Block P OSPES KGMC 2025 Preprofs

By Fatima Haider

Table 8: OSCE station distribution of different subjects

BLOCK-P (TOTAL STATIONS=20 and 6 marks/station)					
Subjects	OSCE stations	Viva stations	Short cases	Logbook and history books (1-station)	Structured Long case -30 marks)
Gynaecology	7	1	2	Gynaecology And Obstetrics	Gynaecology And Obstetrics
Medicine+ Endocrinology	2	1	1		
Paediatrics	1	1	0		
Surgery	1	1	1		
Total	11	4	4	1	1

Instruments: OBGYN

Dr. Prassan Vij

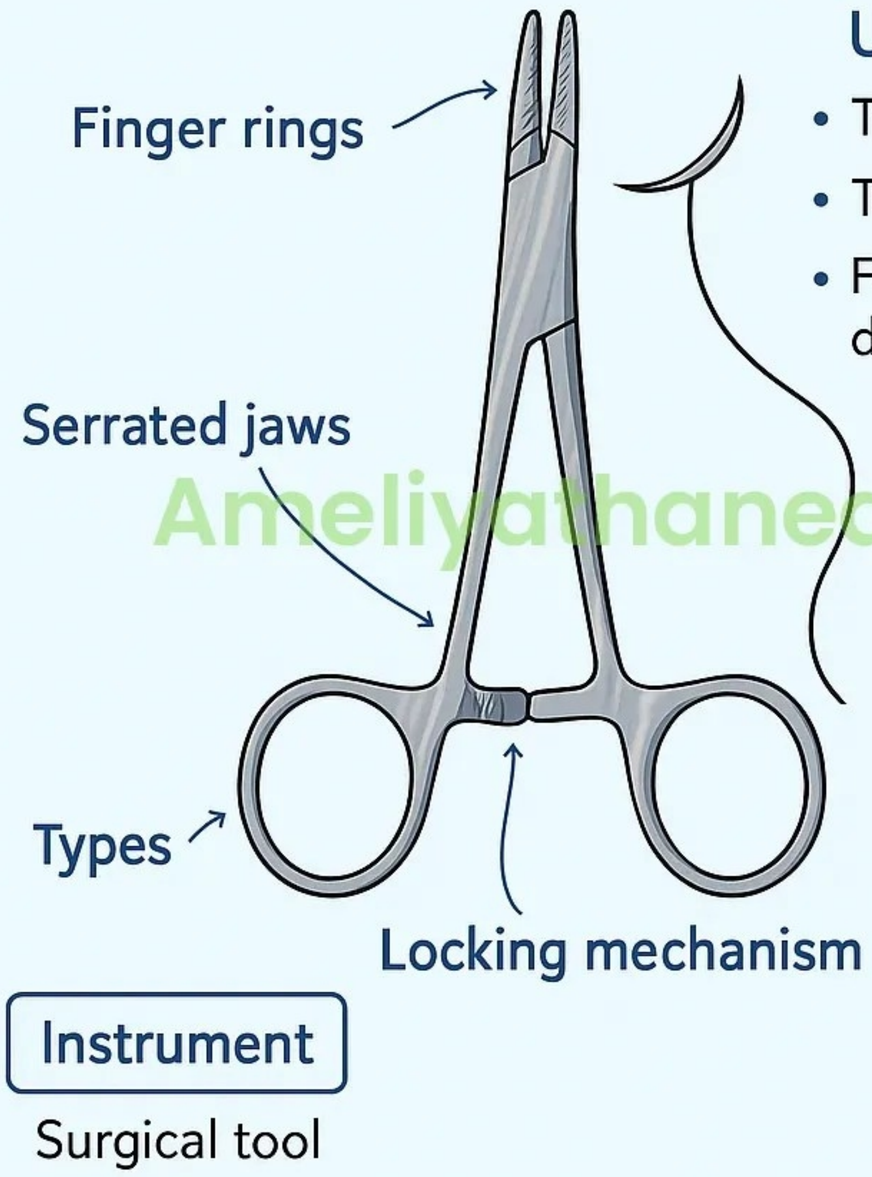
SIMS SPECULUM (DUCK BILLED SPECULUM)

- Inspection & examination of vagina and cervix
- Examination of obstetric trauma or vaginal trauma
- Used for DNC
- 2 blades of different sizes

Episiotomy Scissor Use

Episiotomy scissors are used to make episiotomy incisions for easier delivery of the baby by widening the opening of the vagina. These scissors are angled to make a precise incision by the obstetrician.

Needle Holder



Instrument

Surgical tool

Uses

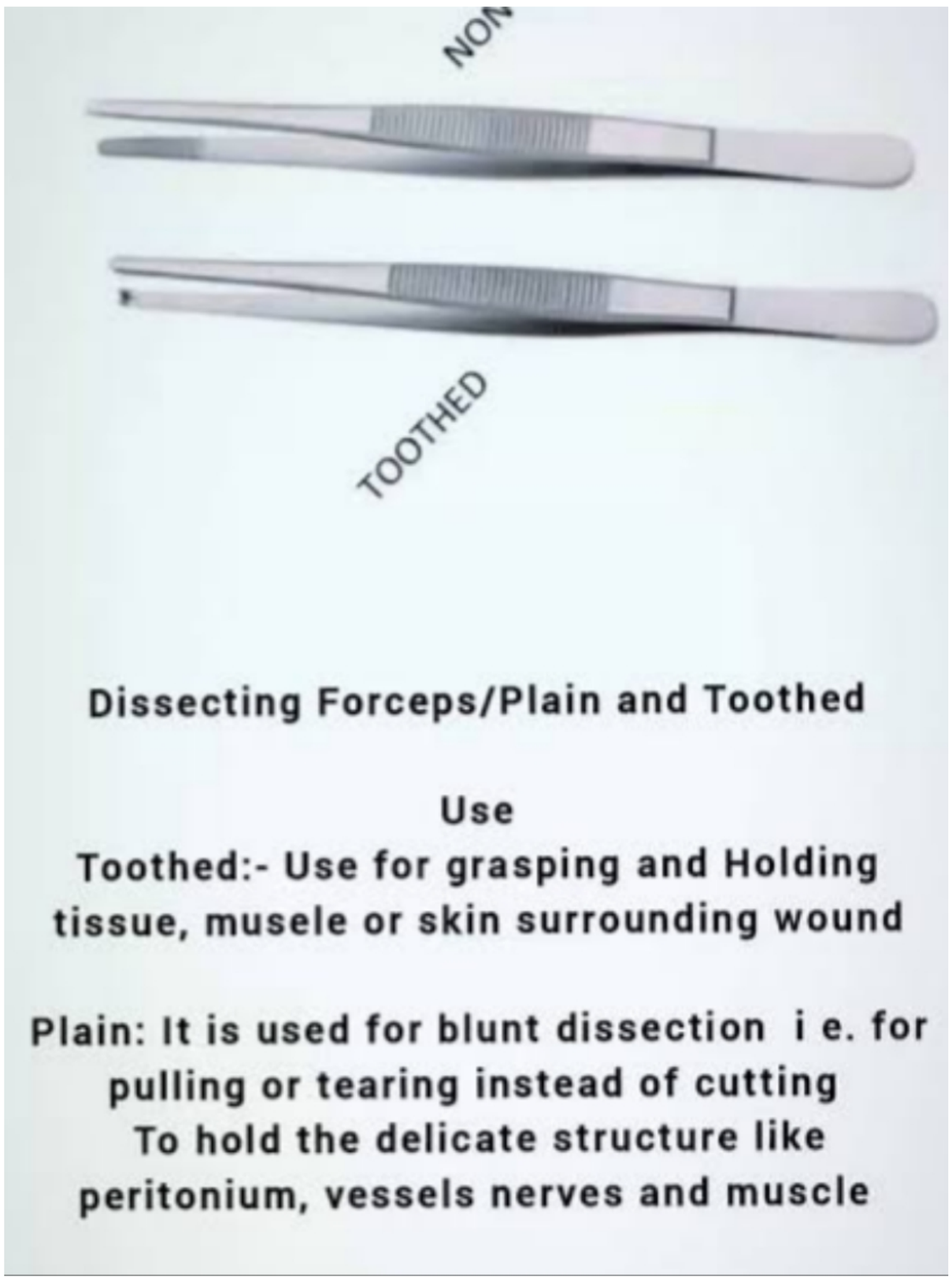
- To hold suture needles
- To grasp suture material
- For suturing in surgery, dentistry, etc.

Types

- Mayo-Hegar
- Crile-Wood
- Castroviejo

Types:

- Mayo-Hegar
- Crile-Wood
- Castroviejo

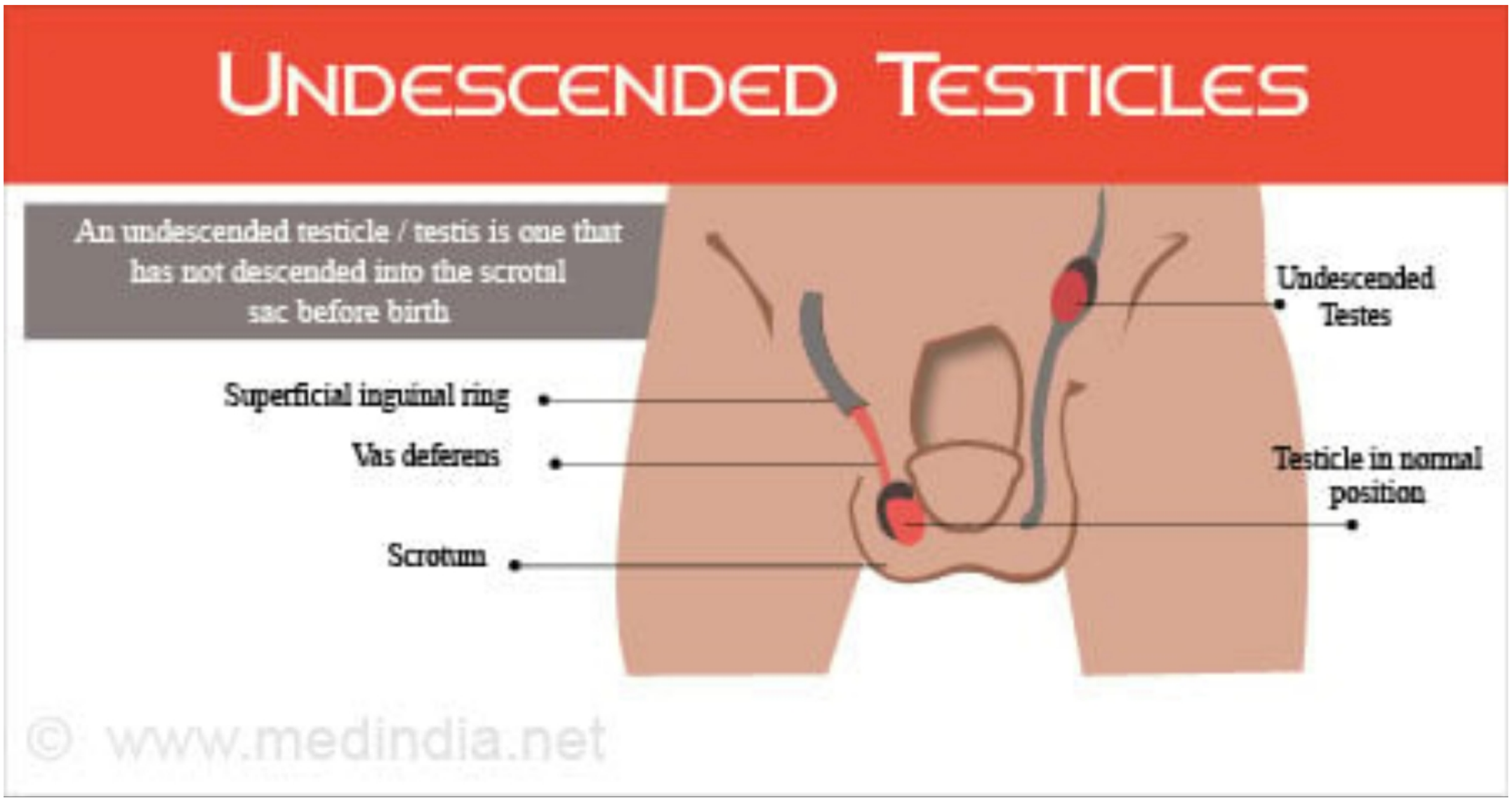


Dissecting Forceps/Plain and Toothed

Use

Toothed:- Use for grasping and Holding tissue, musele or skin surrounding wound

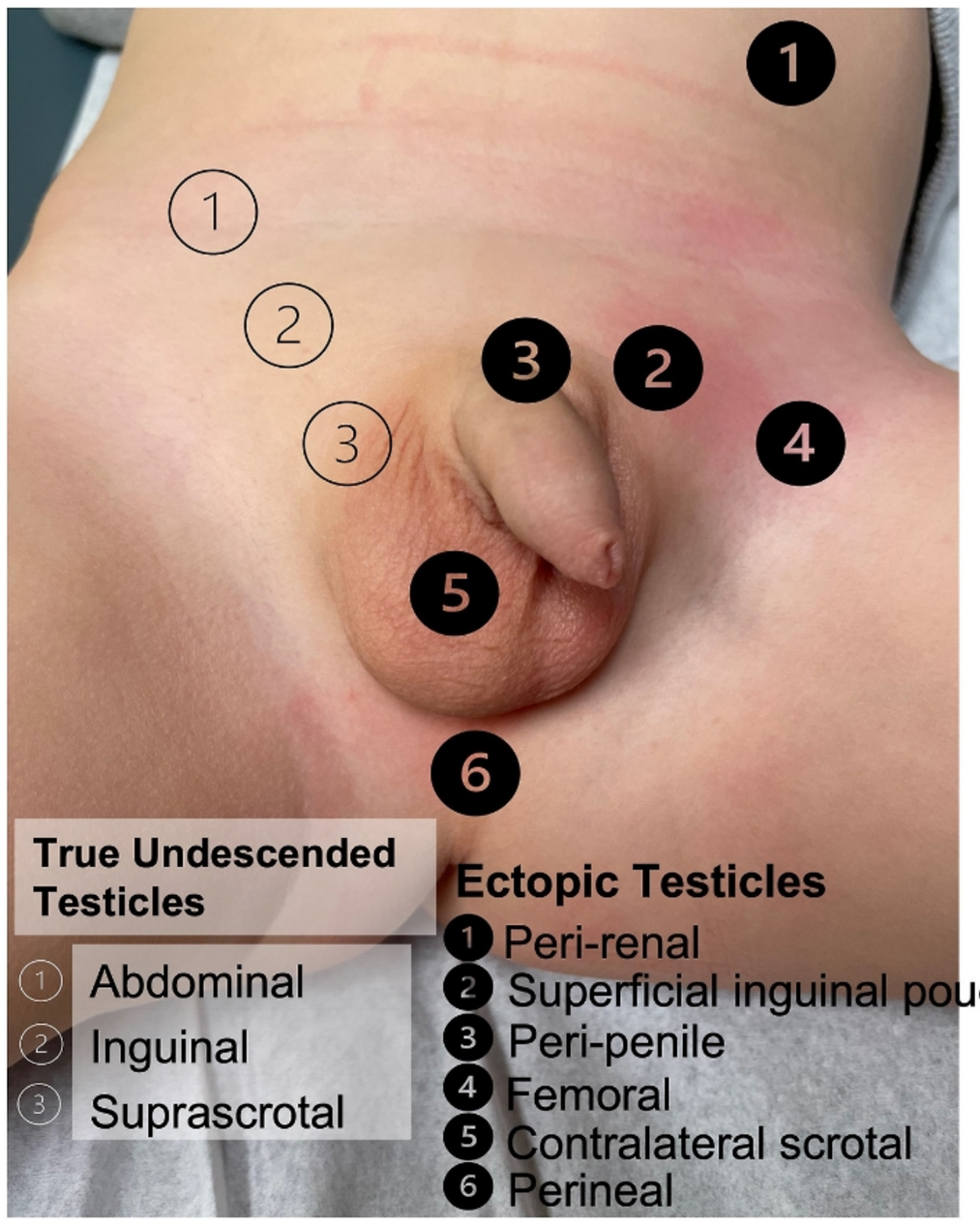
Plain: It is used for blunt dissection i e. for pulling or tearing instead of cutting To hold the delicate structure like peritonium, vessels nerves and muscle



14 year old boy with left inguinal swelling, pain and backache for 6 months (picture was given).

Q 1. Diagnosis

Q2. Write findings in image in 3 lines



Counseling of a CKD patient

* Define episiotomy
* What surgical grade is it
* Types of episiotomy
* Indications
* Complications

An episiotomy is a surgical incision made in the perineum (the tissue between the vaginal opening and the anus) during childbirth to widen the vaginal opening.

★ Second Degree Perineal Laceration
ie tear to cutaneous and subcutaneous tissue
plus perineal muscles

Indications of episiotomy:

- Fetal distress.
- Short or inelastic perineum.
- Shoulder dystocia.
- Fetal malposition, e.g. occipito-posterior.
- An instrumental or breech delivery.
- Previous pelvic floor surgery.

Complications

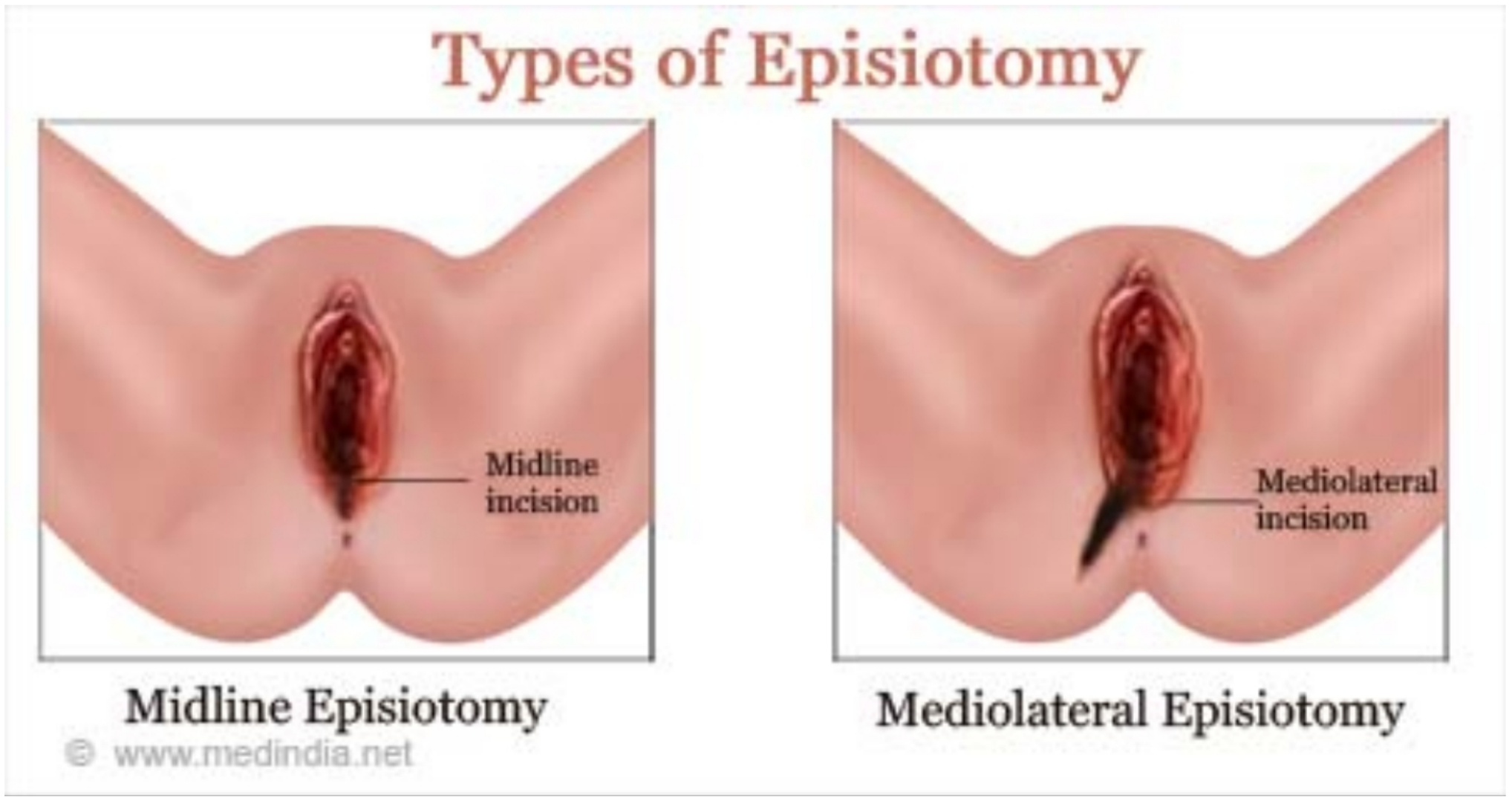
- **Immediate**
- Extension of the incision to involve the rectum
- Vulval haematoma
- Infection
- Wound dehiscence
- Injury to anal sphincter causing incontinence of flatus or faeces
- Rectovaginal fistula (Rarely)
- Necrotising fascitis

Types of Episiotomy

(ii). Types & Procedure:

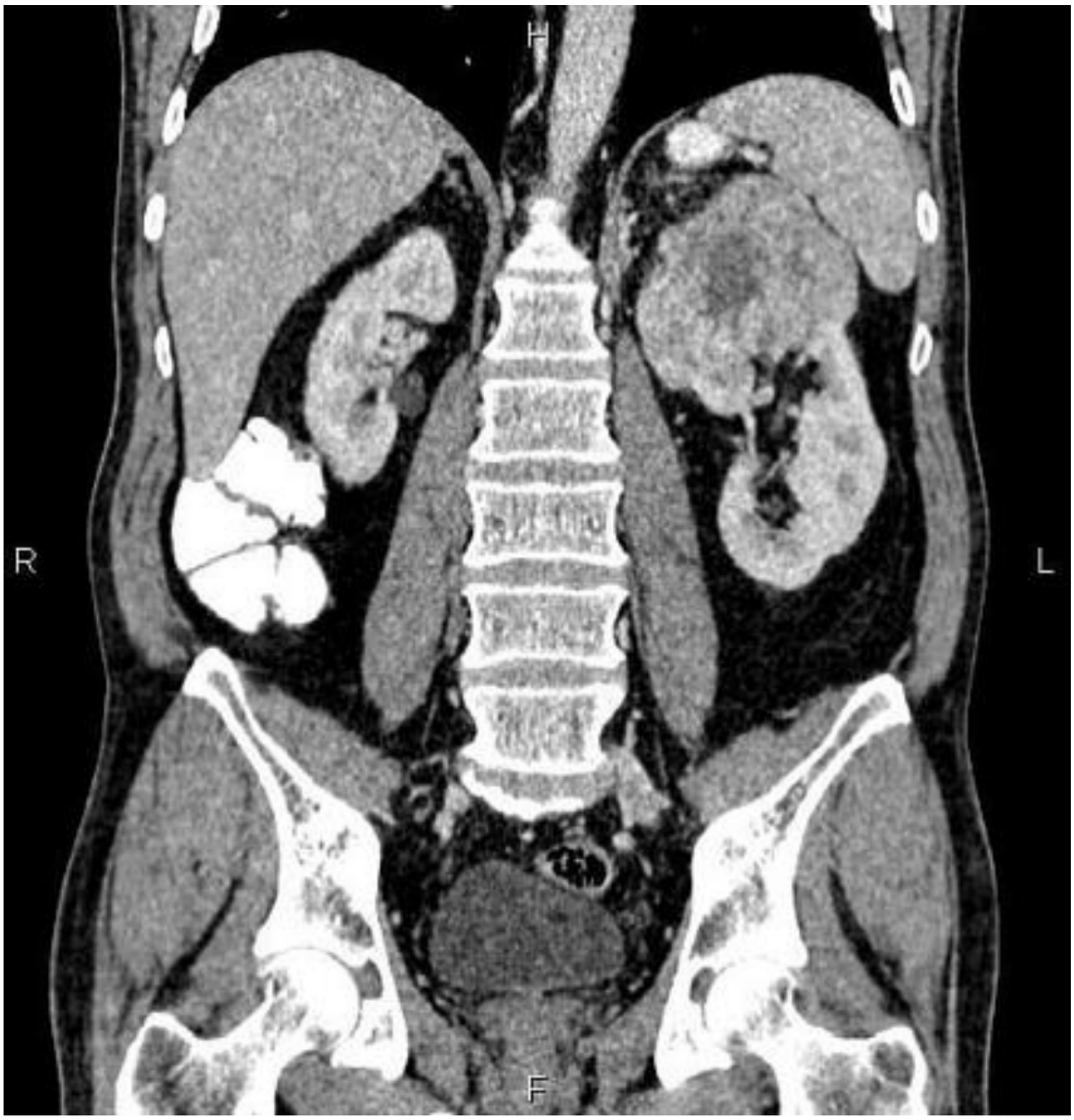
- Episiotomy is performed by two different techniques:

Midline Episiotomy	Mediolateral Episiotomy
▪ It extends from the fourchette towards the anus. ▪ It is associated with: ○ Less blood loss ○ Easier to repair ○ Heals quickly ○ Less pain in postpartum period ○ Anal sphincter injury ○ Reduced incidence of dyspareunia	▪ ~~It extends from the fourchette towards the anus.~~ Starting at vaginal opening and angling downward abt outward (typically 60°) to protect anal sphincter ▪ It is associated with: ○ **Reduced risk of anal sphincter injury therefore the recommended incision** ○ More blood loss ○ Difficult to repair ○ Delayed healing ○ More pain in postpartum period



Diagnose

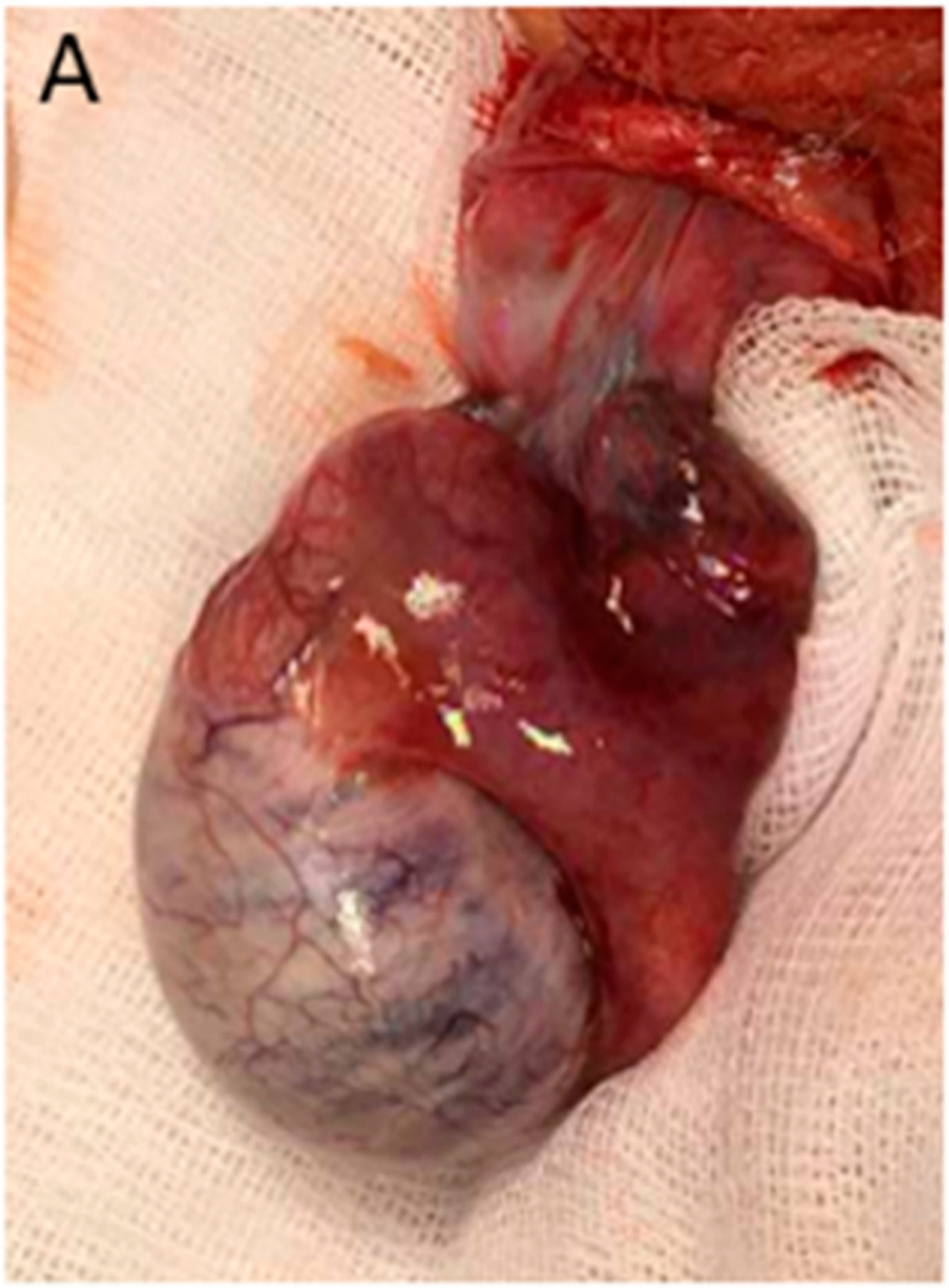
Varicocele grades
Grade 0 not detectable in physical exam but detected on ultrasound
Grade 1 palpable after valsalva
Grade 2 palpable after standing position
Grade 3 visible

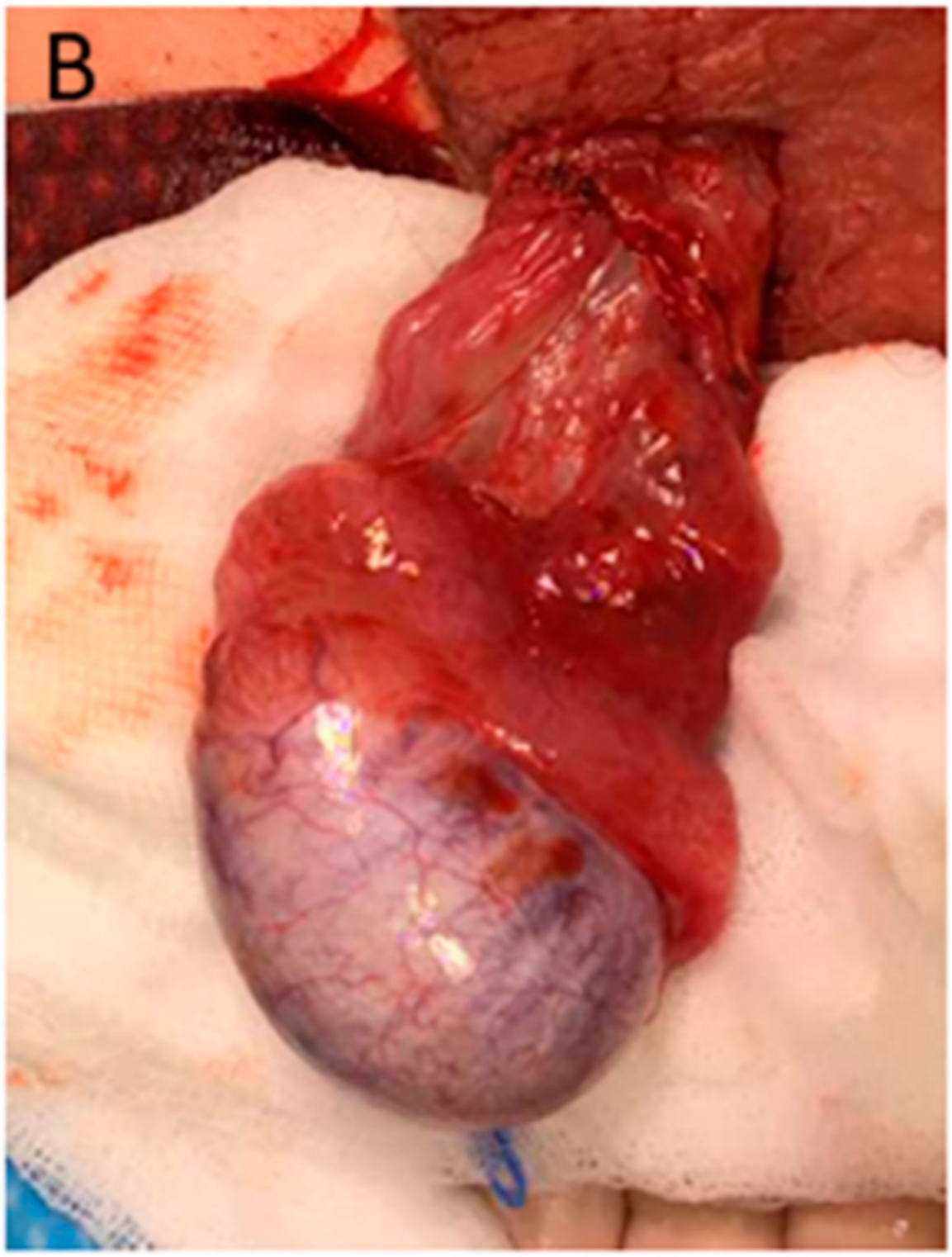


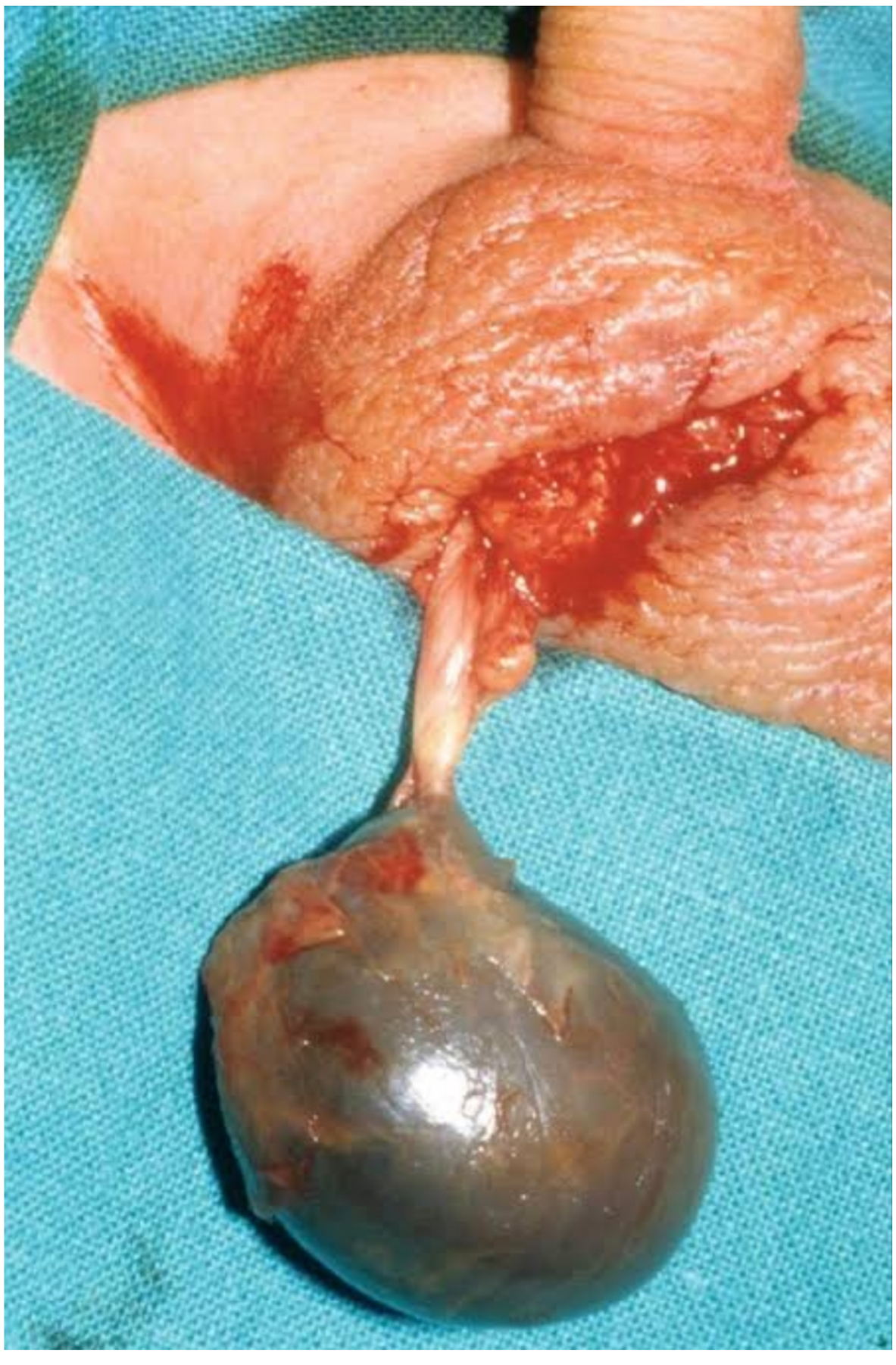
Left renal mass
Renal cell carcinoma

Types of Nephrectomy

Type	Tissue Removed	Common Indication
Simple	Kidney	Non-functioning kidney
Radical	Kidney + fat + fascia ± adrenal ± nodes	RCC, large tumors
Partial	Part of kidney	Small tumor, preserve function
Laparoscopic	Kidney via minimal incision	Any of above, if suitable
Donor	Kidney	Living kidney transplant





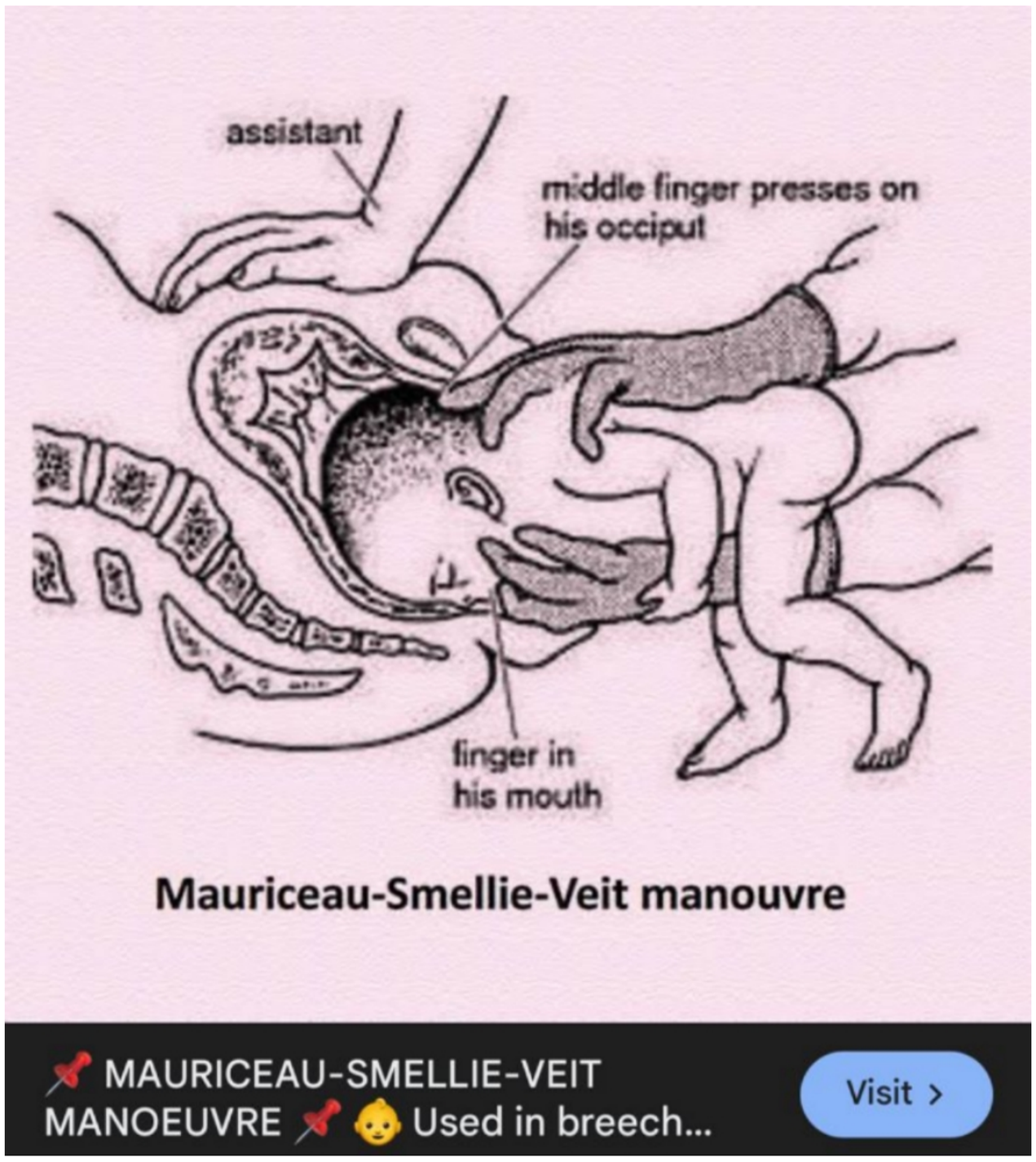


Testicular Torsion

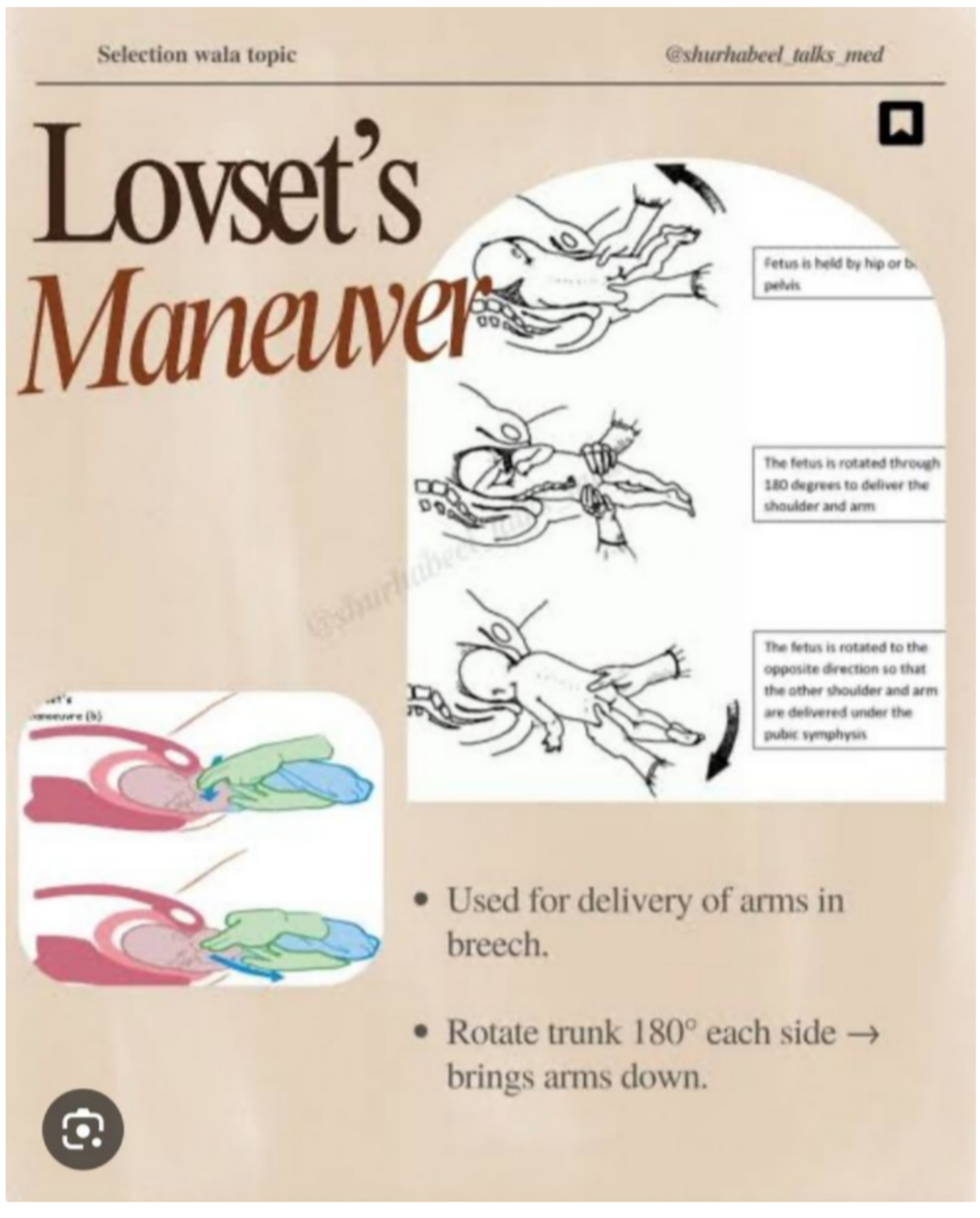
Testicular Torsion

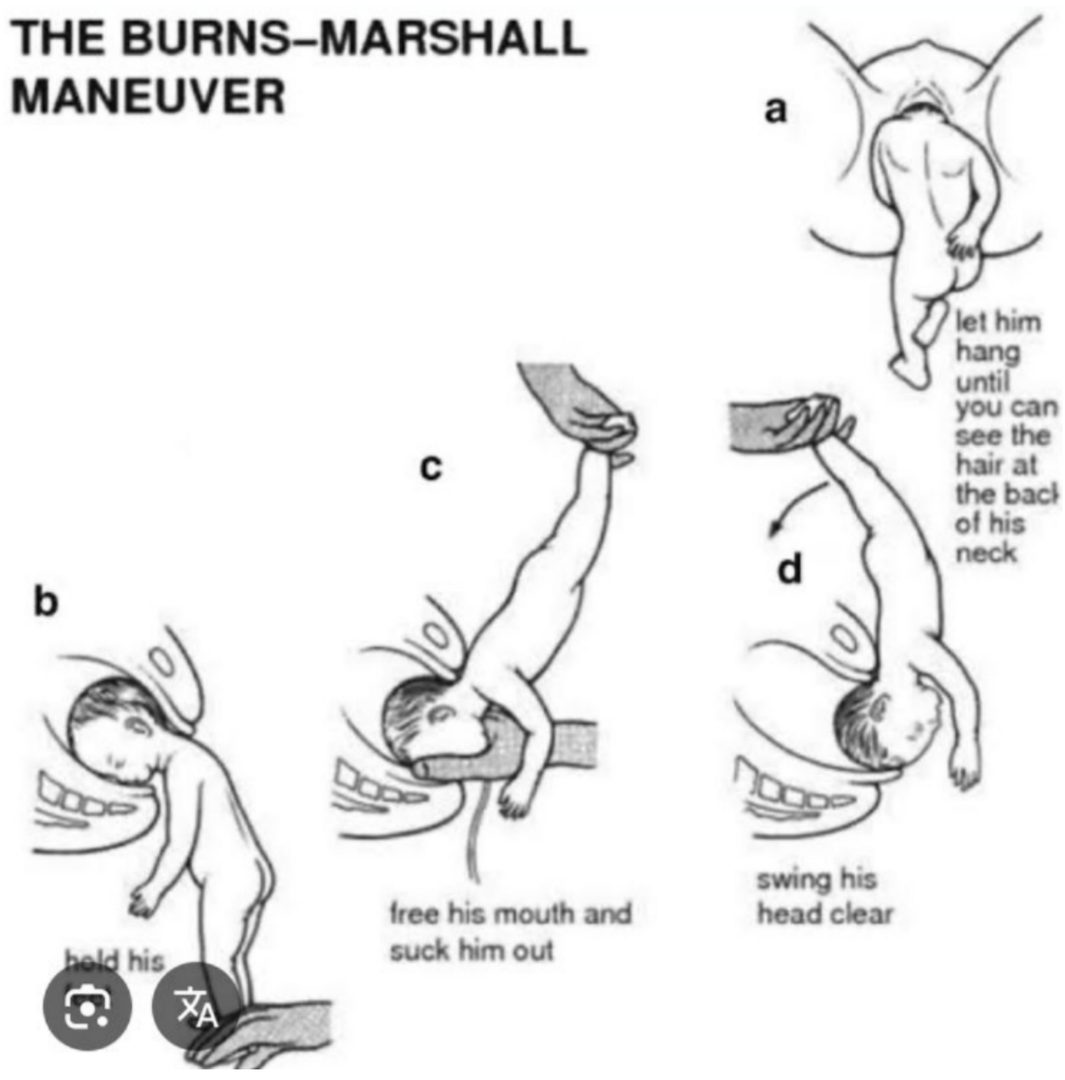
- Adolescent boy with sudden, severe unilateral scrotal pain, often waking him from sleep, associated with nausea and vomiting.
- Sudden onset scrotal pain
- Nausea & vomiting (very common)
- Neonates and adolescents (12–18 years)
- Physical Examination Findings
    - High-riding testis - Affected testis sits higher than normal
    - Horizontal lie of testis - Due to bell-clapper deformity
    - Absent cremasteric reflex - Most sensitive physical sign (Stroking inner thigh → no testicular elevation)
    - Swollen, tender scrotum
    - Negative Prehn sign - Elevation of testis does NOT relieve pain
- Do NOT delay surgery for imaging if suspicion is high
- Doppler US shows absent blood flow (if done)
- Immediate surgical exploration should be done
- Bilateral orchiopexy (even if torsion is unilateral)
- “Sudden scrotal pain + vomiting in adolescent” → torsion
- “Absent cremasteric reflex” → torsion
- “High-riding, horizontal testis” → torsion
- “Negative Prehn sign” → torsion

Maneuvers Names in Breech Maneuvers

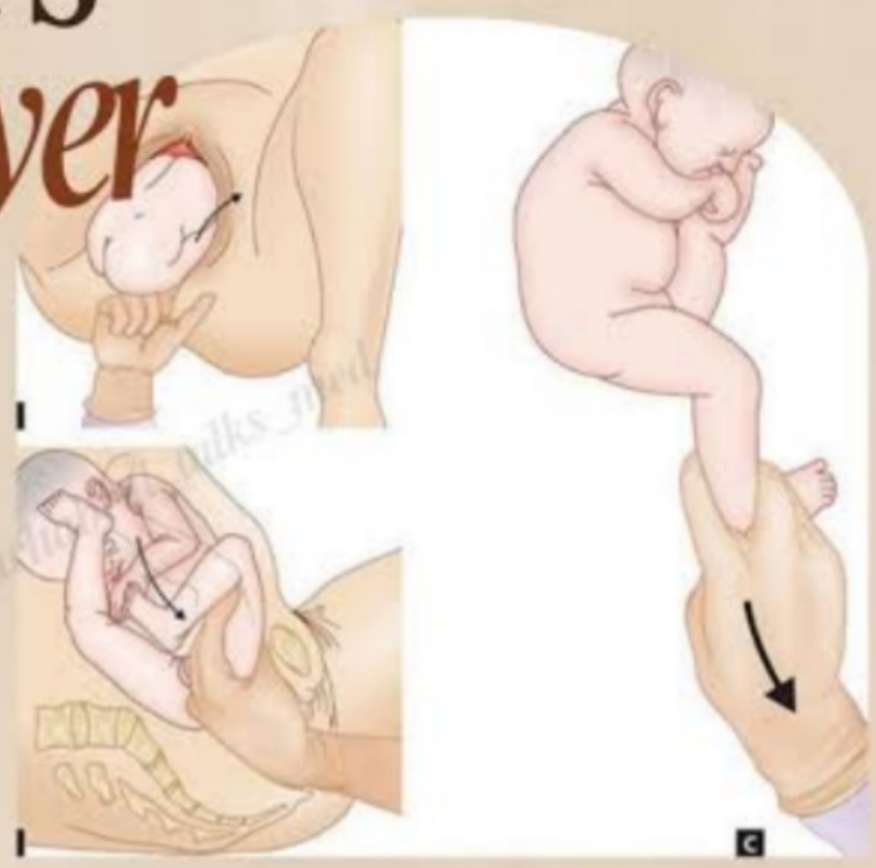


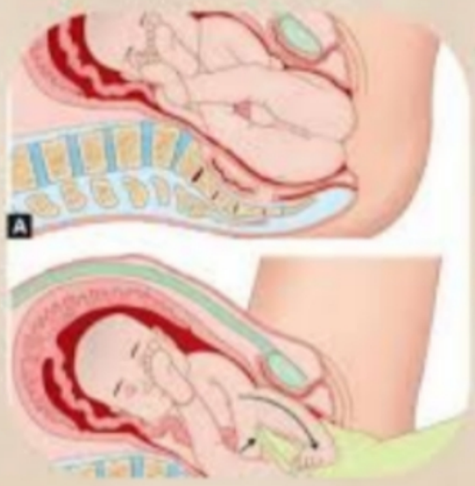
Manoeuvre of Breech identification
1) Mauriceau-Smellie-Veit (MSV) maneuver
2)burns Marshall manoeuvre
3)lovset's maneouvere





Pinard's *Maneuver*

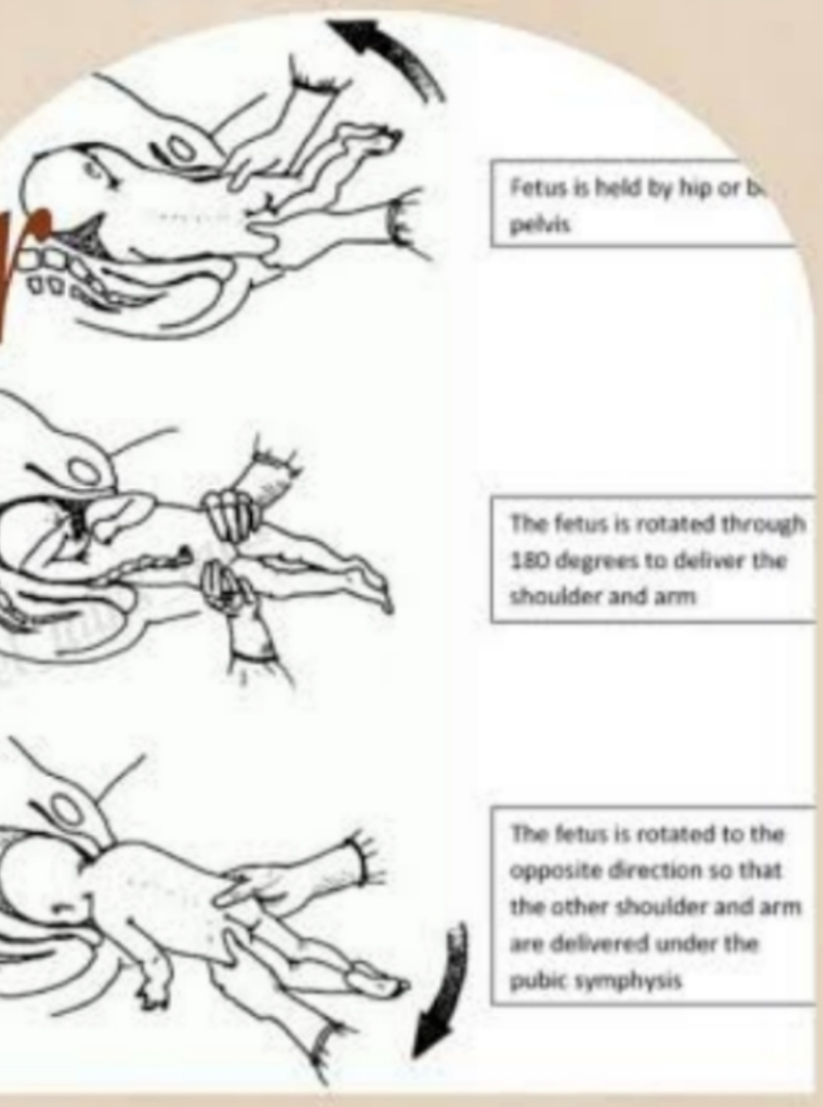


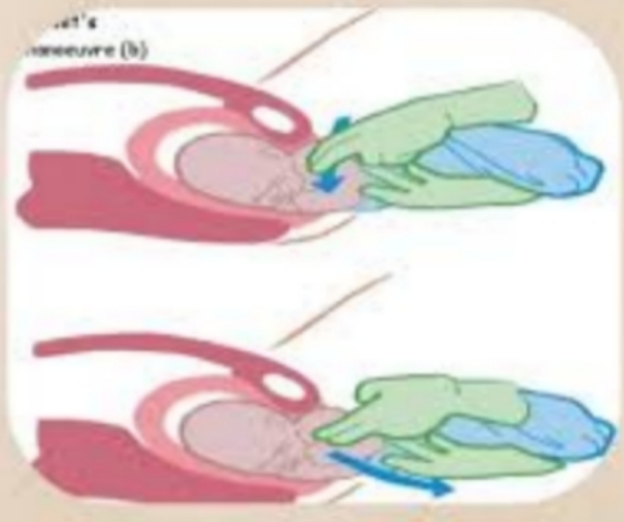


- First-line maneuver.

- For extended legs in breech → apply pressure in popliteal fossa → flex and bring out leg.

Lovset's *Maneuver*

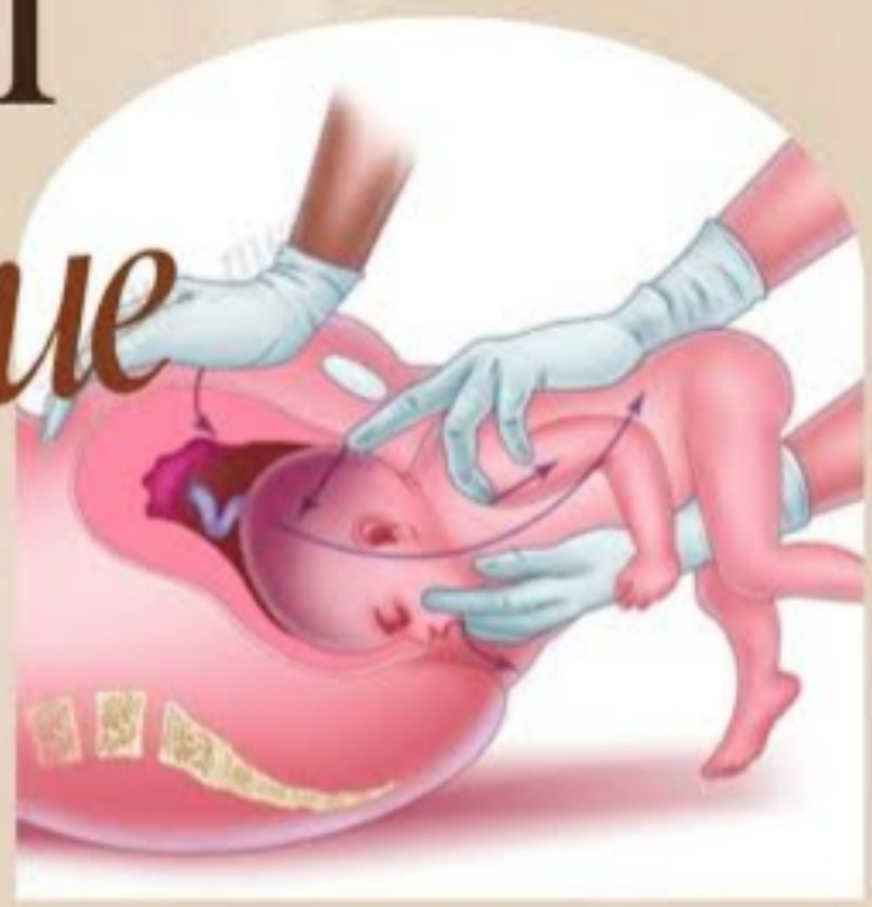


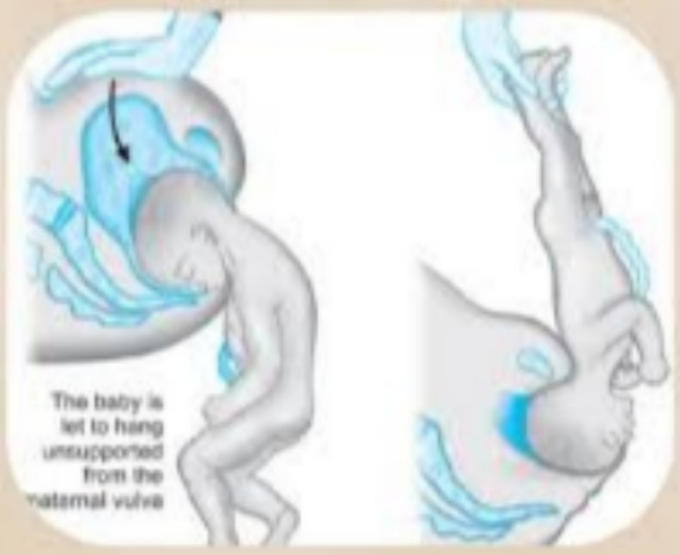


- Used for delivery of arms in breech.

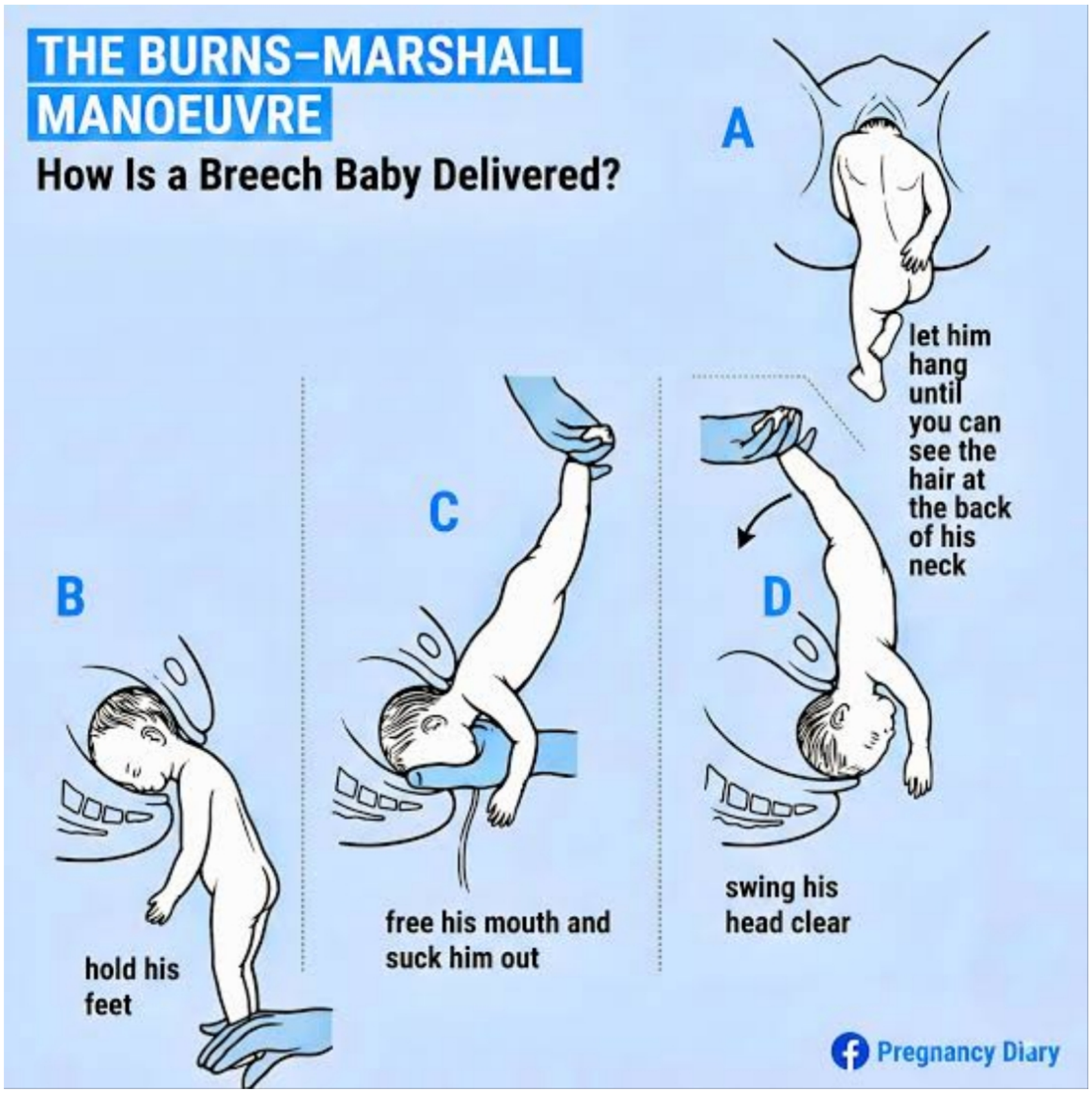
- Rotate trunk 180° each side → brings arms down.

Burns–Marshall Technique





- After body delivery → allow fetus to hang until nape visible → then lift body upwards for head delivery.



Mauriceau Smellie Veit *Maneuver*

- For delivery of after-coming head.
- Baby astride forearm → two fingers in fetal mouth for flexion, other hand applies pressure on shoulders → controlled head delivery.

Prague *Maneuver*

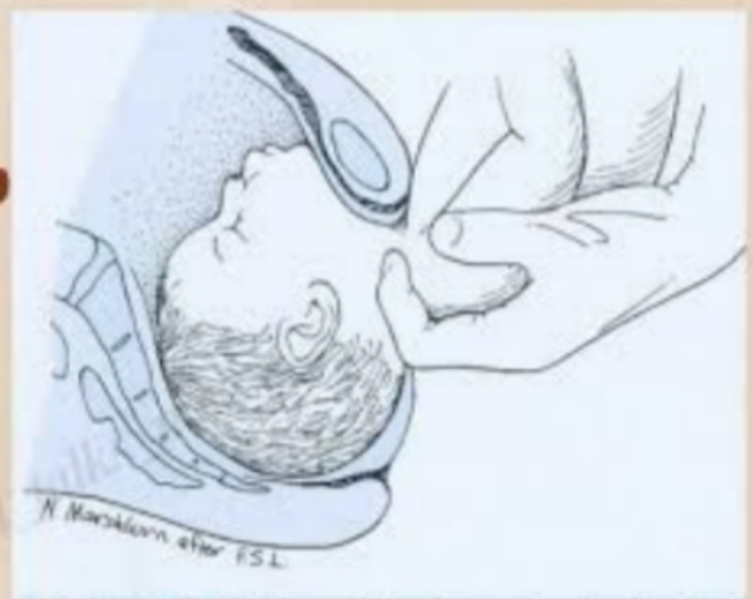
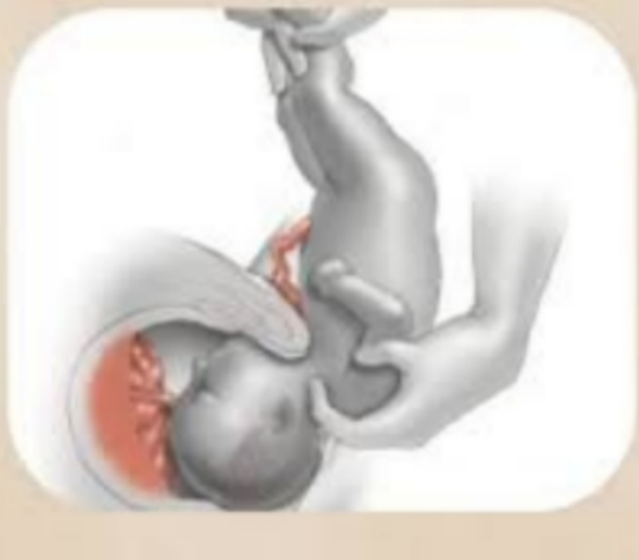
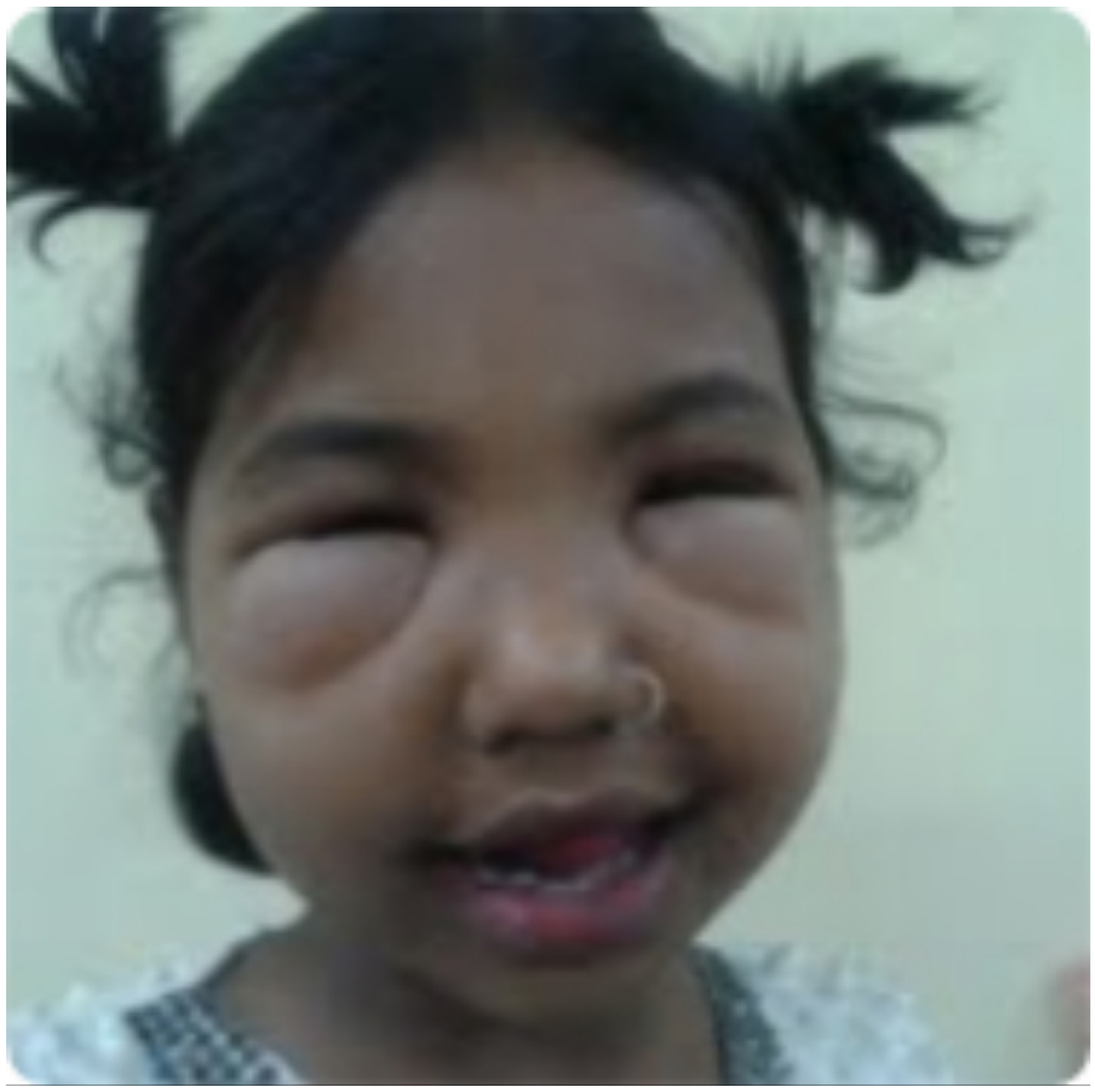


FIGURE 22–18. Delivery of the aftercoming head using th modified Prague maneuver necessitated by failure of the fet trunk to rotate anteriorly.



- For after-coming head when fetus is partly extended.
- Grasp shoulders with one hand and hook fingers of other hand on occiput → flex and deliver head.

A 7 yr old boy with swelling in eyes: nephrotic syndrome
Investigations and treatment



Investigations

* Urine Dipstick test - Specific for albumin (detects concentration of 30 mg/dL or higher)
* Urinalysis
RBC cast suggest glomerulonephritis
WBC cast suggest Pyelonephritis and interstitial nephritis
Fatty casts suggest Nephrotic syndrome
* Test for Microalbuminuria - corresponds to albumin excretion of 30 to 300 mg/day

3. Management of Minimal Change Disease

A. General Measures

- **Edema management:**
  - Salt restriction (2 g/day)
  - **Diuretics** if severe edema (furosemide)
  - Monitor weight & electrolytes
- **Infection prevention:**
  - Vaccinate (pneumococcal, influenza)
  - Early treatment of infections
- **Thrombosis prevention:**
  - Usually not required in children unless severe hypoalbuminemia (<2 g/dL) or immobilized

B. Specific Therapy: Corticosteroids

First-line:

- **Prednisolone**: 60 mg/m²/day (max 80 mg) for **4–6 weeks**
- Then **alternate-day prednisolone** 40 mg/m² for **2–4 weeks**
- **Taper gradually** over total 2–3 months

Response:

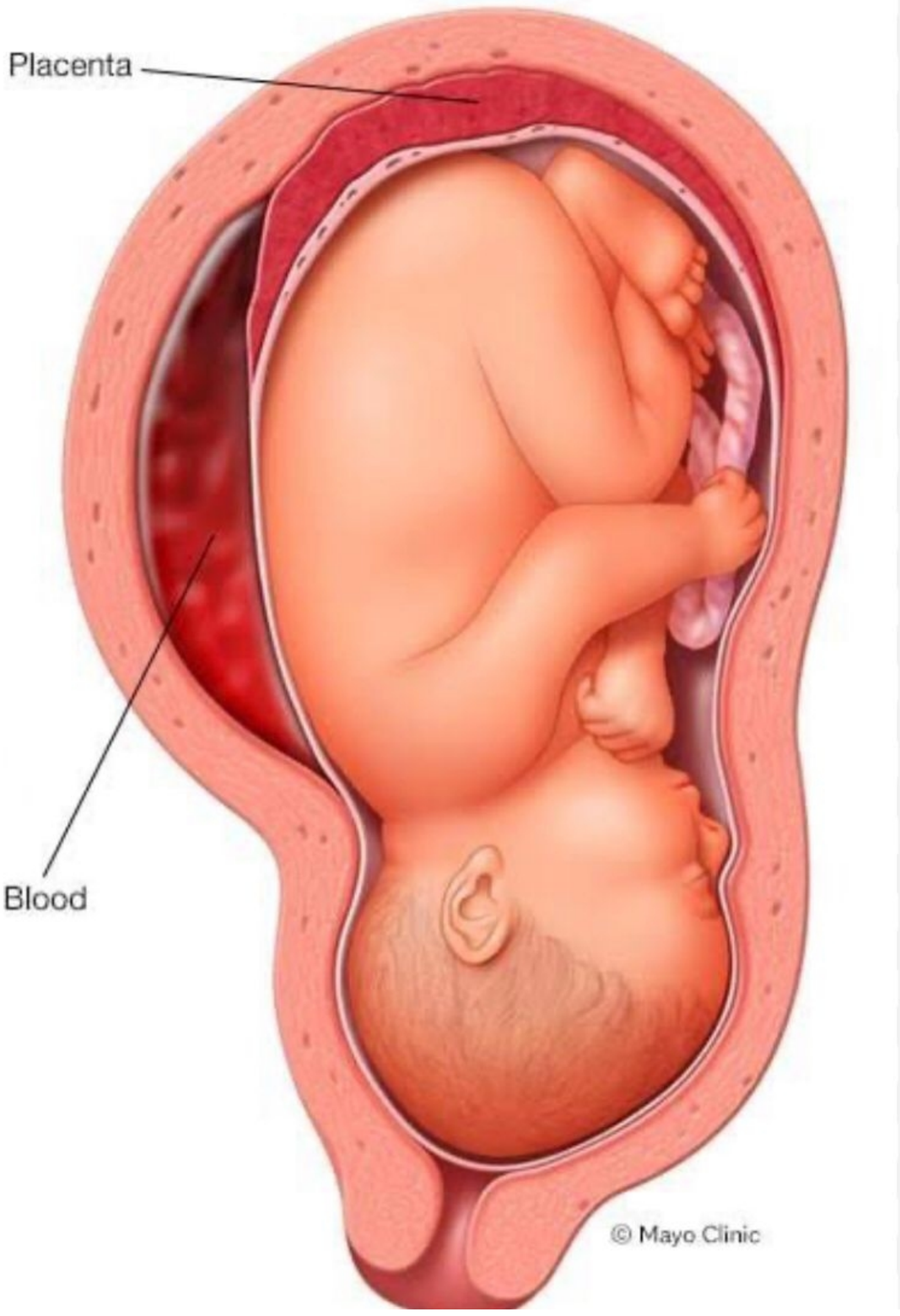
- **Children:** 80–90% respond (steroid-sensitive)
- **Adults:** 60–70% respond; response may be slower

C. Relapse Management

- **Relapses** are common, often triggered by infections
- **Treatment:** same steroid protocol; may use **alternate-day dosing**
- **Frequent relapsers:** consider **steroid-sparing agents**:
  - Cyclophosphamide
  - Levamisole (children)
  - Calcineurin inhibitors (cyclosporine/ tacrolimus)

D. Supportive Measures

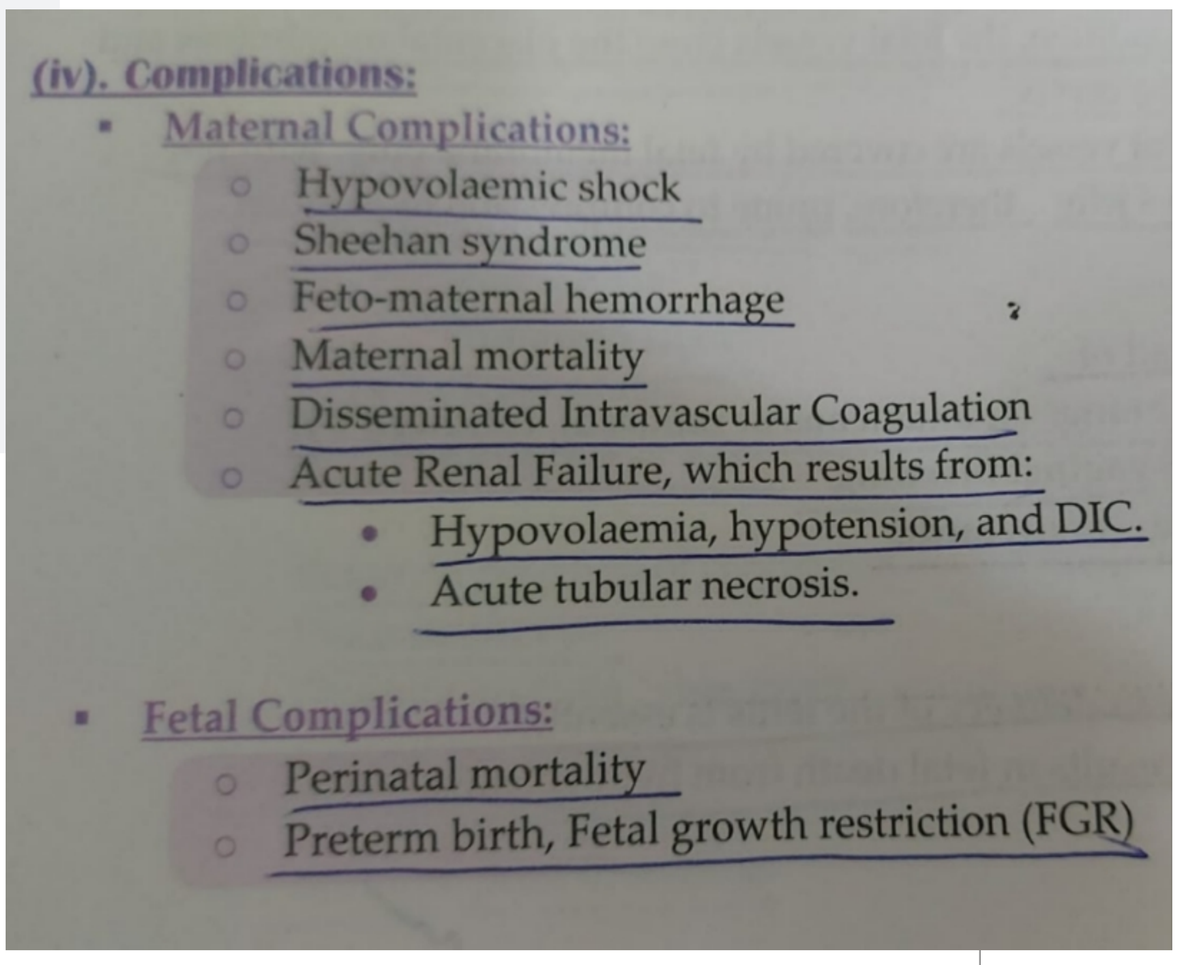
- **Nutrition:** moderate protein (1 g/kg/day)
- **Hyperlipidemia:** usually resolves after remission
- **Avoid nephrotoxic drugs**



Placental abruption picture
1) Identify the photograph
2) what are the maternal risks
3) what are the feral risks

✱ Placental Abruption

The partial or complete separation of the placenta from the uterus prior to delivery; subsequent hemorrhage occurs from both maternal and fetal vessels.



(iv). Complications:

- Maternal Complications:
  - Hypovolaemic shock
  - Sheehan syndrome
  - Feto-maternal hemorrhage
  - Maternal mortality
  - Disseminated Intravascular Coagulation
  - Acute Renal Failure, which results from:
    - Hypovolaemia, hypotension, and DIC.
    - Acute tubular necrosis.
- Fetal Complications:
  - Perinatal mortality
  - Preterm birth, Fetal growth restriction (FGR)

Maternal and Fetal Risks

- Intrauterine fetal death
- Maternal DIC and hypovolemic shock: occurs as a result of blood loss and massive coagulation; the placenta is rich in tissue thromboplastin, which is released as a result of the placental abruption.
- Couvelaire uterus
  - Retroplacental hemorrhage may extend through the uterus into the peritoneum.
  - The myometrium is weakened, with possible subsequent **uterine rupture** during contractions.

Ospe Station block P
1.What is CTG? Definition?
2. What are it's 5 variables
3. What are it's uses in obstetrics
4. What does late declaration signify

What is cardiotocography?

Cardiotocography (CTG) is used during pregnancy to monitor fetal heart rate and uterine contractions. It is most commonly used in the third trimester and its purpose is to monitor fetal well-being and allow early detection of fetal distress. An abnormal CTG may indicate the need for further investigations and potential intervention.

Variables of ctg
1. Baseline FHR
2. Beat to beat variability
3. FHR Accelerations
4. Decelerations

- A CTG (cardiotocography) machine is used to monitor a baby's heart rate and the mother's uterine contractions during pregnancy and labor. Its primary uses include assessing fetal well-being, identifying signs of fetal distress or lack of oxygen (hypoxia), and helping guide decisions about the delivery

- Late Decelerations indicate insufficient blood flow to uterus and placenta
  - Causes of insufficient blood flow
    - Maternal hypotension
    - Pre eclampsia
    - Uterine hyperstimulation
  - indicates fetal hypoxia

Normal vaginal delivery on dummy

Station : Normal vaginal delivery not labor !!!
And delivery of placenta

🔹 Steps of Normal Vaginal Delivery (Vertex Presentation)

1. **Engagement**
    - Biparietal diameter passes the pelvic inlet.
    - Head enters pelvis (usually in occipito-transverse position).
2. **Descent**
    - Downward movement of the fetal head through the pelvis.
    - Occurs throughout labor, especially in second stage.
3. **Flexion**
    - Chin moves towards chest.
    - Smaller diameter (suboccipito-bregmatic, 9.5 cm) presents.
4. **Internal Rotation**
    - Occiput rotates anteriorly towards the symphysis pubis.
    - From transverse → occipito-anterior (OA).
5. **Extension**
    - Head extends under the pubic symphysis.
    - Vertex → brow → face → chin delivered.
6. **Restitution**
    - Head rotates 45° to realign with shoulders.
7. **External Rotation**
    - Shoulders rotate into anteroposterior diameter of pelvis.
    - Head rotates accordingly.
8. **Expulsion**
    - Anterior shoulder delivers under pubic symphysis.
    - Posterior shoulder and rest of body follow.

G3p2 women present to ER with profuse bleeding after delivering a 4kg baby.Write the management for this patient.

III. Management:

- Obstetric hemorrhage protocol (ABCDE) & call senior help
- Stop uterine bleeding:
  - Massage the uterus
  - Bimanual compression if atony is the cause
  - Remove any clots in the uterus and vagina
- Uterotonic Agents in a stepwise manner:
  - Oxytocin 5 10 units IM/IV
  - Oxytocin 40 units in 100mL normal saline over 4 hours
  - Rectal misoprostol 800 1000 microgram
  - Syntometrine (ergometrine 500 μg + syntocinon 5 units)
  - Repeat ergometrine 500 μg IM or IV
  - Carbaprost 0.25 mg by IM with intervals of ≥ 15 minutes (up to maximum 8 dose)
- In cases of persistent bleeding:
  - Look for genital tract trauma and repair.
  - Correct coagulopathy if DIC is present
  - Call senior help interventional radiologist, obstetrics
- Surgical Options:
  - Uterine artery embolization (UAE)
  - Iliac artery ligation
  - Uterine balloon insertion
  - Hysterectomy → confidered as last resort in uncontrolled PPH

Postpartum Hemorrhage (PPH)

- Blood loss ≥ 500 ml or blood loss manifesting with features of hypovolemia within 24 hours of delivery

* Common Causes of PPH
  - Uterine Atony
  - Uterine Inversion
  - Abnormal placental separation
    - Retained placenta
    - Abnormal placentation
  - Birth trauma
    - Iatrogenic Injury
  - Velamentous cord insertion

* Secondary Causes
  - Retained products of conception
  - Subinvolvement of placental site
  - Coagulation Disorder
  - Postpartum endometritis

BPP COMPONENTS AND SCORE

to lack of evidence from randomized trials.

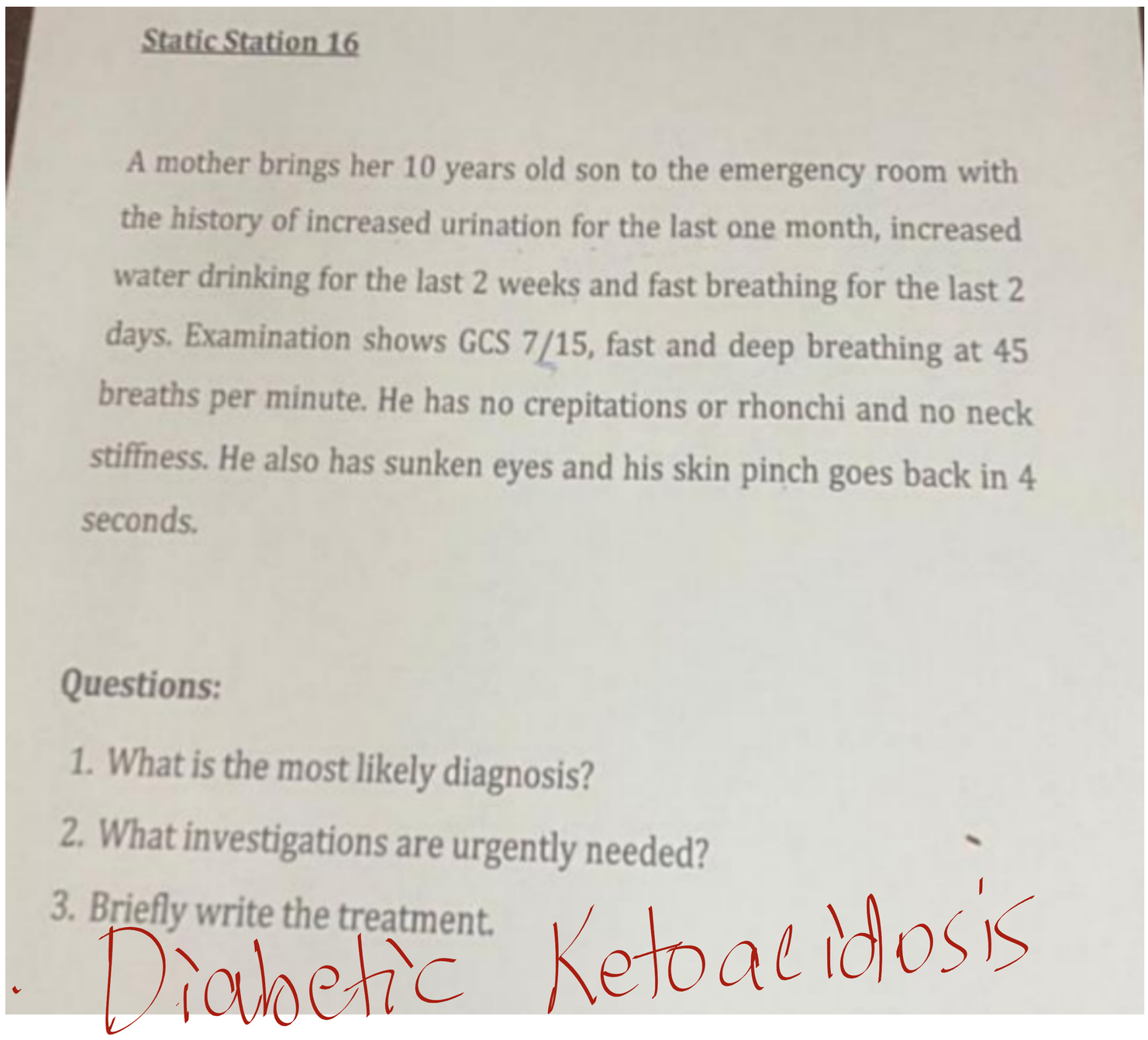
- BPP consists of:

	Variables	Normal (Score 2)	Abnormal (Score 0)
1	Breathing movements	≥ 30 movements in 30 min	< 30 movements in 30min
2	Gross body movements	≥ 3 body movements in 30 min	<3 body movements in 30 min
3	Fetal tone	≥ 1 episode body/limb extension followed by return to flexion	Absent fetal movement or flexion
4	CTG (Cardiotocograph)	Reactive (see below)	<2 accelerations in 40 min
5	Amniotic Fluid Volume	>1 pool of fluid	< 1 cm pocket of fluid

- Interpretation:
  - Score of 8 or 10:
    - Highly reassuring of fetal well-being
    - Repeat the test weekly or as indicated.

  - Score of 4 or 6:
    - This is worrisome.
    - Delivery if fetus is >36 weeks
    - Repeat after 12-24 hr if < 36 weeks.

  - Score of 0 or 2:
    - Highly predictive of fetal hypoxia.
    - Prompt delivery regardless of gestational age.


Static Station 16

A mother brings her 10 years old son to the emergency room with the history of increased urination for the last one month, increased water drinking for the last 2 weeks and fast breathing for the last 2 days. Examination shows GCS 7/15, fast and deep breathing at 45 breaths per minute. He has no crepitations or rhonchi and no neck stiffness. He also has sunken eyes and his skin pinch goes back in 4 seconds.

Questions:

1. What is the most likely diagnosis?
2. What investigations are urgently needed?
3. Briefly write the treatment.

1. Diabetic Ketoacidosis

2️⃣ Urgent Investigations

These must be done immediately:

🧪 Bedside

- **Random blood glucose (RBS)**
- **Urine ketones**
- **Capillary blood ketones (if available)**

🧪 Blood tests

- **ABGs** → metabolic acidosis (↓ pH, ↓ HCO_3^-)
- **Serum electrolytes** (especially potassium)
- **Serum urea & creatinine**
- **Serum osmolality**

📊 Diagnostic Criteria of DKA

- Glucose > 200 mg/dL
- pH < 7.3
- HCO_3^- < 15 mEq/L
- Ketonemia/ketonuria

1️⃣ Most Likely Diagnosis

Severe Diabetic Ketoacidosis (DKA) with dehydration and altered consciousness

Why?

- **Polyuria (1 month)** → osmotic diuresis
- **Polydipsia (2 weeks)** → dehydration
- **Fast deep breathing (45/min)** → **Kussmaul breathing** (metabolic acidosis compensation)
- **GCS 7/15** → severe DKA / possible cerebral edema
- **Sunken eyes + skin pinch 4 sec** → severe dehydration
- No chest signs or meningitis signs

Most likely underlying condition:

👉 New-onset **Type 1 Diabetes Mellitus**

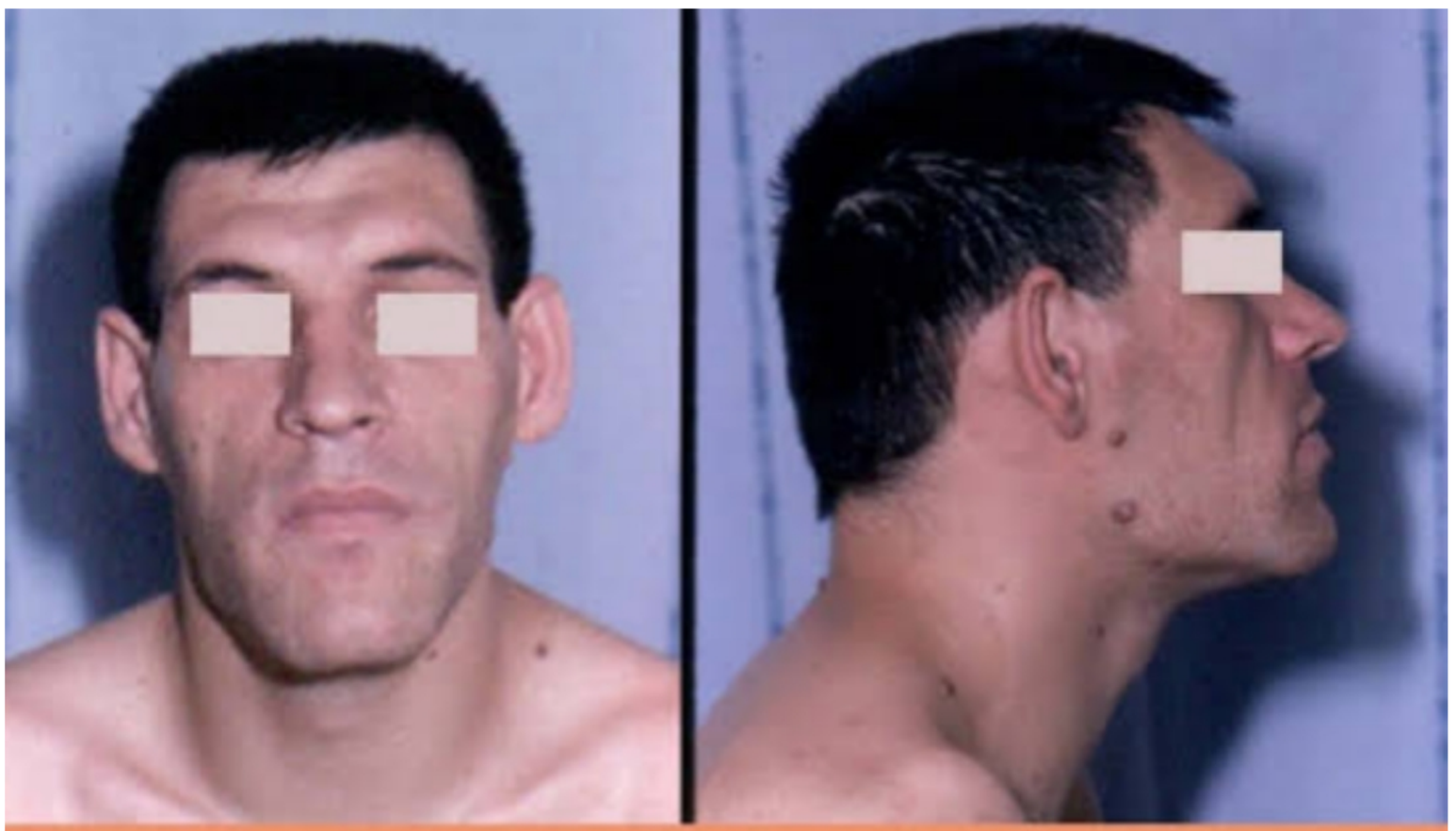
3️⃣ Brief Treatment (Emergency Management)

Management priority:

Fluids → Insulin → Electrolytes → Monitoring

1. Fluid Resuscitation (FIRST STEP)
2. Insulin Therapy
3. Potassium Replacement
4. Add Dextrose
5. Monitor for Cerebral Edema

Acromegaly Scenario



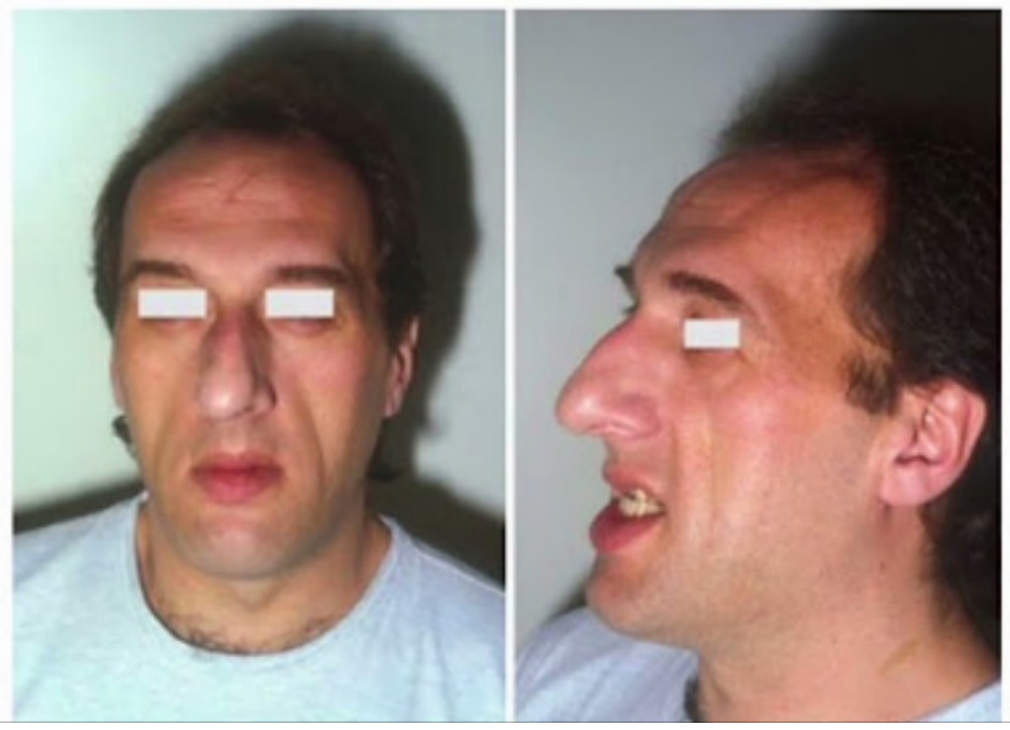
Facial features of acromegaly: a prominent jaw line (macrognathia) as well as frontal bossing (prominent, protruding forehead).

- Two Signs
- Investigations

Investigation for acromegaly
Serum GH and IGF 1
Serum prolactin
Ogtt(gh suppression test)
Mri brain

Pituitary overproduction of growth hormone → enlarged connective tissue, bones, and visceral organs

- macrognathia (enlarged jaw)
- macroglossia (enlarged tongue)
- enlargement of nose, epiglottis, pharyngeal tissue, laryngeal tissue



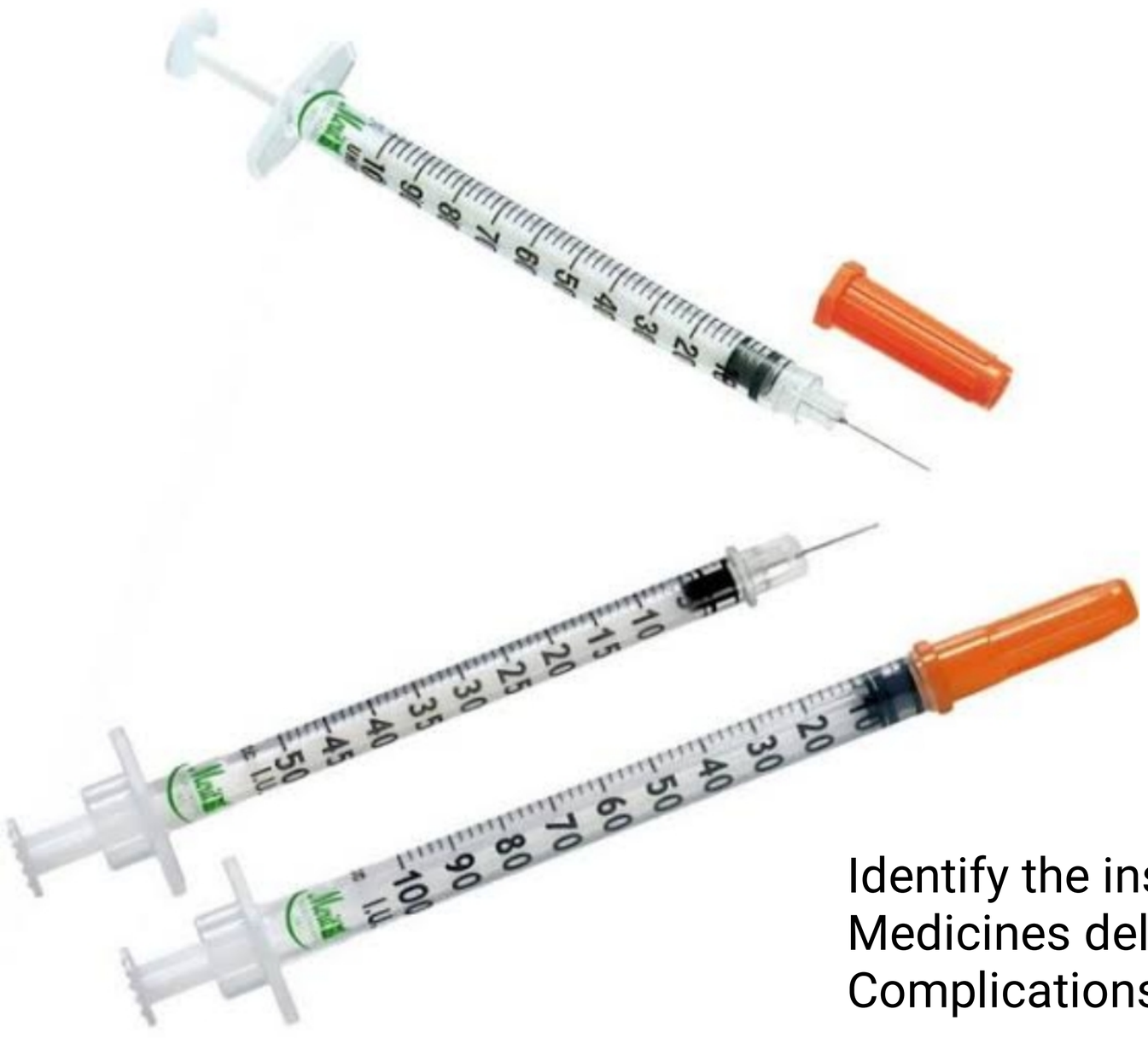
Two classic clinical signs of **Acromegaly**:

1️⃣ Enlarged hands and feet

- Increased ring or shoe size
- Spade-like hands

2️⃣ Coarse facial features

- Frontal bossing
- Enlarged nose and lips
- Prognathism (protruding jaw)



Identify the instrument
Medicines delivered by it
Complications

1. Insulin Syringe

2- Medicines Delivered by it:

- GH
- Insulin
- Octreotide

Complications of Insulin Therapy

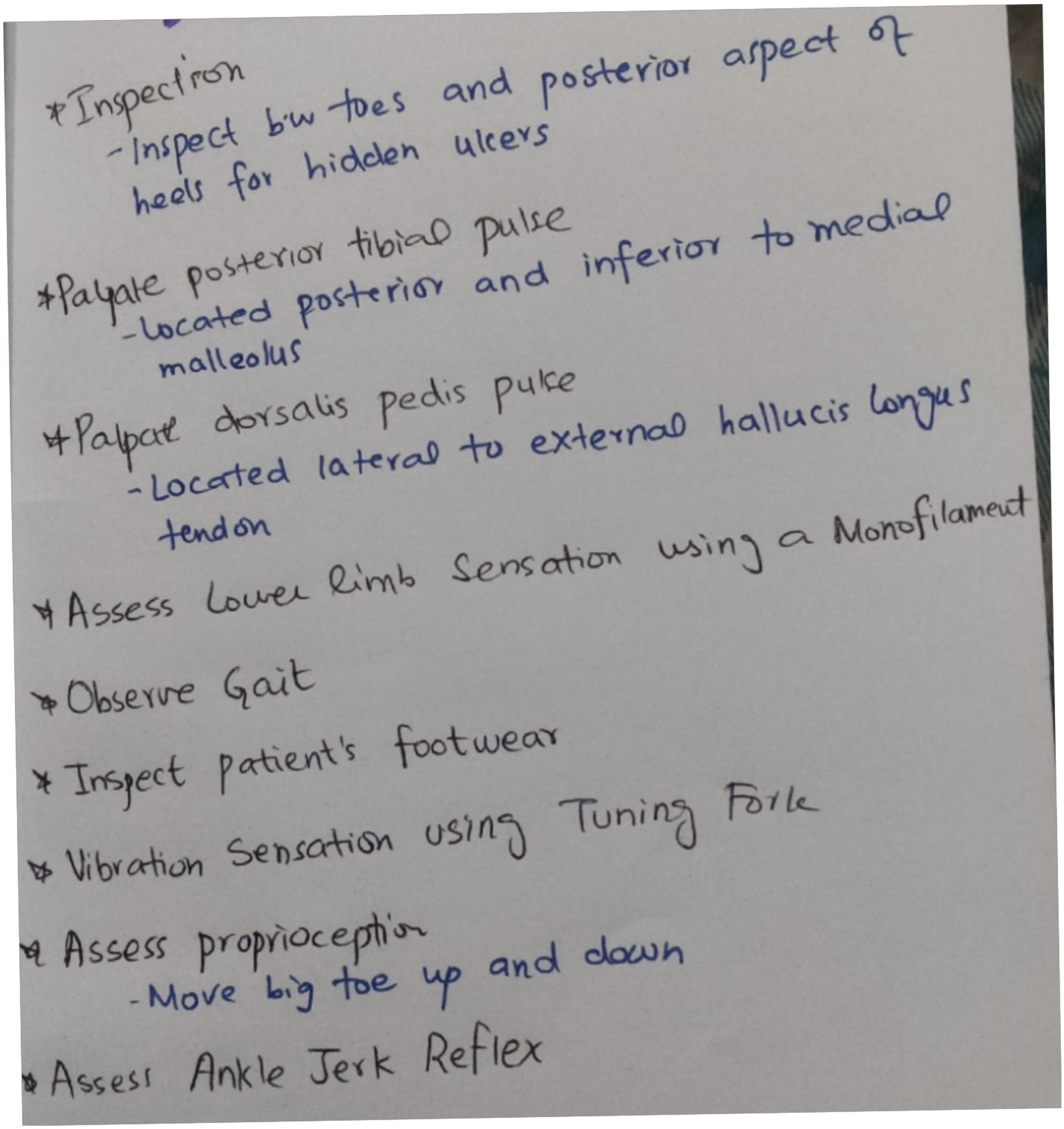
1. **Local allergic reactions** - redness, swelling, tenderness, induration or a 2 to 4 cm wheal) may appear at injection site 1 to 2 hrs. after insulin administration.

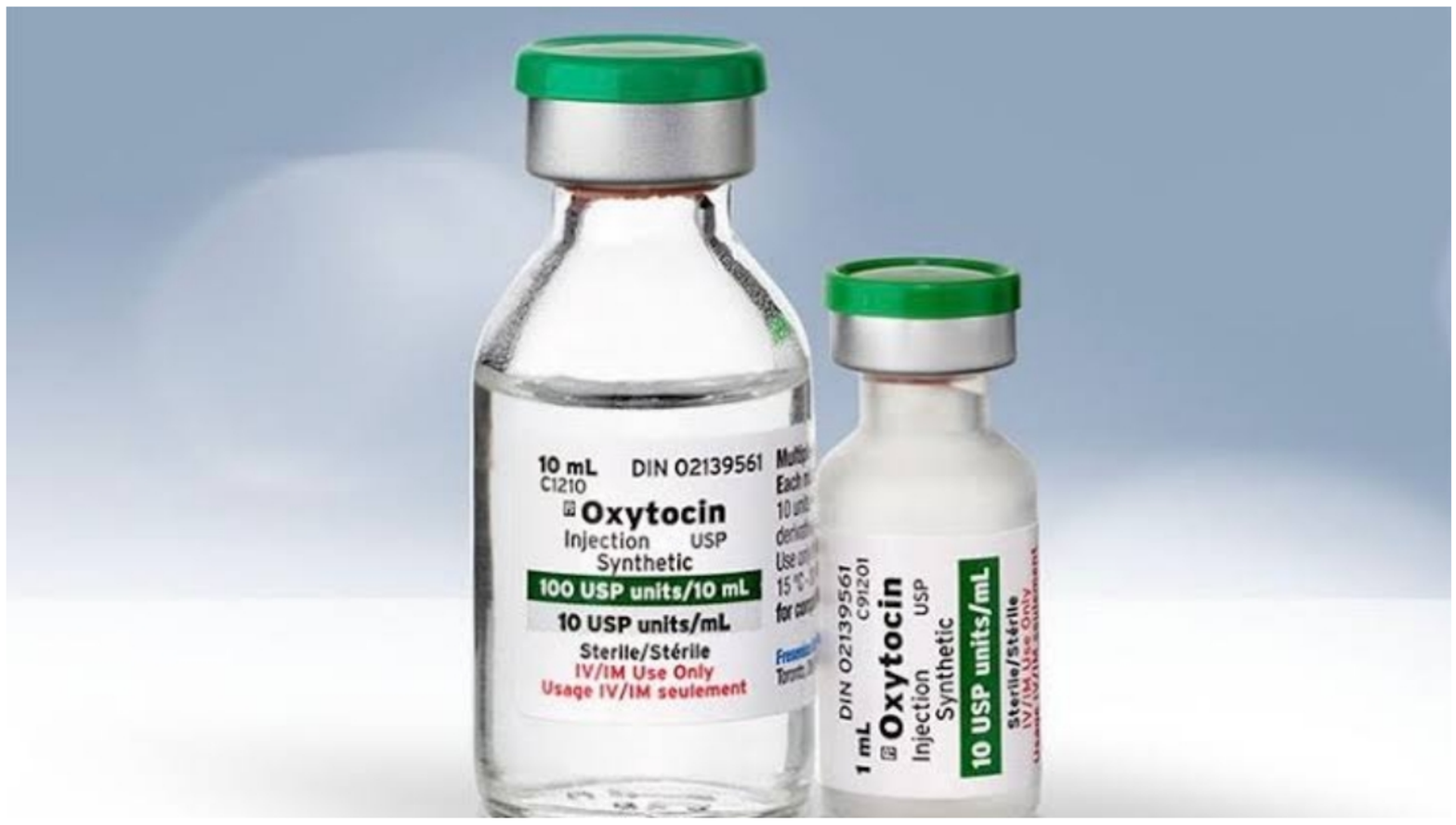
2. **Systemic allergic reactions –** rare; immediate local skin reaction that gradually spreads into generalized urticaria.

3. **Insulin Lipodystrophy** – localized reaction occuring at the site of the insulin injections.

- **Lipoatrophy** – loss of sub Q fats and appears as slight dimpling of sub Q fats.
- **Lipohypertrophy** – dev't. of fibrofatty masses at the injection site.

Diabetic Foot Examination





Oxytocin
Mechanism of action Uses
Uses in obs
Complications

Oxytocin

Mechanism of action:

- Acts through **oxytocin receptors** present in smooth muscles of myometrium.
- Stimulates the amniotic and decidual prostaglandin production.
- Mobilization of bound intracellular calcium from sarcoplasmic reticulum to activate the contractile protein.
- There is increase in frequency and force of uterine contractions, similar to physiological uterine contractions

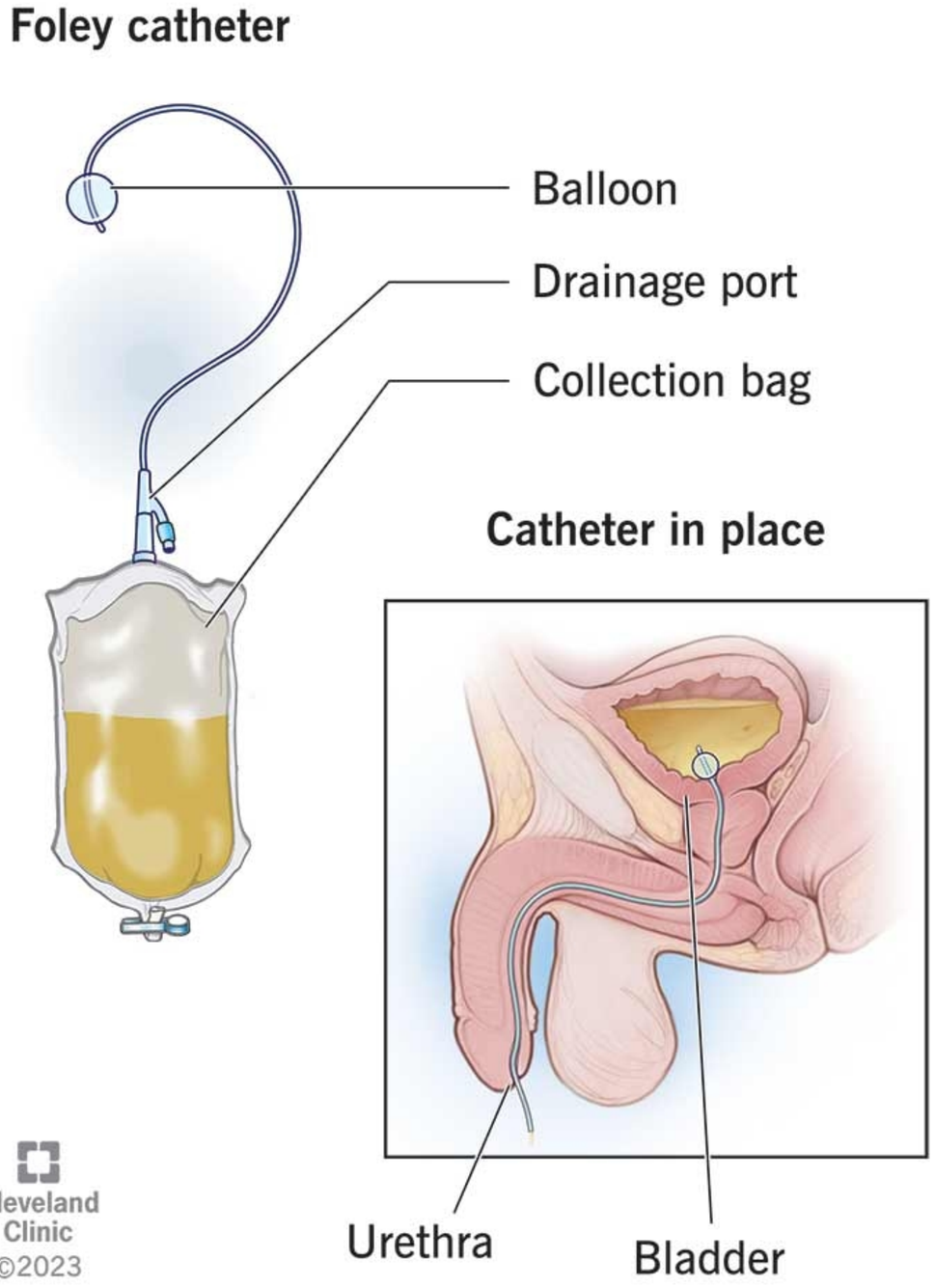
INDICATIONS

1. Induction of labour.
2. Augmentation of labour (when contractions are weak).
3. Active management of third stage of labour.
4. Prevention and treatment of postpart-um hemorrhage (PPH).
5. Facilitation of uterine contraction after

Complications of oxytocin – Maternal.

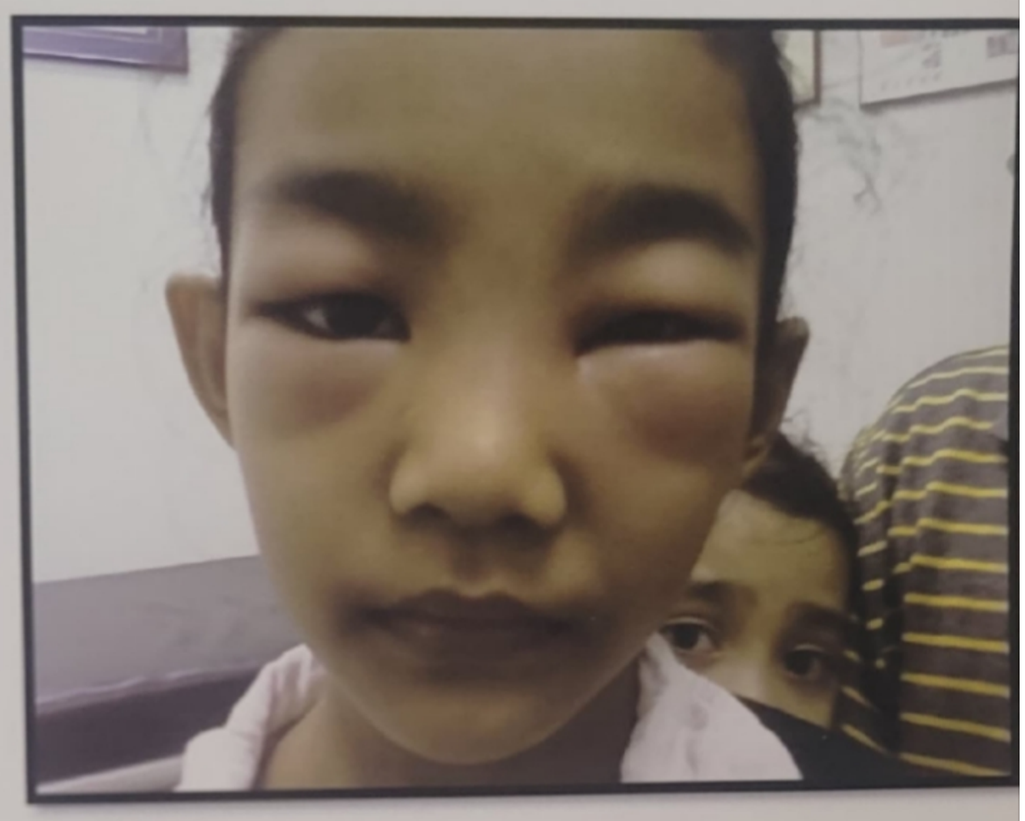
- Uterine hyperstimulation
- Uterine rupture
- Water intoxication
- Hypotension
- Antidiuresis

Foley catheter



A 12-year-old boy presented to the outdoors with increasing generalized body swelling and facial puffiness. On Examination, he has a BP of 110/60 mmHg and bilateral pitting oedema.

- **Hb** = 12 g/dL
- **TLC** = 9000
- **Platelets** = 320,000
- **RBS**= 120
- **Urea** =110 mg/dl
- **Serum creatinine**=1 mg /dl
- **Chest X-ray** = normal
- **Urinalysis**= Protein+++, RBC nil.
- **Echo**= Normal
- **HBsAg**= Negative
- **Anti-HCV**= Negative
- **Anti-HIV**= Negative



Minimal Change Disease

QUESTIONS:

1. What is the most probable diagnosis? (2)
2. Enlist at least two further investigations to be performed for confirmation of the diagnosis. (2)
3. Enlist at least two management options. (2)

2. Further Investigations for Confirmation (any 2)

1. **24-hour urine protein / spot urine protein/ creatinine ratio** → confirm **nephrotic-range proteinuria**
2. **Kidney biopsy** (if atypical features, steroid resistance, age <1 or >10, or hematuria) → usually **not needed initially in typical childhood MCD**

Optional / supportive investigations:

- Serum albumin (usually <2.5 g/dL)
- Lipid profile (hypercholesterolemia, hypertriglyceridemia)

3. Management Options (any 2)

A. General Measures

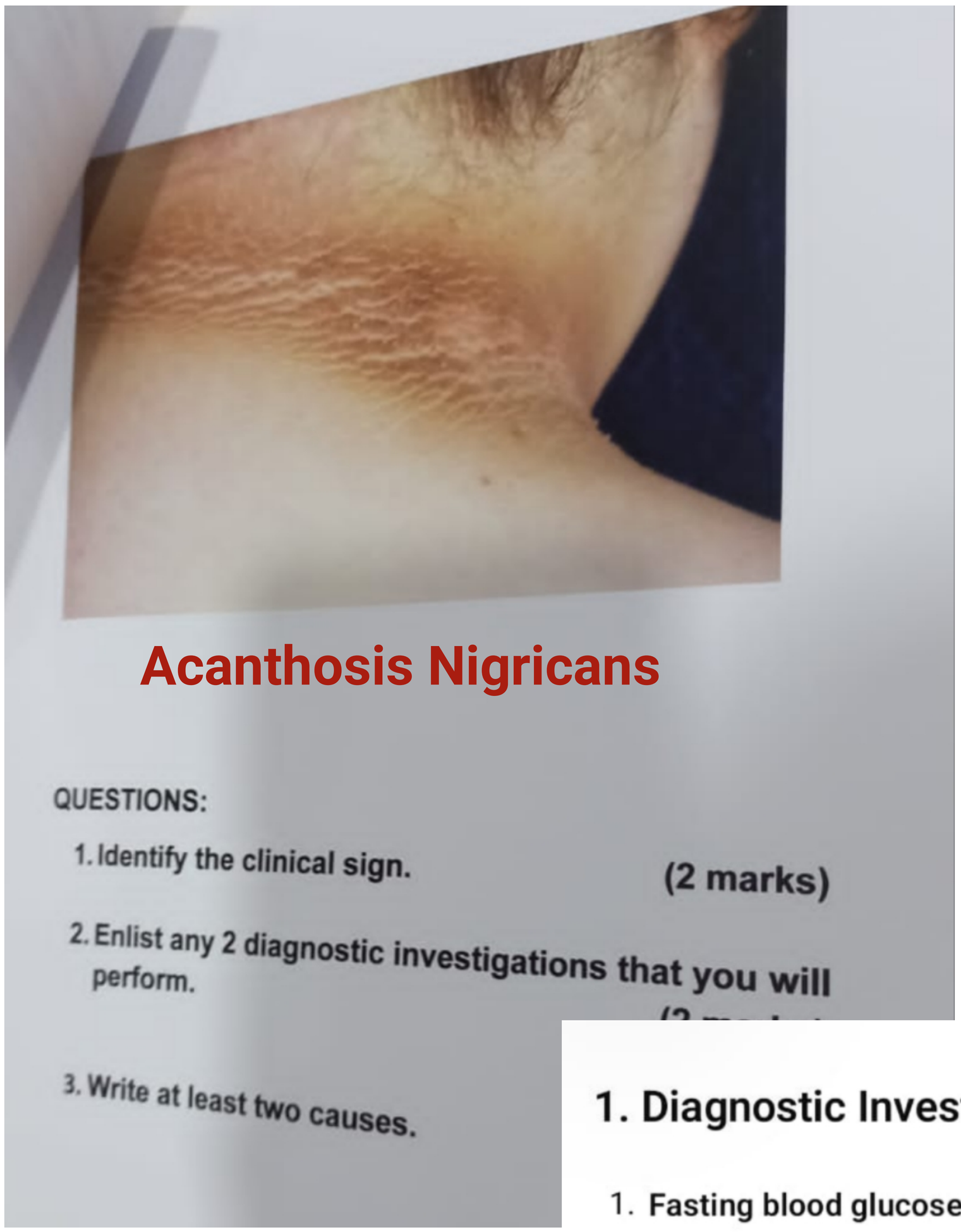
- **Edema management:** salt restriction, diuretics if severe
- **Infection prevention:** vaccinations, prompt treatment of infections

B. Specific Therapy

- **Corticosteroids (first-line):**
  - Prednisolone 60 mg/m²/day for 4–6 weeks, then taper
  - Most children respond (steroid-sensitive)

Other options (if steroid-resistant or frequent relapsers):

- Immunosuppressants: cyclophosphamide, levamisole, cyclosporine



1. Diagnostic Investigations (any 2)

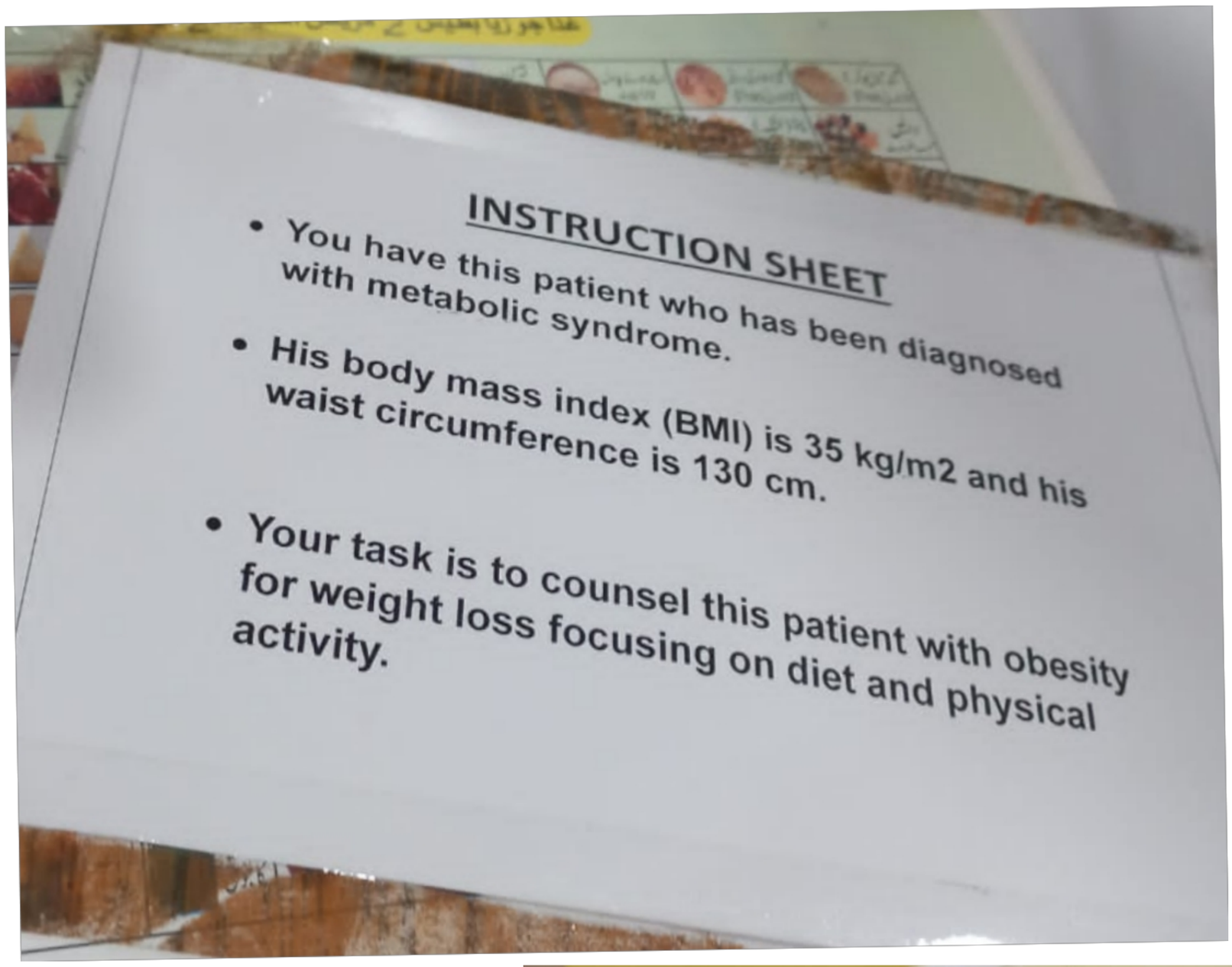
1. **Fasting blood glucose / HbA1c** → to check for **insulin resistance or diabetes**
2. **Lipid profile** → often associated with **obesity and metabolic syndrome**

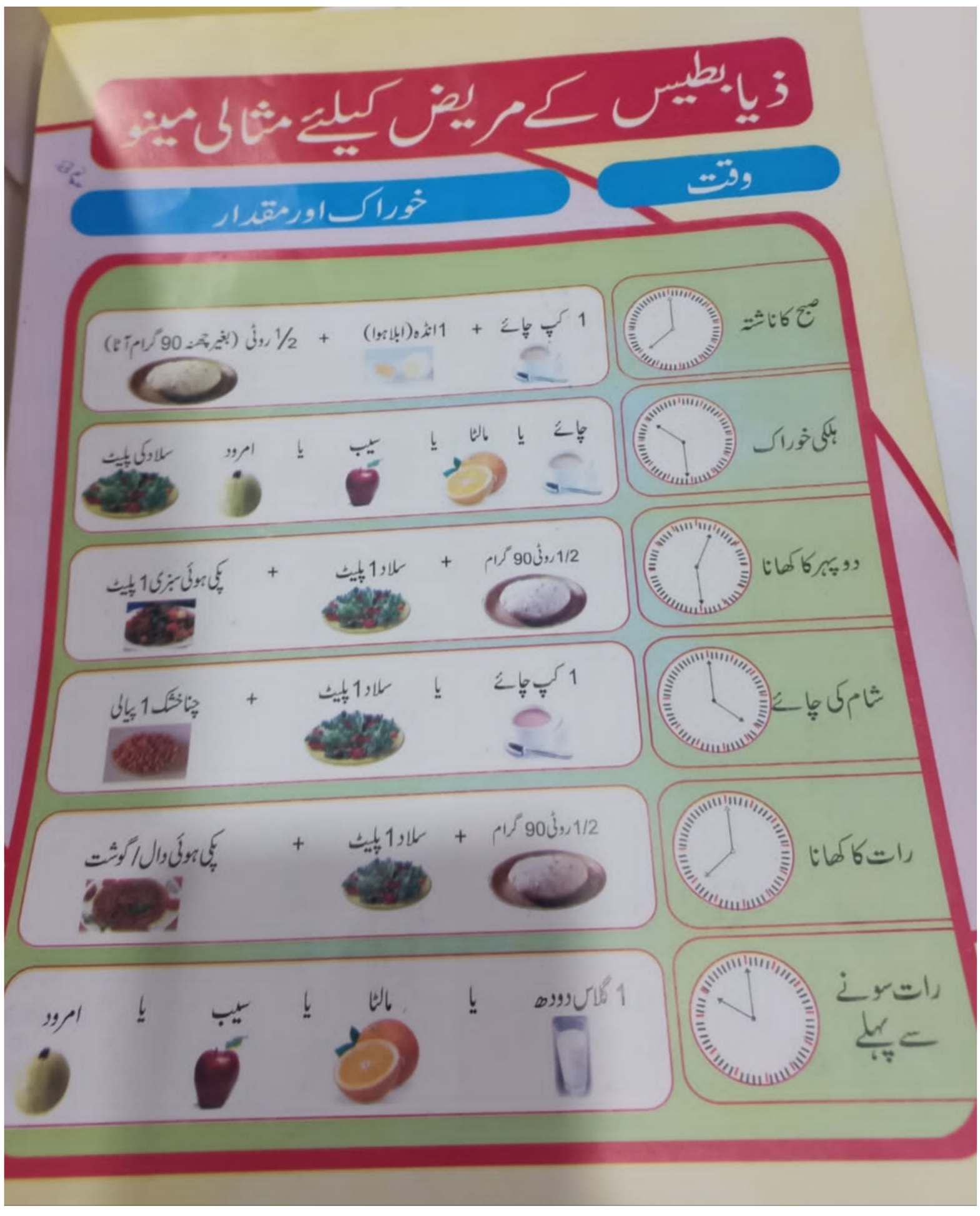
> Optional: Serum insulin levels, endocrine workup if malignancy suspected

---

2. Causes of Acanthosis Nigricans (any 2)

1. **Obesity / Insulin resistance** (most common)
2. **Endocrine disorders** → e.g., **Type 2 diabetes, Cushing's syndrome**
3. **Malignancy-related** → especially **gastric adenocarcinoma** (less common)

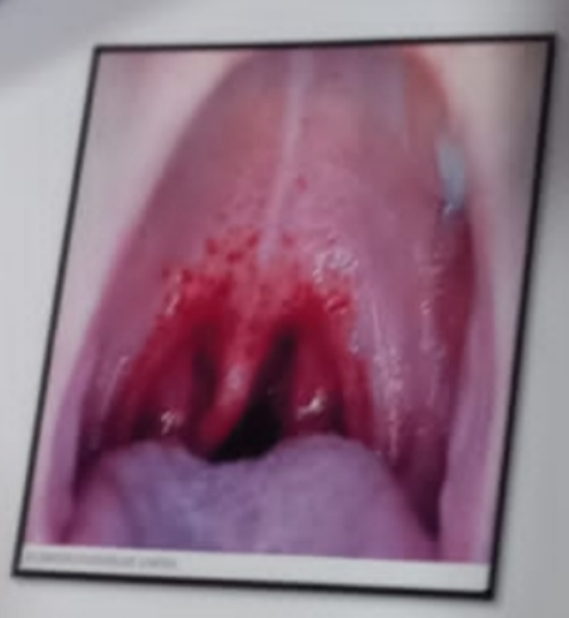

INSTRUCTION SHEET
You have this patient who has been diagnosed with metabolic syndrome.
His body mass index (BMI) is 35 kg/m2 and his waist circumference is 130 cm.
Your task is to counsel this patient with obesity for weight loss focusing on diet and physical activity.

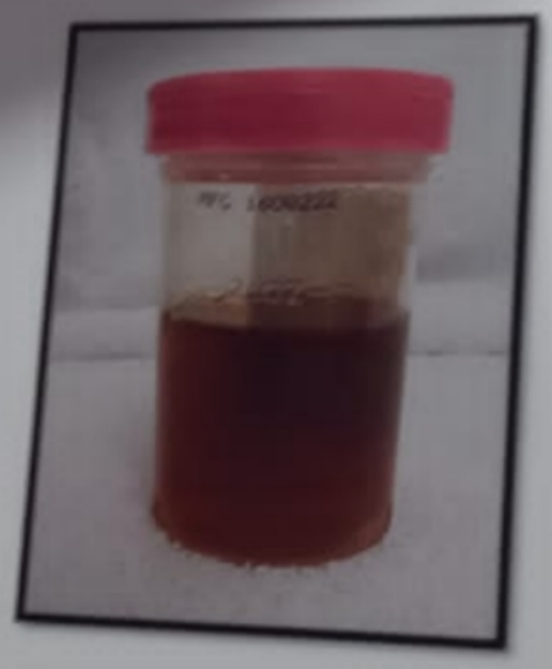

ذیابطیس کے مریض کیلئے مثالی مینو
وقت
خوراک اور مقدار
صبح کا ناشتہ
1 کپ چائے + 1انڈہ (ابلا ہوا) + 1/2 روٹی (بغیر چھنہ 90 گرام آٹا)
ہلکی خوراک
چائے یا مالٹا یا سیب یا امرود سلاد کی پلیٹ
دوپہر کا کھانا
1/2 روٹی 90 گرام + سلاد 1 پلیٹ + پکی ہوئی سبزی 1 پلیٹ
شام کی چائے
1 کپ چائے یا سلاد 1 پلیٹ + چنا خشک 1 پیالی
رات کا کھانا
1/2 روٹی 90 گرام + سلاد 1 پلیٹ + پکی ہوئی دال/گوشت
رات سونے سے پہلے
1 گلاس دودھ یا مالٹا یا سیب یا امرود


غذا جو زیا بطیس کے مریض نہیں کھا سکتے
کیک
پیسٹری
مٹھائی
جیلی
شہد
گڑ
شکر
چیونگم
آئس کریم
کولڈ ڈرنکس
شربت ملک شیک
پھلوں کے رس
ڈبل روٹی
بسکٹ
ڈائٹ کولڈ ڈرنک
کشمش
میدہ
گاجر سوجی کا حلوہ
کھیر
فرنی
چاکلیٹ
ڈائٹ میٹھائی
جیم
ڈبوں میں پیک غذا
ڈائٹ جوس
کریلے کا جوس
انجیر
کھجور


DEPARTMENT OF DIABETES & ENDOCRINOLOGY
شعبہ امراض شوگر و غدود حیات آباد میڈیکل کمپلیکس پشاور
ذیابطیس ، موٹاپا کے مریضوں کے لئے ضروری ھدایات
غذا جو زیا بطیس کے مریض احتیاط سے کھائیں
گندم (چوکر) 1/2 روٹی 100 گرام
مکئی / جوار کی روٹی 1/2 روٹی 100 گرام
ابلے ہوئے چاول 1/2 پلیٹ
بیسن 50 گرام
دلیہ 1 پیالہ 100 گرام
مکئی 1 1/2 یا 1 عدد
اسپیگٹی 1/2 پلیٹ
نوڈلز 1/2 پلیٹ
چنا (خشک) 1/2 پیالہ 100 گرام
انڈے کی سفیدی 2 عدد
بغیر چربی گوشت 3 سے 4 ٹکڑے
مرغی 3 سے 4 ٹکڑے
مچھلی 2 سے 3 ٹکڑے
پنیر 2 سے 4 ٹکڑے
مارجرین مکھن 50 گرام
پاستہ 1/2 پلیٹ
امرود 1 عدد
سیب 1 عدد
مالٹا / کینو 1 عدد
خوبانی 2 عدد
سٹرابری 2 سے 3 عدد
آلوچہ 2 عدد
انار 1/2 حصہ
خربوزہ 2 ٹکڑے
جامن 10 سے 15 دانے
2 سے 4 عدد چیری
آڑو 1 عدد
شلجم کبھی کبھار
کچالو کبھی کبھار
آلو کبھی کبھار
کچھ بوز 1 سے 2 ٹکڑے
گوشت کی کڑاہی 1/2 پلیٹ
سینڈوچ 1/2
پیزا 1 ٹکڑا
سویٹز 6 سے 8 عدد تک
امرود 1 عدد
کیلا 1/2 عدد انگور 4 سے 6 دانے
سیخ کباب 3 سے 5 عدد
دال چنا آدھا پیالہ
دال لوبیہ آدھا پیالہ
کلول آدھا پیالہ
چھولے آدھا پیالہ
مسور آدھا پیالہ
تیل میں تلا ہوا 1 عدد چپلی کباب
تیل میں تلے ہوئے 3 عدد پکوڑے
انڈا 1 عدد
کھانے کا تیل 2 چمچ
بغیر بالائی کا دودھ 1 سے 2 گلاس روزانہ
دیسی لسی 1 سے 2 گلاس روزانہ
کھجور 1 سے 2 عدد
تازہ انجیر 2 سے 3 عدد
گرمی دار میوے ایک کھانے کے چمچ (دن میں ایک بار)
سورج مکھی اور تخم ملنگا کے چمچ (ایک کھانے کے چمچ دن میں ایک بار)
غذا جو زیا بطیس کے مریض کھا سکتے ہیں
بھنڈی
بینگن
پھول بند گوبھی
کرہلا
کدو، توری
مٹر
پالک
فریش بین
شملہ مرچ
ٹماٹر
سلاد
ہری سوکھی پیاز
گاجر
کھیرا
ادرک لہسن
مولی
لیموں
ساگ
ہری مرچ
پودینہ / دھنیا
غذا جو زیا بطیس کے مریض نہیں کھا سکتے
سینئر ڈائیٹیشن شعبہ شوگر و غدود حیات آباد میڈیکل کمپلیکس پشاور

INTRODUCTION / RAPPORT	0.5	0·5	0·5	0·5	0·5	0·5		
ASSESS BACKGROUND KNOWLEDGE	0.5	0·5	0·5	0·5	0·5	0·5		
EXPLAIN THE RISKS ASSOCIATED WITH OBESITY	1	0·5	0·5	0	1	0·5		
ADVISE DIETARY MODIFICATIONS FOCUSING ON CALORIC AND CARBOHYDRATE RESTRICTION	2	1	1	1	1·5	1		
ADVISE PHYSICAL ACTIVITY	1	1	1	1	1	1		
ADDRESS PATIENT CONCERNS/QUERY	0.5	0·5	0·5	0·5	0·5	0·5		
THANKING THE PATIENT	0.5	0·5	0·5	0·5	0·5	0·5		
MARKS	6	4·5	4·5	4	5·5	4·5		





- An 11-Year-old boy presented to the outdoor with an increasing generalized body swelling and facial puffiness and dark color urine started 2 weeks after sore throat. On Examination he has B.P of 150/90 mmhg.

QUESTIONS:

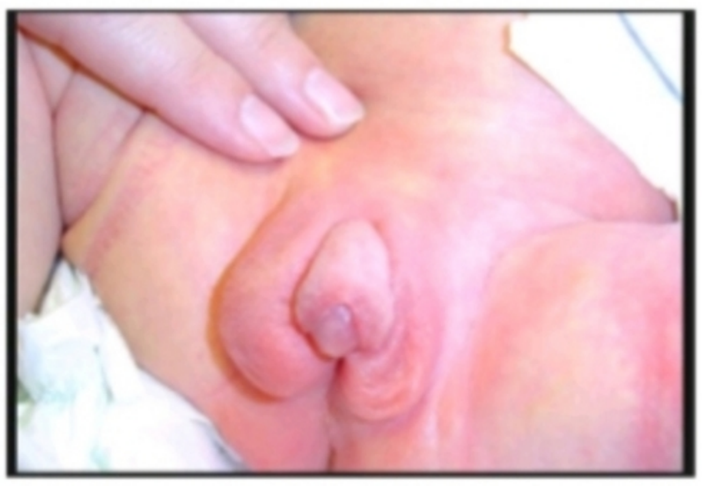
1. Mention three on diagnostic test (3)
2. What is the most probable diagnosis (3)

LASS YEAR:

1) * ASO titer ; Urinalysis
   * CBC, ESR, CRP
   * Biopsy.

2) Post streptococcal - GN.

Paediatric station
Small months old child presented with nausea vomiting one episode of fits hyponatraemia hyperkalaemia and there was a picture of genitalia region
what could you see in the picture? Ambiguous genitalia & undeserved testes in left
What would be the diagnosis (congenital adrenal hyperplasia)
what investigation would you order



"An infant with vomiting, seizure, hyponatremia and hyperkalemia with ambiguous genitalia is most likely congenital adrenal hyperplasia due to 21-hydroxylase deficiency. The investigation of choice is serum 17-hydroxyprogesterone."

⚠️ Why Hyponatremia + Hyperkalemia?

Due to:

- ↓ Aldosterone → salt wasting
- ↓ Cortisol
- ↑ ACTH → adrenal hyperplasia
- ↑ Androgens → virilization

🧪 Investigation to Order (Most Important)

👉 **Serum 17-hydroxyprogesterone** (Diagnostic test)

This will be markedly elevated.

Repeat

Scenario of a child with polydipsia polyuria no ketones no pH abnormality non-diabetic and had a trauma and all of these symptoms have appeared after that trauma
abnormal urine osmolality
diagnosis central diabetes insipidus
Causes any three (pituitary adenoma trauma infections haemorrhage ischaemia brain congenital)
Treatments three
(Desmopressin water intake increase salt restriction)

🧠 Diagnosis

Central diabetes insipidus

Why?

Head trauma → damage to posterior pituitary → ↓ ADH secretion → inability to concentrate urine → dilute urine + excessive urination

🔎 Key Investigation Finding

- ↓ Urine osmolality
- ↓ Urine specific gravity
- ↑ Serum osmolality
- ↑ Serum sodium
- Water deprivation test: urine remains dilute
- Responds to desmopressin (confirms central type)

🧾 Causes (Any Three)

1. Head trauma
2. Pituitary adenoma
3. CNS infections (meningitis, encephalitis)
4. Intracranial hemorrhage
5. Ischemia
6. Brain tumors (e.g., craniopharyngioma)
7. Congenital absence of ADH

💊 Treatment (Any Three)

1️⃣ **Desmopressin** (Drug of choice)

- Intranasal / oral / IV

2️⃣ Adequate water intake

- Prevent dehydration

3️⃣ Salt restriction

- Reduces urine output

Additional:

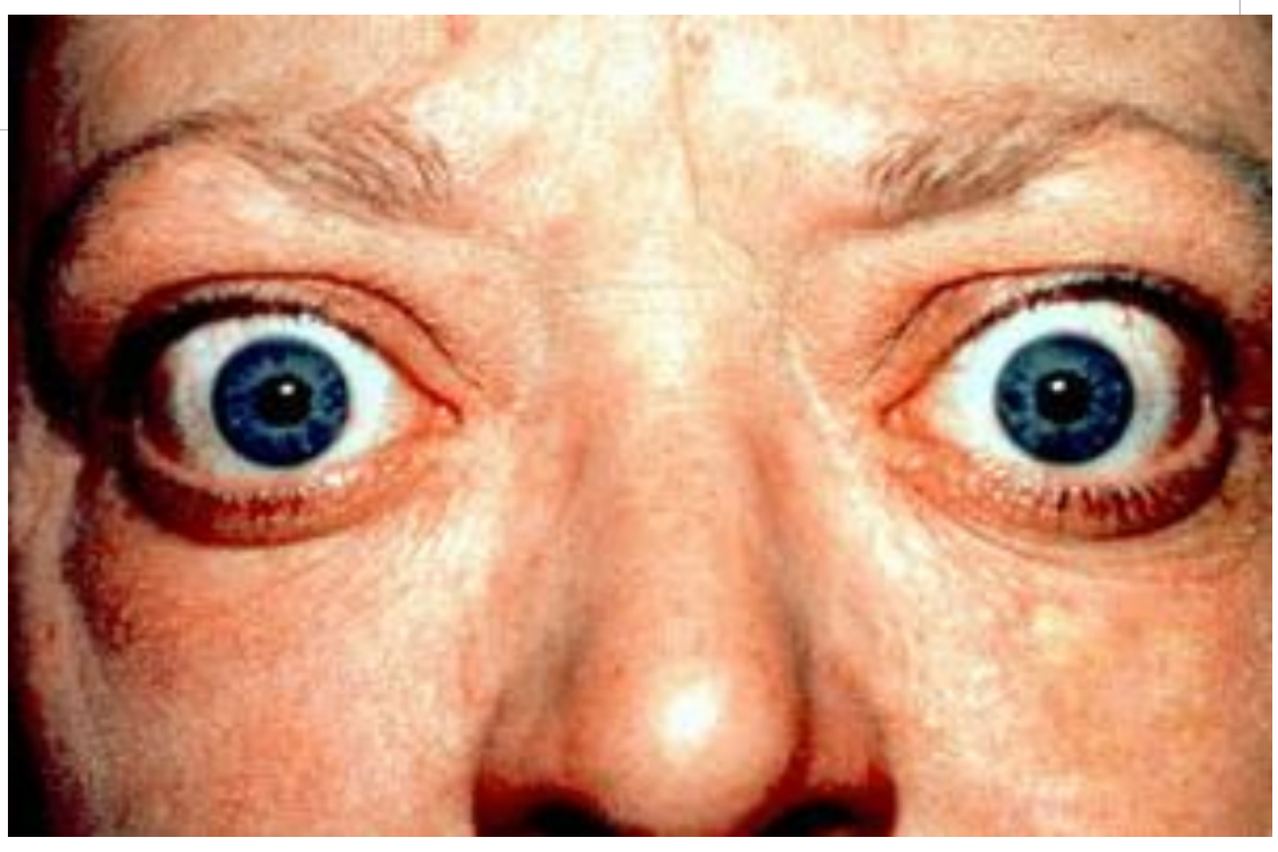
- Treat underlying cause
- Monitor electrolytes

Exophthalmos

What investigations would you do?

What would be your probable diagnosis?

How will you treat this condition?



Probable Diagnosis

Graves' disease

Leading to Graves' ophthalmopathy

🔎 Investigations

1️⃣ Thyroid Function Tests (First line)

- ↓ TSH
- ↑ Free T3
- ↑ Free T4

2️⃣ Thyroid Antibodies

- TSH receptor antibodies (TRAb)
- Anti-TPO antibodies

3️⃣ Imaging

- **CT orbit** → Enlarged extraocular muscles (muscle belly enlarged, tendon spared)
- MRI orbit (if optic nerve compression suspected)

4️⃣ Eye Assessment

- Visual acuity
- Intraocular pressure
- Fundoscopy
- Exophthalmometry (to measure degree of proptosis)

💊 Treatment

Management depends on severity.

🔹 1. Treat Hyperthyroidism

- Antithyroid drugs (Carbimazole / Methimazole)
- Beta blockers (e.g., Propranolol)
- Radioiodine (caution: may worsen eye disease)
- Thyroidectomy (in selected cases)

🔹 2. Treat Eye Disease

Mild:

- Artificial tears
- Lubricating ointment
- Elevate head during sleep
- Stop smoking (very important)

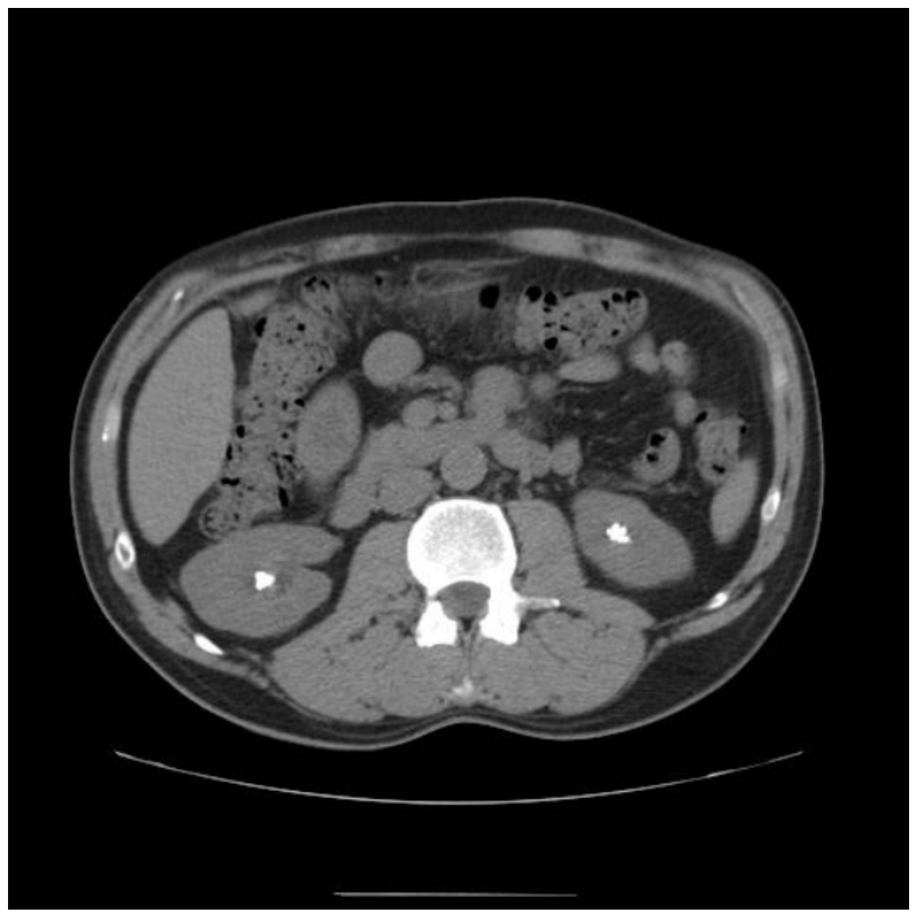
Moderate–Severe:

- IV steroids (Methylprednisolone)
- Orbital radiotherapy

Sight-threatening:

- Urgent IV steroids
- Orbital decompression surgery

📌 Clinical Scenario
Elderly woman with sudden bilateral flank pain → CT renal report shows large stones in both kidneys



🧾 Interpretation of CT Scan (Renal CT KUB)
Typical findings would include:

Hyperdense calculi in both renal pelvicalyceal systems

Stones likely >2 cm in size

Possible:

Hydronephrosis (if obstruction present)

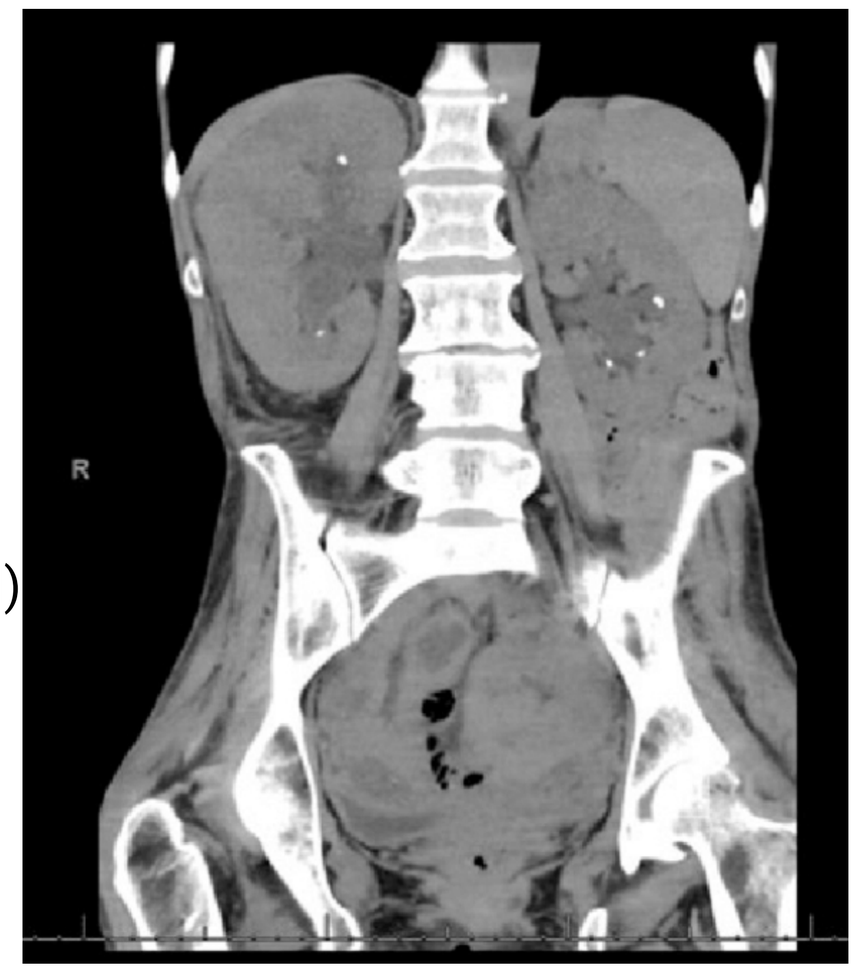
Dilated calyces

Perinephric fat stranding (if infection/inflammation)

If stones are occupying most of the renal pelvis → think staghorn calculi

🩺 Diagnosis
Bilateral large renal calculi
(If branching and filling pelvis → Bilateral staghorn calculi)

🏥 Management
Management depends mainly on stone size, location, obstruction, renal function, and infection.



1️⃣ First stabilize patient
Pain control (NSAIDs like diclofenac)

IV fluids

Check renal function (Urea, Creatinine)

Urine analysis & culture

If infection + obstruction → Emergency decompression (DJ stent / PCN)

2️⃣ Definitive Management
Since stones are large (>2 cm) and bilateral:

- First-line: Percutaneous Nephrolithotomy (PCNL)

✔ Treatment of choice for stones >2 cm
✔ Also best for staghorn calculi
✔ Minimally invasive
✔ High stone clearance rate

Images identification of

testicular torsion

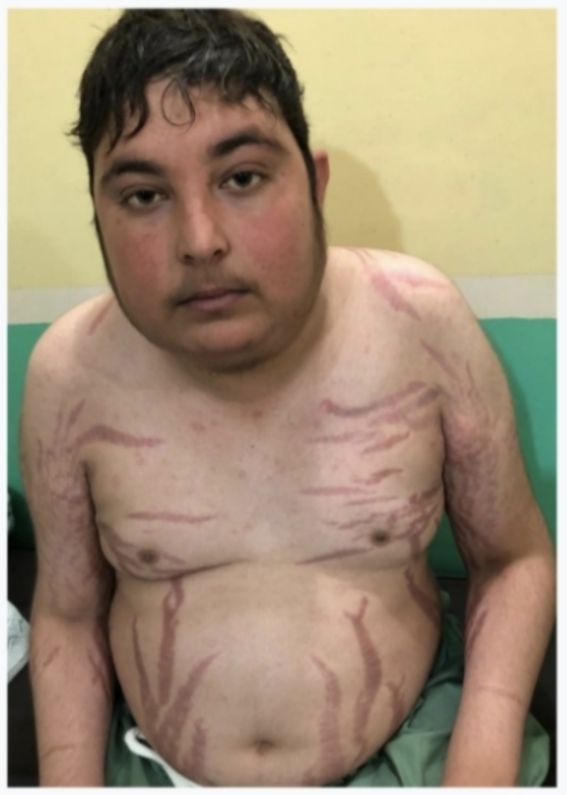
Grade 3 varicose

Grade 3 haematoma around the kidney

Renal tumour of the lower pole of right kidney in a solitary functioning kidney (there was no kidney on the left side in the image)

Penile fracture

Cushing syndrome there is excess of glucocorticoids, leading to central obesity, moon shaped greasy face with facial hairs, diabetes, proximal myopathy,, pink stria & secondary hypertension.



Cushing syndrome

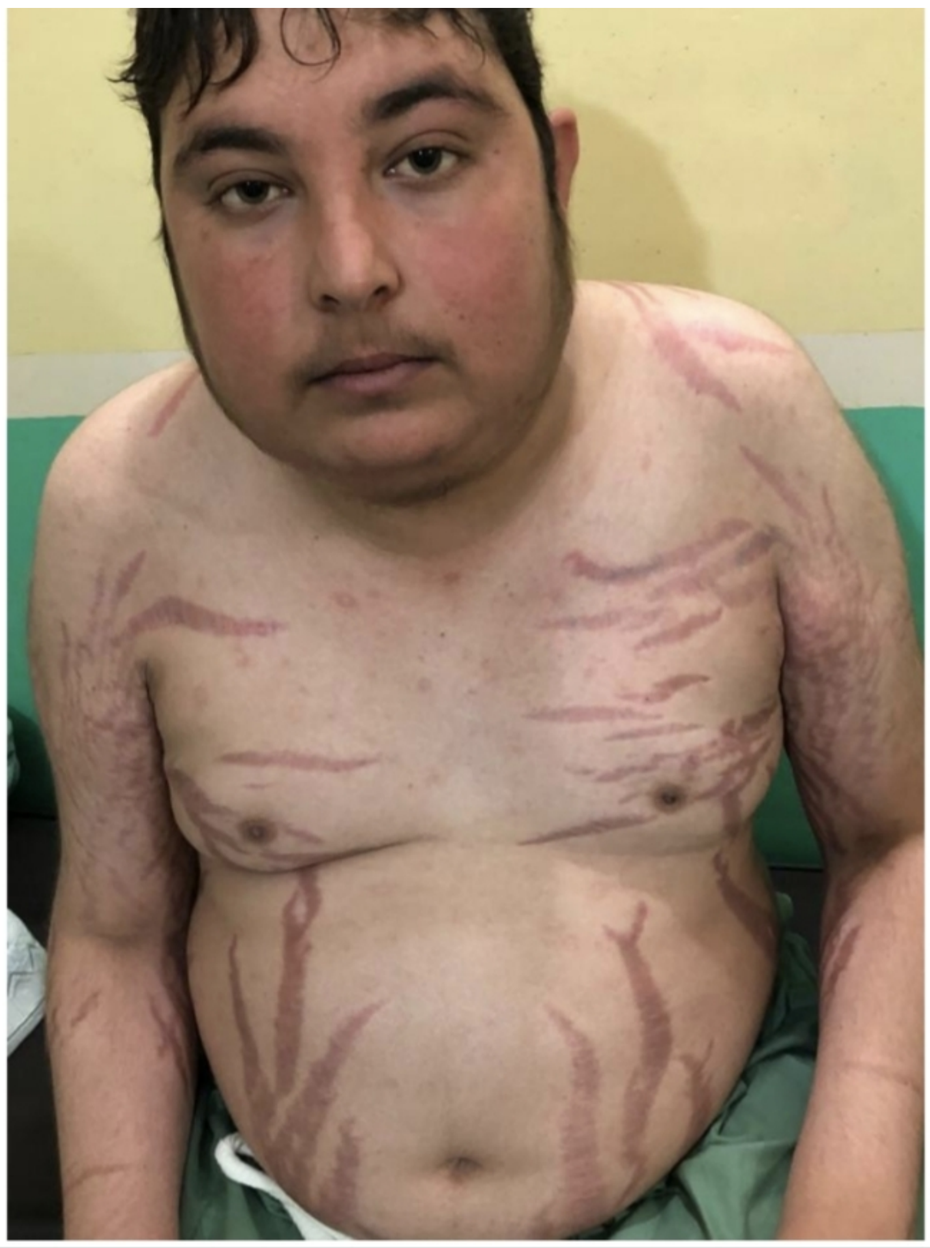
Two pictures, one of moon faces and other of abdominal striae

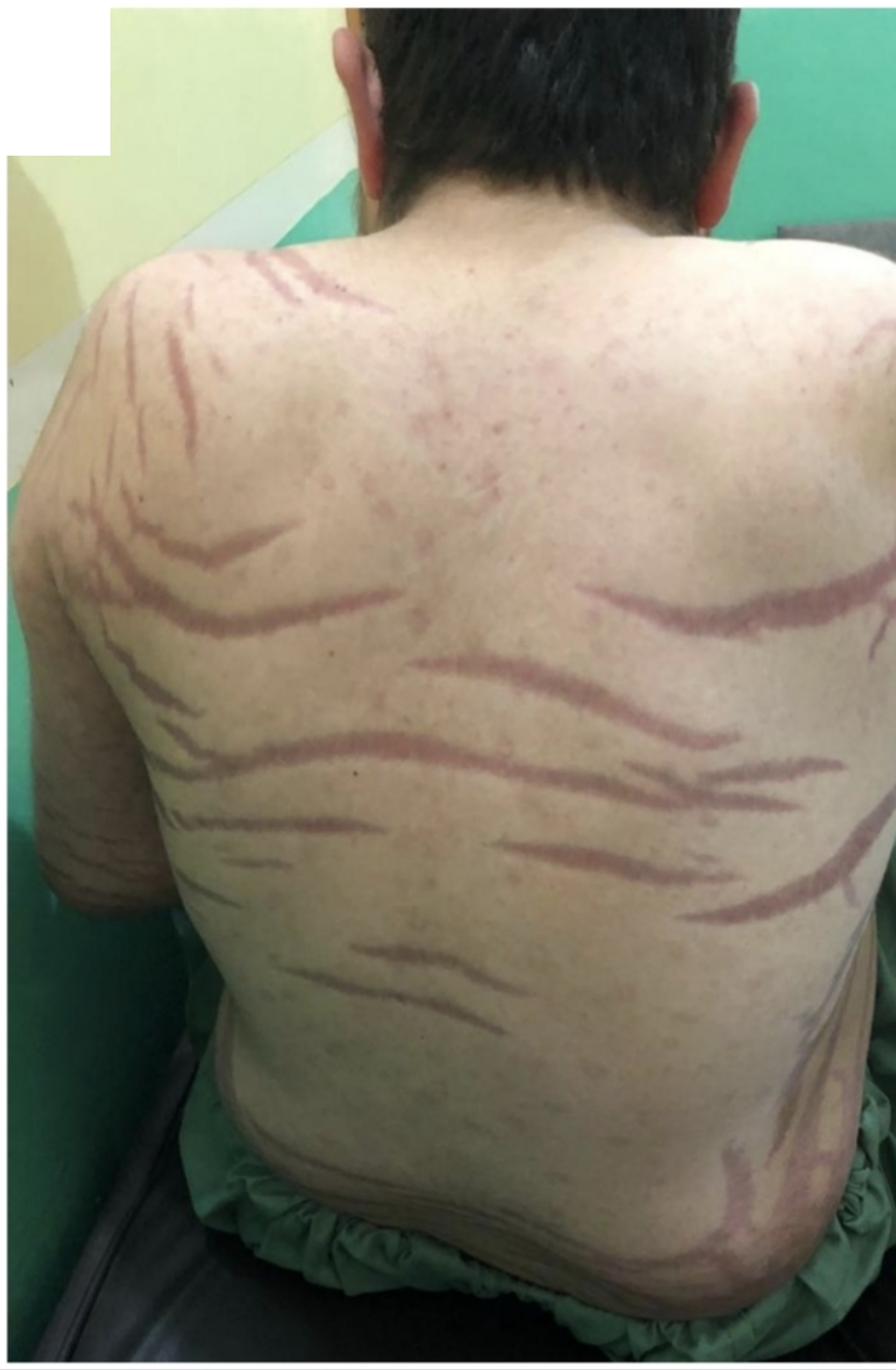
1 write the findings of the pictures

2 write the diagnosis

3 write four investigations

4 causes 2





3️⃣ Four Investigations

In exams, they want screening tests first.

🔹 Initial Screening Tests (Any 2–3 of these)

1. **24-hour urinary free cortisol**
2. **Low-dose dexamethasone suppression test**
3. **Late-night salivary cortisol**
4. Serum cortisol level

🔹 To Find the Cause

5. Plasma ACTH level
6. CT scan of adrenals
7. MRI of pituitary

(Write any four total — usually 2 screening + 2 etiological = safe answer)

4️⃣ Two Causes

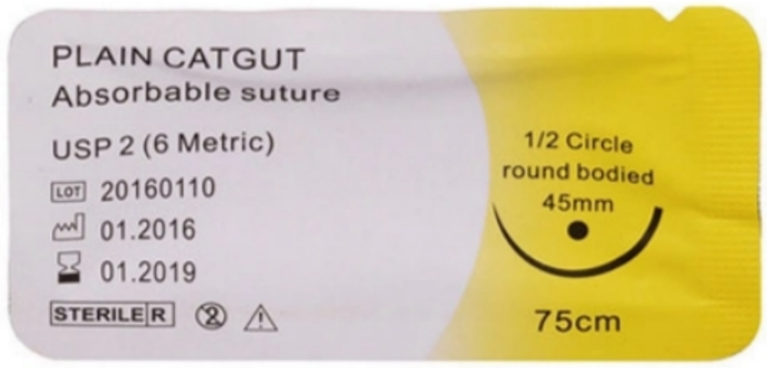
🔹 1. Exogenous steroids (MOST COMMON overall cause)

- Long-term corticosteroid therapy

🔹 2. Endogenous causes:

- Cushing disease (pituitary ACTH-secreting adenoma)
- Adrenal adenoma
- Ectopic ACTH production (e.g., small cell lung carcinoma)

station of sutures
Name some types of sutures
On the station, there were needle holder plane forceps catgut suture and a silk suture and a suture pad gloves
Why cat gut is not used now (cause this bovine spongiform encephalopathy)
What is catgut derived from? sheep intestine
Then show how to hold a needle holder and forceps and how to grab the suture with them



Needle Holder

🔹 1. Types of Sutures (Exam Answer)

You can classify sutures as:

A. Based on Absorbability

Absorbable:

- Plain catgut
- Chromic catgut
- Vicryl (polyglactin 910)
- Monocryl (poliglecaprone)
- PDS (polydioxanone)

Non-absorbable:

- Silk
- Nylon
- Prolene (polypropylene)
- Polyester
- Stainless steel

🔹 2. About Catgut (Very Common Viva Question)

❓ Is catgut used nowadays?

- Rarely used now.
- Largely replaced by synthetic absorbable sutures (e.g., Vicryl).
- Risk concerns included disease transmission (like **bovine spongiform encephalopathy**), plus:
  - Unpredictable absorption
  - More tissue reaction

❓ What is catgut derived from?

- **Submucosa of sheep intestine**
- Or bovine intestine

👉 Important viva line:
"Catgut is a natural absorbable suture derived from sheep intestinal submucosa."

Examining patient for ascites pedal edema and kidney palpation

Obstetrics 3

Council a patient of 40 years having a 16 week size fibroid in the uterus for hysterectomy

Is there any other management? no because the size is big

Can the surgery be performed vaginally? normally can be performed but in this case again it is big fibroid so no.

Explain the whole procedure why it is needed what could be the complications if she does not

Could be there any, could there be any complications after surgery?

So bleeding infection and in long-term menopausal symptoms

Obstetrics 4

Perform breech vaginal delivery

Types of breech

Modes of delivery for breech

Two maternal and two fetal causes of breech

Incidence of breech (3 -5%)

Obstetrics 5

Shoulder dystocia scenario

Diagnose

For manoeuvers that are performed for it

Tell all the management

The two invasive methods that are used (cleidotomy symphysiotomy)

What would be the management for her the next time her baby is macrosomic?

(do not attempt VD go for elective CS)

Obstetric 6

Define PPROM

Complications of PPROM for mother and fetus

Preterm baby will have low birth weight what is the main consequence of this (hypothermia due to less fat pads and hypoglycemia)

Percentage incident of PPROM

Causes of PPROM 3%

Obstetrics 7

40 weeks POG Pregnant female comes with generalised tonic colonic seizure

Diagnosis eclampsia

Management

Shift to ICU

ABC

MGSO4 &/or diazepam

Definitive treatment would be to deliver the fetus

Obstetrics 8

Female with the one years of sub fertility hair on the face amenorrhea

Diagnosis

Medical management for conception

Surgical management for concept

Long-term consequences

What test would you want to perform?

Repeat

Obstetrics 9

Vacuum

Identify

Three indications

Maternal and fetal

complications 2 each

Obstetrics 10

Female with six weeks amenorrhea pain abdominal but there is no signs of pregnancy pregnancy test is negative

Scenario of ectopic pregnancy

Risk factors of ectopic pregnancy

Medical management of ectopic

Surgical management of ectopic

And what is used to monitor the progress?

Obese wala counselling
“Your BMI and waist circumference are higher than recommended. This increases the risk of:
Type 2 diabetes
High blood pressure
Heart disease
Stroke
Joint problems
The good news is that even 5–10% weight loss can significantly reduce these risks.”
🥗 1️⃣ Diet Advice
🎯 Goal:
Create a calorie deficit (reduce 500–750 kcal/day)
A. General Principles
Eat 3 main meals + 1–2 healthy snacks
Avoid skipping meals
Reduce portion size
Eat slowly (20 minutes per meal)
Avoid late-night eating
B. What to Reduce ❌
Fried foods (samosa, pakora, fries)
Sugary drinks (colas, juices)
Bakery items (cakes, biscuits)
White rice in large amounts
Parathas with excess oil/ghee
C. What to Increase ✅
Vegetables (half plate rule)
Whole grains (brown roti, brown rice)
Lean protein (dal, chicken, fish, eggs)
Fruits (1–2 portions/day)
Water (2–3 liters daily)
D. Plate Method (Easy Rule)
½ plate → Vegetables
¼ plate → Protein
¼ plate → Whole grains
¼ plate → Whole grains
🏃‍♀️ 2️⃣ Exercise Advice
🎯 Minimum Recommendation:
👉 150–300 minutes/week moderate exercise
A. Beginners
Brisk walking 30 minutes/day, 5 days/week
Start with 10–15 minutes and gradually increase
B. Add Strength Training
2–3 times/week
Bodyweight exercises:
Squats
Wall push-ups
Lunges
Planks
C. Increase Daily Activity
Take stairs
Park farther away
Avoid prolonged sitting
8,000–10,000 steps/day goal
🧠 3️⃣ Behavioral Modifications
Keep a food diary
Avoid emotional eating
Sleep 7–8 hours
Manage stress
Avoid crash dieting
📏 4️⃣ Waist Circumference Targets
Men: < 90 cm (South Asians)
Women: < 80 cm
Abdominal obesity increases heart risk more than BMI alone.
💊 5️⃣ When to Consider Medication?
If:
BMI ≥ 30
OR
BMI ≥ 27 with comorbidities
Medications may be considered along with lifestyle changes.
🔪 6️⃣ Bariatric Surgery (If Severe)
Consider if:
BMI ≥ 40
OR
BMI ≥ 35 with diabetes/hypertension

Types of Sutures

- Based on Absorbability

Absorbable
Catgut (plain, chromic)
Vicryl (polyglactin 910)
Monocryl
PDS
Non-absorbable
Silk
Nylon (Ethilon)
Prolene (polypropylene)
Polyester

- Based on Structure

Monofilament → Nylon, Prolene
Multifilament (braided) → Silk, Vicryl
2️⃣ Why is Catgut Not Used Now?
Main reasons:
❌ Risk of transmission of prion diseases
e.g., Bovine spongiform encephalopathy
❌ Unpredictable absorption
❌ More tissue reaction
❌ Lower tensile strength
Now we prefer synthetic absorbable sutures (e.g., Vicryl).
3️⃣ What is Catgut Derived From?
👉 Submucosa of sheep small intestine
(or sometimes bovine intestine)

Obstetrics 2
Copper IUCD
Identify
Mechanism of action
Two indications
Two complications
Two contraindications

Mechanism of Action

- Copper ions cause spermicidal effect (toxic to sperm).
- Causes sterile inflammatory reaction in endometrium → prevents fertilization.
- May prevent implantation (secondary effect).

👉 Main action = Prevents fertilization

3️⃣ Two Indications

Long-term reversible contraception
Emergency contraception (within 5 days of unprotected intercourse)

4️⃣ Two Complications

Menorrhagia (heavy menstrual bleeding)
Uterine perforation
(Other possible: pelvic infection, expulsion)

5️⃣ Two Contraindications

Pregnancy
Active pelvic inflammatory disease (PID)
(Also: unexplained vaginal bleeding, uterine anomaly)

Obstetrics 1

Female with heavy regular bleeding for past few years

What is the new name for this? (Heavy menstrual bleeding) old is menorrhagia

How will you medically manage this?

How will you surgically manage this?

Menstrual bleeding

What is the New Name?

👉 Heavy Menstrual Bleeding (HMB)

Old term: Menorrhagia

Definition:

Excessive menstrual blood loss that interferes with physical, social, emotional, or material quality of life.

Medical Management of Heavy Menstrual Bleeding

(If patient is stable and no structural cause needing surgery)

- 🔹 A. First-Line (Very Important)

1️⃣ Tranexamic Acid

Taken during menses

Reduces blood loss by ~40–50%

2️⃣ NSAIDs (e.g., mefenamic acid)

Reduce prostaglandins

Also relieve pain

- 🔹 B. Hormonal Treatment

3️⃣ Combined Oral Contraceptive Pills (COCP)

4️⃣ Oral Progesterone

(e.g., norethisterone in luteal phase)

5️⃣ Levonorgestrel intrauterine system (Mirena)

⭐ Most effective medical option

Reduces bleeding up to 90%

3️⃣ Surgical Management

(If medical treatment fails or structural cause present)

- 🔹 A. Conservative Surgery

1️⃣ Endometrial ablation

Destroys endometrial lining

For women who completed family

- 🔹 B. Definitive Surgery

2️⃣ Hysterectomy

Permanent cure

For severe refractory cases

If fibroid-related:

Myomectomy

Uterine artery embolization

Counselling hysterectomy
Introduction & Rapport
“Assalam o Alaikum. I am Dr ___. I understand you have been diagnosed with a large fibroid in your uterus. I would like to explain your condition and discuss treatment options with you. Please feel free to stop me anytime.”
2️⃣ Explain the Condition (Simple Language)
“You have a fibroid, which is a non-cancerous growth in the muscle of the uterus.
Your fibroid is about the size of a 16-week pregnancy, which means it is quite large. That is likely causing your symptoms such as:
Heavy bleeding
Abdominal swelling
Pelvic pressure
Pain”
Reassure: “Fibroids are benign and not cancer.”
3️⃣ Why Surgery is Recommended
“Because of the large size and your symptoms, medical treatment is unlikely to shrink it sufficiently. The most definitive treatment is removal of the uterus, called hysterectomy.”
4️⃣ What is Hysterectomy?
“It is a surgery to remove the uterus. After this:
You will not have periods
You cannot become pregnant
Your ovaries may or may not be removed depending on your condition”
(At 40 years, usually ovaries are preserved unless indicated.)
5️⃣ Benefits
Permanent relief from heavy bleeding
Relief from pressure symptoms
No recurrence of fibroid
Improved quality of life
6️⃣ Risks (Must Mention in OSCE)
Bleeding
Infection
Injury to bladder or bowel
Anesthesia risks
Blood clots
Early menopause (if ovaries removed)
7️⃣ Alternatives
Myomectomy (removal of fibroid only)
Uterine artery embolization
Hormonal treatment (temporary relief)
But explain: “Because your fibroid is large and you are 40 years old, hysterectomy is often the most definitive option.”
8️⃣ Postoperative Information
Hospital stay: 2–4 days
Recovery: 4–6 weeks
Avoid heavy lifting
Follow-up visit required
9️⃣ Emotional Support
“I understand this is a big decision, especially because it involves removal of the uterus. If you would like, you can discuss this with your family. I am here to answer any questions.”
🔟 Check Understanding
“Do you have any concerns or questions?”

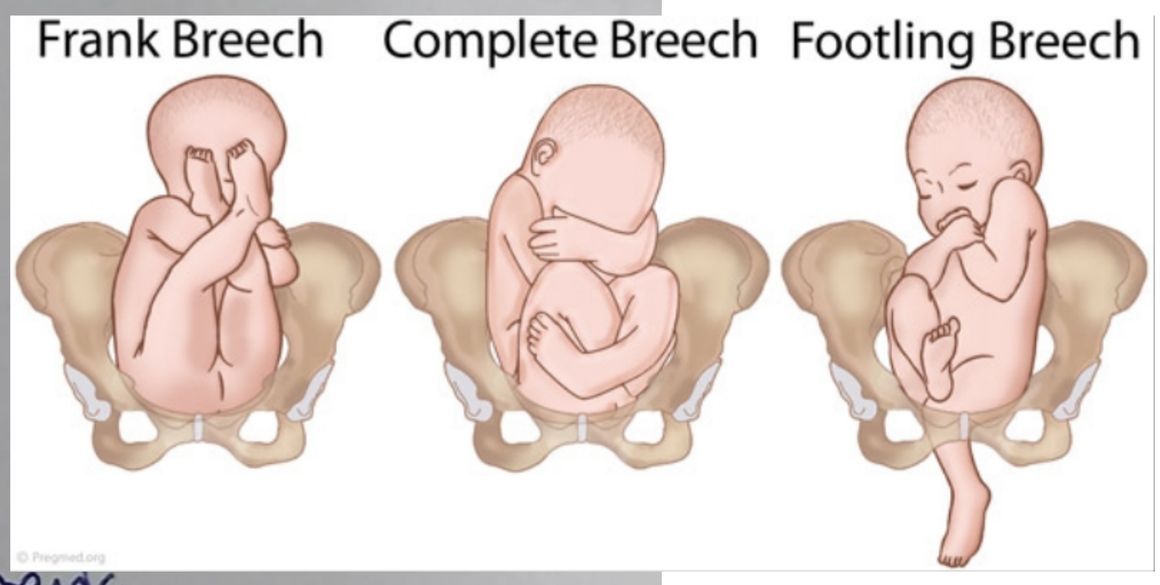
Breech types mode of delivery and risk factors

- Extended Breech:
  - Also known as frank breech , is most common (70%).
  - Thighs are flexed and legs are extended.
- Flexed Breech:
  - Also known as complete breech , accounts for 20%.
  - Thighs and legs are flexed.
- Footling Breech:
  - It is the least common, and predisposes to cord and foot prolapse.
  - One leg is flexed and one extended.

Risks Factors & Diagnosis:

Risk Factors:

- Maternal Factors:
  - Fibroids
  - Uterine abnormalities (bicornuate uterus)
  - Oligohydramnios
  - Polyhydramnios
  - uterine surgery.
- Fetal Factors:
  - Multiple gestation
  - Anencephaly
  - Hydrocephalus
  - Neuromuscular condition
  - premature - placenta previa



iv). Mode of Delivery:

- Factors that increase the likelihood of C-section:
  - Large or small baby
  - Small pelvis on pelvimetry
  - Primigravida
  - Previous C-section
  - Extended neck
- Factors that increase the likelihood of Vaginal delivery:
  - Normal-size baby (2.5-3.5 kg)
  - Good pelvimetry
  - Flexed neck
  - Multiparous
  - Breech deeply engaged

prerequ

- manage

Shoulder Dystocia

(iii). Management:

- The mnemonic "**HELPERR**" has been suggested to aid in remembering the sequence.
- The main objectives are to facilitate the entry of anterior (or posterior) shoulder into the pelvis and to ensure rotation of the shoulders to the larger oblique or transverse diameter of the pelvis.

- H – Call for help.
- E – Episiotomy (consider episiotomy as it may help with internal maneuvers).
- L– Legs into **McRobertsPosition** i.e. hyperflexed at the hips with thighs abducted & externally rotated – this flattens the lumbosacral spine.
- P– Suprapubic pressure applied to the posterior aspect of the anterior shoulder to dislodge it from under the pubic symphysis.
- E – Enter pelvis for internal maneuvers, which include:
  - Pressure exerted on the posterior aspect of **"anterior"** shoulder to adduct and rotate the shoulders to the larger oblique diameter **(Rubin II).**
  - If this fails combine it with pressure on the anterior aspect of the **"posterior"** shoulder **(Woods' screw).**
  - If this fails, reversing the maneuver may be tried with pressure on anterior aspect of anterior shoulder and posterior aspect of posterior shoulder in the opposite direction **(reverse Woods' screw)**
- R – Release of posterior arm by flexing the elbow, getting hold of the fetal hand, and sweeping the fetal arm across the chest and face to release the posterior shoulder.
- R – Roll over to all fours may help aid delivery by the changes brought about in the pelvic dimensions **(Gaskin maneuver).**

- Finally consider **"Zavanelli Maneuvers"**– it is a series of steps that pushes the fetal head back into the pelvis, followed by C-section:
  - Give uterine relaxation – terbutaline (subcutaneously), nitroglycerine (IV)
  - Place a fetal scalp electrode.
  - Rotate the head back into occiput anterior position (reverse of restitution)
  - Flex the head & push it cephalad as much as possible
  - Once cephalad replacement is successful, patient is prepared for C-section.

Link on Koracademy.com

https://koracademy.com/ospes-final-year-kgmc/

BLOCK P EXAMINATIONS

- Obstetrical examination (videolink)
- Thyroid examination (videolink)
- Diabetic foot examination (videolink) (videolink)
- Shoulder dystocia maneuvers (videolink)
- Breech delivery maneuvers (videolink)
- Breast examination (videolink)
- Forceps delivery demonstration (videolink)

Obstetric 6
Define PPROM
Complications of PPROM for mother and fetus
Preterm baby will have low birth weight what is the main consequence of this (hypothermia due to less fat pads and hypoglycemia)
Percentage incident of PPROM
Causes of PPROM 3%

Pprom :preterm prelabour rupture of membranes
Leakage of amniotic fluid in absence of uterine activity occuring between 24 to 36+6 weeks of gestation

2️⃣ Complications of PPROM

👩 Maternal Complications

1. Chorioamnionitis
2. Endometritis
3. Sepsis
4. Placental abruption

👶 Fetal / Neonatal Complications

1. Prematurity
2. Respiratory distress syndrome (RDS)
3. Neonatal sepsis
4. Cord prolapse
5. Pulmonary hypoplasia (if early PPROM)
6. Intraventricular hemorrhage

3️⃣ Preterm Baby → Low Birth Weight

Main Consequences?

⭐ 1. Hypothermia

- Due to ↓ subcutaneous fat
- Large surface area to body mass ratio

⭐ 2. Hypoglycemia

- Low glycogen stores
- Poor feeding

(These are most important viva points)

4️⃣ Percentage Incidence of PPROM

- Occurs in about **3% of all pregnancies**
- Accounts for ~30–40% of preterm births

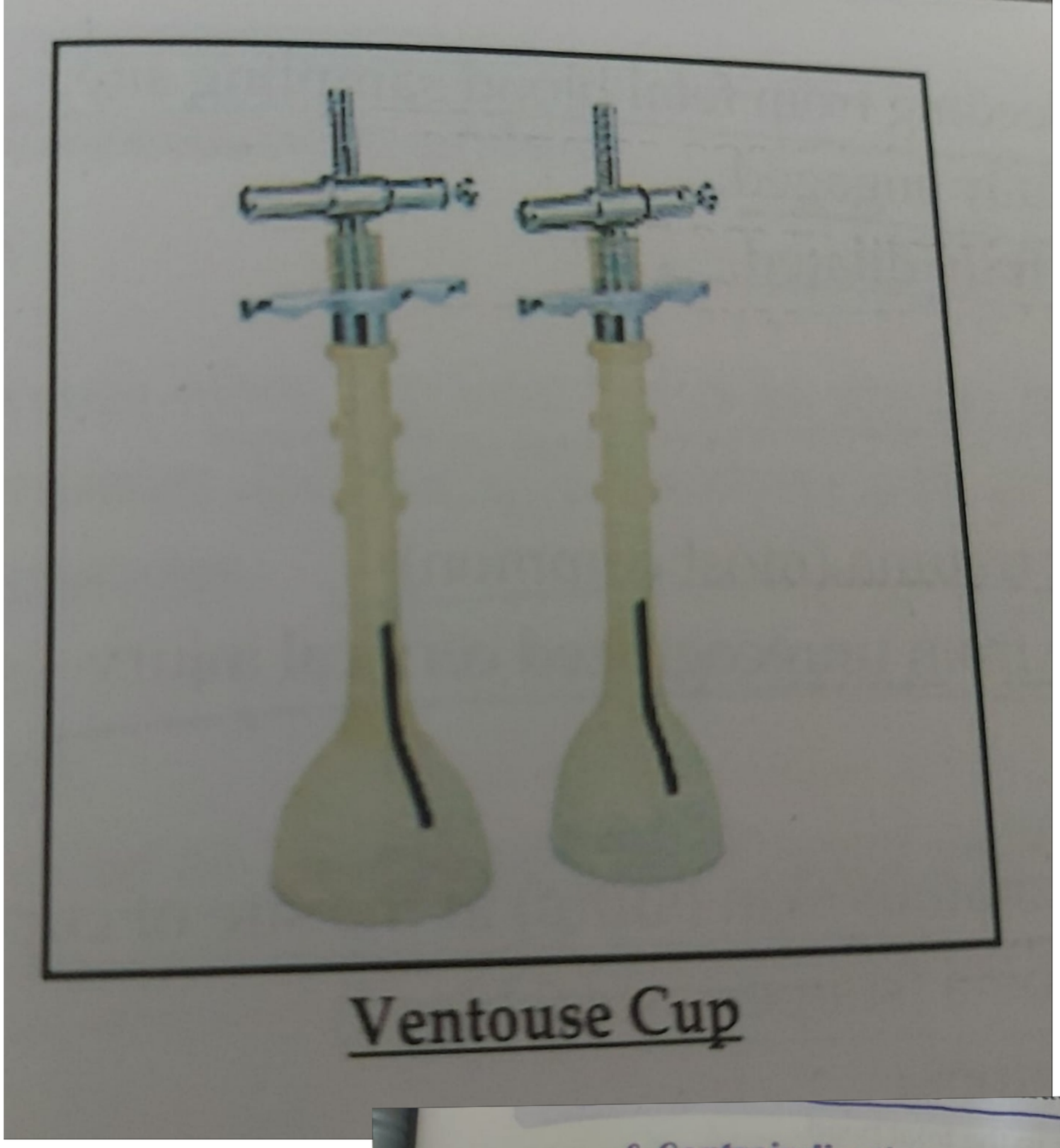
5️⃣ Causes of PPROM

Common causes:

1️⃣ Genital tract infection (most common)
2️⃣ Previous history of PPROM
3️⃣ Overdistension of uterus

- Twins
- Polyhydramnios

4️⃣ Cervical incompetence
5️⃣ Smoking
6️⃣ Trauma



Ventouse Cup

changes upward through an arc of over 90°

(iii). Indications & Contraindications:

- **Indications:**
  - Delay in the 2nd stage of labour.
  - Fetal distress in the 2nd stage.
  - Maternal conditions requiring a short 2nd stage.
    - Cardiac disorders
    - Respiratory disorders

- **Contraindications:**
  - Face presentation
  - Breech presentation
  - Gestation <34 weeks increased risk of Cephalhematoma, Intracranial Bleeding
  - Gestation 35- 36 week s is relative contraindication.

32

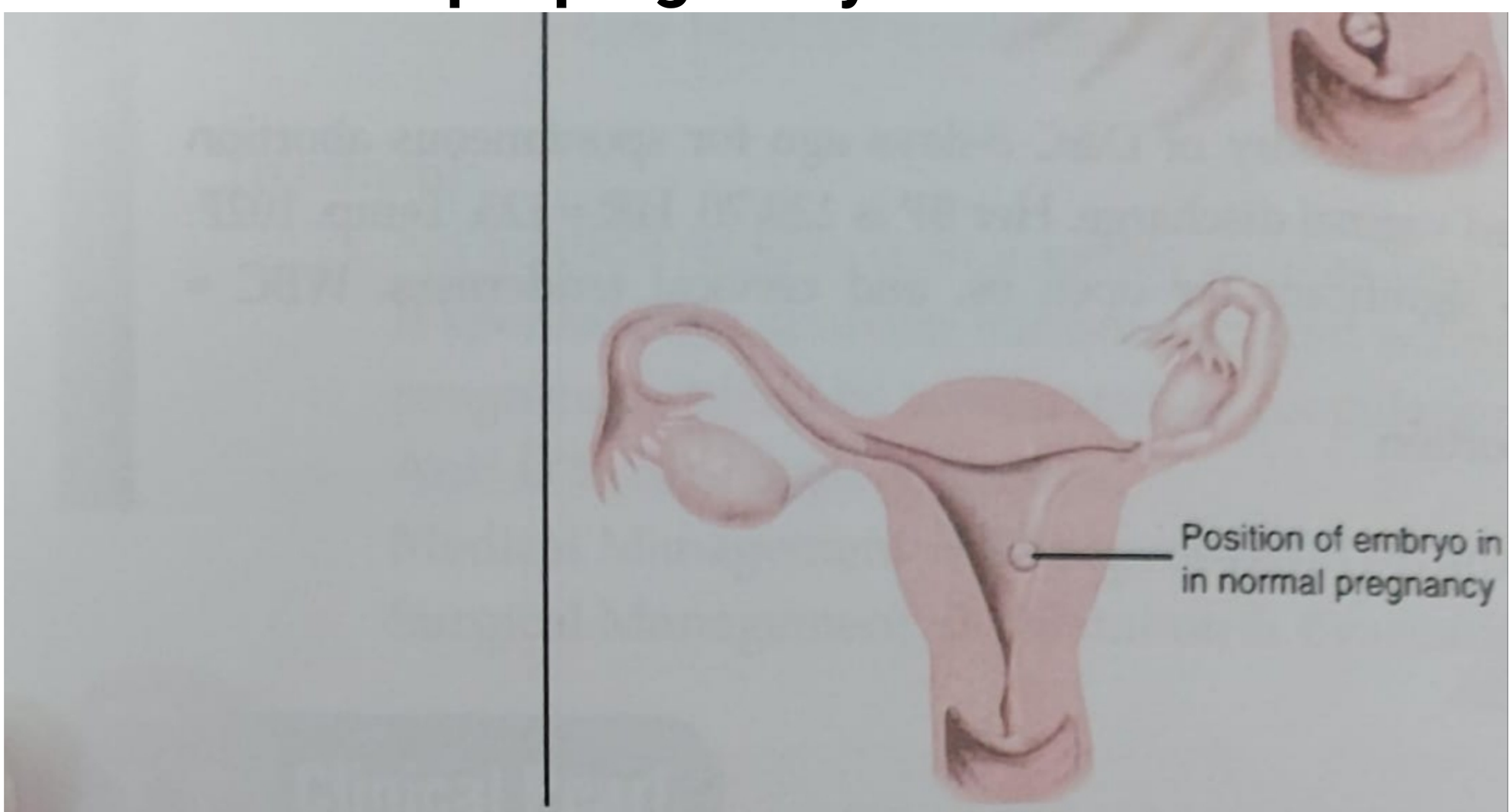
  - Marked bleeding from fetal blood sampling site.
  - Head not fully engaged.
  - Cervix not fully dilated.

(iv). Complications:

- Maternal:
  - Genital tract trauma (most common)
  - Hemorrhage from unrecognized cervical injury.

- Fetal:
  - Chignon (edematous skin bump) at the site of cup application
  - Cephalhematoma (subperiosteal bleed).
  - Subgleal hematoma
  - Intracranial hemorrhage
  - Retinal hemorrhage

Ectopic pregnancy



Ectopic Pregnancy

II. Risk Factors & Differential Diagnosis:

- Risk Factors:
  - Previous PID (most common)
  - Previous ectopic pregnancy
  - Previous tubal surgery
  - Intrauterine device in place
  - Prolonged infertility

- Differential Diagnosis:
  - Acute appendicitis
  - Diverticulitis
  - Threatened abortion
  - Molar pregnancy
  - Ruptured corpus luteum

Ectopic pregnancy
What is Used to Monitor Progress?
👉 Serial serum β-hCG levels
Check on day 4 and day 7 after methotrexate
Expect ≥15% drop
Then weekly until negative
Also follow-up ultrasound if needed.

V. Management:

(i). Medical Management:

- It should be considered when following criteria are met:
  - Clinically stable
  - β-hCG is< 3000 IU/L
  - Ectopic pregnancy is < 4 cm and no fetal cardiac activity on TVS.
  - No hemoperitoneum on TVS
  - Live in close proximity to the hospital (due to need for regular follow-ups)

- Methotrexate:
  - It is the agent of choice for medical management of ectopic pregnancy.
  - It is a folic acid antagonist and given intramuscularly as a single dose.
  - β-hCG should be checked on days 4, 7, 11, and then weekly until undetectable.
  - β-hCG should drop by 15% between day 4 & 7.
  - Contraindications:
    - Chronic liver disease
    - Chronic kidney disease
    - Active infection
    - Immunodeficiency & hematologic disorder
    - Breastfeeding

  - Follow-up:
    - Avoid sexual intercourse during treatment with methotrexate.
    - Avoid conceiving for at least 3 months after methotrexate therapy (risk of teratogenicity)

(ii). Surgical Management:

- Unstable (ruptured) → laparotomy & salpingectomy (removal of tube)
- Stable (Un-ruptured):
  - Laparoscopy and salpingectomy – treatment of choice.
  - Salpingotomy (i.e. opening the tube and excision of the ectopic) is an option if the patient has only one fallopian tube.

Clinical Pearl

- A 25-year old female with 7-weeks of gestational amenorrhea presents with vaginal spotting. She is hemodynamically stable. Abdominal examination reveals mild tenderness in RLQ. Pelvic examination shows closed os with no tenderness. TVUS shows no intra-uterine gestational sac and no adnexal masses. Serum Beta-hCG is positive (2500 mIU/mL).
- Diagnosis: Suspected ectopic pregnancy. Patient should undergo Laparoscopy. (Elevated beta-hCG > 2000 with no intra-uterine gestational sac is suspicious for ectopic, even if US doesn't show any adnexal mass).

1.CTG graph read
2.*Normal BHR, Reduced variability, No acceleration, No deceleration
3. Fetal hypoxia
4. Change maternal position to left lateral tilt , iv fluids

3.Viva: what's hyperthyroidism, levels of t3 t4 tsh in it. What's multinodular goiter. Are nodules soild ot Cystic. Can it be malignant. Tsh high but t3 t4 normal what's it called?? Subclinical hypothyroidism baby. T4 concentration near the thyroid. What cells are making the actual t3. And what gland makes the t3 and what gland makes the tsh.

Hyperthyroidism

Definition:
A condition in which there is excess thyroid hormone production, leading to increased metabolic activity.

Lab Findings:

Hormone

Expected in Hyperthyroidism
T3 ↑ Elevated
T4 ↑ Elevated
TSH ↓ Suppressed (low)
Example: Graves’ disease, Toxic multinodular goiter

2️⃣ Multinodular Goiter (MNG)

Definition:
Enlarged thyroid with multiple nodules, usually heterogeneous.
Features of nodules:
Can be solid or cystic
Usually benign, but small risk of malignancy (~5%)
"Hot" nodules → functioning (hyperthyroid)
"Cold" nodules → non-functioning (higher risk of malignancy)

3️⃣ TSH High, T3/T4 Normal

✅ This is called: Subclinical hypothyroidism

Patient usually asymptomatic
Only lab abnormality: high TSH, normal free T4 and T3

4️⃣ Thyroid Hormone Production

- T4 and T3 Production

T4 (thyroxine) → main hormone secreted by thyroid gland
T3 (triiodothyronine) → mostly produced by peripheral conversion of T4 in liver, kidney, and other tissues
~20% of T3 is secreted directly by thyroid follicular cells

- Cells in Thyroid

Follicular cells → produce T4 and T3
Parafollicular (C) cells → produce calcitonin, not T3/T4

5️⃣ Glands Making the Hormones

Hormone
Gland
T3 & T4
Thyroid gland (follicular cells)
TSH
Anterior pituitary (thyrotrophs)

Block P:
1. Counselling patient about CKD and he is unwilling for dialysis.

Questions asked were: what happens to me if I don't do dialysis and what are the alternatives to haemodialysis? What's the entire procedure. Two ways of it; fistula and central line What are the cost associated(5_8k per dialysis session and 3
2_3 times a week depends patient to patient)

Counseling CKD Patient About Dialysis

1️⃣ Introduction

Greet the patient and establish rapport:

“Assalam-o-Alaikum. I understand you have chronic kidney disease and you are concerned about starting dialysis. I would like to explain your condition, the procedure, alternatives, and what may happen if you don’t start dialysis.”

Ensure privacy and allow patient to express fears.

2️⃣ Explain CKD and Need for Dialysis

CKD → kidneys lose their function gradually.

Dialysis is needed when kidneys can no longer remove toxins, excess fluid, and waste from the blood.

Without dialysis:

Fluid overload → swelling, shortness of breath

High potassium → heart rhythm problems

Waste accumulation → nausea, fatigue, confusion

Eventually → life-threatening complications

Use simple terms, avoid medical jargon.

3️⃣ Explain Haemodialysis Procedure

Haemodialysis removes toxins and excess fluid using a machine:

Access: Blood is taken from your body, passed through a dialyzer (artificial kidney), and returned.

Session duration: ~3–4 hours per
hours per session

Frequency: Usually 2–3 times per week

🔹 Two Types of Vascular Access

Arteriovenous Fistula (AV Fistula)

Surgical connection of artery and vein in arm

Long-term use

Fewer complications (infection, clotting)

Central Venous Catheter / Line

Tube inserted in neck, chest, or groin vein

Short-term or urgent use

Higher risk of infection

4️⃣ Alternatives to Haemodialysis

Peritoneal dialysis (using abdomen lining to filter blood)

Kidney transplant (ideal, but depends on donor availability)

Conservative management (only supportive care)

Control blood pressure, diet, medications

This is not curative; disease will progress

5️⃣ Cost of Haemodialysis (Pakistan context)

Each session: 5,000–8,000 PKR

Frequency: 2–3 times per week

Depends on patient and center

Recurrent Calcium Oxalate Stones – Dietary Modification

Key Principles

Goal: Reduce stone formation without compromising nutrition

Dietary Advice

Nutrient

Recommendation

Reason

Calcium

Normal dietary calcium (1,000–1,200 mg/day)

Binds oxalate in gut → reduces absorption

Oxalate

Limit high-oxalate foods (spinach, rhubarb, nuts, tea)

↓ urinary oxalate

Protein

Moderate animal protein

Excess protein → ↑ uric acid & calcium excretion

Salt

Low sodium (<2 g/day)

High sodium ↑ calcium excretion

Fluids

2–3 L water/day

Dilutes urine → prevents crystallization

Citrate

Lemonade, citrus fruits

Citrate inhibits stone formation

Additional Tips

Avoid excessive vitamin C supplementation

Avoid crash diets or high-protein diets

Bladder Carcinoma

Risk Factors

Smoking (most important)
Chronic irritation (e.g., catheter, stones)
Occupational exposure (aromatic amines, dyes, rubber industry)
Schistosomiasis (in endemic areas)

Investigations

Urine cytology
Cystoscopy with biopsy (gold standard)
Imaging: CT urography / Ultrasound
Lab tests: CBC, renal function

Treatment

Non-muscle-invasive (Ta, T1)

TURBT (transurethral resection of bladder tumor)
Intravesical therapy: BCG, Mitomycin C

Muscle-invasive

Radical cystectomy + urinary diversion
+/- Chemotherapy (neoadjuvant/adjuvant)

Follow-up

Regular cystoscopy for recurrence

Molar Pregnancy (Hydatidiform Mole)

Types

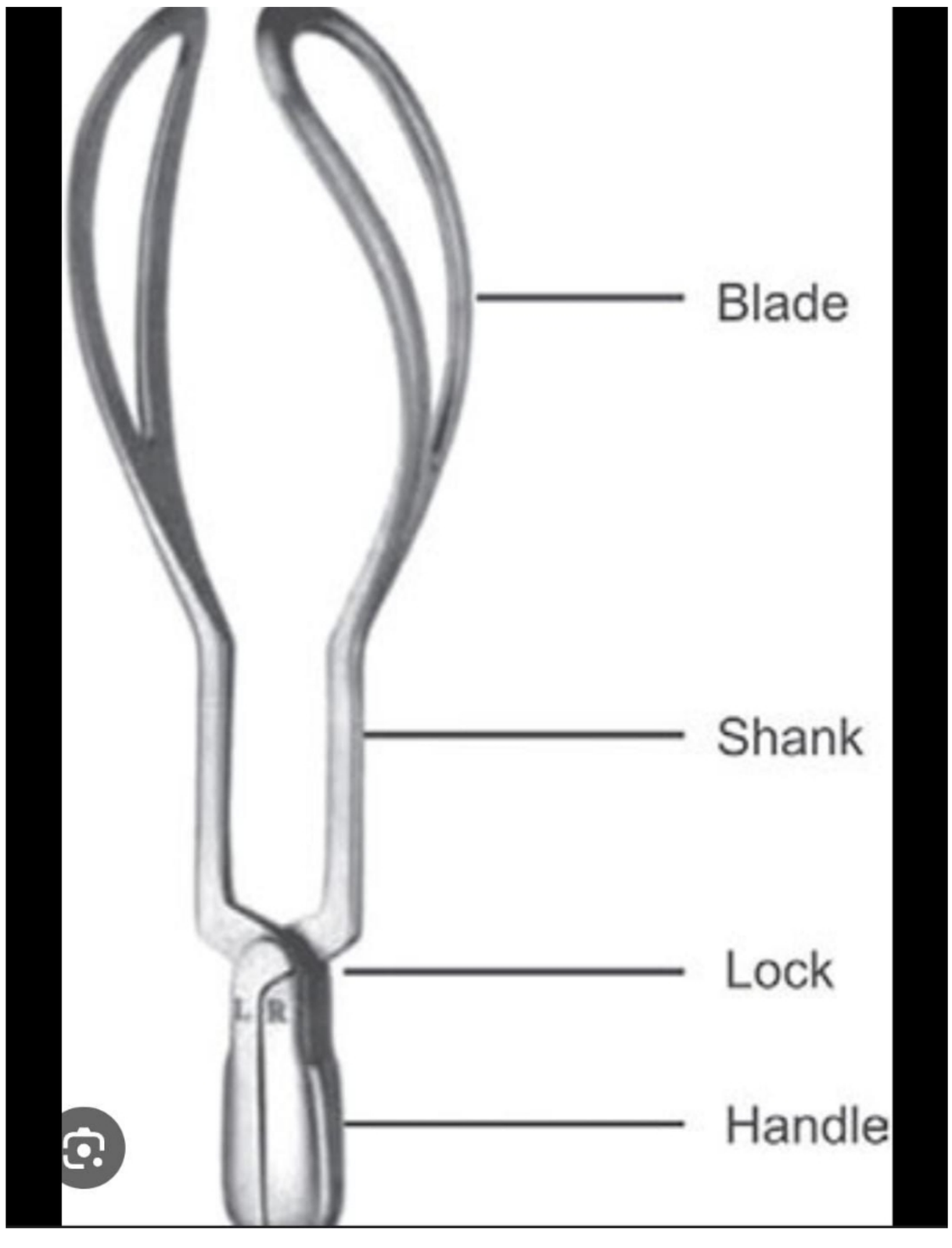
Complete mole
Fertilization of empty egg by 1 or 2 sperm
No fetal tissue
High risk of malignancy (~15–20%)

Partial mole
2 sperm fertilize normal egg → triploid
Some fetal tissue
Lower risk of malignancy (~1–5%)

Treatment
Suction & curettage (uterine evacuation)
Rh immunoglobulin if Rh-negative
Avoid pregnancy for 6–12 months

Follow-up
Serial β-hCG levels weekly until undetectable
Monthly β-hCG for 6 months
Monitor for gestational trophoblastic neoplasia
Contraception advised during follow-up

Wrigley Forceps



Short obstetric forceps
Used for low or outlet deliveries
Blades: slightly curved
Shorter than standard Simpson or Elliot forceps

Indications

Assisted vaginal delivery:
Prolonged second stage of labor
Maternal exhaustion
Fetal distress (if head at +2 or +3 station)

Pre-requisites

Fully dilated cervix
Ruptured membranes
Analgesia/epidural
Vertex presentation
No cephalopelvic disproportion

Complications

Maternal: vaginal/cervical tears, perineal trauma, hematoma
Fetal: scalp injuries, cephalohematoma, facial nerve injury

$MgSO_4$ (Magnesium Sulphate)

Identification / Use
Anticonvulsant for eclampsia prevention and treatment

Dosage (example)
Loading: 4–6 g IV over 15–20 min
Maintenance: 1 g/hour IV or 5 g IM every 4 h

Antidote
Calcium gluconate 10% (1 g IV slow)

Side Effects / Toxicity Signs
Loss of deep tendon reflexes
Respiratory depression
Hypotension
Flushing, nausea

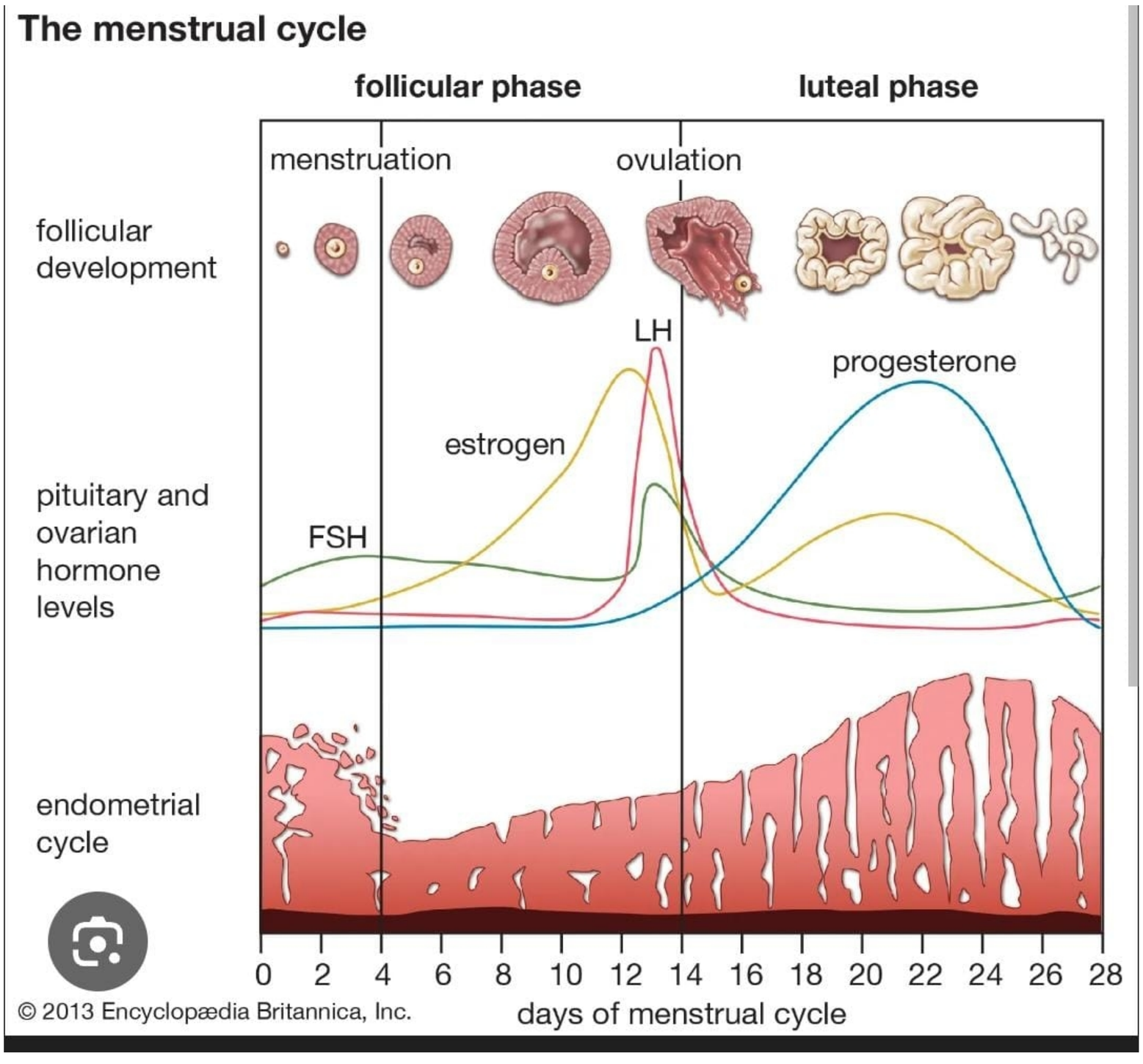
UTI in Pregnancy – Scenario/Urine Report

Identification
Urine: WBCs ↑, nitrite +, bacteria on culture

Treatment
Safe antibiotics in pregnancy:
Nitrofurantoin (except 3rd trimester)
Amoxicillin / Amoxicillin-Clavulanate
Cephalexin

Duration: Usually 5–7 days

Complications if Untreated
Pyelonephritis
Preterm labor
Low birth weight
Sepsis



Menstrual Cycle Hormones Graph
Hormones to plot
FSH → rises early in follicular phase, small mid-cycle peak
LH → small rise follicular, LH surge mid-cycle triggers ovulation
Estrogen → rises follicular, peaks before ovulation, mid-luteal secondary peak
Progesterone → low follicular, rises luteal phase
GnRH → pulsatile, drives FSH/LH
Phases
Follicular (Days 1–14) → FSH ↑ → follicle maturation → estrogen ↑
Ovulation (~Day 14) → LH surge → ovulation
Luteal (Days 15–28) → corpus luteum → progesterone ↑, moderate estrogen
Menstruation → hormone drop if no pregnancy

12 Mentoanterior and Other Presentations

Definitions & Diameters

Presentation	Fetal Head Orientation	Pelvic Diameter
Mentoanterior (MA)	Face anterior, chin toward pubis	Submentobregmatic 9.5 cm
Mentoposterior (MP)	Face posterior, chin toward sacrum	Submentobregmatic 9.5 cm
Brow presentation	Forehead leads	Mentofrontal ~13.5 cm
Face presentation (general)	Chin anterior or posterior	Submentobregmatic (9.5 cm)
Vertex / Occiput anterior	Head flexed, occiput leading	Occipitofrontal ~11.5 cm

Diabetes Insipidus (DI)
Definition:
Excessive urination (polyuria) and thirst (polydipsia) due to inability to concentrate urine.

Causes

A. Central DI (ADH deficiency)
Idiopathic
Head trauma / neurosurgery
Tumors (pituitary, hypothalamic)
Infections (meningitis)

B. Nephrogenic DI (renal resistance to ADH)
Genetic
Drugs: lithium, demeclocycline
Chronic kidney disease
Electrolyte disturbances (hypercalcemia, hypokalemia)

C. Gestational DI
Increased vasopressinase in pregnancy

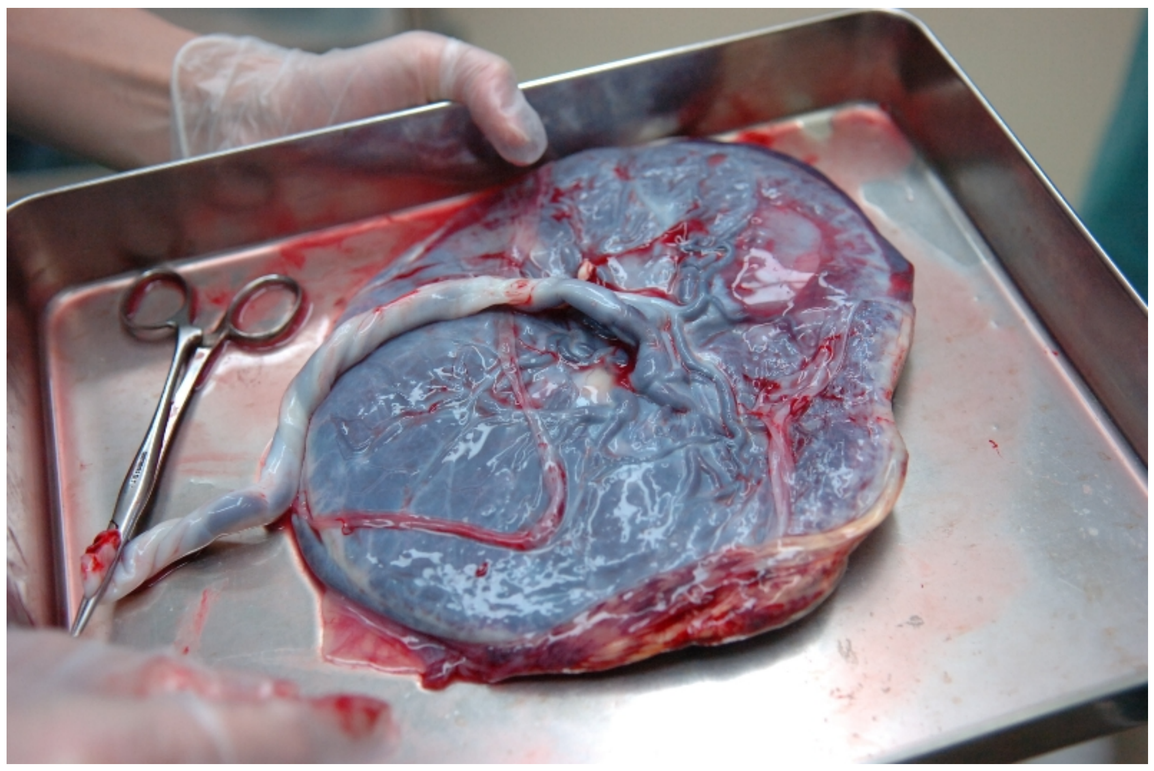
Treatment

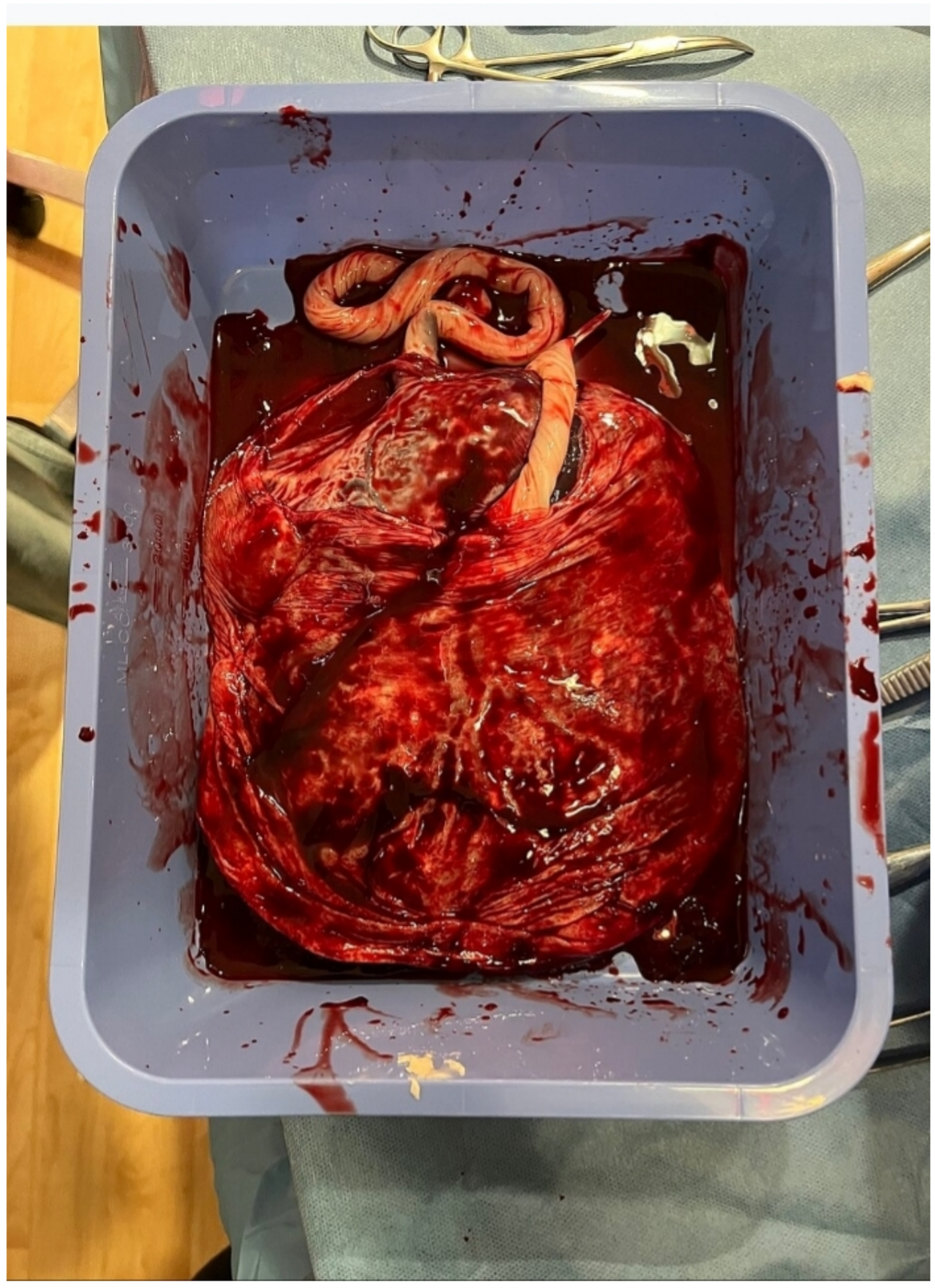
Central DI
Desmopressin (DDAVP) – nasal or oral

Nephrogenic DI
Correct underlying cause, low-salt diet, thiazide diuretics, NSAIDs (indomethacin)

Gestational
Desmopressin (safe in pregnancy)

Supportive: Ensure adequate hydration to prevent dehydration.





1️⃣5. Placenta

Identification / Picture

Flat, disc-shaped organ with maternal (red, rough) and fetal (shiny, smooth, chorionic) surfaces.
Umbilical cord attached centrally or eccentrically.

Functions of Placenta

Respiratory: Gas exchange (O_2/CO_2)
Nutrition: Glucose, amino acids, fats
Excretory: Removes fetal waste (urea, CO_2)
Endocrine: hCG, progesterone, estrogen, placental lactogen
Immunological: IgG transfer to fetus
Barrier: Protects against some infections

Active Management of Third Stage of Labour (AMTSL)

Purpose: Reduce postpartum hemorrhage (PPH)
Steps:
Uterotonic drug – Oxytocin 10 IU IM or IV infusion immediately after delivery of baby
Controlled cord traction (CCT) – Gently pull the cord while supporting uterus
Uterine massage – After delivery of placenta to ensure contraction

Optional / Additional:
Inspect placenta for completeness
Monitor maternal vitals and bleeding

Placental Abruption (Abruptio Placentae)

Scenario Clues:
Third-trimester bleeding, abdominal pain, uterine tenderness
Uterine hypertonicity / hard uterus
Fetal distress

Diagnosis: Placental Abruption

Clinical: painful vaginal bleeding, tender uterus, hypertonicity

Ultrasound: may detect retroplacental clot (not always)

Emergency Management:
Maternal stabilization:
IV access, fluids, blood cross-match
Monitor vitals
Fetal assessment: Continuous CTG
Delivery:
If term / fetal compromise / maternal instability → immediate cesarean section
If vaginal delivery safe and fetal/maternal stable → expedite vaginal delivery

Other Measures:
Correct coagulopathy if present
Continuous monitoring

Intrahepatic Cholestasis of Pregnancy (ICP)

Scenario Clues:

Pregnant woman (usually 2nd/3rd trimester)

Severe pruritus, worse at night, mainly on palms and soles

Jaundice may be present

Diagnosis / Investigations:

Serum bile acids ↑ (diagnostic, gold standard)

LFTs: Mild ↑ ALT, AST

Rule out other causes of jaundice

Diagnosis:

Clinical pruritus + elevated serum bile acids

Management:

Ursodeoxycholic acid (UDCA) – relieves itching, improves bile flow

Antihistamines for symptom relief

Early delivery at 37–38 weeks (due to fetal risk: stillbirth, preterm)

Monitor fetal wellbeing

Uterine Rupture

Definition:

Tearing of the uterine wall during pregnancy or labor, potentially life-threatening.

Causes:

Previous cesarean section or uterine surgery → scar rupture
Grand multiparity
Obstructed labor / prolonged labor
Oxytocin / prostaglandin overuse
Trauma (e.g., accident)

Signs & Symptoms:

Maternal:

Severe abdominal pain, “ripping” sensation
Vaginal bleeding
Shock (hypotension, tachycardia)
Loss of uterine contractions / abnormal uterine contour

Fetal:

Fetal distress (bradycardia, decelerations)
Loss of fetal station

Management:

Immediate:
Call senior staff, IV fluids, oxygen, blood cross-match
Emergency cesarean section if alive fetus
Hysterectomy if uncontrolled bleeding or irreparable rupture
Repair if small, localized rupture

Supportive:

Blood transfusions
Monitor maternal vitals

Obstetrics 7

40 weeks POG Pregnant female comes with generalised tonic colonic seizure

Diagnosis eclampsia

Management

Shift to ICU

ABC

MGSO4 &/or diazepam

Definitive treatment would be to deliver the fetus

Magnesium Sulphate ($MgSO_4$) – Eclampsia

Loading Dose

4–6 g IV over 15–20 min

Maintenance Dose

1 g/hour IV or 5 g IM every 4 h

Side Effects / Toxicity

Loss of deep tendon reflexes, respiratory depression, hypotension, flushing

Antidote

10% Calcium gluconate, 1 g IV slowly

Postpartum Psychosis

Scenario Clues
Usually within 2 weeks postpartum
Severe mood swings, hallucinations, confusion, agitation

Diagnosis
Clinical assessment (acute onset, severe mood/psychotic symptoms)
Exclude medical causes: infection, thyroid, anemia, hypoglycemia

Drug of Choice
Antipsychotic: Haloperidol or olanzapine

Other Treatment Plan
Hospitalization for safety
Mood stabilizers if indicated (lithium)

Supportive care: family involvement, sleep regulation

Complications
Suicide risk
Harm to infant
Relapse in future pregnancies

First Antenatal Visit – Investigations & Homecare Advice

Investigations

Blood:

Hb / CBC → anemia
Blood group & Rh typing
VDRL → syphilis
HBsAg → hepatitis B
HIV
Rubella / varicella immunity
Fasting blood sugar → gestational diabetes baseline

Urine:

Routine urinalysis → protein, sugar, infection
Urine culture if indicated

Other:

Pap smear if due
Optional: baseline renal/liver function if risk factors

Homecare Advice

Diet: balanced, iron-rich, folate 400 mcg/day
Supplements: Iron, folic acid, calcium
Avoid alcohol, smoking, and teratogens
Physical activity: mild/moderate exercise
Vaccinations: Influenza, Tdap if indicated
Awareness of danger signs: vaginal bleeding, severe headache, blurred vision, fever, reduced fetal movements

Herpes in Pregnancy

Scenario / External Viva Clues
Genital vesicular lesions
Painful, grouped, recurrent

Diagnosis
Clinical: painful vesicles, ulcers
PCR or viral culture
Serology (HSV-1/2) if needed

Complications
Maternal: secondary infection, recurrent outbreaks
Neonatal: neonatal herpes (can be severe, systemic)

Mode of Delivery
Cesarean section if active lesions at labor onset
Vaginal delivery if no active lesions and >36 weeks

Drug of Choice
Acyclovir 400 mg orally 5×/day or IV if severe
Suppressive therapy in late pregnancy to prevent outbreaks

Postpartum Sepsis

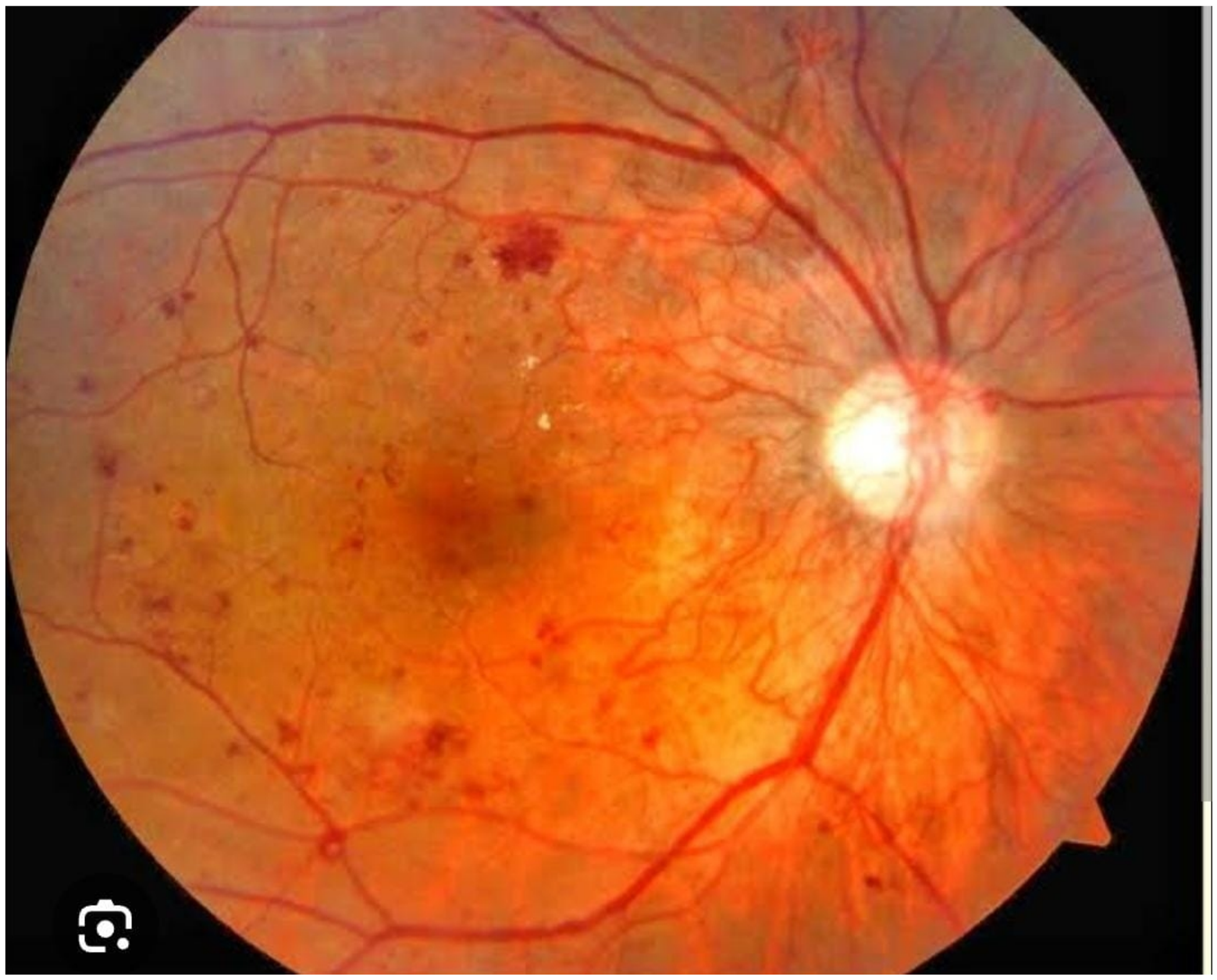
Scenario Clues
Fever >38°C within 6 weeks of delivery
Abdominal pain, foul-smelling lochia, uterine tenderness
Tachycardia, hypotension

Diagnosis
Clinical suspicion (uterine tenderness, fever, systemic signs)
Blood culture if needed

Investigations
CBC → leukocytosis
CRP → inflammatory marker
Blood / urine cultures
Vaginal swab for pathogens
Ultrasound: retained products

Management
Hospital admission
IV broad-spectrum antibiotics (e.g., Ampicillin + Gentamicin ± Metronidazole)
Treat underlying cause (evacuation if retained products)

Supportive care: fluids, monitoring, analgesia



Diabetic Retinopathy

Findings on Fundoscopy
Microaneurysms (small red dots)
Cotton wool spots (white patches)
Retinal hemorrhages (flame-shaped)
Hard exudates (yellow spots)
Neovascularization (advanced, proliferative)

Diagnosis
Fundoscopy, fundus photography
Fluorescein angiography if needed

Complications
Vitreous hemorrhage
Retinal detachment
Vision loss / blindness

Management
Glycemic, BP, lipid control
Laser photocoagulation for proliferative stage
Anti-VEGF injections
Vitrectomy in severe cases

Fibroadenoma (Breast – Surgical Viva)

Identification / Clinical Features

Well-circumscribed, mobile, firm, painless breast lump
Usually in women <35 years

Investigations

Ultrasound / mammography
FNAC for confirmation if uncertain

Management

Reassurance if small, stable, <3 cm

Surgical excision if:

Rapidly growing
Symptomatic
Diagnostic uncertainty

Mastitis (Surgical Viva)

Clinical Features
Breast pain, redness, swelling, warmth
Fever, malaise
Usually lactating women

Investigations
Mostly clinical
Ultrasound if abscess suspected

Management
Continue breastfeeding / milk expression
Antibiotics: Flucloxacillin or cephalexin
Incision & drainage if abscess present

Hyperthyroidism (History Taking – Medicine Viva)
Important History Points
Symptoms: weight loss, heat intolerance, palpitations, tremors, increased sweating, diarrhea
Menstrual irregularities
Eye changes: exophthalmos, diplopia
Past history: thyroid disease, medications (amiodarone, iodine)
Family history of thyroid disease
Examination Tips
Tremors, tachycardia, goiter, eye signs, warm moist skin

Pediatric Hypothyroidism (Picture / Scenario)
Clinical Features
Growth retardation, delayed milestones
Puffy face, macroglossia
Constipation, lethargy
Coarse hair, dry skin
Diagnosis / Investigations
TSH ↑, free T4 ↓
Thyroid imaging if needed (dysgenesis vs dyshormonogenesis)
Neonatal screening
Management
Lifelong levothyroxine replacement

Vacuum-Assisted Vaginal Delivery

Indications

Prolonged second stage of labor
Fetal distress
Maternal exhaustion

Pre-requisites

Fully dilated cervix
Ruptured membranes
Vertex presentation
No cephalopelvic disproportion

Procedure / Key Points

Apply cup to fetal scalp
Suction to vacuum device
Gentle traction during maternal pushing
Limit attempts to reduce trauma

Complications

Maternal: perineal tears, hematoma
Fetal: scalp bruising, cephalohematoma, subgaleal hemorrhage

2️⃣ Repair of Episiotomy

Indications

After vaginal delivery with episiotomy or perineal tear

Steps

Local anesthesia
Clean area, identify muscle layers
Continuous or interrupted sutures:
Vaginal mucosa: absorbable
Perineal muscles: absorbable
Skin: subcuticular or interrupted
Hemostasis and dressing

Complications

Infection, hematoma, wound dehiscence, dyspareunia

HIV-Positive Mother (Obstetrics)

Treatment

HAART during pregnancy: triple therapy as per guidelines (e.g., TDF + 3TC + EFV)

Mode of Delivery

Elective cesarean if high viral load
Vaginal delivery possible if viral load <50 copies/ml

Advice

Avoid breastfeeding (if formula feeding available)
Neonatal prophylaxis for baby (Zidovudine for 6 weeks)
Regular monitoring of maternal viral load and CD4

Hematuria – Specific History
Onset: painless vs painful
Associated symptoms: dysuria, frequency, urgency
Systemic: fever, weight loss
Past history: stones, trauma, infection, malignancy
Medications / anticoagulants
8️⃣ Iron-Deficiency Anemia in Pregnancy
Signs / Symptoms
Fatigue, pallor, palpitations, shortness of breath
Investigations
Hb, MCV, MCH, peripheral smear (microcytic hypochromic)
Ferritin ↓
Reticulocyte count normal/low
Management
Oral iron (ferrous sulfate) 100–200 mg/day
Vitamin C to enhance absorption
Monitor Hb and ferritin

🔟 Hypertension in Pregnancy (Scenario)
Classification
Chronic hypertension
Gestational hypertension
Preeclampsia: BP ≥140/90 + proteinuria or end-organ damage
Eclampsia: Preeclampsia + seizures
Investigations
BP measurement
Urinalysis / proteinuria
CBC, LFTs, creatinine
Fetal assessment: USG, Doppler
Management
Mild gestational hypertension: monitoring, lifestyle
Severe: antihypertensives (labetalol, methyldopa, nifedipine)
Preeclampsia: magnesium sulfate for seizure prophylaxis, plan delivery

Diabetes

I. Introduction:

- WHO Diagnostic Criteria:
  - Diabetes in pregnancy is diagnosed if ≥ 1 criteria are met:
    - Fasting blood glucose of ≥ 126 gm/dL (≥ 7 mmol/L)
    - 2-hour blood glucose of ≥ 200 gm/dL (≥ 11.1 mmol/L) after a 75-g oral glucose tolerance test.
    - Random blood glucose of ≥ 200 gm/dL (≥ 11.1 mmol/L) in the presence of diabetic symptoms.

  - Gestational Diabetes in pregnancy is diagnosed if ≥ 1 criteria are met:
    - Fasting blood glucose of > 92 - 125 mg/dL (> 5.1 – 6.9 mmol/L).
    - 1-hour plasma glucose of > 180 mg/dL (10.0 mmol/L) after 75-g OGTT.
    - 2-hour plasma glucose of > 153 – 199 mg/dL (8.5 – 11 mmol/L) after 75-g OGTT

  - **Therefore, Gestational Diabetes (GDM) can be diagnosed at any stage of pregnancy when patient has hyperglycemia that doesn t meet the criteria for overt diabetes mellitus, but meets criteria for GDM.**

Gestational Diabetes (GDM)

Screening
24–28 weeks: OGTT (75 g glucose)

Diagnosis
Fasting ≥92 mg/dL
1h ≥180 mg/dL
2h ≥153 mg/dL

Management
Diet & lifestyle first-line
Insulin if not controlled
Monitor fetal growth

BPH (Benign Prostatic Hyperplasia)

History

LUTS: frequency, urgency, nocturia, weak stream, incomplete emptying
Hematuria / recurrent infections

Investigations

Digital rectal exam
PSA
Ultrasound: prostate size, post-void residual

Management

Medical: α-blockers (tamsulosin), 5α-reductase inhibitors (finasteride)
Surgical: TURP if refractory

5️⃣ PCNL (Percutaneous Nephrolithotomy) – Counseling
Indication: Large kidney stones
Procedure: Small incision in back, nephroscope to remove stones
Risks: Bleeding, infection, adjacent organ injury
Post-op: Catheter care, hydration, follow-up imaging

6️⃣ AKI Discharge Counseling
Medication review: avoid nephrotoxins
Fluid and dietary advice (low salt, adequate protein as per renal function)
Monitor urine output
Follow-up labs: serum creatinine, electrolytes
Warning signs: edema, reduced urine, confusion

Teratogenic Effects of Drugs

Sulfonamides
Kernicterus in newborn (late pregnancy)

Warfarin
Fetal warfarin syndrome: nasal hypoplasia, stippled epiphyses, CNS anomalies

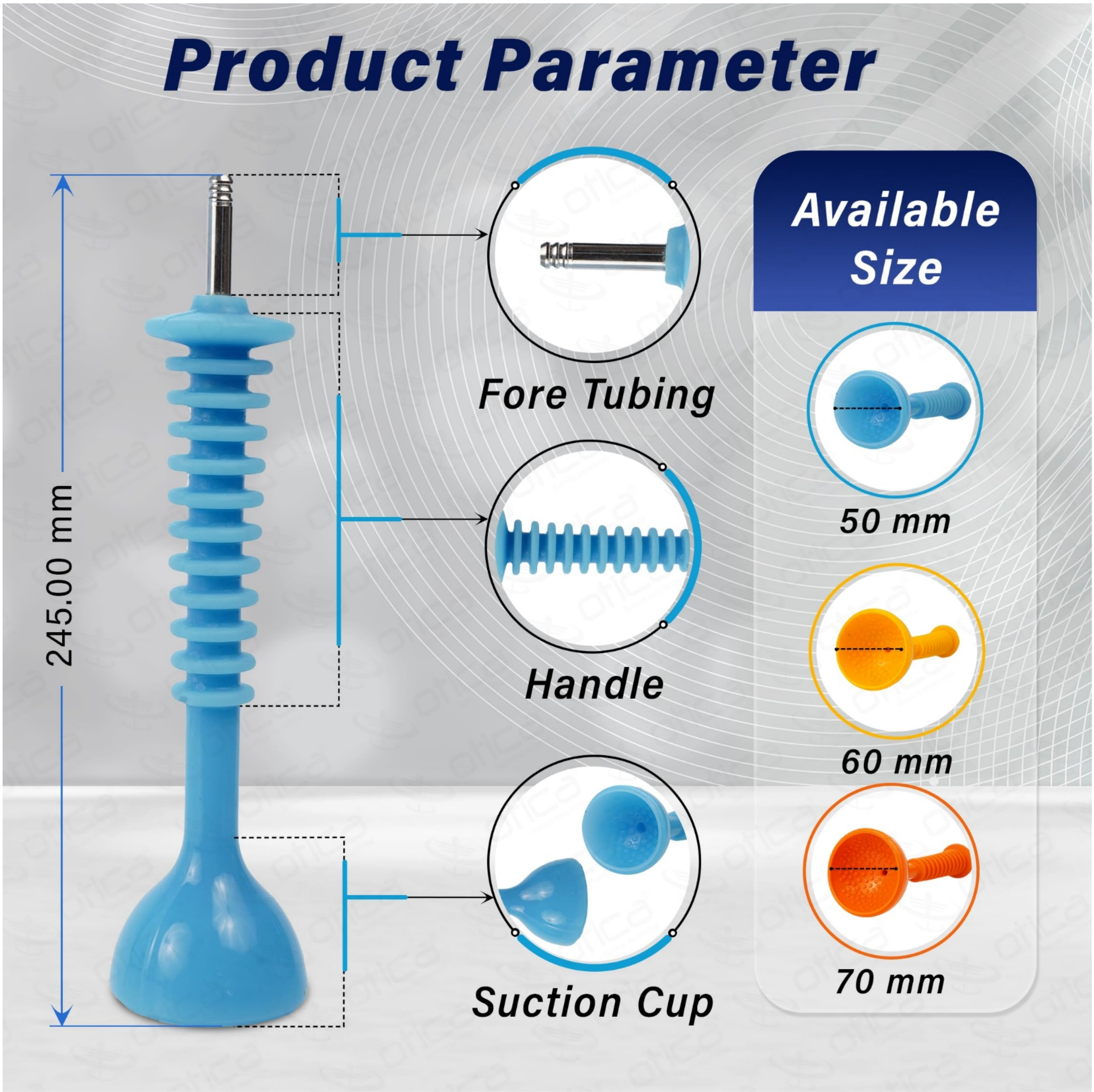
Antiepileptics (phenytoin, valproate)
Neural tube defects, cleft lip/palate, cardiac defects

NSAIDs
Premature closure of ductus arteriosus (3rd trimester), oligohydramnios

Bishop score

Bishop score [32]				
	Score			
	0 points	1 point	2 points	3 points
Cervical position	Posterior	Midline	Anterior	
Cervical consistency	Firm	Moderately firm	Soft (ripe)	
Cervical effacement	≤ 30%	31–50%	51–80%	> 80%
Cervical dilation	Closed	1–2 cm	3–4 cm	≥ 5 cm
Fetal station	-3 cm	-2 cm	-1/0 cm	+1/+2 cm

Ventouse Cup Parts

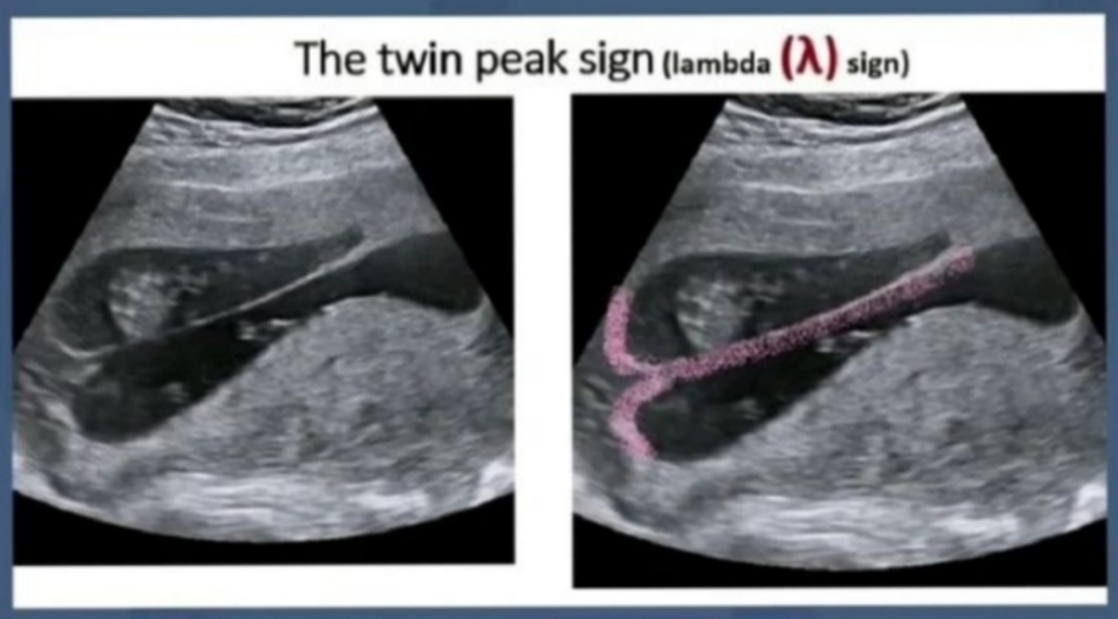


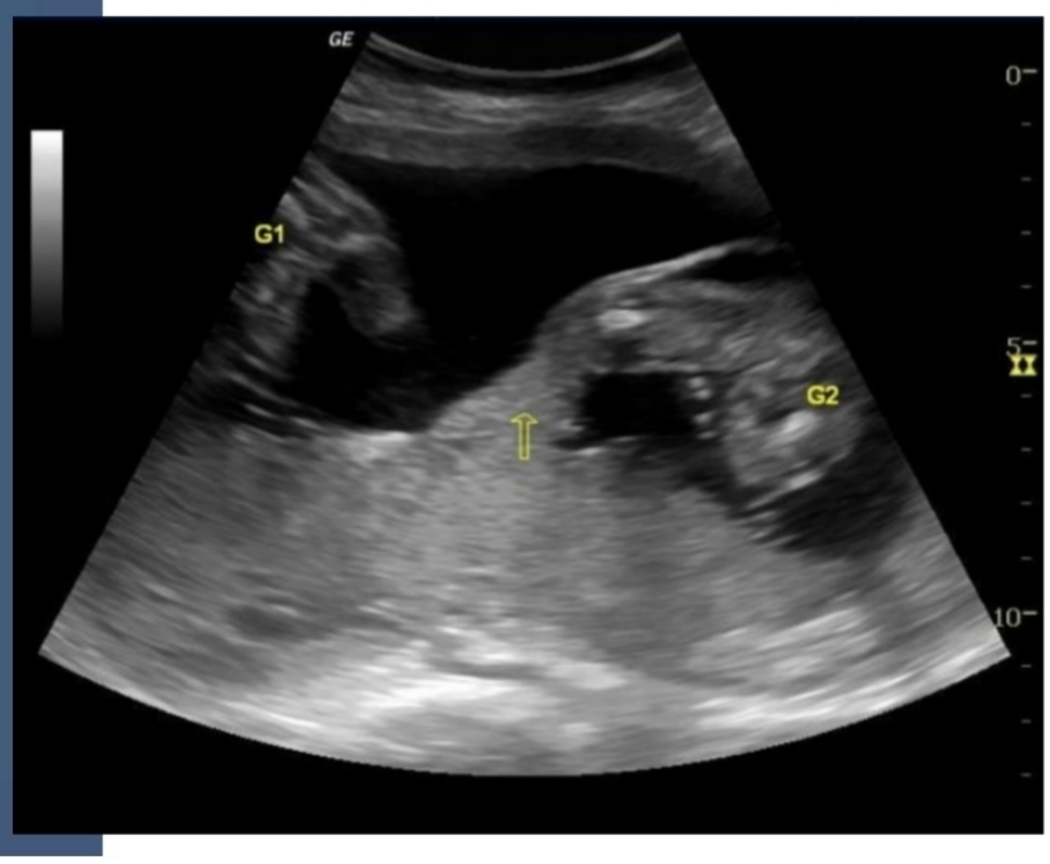
MNEMONIC

Dichorionic Diamniotic

LaDDu

» L - Lambda sign (λ)





» D - Dichorionic

D - Diamniotic