and septol and its analogues) - significantly increases the risk of congenital anomalies and the fetus ;

-r and fampicin, l and nkom and tsin, eti onam and d, chloroch and n (delag and l), gr and zeofulv and n, levor and n.

Other LPs : _

- all statins (lovastatin , si mvastatin , mevacor , zocor) ;
- indirect anti - coagulants (phenilin , pelentan) ; _

- Antistimulant drugs (dimedrol , ppolfen , suprast) ; _ _ _ _ _
- oral and sugar-lowering drugs ;
- antigonadotropic drugs (danazol , klostil beg and t) ; _
- androgen and ;
- antidepressants , barbiturates , neuroleptics (galoper and dol , and zercin) ;
- benzodiazepines and azepines ; _ _ _
- antiparkinson and other drugs (parkopan , cyclodol, nacom) ;
- nonsteroidal anti - inflammatory drugs (melox and kam , butad and on) .

Beta-lactam antibiotics.

Penicillins. Natural (biosynthetic) penicillins: phenoxymethylpenicillin, bicillins are drugs of a narrow respiratory spectrum. The causative agents of diphtheria, syphilis and most anaerobes are sensitive to them. Semi-synthetic penicillins are divided into:

-penicillinase-resistant with predominant activity against Gram (+) microorganisms ("antistaphylococcal"): methicillin, oxacillin, cloxacillin, dicloxacillin;

- broad-spectrum penicillins (with the exception of penicillinase-producing staphylococci and Pseudomonas aeruginosa): ampicillin, amoxicillin;

- a wide spectrum of action with additional activity against blue-pustular bacillus: carbenicillin, azlocillin;

- penicillins with predominant activity against Gram(-) microorganisms: mecilinam, acidocilin.

Cephalosporins exceed penicillin in antibacterial activity.

Cephalosporins of the first generation: cefazolin, cephalothin, cephalexin - antibiotics with a relatively narrow spectrum of action.

Cephalosporins of the II generation: cefotoxin, cefuroxime have a wider spectrum of antimicrobial action. The possibilities of antibacterial therapy of pregnant women with drugs of the II generation are extended by means that can be used in two therapeutic forms. Cefuroxime has a bactericidal effect against streptococci, methicillin-sensitive staphylococci and a number of Gram (-) microorganisms (hemophilic bacilli, gonococci, enterobacteria).

In *third-generation cephalosporins,* the spectrum of antimicrobial activity is shifted towards Gram(-) pathogens and anaerobes - the main pathogens of nosocomial infections. Ceftazidime exceeds all other antibacterial agents in terms of its anti-blue fever activity. Ceftriaxone is characterized by prolonged action (used once a day) and high penetrating ability to various organs and tissues, including through the blood-brain barrier.

Cephalosporins of the I and V generations overcome the resistance of most Gram (-) bacteria and have high activity against Gram (+) bacteria, including penicillin-resistant pneumococci. The standard is cefepime. The drug penetrates well into all organs and tissues, and its high concentration in the blood after intravenous use requires a 2-time administration regimen. A wide spectrum of antimicrobial action allows the use of cefepime for monotherapy of nosocomial infections, but when anaerobic flora is suspected or the presence of Pseudomonas aeruginosa, it must be combined with metronidazole or amikacin, respectively. It is safe during pregnancy, does not cause damage to the fetus, does not increase the allergy of the pregnant woman. It also does not have a negative effect on the newborn, as it penetrates into breast milk in low concentrations.

Carbapenems: (thienam, meronem) have an extremely wide spectrum of antimicrobial activity, which includes almost all clinically significant Gram (+) and Gram (-) aerobes and anaerobes.

Aminoglycosides . Aminoglycosides are not absorbed from the gastrointestinal tract, so they are used parenterally. First-generation drugs include streptomycin and kanamycin, which have high oto- and nephrotoxicity and even limited indications for use.

Tetracyclines. They are characterized by a bacteriostatic effect, a wide spectrum of antimicrobial action, however, they are highly toxic, which does not allow their use during pregnancy.

Macrolides. They are considered relatively safe during pregnancy (with the exception of roxithromycin). They are effective against a relatively wide range of Gram (+) and Gram (-) bacteria, as well as rickettsiae and spirochetes, and can suppress the development of some strains of pathogens resistant to penicillins.

Spiramycin (rovamycin) is more active than other macrolides against streptococci, including pneumococci, resistant to being successfully used to treat toxoplasmosis during pregnancy.

Rifampicins. They are characterized by a wide spectrum of bactericidal action, which includes mycobacteria, rickettsia, bacteroids, legionella, chlamydia. However, pathogens quickly develop resistance to it, so it is mainly used for tuberculosis and severe coccal infections. In an experiment on animals, a teratogenic effect was found.

Lincosamines. Lincomycin and clindamycin are among the effective reserve antibiotics for infections caused by strains of staphylococci and other Gram (+) pathogens.

Vancomycin is the only antibiotic that is effective against methicillin-resistant strains of staphylococci.

Sulfanilamides . They have a wide range of antimicrobial action against aerobes and anaerobes, actinomycetes and the causative agent of toxoplasmosis. But they cause many side effects.

Fluoroquinolones. Ciprofloxacin, ofloxacin are highly active antimicrobial drugs of a wide spectrum of action, effective against both Gram (+) and Gram (-) microorganisms.

Antifungal agents.

Azole derivatives - fluconazole, itraconazole are not recommended during pregnancy. One of the effective and safe means that can be used in pregnant women is natamycin, which is recognized as one of the drugs of choice for the treatment of candidiasis. It contributes not only to etiopathogenetic treatment, but also eliminates the factors contributing to fungal infection (remediation of the "depot" infection in the intestine).

In case of local candidiasis and other fungal lesions, nystatin is relatively safe. However, its effectiveness is low, especially for genital candidiasis in pregnant women. Clotrimazole has a wide spectrum of action. One of the most effective means of treatment of systemic mycoses is fluconazole. During pregnancy, the drug should be used only for life-threatening fungal infections.

Peripheral vasodilators .

Verapamil affects the elements of the conduction system of the myocardium, slows down the heart rate and has an antiarrhythmic effect. It is used for increased blood pressure in pregnant women and for the treatment of fetal tachycardia.

Nifedepine is used for the treatment of arterial hypertension and preeclampsia, as well as as a tocolytic agent for the treatment of the threat of premature birth, the pathological preliminary period, and for the preparation of pregnant women for childbirth. In animals, nifedepine has a teratogenic and embryotoxic effect.

Diuretics

Diuretics should be prescribed with caution to pregnant women, especially in severe forms of late gestosis.

Thiazide and thiazide-like diuretics act on the distal segment of the initial part of the renal tubules, increase the excretion of sodium, water and chlorine. They lower blood pressure by increasing sodium excretion, decreasing plasma volume, extracellular fluid, and cardiac output. The hypotensive effect of diuretics is also associated with a decrease in total peripheral vascular resistance.

Hydrochlorothiazide is a diuretic with moderate strength and medium duration of action. In the first trimester of pregnancy, it reduces blood flow in the vessels of the umbilical cord and placental transfusion, reduces the endocrine function of the placenta, changes the clearance of estradiol, thereby can lead to the appearance of congenital malformations of the fetus. When it is used in the third trimester of pregnancy, there is more frequent induction of labor, inertness of the uterus, and an increase in perinatal mortality.

furosemide penetrates well through the placenta, its concentration in umbilical cord blood is equal to that in the mother's blood plasma.

Antiarrhythmic drugs.

Lidocaine is an effective means of treating gastric rhythm disorders in pregnant women. It quickly penetrates the placenta. The tool can cause respiratory depression of the newborn, various changes in the heart rate of the fetus.

Antiplatelets and anticoagulants .

Heparin is a natural anticoagulant of direct action, it forms a complex with antithrombin III, converts it into an active form, as a result of which the blood coagulation process slows down. It does not penetrate the placenta, so it does not cause congenital anomalies, however, a decrease in calcium content may adversely affect the condition of the fetus. Long-term use of heparin can lead to osteopenia in the mother and fetus. The risk of fetal bleeding increases.

Anticoagulants of indirect action are used to prevent venous thrombosis.

Analgesic means.

Paracetamol is characterized by an optimal ratio of effectiveness and safety, as well as a variety of dosage forms. It has analgesic, antipyretic and moderate anti-inflammatory effects. Does not have a damaging effect on the mucous membrane of the gastrointestinal tract. Has no effect on the function of platelets and does not increase the risk of hemorrhages. Penetrates through the placenta, but does not have a negative effect on the fetus.

Analgin has analgesic, anti-inflammatory and antipyretic effects. With long-term use, suppression of hematopoiesis is possible. In large doses and with long-term treatment, it can cause anemia, impaired liver and kidney function of the fetus.

Narcotic analgesics .

Morphine is the main representative of the group of narcotic analgesics. It quickly penetrates the placenta and can cause drug addiction in the fetus and later in the newborn. Morphine increases the contractility of the uterus and causes respiratory depression in the newborn.

Promedol does not increase the number of congenital anomalies, but the formation of drug addiction in the fetus is likely. Causes depression of the newborn's breathing. Duration of depression 1 hour or more after childbirth. The mental parameters of the child do not suffer.

Tramadol - has a relatively low narcotic potential and a wide range of indications for moderate and severe acute and chronic pain syndromes.

Anti-inflammatory agents and.

Glucocorticoids have anti-inflammatory and immunosuppressive effects. When taken during the entire pregnancy, their influence on the duration of pregnancy and the frequency of birth defects was not noted, but a slight decrease in the body weight and length of newborns was observed. The children's neurological condition and mental development were normal.

Cortisone is used only as a means of replacement therapy for adrenal insufficiency during pregnancy.

Prednisolone can lead to the development of congenital cataracts and a decrease in the function of the adrenal cortex, causes immunosuppression, which increases the risk of infection of the mother and fetus.

Dexamethasone is more anti-inflammatory than prednisolone. Its mineralocorticoid effect is the least pronounced. It penetrates the placenta and can have a negative effect on the fetus. It causes leukocytosis in the fetus, a decrease in the function of the cortex of the adrenal glands, an increase in the level of androgens, and virilization of the female fetus. The drug reduces the level of estriol and cortisol in the mother's blood. In humans, it does not increase the frequency of congenital anomalies of the fetus. It significantly reduces the likelihood of development and severity of the syndrome of respiratory disorders in newborns and mortality from these and other complications in premature infants.

Nonsteroidal anti-inflammatory drugs.

Acetylsalicylic acid in low doses (60-80 mg per day) is used to prevent preeclampsia and eclampsia. The toxic effect on the fetus is not manifested in these doses. The use of acetylsalicylic acid in large doses increases the number of congenital anomalies and perinatal mortality, reduces the weight of the fetus, and leads to intrauterine intoxication with salicylates.

Indomethacin during pregnancy is used in patients with joint diseases, autoimmune diseases, and is also sometimes used when there is a threat of premature birth, as it has a tocolytic effect. It is relatively safe for the fetus during pregnancy, but care should be taken when prescribing it, as it crosses the placenta and is detected in the blood of the fetus. The fetus may have early closure of the ductus arteriosus, which causes pulmonary hypertension in infants.

3.Formation of professional skills and practical abilities.

1. A 25-year-old pregnant patient came to the maternity ward with the diagnosis: Pregnancy I, 32-33 weeks. Childbirth I, I position, front view, main presentation. Threatening premature birth.
What drug should the doctor prescribe for tocolytic therapy?
2. The first pregnant woman , 30 years old, came to the maternity ward with complaints about a pregnancy of 35-36 weeks . Childbirth I , I position, front view, main presentation. Severe preeclampsia ?
What medicinal substance is the drug of choice ?
3. Patient N., 44 years old, pregnant again, 28-28 weeks, complained of pain in the right iliac region, nausea, vomiting, elevated body temperature to the gynecologist of the women's consultation.During the external obstetric examination, the following was established: longitudinal position of the fetus, main presentation, I position, front view. During the
4. examination, gynecological problems do not bother the patient.

On general examination, the woman is frail, pale, has no appetite, and is bothered by pain in the right iliac region.

What is the previous diagnosis? What are the further tactics of the examination, where to conduct the examination?

4.Patient M, 30 years old, 32-33 weeks pregnant, complained of swelling of the left lower limb, pain in it. After hospitalization, a duplex scan of the veins of the lower extremities was performed, during which a floating thrombus of the deep femoral vein was detected.

External obstetric examination diagnosed the position of the fetus longitudinally, main presentation, II position, posterior view. No problems were found in obstetric pathology.

What is the previous diagnosis? What complication can threaten the patient's life?

TOPIC 6

"Curation of a pregnant woman."

Purpose: learn the basics of counseling; basics of psychological support for a woman during childbirth; advantages of partner childbirth; principles of medical ethics and deontology; basic forms of primary accounting documentation.

Basic concepts (list of questions): peculiarities and rules of curation in the obstetric department. The structure of the birth story. Stages of general objective examination of pregnant women. Stages of special examination of pregnant women. The course of the I, II, III period of childbirth.Clinical management of I, II, III periods of childbirth. Rules for filling out the partogram. Rules for examination of the birth canal. The primary toilet of a newborn.

Basic concepts for the lesson:

1. Hygiene and nutrition of a pregnant woman.
2. Determination of maternity leave and date of delivery.
3. Management of physiological pregnancy. Gravidogram.
4. Psychoprophylactic preparation for childbirth.
5. Childbirth periods. Their duration in first and second births.
6. The period of opening of the cervix during childbirth. Clinic, management. Partogram.
7. The period of expulsion of the fetus. Clinic, management.
8. Determination of litter integrity. Concept of physiological and pathological blood loss.
9. Evaluation of the newborn according to the Apgar scale.
10. The primary toilet of a newborn. Compliance with the thermal chain.
11. Psychoprophylactic analgesia for childbirth. Medicinal analgesia for childbirth.
12. Changes in the body of the mother, genitals, mammary glands.
13. Breastfeeding concept.

14. Postpartum contraception. The method of lactational amenorrhea.
15. Advantages of mother and child staying together.

Plan:

1. **Knowledge control.**

1. A first-time pregnant woman in the period of 31-32 weeks notes the appearance of bloody discharge from the genital tract in a small amount, which appeared against the background of absolute rest. The general condition of the pregnant woman and the fetus is satisfactory. (BP – 110/70 mmHg, pulse 78 bpm, heart rate – 142 beats per minute), the uterus is in normal tone, the fetal position is oblique, the head is more on the right, high above the entrance to the pelvis. The doctor's tactics?

A. +Hospitalize in an obstetric hospital

B. Organize a hospital stay at home

C.Examine the patient in the oncology clinic

D.Prescribe hemostatic agents

E.Appoint a consultation with a proctologist

2. Dizziness, general weakness, flickering of "flies" in front of the eyes, shortness of breath suddenly appeared in a parturient with polyhydramnios during the supine position. There is a decrease in blood pressure to 90/40 mm Hg. Make the most likely diagnosis.

A. +Sydrome of the inferior vena cava

B. Hemorrhagic shock of the house

C.Anaphylactic shock

D.Septic shock

E.Cardiogenic shock

2. **Discussion of theoretical questions.**

List of practical skills mastered on rotation:

Work in the reception department

Maternity reception. The student must be able to determine the blood group, the Rhesus factor, count the pulse, measure blood pressure, conduct a test with sulfosalicylic acid, measure the main and additional dimensions of the pelvis, the height of the uterine fundus, the circumference of the abdomen, listen to the heartbeat of the fetus, conduct external obstetric examination techniques, evaluate obstetric activity, the location of the presenting part in relation to the planes of the pelvis, fill out the medical documentation. External obstetric examination: measurement of the main and

additional dimensions of the pelvis, determination of the position, position, type of position and presentation of the fetus using methods of external obstetric examination (Leopold-Levytskyi).

Determination of the term of pregnancy, the expected date of delivery. Determination of the standing height of the bottom of the uterus, the circumference of the abdomen, the estimated weight of the fetus. Determine factors, degree and risk groups of perinatal pathology, factors and degree of risk of perinatal infection.

Make a diagnosis and make a delivery plan.

Work in the maternity ward

Conducting the 1st period of giving birth. Collection of anamnesis in a woman in labor. Observations in the dynamics of labor activity: frequency, duration and strength of contractions. Partogram maintenance. Listening to the heartbeat of the fetus with an obstetrical stethoscope and a sensor on a cardiac monitor. Assessment of CTG. Perform an internal obstetric examination together with an assistant or doctor on duty. At the same time, pay special attention to the condition of the vagina, its ducts, the cervix, the integrity of the fetal bladder, clarify the presenting part and its location in the dynamics of childbirth, measure the diagonal conjugate and pay attention to the presence of exostoses and deformations of the pelvic bones.

ConductingII period.Labor analgesia, psychoprophylactic labor analgesia. Evaluation of the effectiveness of powerful activity, advancement of the head along the birth canal. Listening to the heartbeat of the fetus, assessment of the intrauterine state of the fetus. Carrying out the period of expulsion of the fetus, maintaining the "thermal chain", suctioning mucus from the upper respiratory tract of the newborn and carrying out his primary toilet. Be able to assess the condition of the newborn according to the Apgar scale.

ConductingIII period.Active management tactics of the III period. Assess the signs of litter separation, inspect the litter for integrity. Examination of the birth canal in mirrors. Assessment of blood loss during childbirth. To participate in measures to prevent bleeding during childbirth.

Conductingearly postpartum periods.To participate in the implementation of measures to prevent bleeding in the early postpartum period. Together with the neonatologist, he evaluates the possibility of early attachment of the newborn to the mother's breast, their joint stay in the postpartum ward, and the mode of breastfeeding.

Work in the postpartum department. Evaluation of the involution of the uterus, the nature of lochia, the condition of the mammary glands, and sutures in the late postpartum period. Consultation on hygiene, nutrition, contraception. Breastfeeding support.

After the end of the shift, the student must report to the teacher in class for the work done, present a referral to the shift signed by the doctor on duty, as well as a written history of the births at which he was present.

SCHEME OF THE HISTORY OF PREGNANCY, CHILDBIRTH AND THE POSTPARTUM PERIOD

_____

(name of educational institution)

_____

(name of department)

Head of the department

_____

_____

History of pregnancy, childbirth, postpartum period

P.I.B. _____

Clinical diagnosis:

Basic: _____

Complication: _____

Concomitant: _____

Name of operations and assistance in childbirth: _____

Curator:

an student of _____ ___ course _____ group _____ faculty

Teacher:_____

Start of curation: _____

Completion of curation: _____

History protection date:_____

The teacher's note about the admission of history _____

2.1. The passport part of the story

1. Surname, first name, patronymic: _____

2. Age: ____years

3. Gender: female

4. Home address: _____

5. Places of work and profession: _____

6. Nature of admission to the clinic: applied independently, referred by an emergency doctor, polyclinic, other medical institution _____

7. Nature of seeking medical help: urgent, planned

8. Date and time of hospitalization: _____

9. Date of statement: _____

10. Number of bed-days: _____

11. Diagnosis:

a) when sending _____

b) during hospitalization _____

c) clinical _____

d) final: _____

main diagnosis _____

complications _____

concomitant diseases _____

12. Operation (name, date, execution time) _____

_____

13. Information about the newborn: gender _____, weight_____g, height_____ cm,

Born at _____ ____min. The score on the Apgar scale is _____ points.

Complaints

Briefly, clearly and consistently describe the pregnant woman's complaints at the time of hospitalization, their onset. The recording from the words of the pregnant woman is not literal, but meaningful, which includes information obtained through the survey. Complaints must be summarized in appropriate groups and comprehensively detailed. This means that a comprehensive description of one complaint is given, and therefore the detailing of another is carried out.

History of life

In this column, attention should be paid first of all to those determining factors that have a direct or indirect connection with the disease present in the pregnant woman: for example, diet, working conditions, social and household conditions.

Confirmation or denial of infectious, transmissible (viral hepatitis, malaria, AIDS, etc.), contagious (tuberculosis, typhoid, diphtheria, etc.), venereal and oncological diseases, diseases of the genitourinary system, neuropsychiatric diseases.

Suffered diseases and injuries: duration of the disease, type of treatment (conservative, operative; nature of the operation and type of analgesia, medical procedures, medications), place of

treatment (self-medication, outpatient, inpatient), effectiveness of treatment. Special attention should be paid to the gynecological history.

Confirmation or denial of hemo- and plasma transfusion, administration of anti-toxic immune serums, vaccines, antibiotics, hormonal drugs.

Allergological anamnesis: have there been allergic reactions to medicines, allergenic products, smells, insect bites, etc., and how do they manifest themselves.

Confirmation or denial of harmful habits (smoking, alcohol, drug use), occupational hazards.

Hereditary history: birth defects, malignant neoplasms, allergic, endocrine, mental, blood and nervous system pathology, developmental defects, etc. relatives

The development of a pregnant woman in childhood and adolescence (when she started talking, walking, did she suffer rickets, childhood injuries, etc.).

Special anamnesis

Menstrual function

The beginning of the first menstruation is marked (in what year of life, when it was established, for how many days (3-5 or more), after what intervals). The amount of blood that a woman loses during menstruation (a lot, moderately, little). Does the woman notice pain before and during menstruation.

What is the type and nature of menstruation, its changes after the beginning of sexual life, childbirth or abortion.

The date of the first day of the last menstrual period. When the pregnant woman felt the first movements of the fetus. The date of the beginning of the descent of the abdomen. Expected date of birth.

Sexual function

Beginning of sexual life (age). How long after the beginning of sexual life did a woman get pregnant? Did you use contraceptives? If so, which ones and for how long? Date of last intercourse.

Reproductive function

During the survey, it is necessary to find out how many times a woman is pregnant. How many births (urgent, premature), abortions (artificial and involuntary) were there? How did each pregnancy and childbirth go? It is necessary to find out whether there were complications during pregnancy, childbirth or abortion? If so, which ones? How many living children does the pregnant woman currently have? When was the last pregnancy and how did it go?

Secretarial function

Determine whether a woman has discharge from the vagina, their quantity, color, whether they irritate the skin of the inner surface of the thighs, external genitalia. The presence of pathological secretions.

The course of this pregnancy in the first and second half of pregnancy.

It should be clarified what were the complications, against the background of which somatic diseases they passed (nausea, vomiting, headache, visual disturbances, swelling, palpitations, suffocation, bloody secretions, pain in the lower abdomen, etc.).

It is necessary to find out whether the pregnant woman attended a women's consultation, and from what period she was registered, to thoroughly understand the results of the research conducted there. Whether psycho-prophylactic training was carried out in the conditions of women's consultation.

Objective research

*General:*Body temperature, pulse, its frequency, the nature of filling, blood pressure on both arms, body weight, height, fullness, body structure (correct, there are defects), constitution (normosthenic, asthenic, hypersthenic), condition of the skin and visible mucous membranes (skin color, the presence of pigmentation, spots, their localization, rashes, neoplasms, scars). Tongue (color, moisture, coating, presence of cracks and ulcers). Condition of teeth, throat and tonsils. The condition of the front wall of the abdomen. The structure of the skeleton (stigmas of transferred rickets - deformation of the skull, thickening of costal cartilages, chicken chest, thickening of the epiphyses, long bones of the limbs, curvature of the legs, saber-shaped legs, scars, bone tuberculosis, pelvic bone injuries). Activity.

*Assessment of the state of the respiratory system:*Indicate the rhythm, depth, frequency of breathing in 1 minute, type of breathing (thoracic, diaphragmatic, mixed, pathological). Auscultation: the nature of breathing (vesicular, bronchial, amphoric, weakened, absent), the presence of rales (dry, wet, small-, medium- and large-vesicular), crepitation, pleural friction noise.

Assessment of the state of the cardiovascular system: Pulse: rate in 1 min., rhythmic/arrhythmic, tension (satisfactory, firm, soft), filling (satisfactory, weak, stringy), comparison on both hands. Blood pressure (must be measured on both arms).

Auscultation: heart sounds (clear, muffled, deaf), presence of heart murmurs, pericardial friction noise.

Veins: presence of varicose veins, thickening and tenderness; signs of thrombophlebitis or phlebothrombosis, trophic disorders (localization, etc.).

Assessment of the state of the digestive system: Condition of the oral cavity, lips, mucous membrane of the oral cavity, gums (color, pigmentation, ulcers, scars, layering, rashes and other pathological formations).

Abdomen: shape, symmetry, bulging of certain areas, visible peristalsis, navel (flat, bulging, inflamed), swelling (localization), participation of the anterior abdominal wall in the act of breathing.

Percussion: areas of tympanitis or dullness, preservation of "hepatic dullness", borders of the liver and spleen.

Auscultation: sonority of peristaltic noises, the lower border of the stomach.

Superficial palpation: tenderness, tension of the muscles of the anterior abdominal wall (soft, tense).

*Assessment of the state of the urinary system:*Examination of the lumbar region. Pasternacki's symptom.

*Assessment of the condition of the lymphatic system:*Palpation of axillary lymph nodes: tenderness, size, shape, consistency, fixation with each other (conglomerate) or with surrounding tissues.

*Assessment of the state of the endocrine system:*Palpation of the thyroid gland (enlargement is diffuse or nodular), ex- or enophthalmos, obesity, hair type, etc.

*Assessment of the state of the nervous system and the psycho-emotional sphere:*Pupils: condition (dilated, narrowed, symmetrical, asymmetrical). Language.

Obstetric status

Review

Abdomen: its shape, size; pigmentation of the white line. The condition of the navel (protruding, level). The condition of the abdominal press.

Mammary glands: shape, size, development of subcutaneous veins, nipples, pigmentation of nipples and areolae. Development of fat and glandular lobes.

Rhombus of Michaelis: its shape and dimensions (longitudinal and transverse).

Measurement of pelvis:

- External dimensions of the pelvis: intercostal, intercostal, interacetabular, external conjugate.
- Lateral conjugate.
- Diagonal conjugate.
- The dimensions of the pelvic outlet are straight and transverse.
- The height of the pubic joint.
- External oblique dimensions of the pelvis.

Other measurements:

- Radio-carpal index of Solovyov.
- Abdominal circumference.
- The height of the bottom of the uterus (determined by a tazometer or centimeter tape in centimeters).
- External size of the fetal head.

Palpation

Four methods of Leopold (position, position, view, anterior part, degree of insertion into the pelvis). Standing level of the anterior part. The head is above the entrance to the small pelvis, in the entrance to the small segment, in the entrance to the large segment, in the pelvic cavity.

The degree of conformity of the head to the size of the entrance to the pelvis. Henkel-Wasten techniques. Opening of the cervix according to Rogovin, according to Schatz-Unterberg (according to the height of the contraction ring).

Auscultation

- Fetal heartbeat - localization, frequency in 1 minute, sonority, rhythmicity.
- Bowel sounds.

Examination of the external genitalia

Varicose veins, rashes, pustules, bartholinitis, condylomas acuminate, condylomas broad, hemorrhoidal nodes. The condition of the perineum and entrance to the vagina. The presence of an inflammatory process of the mucous membrane of the entrance to the vagina. Allocations, their nature and quantity.

Review in mirrors

The condition of the mucous membrane of the vagina; presence of hymen remnants; state of the cervix: cyanosis, shape – shortened, smoothed; opening of the uterine cavity - there is, for how many cm, there is no; presence of umbilical cord, placental tissue.

Vaginal examination

The width and length of the vagina, the properties of its walls, the state of the cervix (smoothed, thinned, shortened), the opening of the pharynx, the properties of its edges (thick, thin, swollen). Amniotic sac (whole, tense, flaccid), the amount of anterior amniotic fluid (a lot, a little). Anterior part (head). Determination of the placement of sutures and parietal bones on the fetal head in relation to the axis of the pelvis, placement of the leading point. The location of the head: above the entrance to the pelvis, the head of the fetus is pressed against the entrance to the pelvis, the head of the fetus is a small segment, a large segment, in the cavity of the pelvis, the head is on the pelvic floor. Diagonal conjugate. The presence of exostoses in the pelvis.

Obstetric diagnosis and its justification

This section of the history of childbirth is the most important, as it reflects the completeness of the student's knowledge during the curation of a pregnant woman in labor. This work is based on acquired skills, clinical thinking and the laws of logic. Their components are analysis, synthesis and appropriate scientific interpretation of the results of a full clinical examination of a pregnant woman. Identified symptoms form the base of the pyramid, the top of which should be the final chord of clinical logical thinking, which is called "diagnosis".

When establishing an obstetric diagnosis, the following should be indicated:

- What is the pregnancy according to the account.

- What is the gestation period (in weeks).
- According to the account, the birth should be.
- What is the period of labor, the phase (latent, active) of labor.
- What is the nature of the discharge of amniotic fluid, the condition of the amniotic sac.
- What is the position, position and type of position, presentation of the fetus.
- What is the accompanying obstetric and extragenital pathology.

Evaluation of the results of auxiliary laboratory, instrumental and other special methods of examination during pregnancy.

- General blood test.
- General analysis of urine.
- Blood glucose.
- Blood analysis for the Wasserman reaction.
- Blood group, Rh affiliation.
- Biochemical analysis of blood (total protein, bilirubin, creatinine, urea, residual nitrogen, transaminases, electrolytes).
- Coagulogram (fibrinogen, prothrombin time, prothrombin index, recalcification time, ethanol test, fibrinogen "B", heparin tolerance).
- Analysis of urine for glucose.
- Ultrasound diagnostics.
- Electrocardiography.
- Smear on the degree of cleanliness of the vaginal contents.
- Consultations of other specialists.

Childbirth plan

- Risk assessment.
- How to give birth (through natural birth canals, with conditions for cesarean section, by cesarean section).
- How to lead the 1st period of childbirth.
- How to conduct the second stage of childbirth.
- How to conduct the third period of childbirth.

For example: Giving birth through the natural birth canal. In the first period, follow the heartbeat of the fetus and the development of labor activity. In the second period, follow the heartbeat of the fetus and the advancement of the head. In the third period – prevention of hypotonic bleeding.

FORM OF INFORMED CONSENT

ATTENTION PATIENT!

Carefully read and study the document.

Follow its main provisions in your interests.

Clarify questions that are unclear to you with medical professionals.

You can make changes and amendments to the text at your discretion.

Z A I V A

_____

(to: the name of the medical institution and its address)

about consent to a complex of medical examinations and the implementation of the doctor's recommendations during my pregnancy (hereinafter Consent).

1. Please write your full name below.

I,_____

2. Please subscribe _____

Write below the postal address of your actual place of residence and your contact telephone numbers _____

In response to the information I received from my treating doctor about the course of my pregnancy, about the importance of me fulfilling all the recommendations of medical professionals about the responsibility for the health of my future child, as well as the ways the doctor proposed to solve my medical problems, by filling out this form, certified by my signature, I give official consent:

- systematically visit the doctor on the day and time appointed for me (in case of impossibility to visit the doctor, I undertake to inform him by telephone or in another form);

- to undergo all examination methods proposed to me (laboratory, physical, ultrasound) on time;

- if necessary, be examined by other specialists (if there are screenings);

- if necessary, undergo medical and genetic counseling and conduct an examination for hereditary pathology and fetal malformations (laboratory, physical, invasive);

- if necessary, be referred to a higher level of medical care;

- if necessary, undergo a course of treatment on an outpatient basis or in an inpatient setting.

I confirmthat in order to make a decision about Consent, I am sufficiently informed in the form available to me:

- about the purpose, method and terms of the examinations and interventions offered to me;

- about the predicted advantage of medical interventions for me;

- about the risk of possible complications of medical interventions, as well as possible negative consequences of treatment;

- about the professional qualification of medical personnel.

I confirmthat in order to make decisions about the Consent, I am sufficiently informed about other alternative ways of solving my medical problems, as well as about the medical institutions where they are performed (public and private institutions).

I confirmthat in order to make a final decision about consent, I had sufficient opportunities to independently search and obtain the necessary information, as well as its analysis and comparison.

I confirmthat the possible harm from medical interventions is less significant for me than the circumstances that led me to agree to them, and therefore I VOLUNTARILY AND CONSCIOUSLY give my consent to the application of the proposed set of medical interventions to me, as well as other medical interventions that will complement and provide an adequate treatment process.

However, below I indicate the medical interventions from which I refuse under any circumstances, except in the case of an immediate threat to my life and the life of my child or re-negotiation with me:_____

_____

I know, that there are no absolutely safe medical interventions and any medical impact on a person causes corresponding reactions of his body, which can sometimes be atypical and unpredictable. And I understand that medical professionals will take all possible measures to prevent a threat to my life and harm to my health and the health of my child.

I don't mind, so that other competent medical institutions are involved in my interests.

I know, that strict adherence to doctors' prescriptions and recommendations is a necessary condition for a successful outcome, so I undertake to strictly fulfill all requirements for me as a patient. And I acknowledge that I am responsible for the results of medical interventions, in case of deviations on my part from doctors' prescriptions.

I confirm that I am aware that I can withdraw this consent at my discretion, before the start of medical interventions by writing the appropriate statement and mandatory timely notification of this to the attending physician or responsible representative

(name of medical institution)

In the event of my medical incapacity, I hereby designate a person whom I trust to represent my interests and to make decisions on my behalf exclusively in medical matters arising from

doctors and requiring my consent:_____

(P.I.B.)

actual place of residence and contact information (work, home, mobile phones)

I confirm, which had an unlimited opportunity to make changes to the text of this document at its discretion.

Patient_____(_____)

signature, enter your full name

_____

(Indicate the date of your signature in writing)

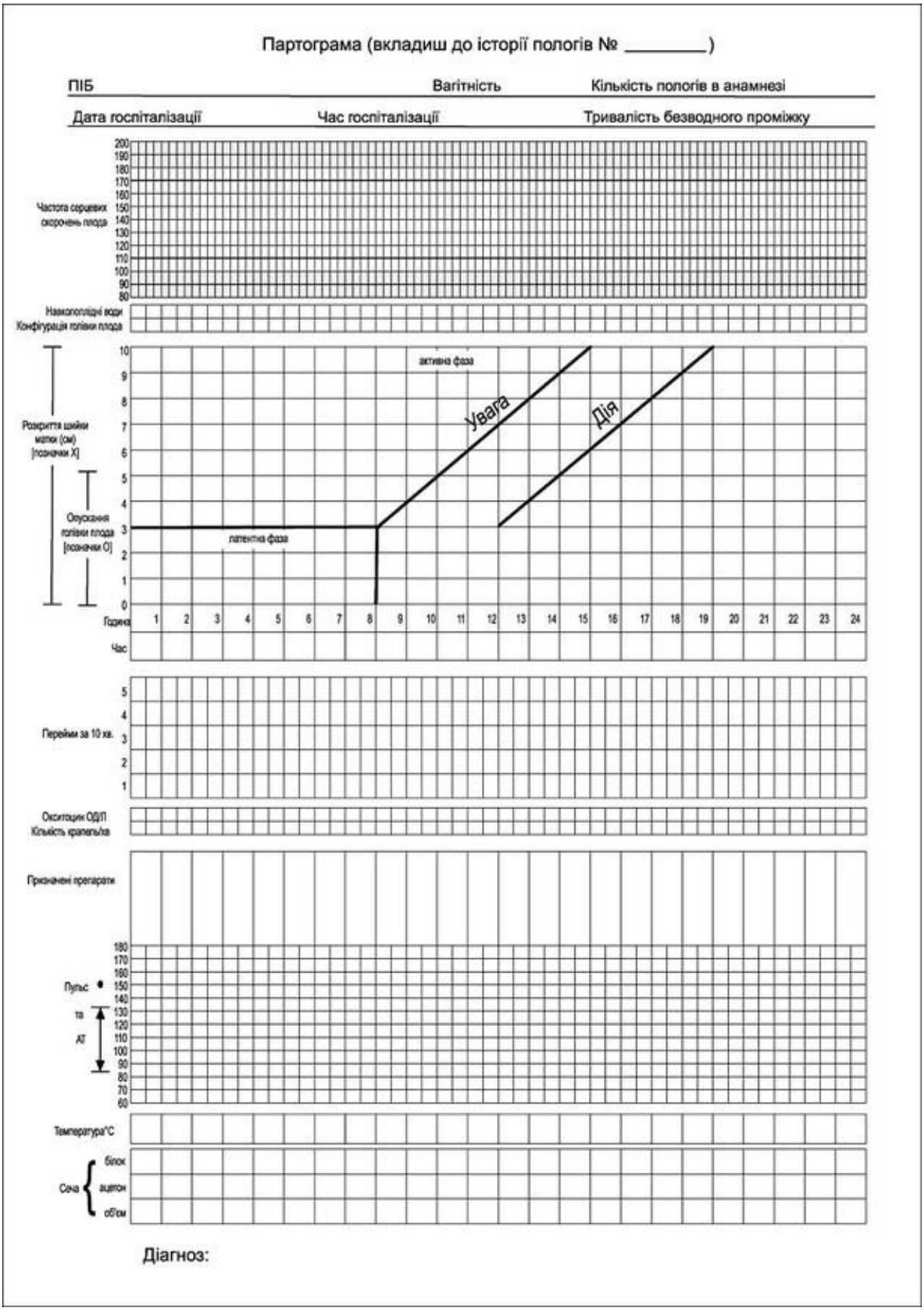
This document is signed in the presence of witnesses:

_____

signature of the witness P.I.B. Contact Information

_____

signature of the witness P.I.B. Contact Information



Childbirth clinic

The first period of childbirth

Observation of the course of the first period of childbirth, the state of the mother and the fetus is carried out using a partogram, on which the following indicators are graphically displayed relative to the time axis:

1.The course of childbirth:

• The degree of opening of the cervix, determined by the method of internal obstetric examination (every 4 hours)

• Lowering of the fetal head, determined by abdominal palpation (every 4 hours)

• Frequency (per 10 minutes) and duration (in seconds) of breaks (every 30 minutes),

2.Fetal condition:

• Fetal heart rate, assessed by auscultation or handheld Doppler analyzer (every 15 minutes)

• Degree of fetal head configuration (every 4 hours),

• Condition of the amniotic sac and amniotic fluid (every 4 hours)

3.State of childbirth:

• Pulse and blood pressure (every 2 hours),

• Temperature (every 4 hours)

• Urine: volume; the presence of protein or acetone - as indicated (every 4 hours).

Advantagespartograms

• Effective observation of the course of childbirth

• Timely detection of birth deviation from the normal course

• Aid in deciding on necessary and sufficient interventions

The second period of childbirth

Biomechanism of childbirth and protection of the perineum in this case.

The primary toilet of the newborn, compliance with the thermal chain. Clamping and cutting the umbilical cord.

Determination of the condition of the fetus according to the Apgar scale at the first and fifth minutes.

The third period of childbirth

Active management of the third period of childbirth.

Expectant management of the third period of labor.

Examination of the placenta (assessment of the integrity of the placenta with membranes).

Examination of the birth canal after childbirth (with the help of vaginal speculums).

Summary of childbirth(total duration of childbirth, duration of I, II and III periods of childbirth).

Postpartum period

*Early postpartum period.*Diary: body temperature, pulse, blood pressure. General condition of the mother.

*Late postpartum period.*The condition of the mammary glands (swelling, the presence of cracks on the nipples). Involution of the uterus (the height of the bottom of the uterus in relation to the pubic joint in cm in dynamics). The nature of lochia (bloody, bloody, serous, intensity of discharge), function of kidneys, intestines. The condition of the seams. Getting out of bed, from what day after childbirth. Blood and urine tests, the presence of protein in the urine in late gestosis of pregnant women. Was prophylactic sensitization on the Rh factor carried out for the mother in labor? Medicinal prescriptions for a woman in labor and justification of their expediency. Mode of the day, food. Purpose: medical physical education, sanitation of external genitalia, care of seams (describe its technique).

Summary of the postpartum period.

Epicris

A brief retelling of the history of childbirth with an emphasis on the peculiarities of the course of childbirth in a particular woman. Results of laboratory and additional examination methods. Application of treatment or surgical intervention and their effectiveness. Causes of complications. Status at the time of discharge, end of curation. Recommendations regarding postpartum contraception, breastfeeding, and mother-child regimen.

Curator's signature _____

BASICS OF CONSULTING, INCLUDING MLA CONSULTING

Counseling is a confidential conversation that requires two-way communication (a dialogue, not a monologue) and focuses on the individual needs of the patient. The consultant provides the patient with clear and objective information and helps to make an informed choice (make an informed and voluntary decision). In order to be effective, the consultant must not simply provide some amount of information, but provide it in a manner favorable to the patient.

Informed choice (consent)- patient's voluntary decision, based on knowledge of all the necessary information. In order for the patient to make an informed (informed) choice, the consultant must provide reliable and sufficient information about the patient's problem (problems) and the means of solving it (them).

Principles of counseling

- **Asking questions**

A skillful interview provides an opportunity to obtain information about the patient. The form in which the consultant asks questions determines not only the quality and volume of information received from the patient, but also affects the relationship between the consultant and the patient. Questions are divided into open and closed.

- **Encouragement and reassurance**

Encouragement and reassurance are important for creating and strengthening contact between the consultant and the patient, help the patient believe in himself, encourage him to seek solutions to his problems. However, if reassurance begins to prevail in counseling, it forms the patient's dependence on the counselor.

- **Representation of content: paraphrasing and generalization**

Paraphrasing and summarizing statements convinces the patient that the consultant listens carefully and understands him. The ability not only to listen, but also to hear is extremely important for more effective communication with the patient.

- **Reflection of feelings**

Reflecting feelings is closely related to paraphrasing. The difference is that paraphrasing focuses on the content, and the reflection of feelings - on what is hidden behind the content. The reflection of feelings contributes to the emergence of interpersonal, emotional contact, because it demonstrates to the patient the desire of the consultant to understand his inner world. The consultant should also express his own feelings, which arise as a result of counseling, but they should be related only to the topic of the conversation. However, in counseling, the feelings of the patient and the non-consultant are always more significant.

- **Pauses of silence**

The ability to remain silent and use silence for therapeutic purposes is one of the most important counseling skills.

- **Providing information**

Counseling tasks are also achieved by providing information: the counselor expresses his opinion, answers the patient's questions, informs him about various aspects of the problems being discussed.

- **Interpretation**

When conducting counseling, it is important to discover the real problems of the patient, which may differ from the issues that the patient touched on in his superficial story. The task of interpretation is to make the incomprehensible understandable.

- **Confrontation**

Confrontation is the counselor's response to the patient's duplicitous behavior (tricks, tricks) that prevent the patient from seeing and solving his problems.

- **Feeling like a consultant and self-disclosure**

Quality counseling requires not only experience, but also emotional enthusiasm for the process. However, emotional involvement must be appropriate and serve the interests of the patient, not the counselor.

- **Structuring of counseling**

Structuring is the organization of the relationship between the consultant and the patient. It takes place during the entire counseling process. Each new stage begins with an assessment of what has been achieved.

- **Non-verbal communication**
- Non-verbal (non-verbal) communication is as important in the counseling process as verbal communication.

Remember the importance of the first impression. The degree of his trust depends on how you greet the patient, on the expression of your face. Such factors as the appearance of the consultant, manners of behavior can influence the creation of a favorable environment, the patient's affection.

Maintain eye contact, listen carefully to the patient, speak kindly. Try to use your tone of voice to convey that you care about the patient's problems. Remove physical barriers between the patient and you.

- **End of counseling**

The issue of termination of consultation meetings is decided by the joint consultant and the patient. The last meeting should be devoted to summing up the results.

Counseling on reproductive health:

- a set of measures aimed at making the patient aware of his problems in the field of reproductive health;
- searching for ways to solve them and means of achieving acceptance of mistakes, including changing behavior towards a less risky one.

Areas of family planning counseling:

- counseling on contraception, including emergency contraception;
- premarital counseling;
- post-abortion counseling;
- family counseling during pregnancy and in the postpartum period;
- counseling of infertile married couples;
- counseling for sexual disorders.
- counseling of adolescents on contraception, which has its own specific approaches and methods.

For all postpartum contraception methods available in the country, the health professional/consultant should know the following:

- Description of the method.
- Its availability (ie, where to find suitable contraceptives).
- Mechanism of (contraceptive) action of the method.
- Effectiveness of the method.
- Advantages of the method.
- Disadvantages of the method.

- The possibility of a reverse effect of the method.
- The cost of the method.
- Contraindications (relative and absolute) to the use of the method.
- Side effects of the method and algorithm of actions in case of their occurrence.
- Alarming symptoms when using the method and an algorithm of actions in case of their occurrence.
- Stereotypes of perception of this method in society and a possible strategy for them.
- Follow-up care of a patient using this method.
- Method application intervals.
- Instructions for its use.
- The effectiveness of the method in protection against STIs.

Algorithm of communication between students (doctors) and patients: start of conversation:

- Initial acquaintance (verbal and non-verbal contact)
- Clarification of the reason(s) for the consultation
- Collection of information
- Studying problems
- Clarification of the reasons related to the problem

Postpartum contraception: method of lactational amenorrhea (MLA).

- high efficiency up to 6 months under the conditions of exclusive breastfeeding and absence of menstrual bleeding (amenorrhea),
- breastfeeding should begin immediately after delivery,
- for maximum effectiveness, feeding should be exclusively breast, at least 8-10 times a day,
- the interval between feedings at night should not exceed 6 hours.

Instructions for the patient:

- It is necessary to feed the child from both breasts at her request about 6-10 times a day.
- Feed the child at least once at night (the interval between two feedings should not exceed 6 hours).
- ***Note:***the main goal of breastfeeding is to provide nutritionvigilance and thus improving the child's health. The child may not need 6-10 meals a day or may skip the usual feeding - these are normal phenomena, but it is necessary to warn the woman, if any of them takes place, the effectiveness of breastfeeding as a method of contraception decreases.
- If the child develops well with satisfactory indicators of physical development, gains weight, the mother's diet is balanced and she rests enough to maintain an adequate amount of breast milk, a child up to 6 months does not need other nutrition.

- As soon as the replacement of breast milk with another food or liquid begins, the child will feed less than 6-10 times a day, breastfeeding will not be an effective method of preventing an unplanned pregnancy - MLA.
- **Renewal of menstruation**means that the reproductive function has recovered and it is necessary to immediately start using other methods of PS.

Women who should not use mla:

- women who have resumed menstruation;
- women who do not exclusively (or almost exclusively) breastfeed;
- women whose child is 6 months or older.

Conditions that require caution

SITUATION	RECOMMENDATIONS
Introduction of regular complementary feeding (instead of breastfeeding)	The patient is helped to choose another method and encouraged to continue breastfeeding.
Restoration of postpartum menstruation	
Interval between feedings > 4 hours during the day and > 6 hours at night	
A child aged 6 months or more	

MEDICAL ETHICS AND DEONTOLOGY

The professional activity of obstetrician-gynecologists is related to solving complex deontological issues: since the situations that arise during counseling or providing medical assistance to women in connection with conception, bearing, birth, feeding a child, the occurrence of diseases of the female genital organs, concern intimate aspects of a woman's life and those around her. This requires treatment and prevention from the staffObstetrics and gynecology institutions to observe certain deontological and moral and ethical rules and norms of behavior in their work.

The issue of psychological support for a woman during childbirth, the role and tasks of medical workers who provide her with medical care

The process of childbirth is a physiological process, at the same time a very responsible period for women. Medical workers providing medical care during pregnancy and childbirth should remember this and by their actions create an atmosphere of calm, trust, and confidence in the positive outcome of childbirth. The staff of an obstetric institution should perceive a pregnant woman, a woman in labor, a woman in labor not as an object of certain medical manipulations with the aim of giving birth, but, first of all, as a person and the main participant in an important moment of her life - childbirth.

At all stages of providing obstetric care, a woman is guaranteed the right to timely receive information from medical workers about the state of her health and the fetus (newborn), all medical interventions and examinations, their necessity or expediency, and possible consequences in accordance with current legislation. Such information is provided by a doctor, midwife or nurse in a calm environment, taking into account the psychological state of the woman (at her request - confidentially). After receiving the information, the woman is asked to consent to the necessary medical interventions for her or her child.

In order to avoid conflict situations, complications during childbirth and the postpartum period, the process of providing medical care to pregnant women, women in labor, women in labor, and newborns by the staff of maternity care institutions should be carried out on the basis of mutual understanding with patients, respect for them, and their involvement in decision-making regarding the tactics of providing medical care. The normal psycho-emotional state of a pregnant, parturient woman contributes to the physiological course of childbirth and the postpartum period. During childbirth, it is necessary to observe the principles of confidentiality: in the delivery room, the presence of one woman in labor and her (if desired) family members, whose task is psychological support of the woman in labor, and medical personnel who directly conduct the delivery, are provided.

Psychological aspects of the activity of medical workers in solving the issues of termination of pregnancy according to indications

If there are indications for termination of pregnancy, the obstetrician-gynecologist consults on the issues of providing the pregnant woman with information on the validity of the termination, providing psychological support, the scope of medical interventions and rehabilitation in the postoperative period.

Pregnancy is terminated with informed consent in accordance with current legislation.

In such cases, it is inappropriate to provide information about the possible negative consequences of pregnancy prolongation in the form of threatening statements, taking into account the psychological state of the pregnant woman and her relatives.

Women who choose to terminate a pregnancy if there are indications are provided with detailed information about the possible consequences for her health.

Patient rights

Every patient has the right to:

- receiving information
- service availability
- freedom of choice
- informed consent
- safety

- communication alone
- privacy
- anonymity
- dignity and respect
- comfort
- continuity of service provision
- expressing your opinion
- Social Insurance

Medical ethics and deontology in the maternity ward (according to Order No. 624 dated November 3, 2008)

- Determination of the birth plan and mandatory informed agreement with the woman/family.
- Encouraging emotional support for the mother during childbirth (organization of partner births);
- Encouraging the woman to move freely during childbirth and ensuring the possibility of freely choosing the position for the birth of the child.
- An individual delivery room, which should be as close as possible to home conditions;
- Personal psychological support of the woman in labor by her husband or her chosen partner, who must be prepared to participate in childbirth
- Achieving mutual understanding, psychological support for childbirth by medical personnel;
- Explanation of the necessity of carrying out each procedure and manipulation and obtaining the woman's permission to carry it out;
- Maintaining a friendly atmosphere during childbirth;
- Respect for the woman's wishes, ensuring confidentiality;

Work with medical documentationis conducted according to:

• Order of the Ministry of Health of Ukraine dated 15.07.2011 No. 417 "On the organization of ambulatory obstetric and gynecological care in Ukraine"

• Order of the Ministry of Health of Ukraine dated February 13, 2006 No. 67 "On approval of forms of primary accounting documentation in institutions providing medical care to pregnant women, women in labor and women in labor and instructions for filling them out"

• Order of the Ministry of Health of Ukraine dated 08.06.2006 No. 545 "Regulation of medical documentation certifying birth and death"

Forms of primary accounting documentation

- Form of primary accounting documentation N 002/o "Journal of admissions of pregnant women, women in labor and women in labor"
- Form of primary accounting documentation N 010/o "Log of births in a hospital"
- Form of primary accounting documentation N102/o "Logbook of newborns in the department (ward)"

- Form of primary accounting documentation N 113/o "Exchange card of the maternity hospital, maternity department of the hospital"
- Form of primary accounting documentation N 153/o "Journal of accounting for cases of perinatal death"
- Form of primary accounting documentation N057/o "Registration card of a pregnant woman suffering from diabetes"

Current control: survey, testing, evaluation of performance of practical skills, evaluation of communication skills during role play, solution of situational clinical tasks, evaluation of activity in class.

Final control: CPE

Assessment of current activity in a practical lesson:

- Evaluation of theoretical knowledge on the subject of the lesson: methods: survey, solving a situational clinical problem

Assessment: maximum – 5, minimum – 3, unsatisfactory – 2

- Evaluation of practical skills and manipulations on the subject of the lesson: methods: assessment of the correctness of the performance of practical skills

Assessment: maximum – 5, minimum – 3, unsatisfactory – 2

- Evaluation of work with patients on the subject of the lesson: methods: communication skills with the patient and his relatives; correctness of appointment and assessment of laboratory and instrumental studies; compliance with the differential diagnosis algorithm; substantiation of the clinical diagnosis; drawing up a treatment plan

Assessment: maximum – 5, minimum – 3, unsatisfactory – 2

The grade for one practical session is the arithmetic average of all components and can only have a whole value (5, 4, 3, 2), which is rounded according to the statistical method.

Current evaluation criteria in practical training

Mark	Evaluation criteria
Perfectly "5"	The student is fluent in the material, takes an active part in discussing and solving a situational clinical problem, confidently demonstrates practical skills. Excellently interprets the data of clinical, laboratory and instrumental studies, expresses his opinion on the topic of the lesson, demonstrates clinical thinking.
Fine "4"	The student has a good command of the material, participates in the discussion and solution of a situational clinical problem, demonstrates practical skills. Interprets the data of clinical, laboratory and instrumental studies well with some errors, expresses his opinion on the topic of the lesson, demonstrates clinical

	thinking.
Satisfactorily "3"	The student does not have sufficient knowledge of the material, is unsure of participating in the discussion and solution of a situational clinical problem, demonstrates practical skills for and interprets clinical, laboratory and instrumental research data with significant errors.
Unsatisfactorily "2"	The student does not possess the material, does not participate in the discussion and solution of the situational clinical problem, does not demonstrate practical skills.

The student is admitted to the CPE on the condition that the requirements of the end-to-end work program of practice are fulfilled and if he received at least 3.00 points for the current activity.

Evaluation of the results of the students' practice during the final control - comprehensive practical exam (CPE).

The methodology of final control in the form of CPE is unified and involves the use of standardized forms. The number of practical skills taught at CPE corresponds to the number of production practice profiles on the corresponding course under the corresponding EPP.

Evaluation of the winner is carried out according to a checklist. During the CPE, the student receives a ticket, and the examiners use a checklist for the corresponding ticket with reference answers and determine which mandatory components of the answer were fulfilled or not fulfilled by the applicant.

Each point of the algorithm, depending on the complexity, is assigned a certain number of points. The specific weight (number of points) of each item may be different - depending on the number of items and the difficulty of performing a particular item. Some scenarios may have critical points, failing which the task is considered failed. Ambiguity of understanding should be excluded when forming checklist items.

When the applicant performs certain actions, he can receive "minus points", namely:

№	Evaluation criterion	Mark
1.	Unregulated action or attempt to communicate with the examiner, not provided for in the task	- 5
2.	The second unregulated action or attempt to communicate with the examiner, not provided for in the task	- 5
3.	The third unregulated action or attempt to communicate with the examiner, not provided for in the task	-5
4.	The fourth unregulated action or attempt to communicate with the examiner, not provided for in the task	- 5
5.	More than 4 unregulated actions	- 20

6.	Dangerous action (which will inevitably lead to deterioration of the patient's condition)	- 20
7.	Unacceptable behavior	- 20
8.	Damage to simulation equipment or inventory	- 20

The maximum score for completing a task at one station is 100 points. The CPE is considered completed if the applicant has scored at least 60% of the maximum number of points at each station.

The overall CPE score is calculated as the arithmetic average of all received scores for all profiles. CPE is held in the Educational and Production Complex of Innovative Technologies of Learning, Informatization and Internal Monitoring of Education Quality of the University during the examination sessions at the end of the semester (autumn and spring) according to the schedule.

List of recommended literature:

Main:

1. Obstetrics and gynecology: in 2 books. – Book 2. Gynecology: a textbook (III-IV university) / edited by V.I. Hryshchenko, M.O. Shcherbyny , B.M. Ventskivskyi - 3 - there is ed., ex., 20 20 . - 376 p.
2. Clinical Obstetrics and Gynaecology: 4th Edition / Brian A. Magowan, Philip Owen, Andrew Thomson. - 2021. - 454 p.
3. Family planning and contraception: study guide / V.I. Boyko, N.V. Kalashnyk, A.V. Boyko and others; in general ed. Dr. Med. Sciences, Prof. V.I. A fight – Sumy: Sumy State University, 2018. – 223 p.
4. Obstetrics and Gynecology: in 2 volumes. Volume 2. Gynecology: textbook/ VI Gryshchenko, MO Shcherbina, BM Ventskivskyi et al. — 3rd edition, 2022. – 360 r .
5. Comprehensive Gynecology - 8 th Ed. / DM Hershenson, GM Lentz, FA Valea et al. Elsevier. 2021 - 881 p.
6. Pragmatic obstetrics and gynecology [Text]: [manual] / LB Markin [et al.]. - Lviv: Lviv Nat. Danylo Halytsky Med. Univ., 2021. - 236 p.
7. Oxford Textbook of Obstetrics and Gynecology / Ed. by S. Arulkumaran, W. Ledger, L. Denny, S. Doumouchtsis. - Oxford University Press, 2020 - 928

Additional:

1. Endoscopic surgery: training. manual / V.M. Zaporozhan, V.V. Grubnik, Yu.V. Grubnik, A.V. Malinovsky and others; under the editorship V.M. Zaporozhana, V.V. Grubnika - K.: VSV "Medicine", 2019. - 592 p.

2. Diagnostics of obstetric and gynecological endocrine pathology: [educational manual for intern doctors and trainee doctors of institutions (fac.) post-diploma. of Education of the Ministry of Health of Ukraine] / edited by V.K. Likhachev; V.K. Likhachev, L.M. Dobrovolska, O.O. Taranovska and others; UMSA (Poltava). – Vinnytsia: E.V. Maksimenko Publisher, 2019. – 174 p.
3. Zaporozhan V.M. Simulation medicine. Experience. Acquisition Prospects: practice. advisor / V.M. Zaporozhian, O.O. Tarabrin – Sumy: University. Book, 2018. – 240 p.
4. Gynecology: a guide for doctors / V.K. Likhachev. – Vinnytsia: Nova Kniga, 2018. - 688 p.
5. Family planning. Educational and methodological manual / N.G. Hoyda, O.V. Hryshchenko, V.P. Kvashenko, O.V. Kravchenko et al. / Kyiv, 2016. – 444 p.
6. Infertility in marriage: study. study guide higher honey. education closing III-I V yr. acre. - Kh.: Khnist National Medical University, 2014. - 126 p.
7. Reproductive function in women with uterine fibroids and endometriosis / N.M. Rozhkovska, D.M. Zhelezov, T.V. Kossei // Women's health - 2018. - #2. - P.5-7.
8. Ovarian reserve during surgical treatment of ovarian endometrioma / A.H. Volyanska, L.M. Popova, T.P. Todorova, O.P. Rogachevskyi, O.I. Shevchenko // All-Ukrainian scientific and practical conference with international participation "Innovative technologies in obstetrics and gynecology: from science to practice" - Ivano-Frankivsk, 2019. - P. 12-13.
9. The influence of surgical energies on the ovarian reserve during endoscopic treatment of ovarian endometriosis / T.P. Todorova // Scientific and practical conference with international participation dedicated to the 150th anniversary of the birth of V.V. Voronov "Modern theoretical and practical aspects of clinical medicine" - Odessa, 2020. - p. 118.
10. Situational problems in gynecology: teaching. manual/ I.Z. Gladchuk, A.H. Volyanska, G.B. Shcherbina and others; under the editorship of Prof. FROM. Gladchuk - Vinnytsia: "Nilan-LTD" LLC, 2018. - 164 p.
11. Williams Gynecology, 4th Edition by Barbara Hoffman, John Schorge et al&. - Mac Grow Hill Education. - 2020. – 1328
12. Oats, Jeremy Fundamentals of Obstetrics and Gynecology [Text]: Liewellyn - Jones Fundamentals of Obstetrics and Gynecology / J. Oats, S. Abraham. – 10 th ed. – Edinburgh [etc.]: Elsevier, 2017. – VII, 375 p.
13. Dutta, Durlav Chandra. DC Dutta's Textbook of Gynecology including Contraception / DC Dutta; ed/ Hiralal Konar. - 7th ed. - New Delhi: Jaypee Brothers Medical Publishers, 2016. - XX, 574 p.
14. Current "Clinical protocols", approved by order of the Ministry of Health of Ukraine for Obstetrics and Gynecology.

Electronic information resources:

1. https://www.cochrane.org/ - Cochrane / Cochrane Library
2. https://www.acog.org/ - American Association obstetricians and Gynecologists / The American

College of Obstetricians and Gynecologists

3. https://www.uptodate.com – UpToDate
4. https://online.lexi.com/ - Wulters Kluwer Health
5. https://www.ncbi.nlm.nih.gov/ - National center biotechnological of information / National Center for Biotechnology Information
6. https://pubmed.ncbi.nlm.nih.gov/ - International medical library / National Library of Medicine
7. https://www.thelancet.com/ - The Lancet
8. https://www.rcog.org.uk/ - Korolevska Association obstetricians and gynecologists / Royal College of Obstetricians & Gynaecologists
9. https://www.npwh.org/ - Practitioners nurses with protection I 'm healthy women / Nurse practitioners in women's health
10. http://moz.gov.ua – Ministry of Health of Ukraine
11. www.ama-assn.org - American medical association / American Medical Association
12. www.who.int - World Health Organization
13. www.dec.gov.ua/mtd/home/ - State Expert Center of the Ministry of Health of Ukraine
14. http://bma.org.uk - British Medical Association
15. www.gmc-uk.org - *General Medical Council (GMC)*
16. www.bundesaerztekammer.de – German Medical Association
17. www.euro.who.int - European Regional Office of the World Health Organization.