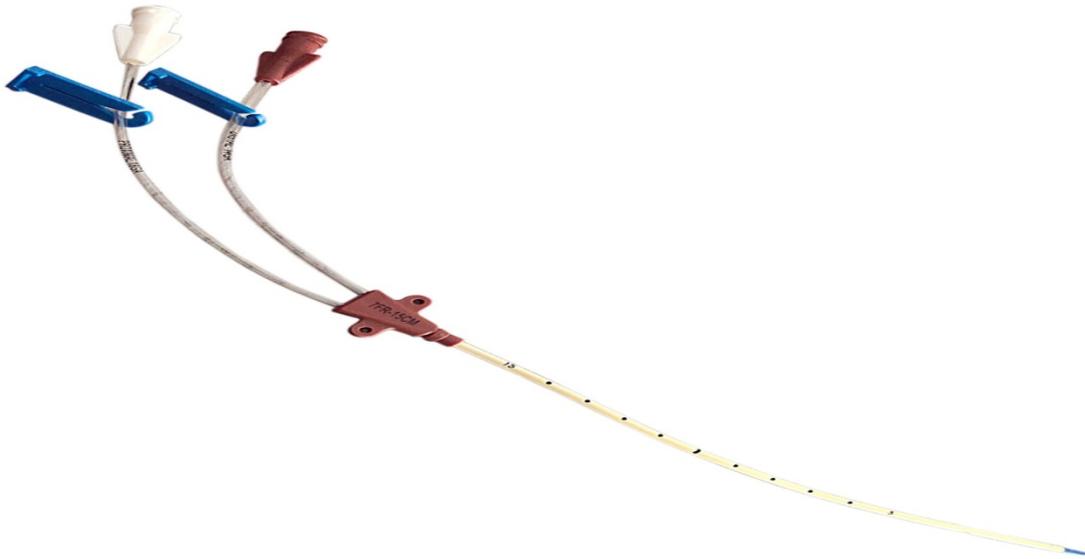


# BLOCK P OSPE STATIONS

## STATION 1



Picture of double lumen cvp line

Uses

Routes of adm

Complications =PNEUMOTHORAX,HEMOTHORAX,AIR  
EMBOLISM,HEMATOMA,THROMBOSIS,INFECTION,SEP  
SIS



Block P. 10/11/2024

Station 1) CVP → double lumen

i) Uses =

- Monitoring → Intravascular volume status
- For administration of medication

- Infusion of fluid & electrolytes

ii) Method/Route =

- IVP (Internal Jugular vein)

- Subclavian vein

- Femoral vein

- External Jugular vein

iii)

## Station 2

Folley's catheter

Indications

Complications

How would you know if its entered bladder?

What will you do in case of any obstruction?



ANSWER

Foley Catheter

Uses:

Urinary retention

Monitoring urine output

Post-surgical drainage

Bladder irrigation

Managing incontinence

Complications:

Infection (UTI)

Hematuria

Urethral injury

Bladder spasms

Catheter blockage

Confirmation of Location:

Urine flow in the catheter

Gentle aspiration of urine

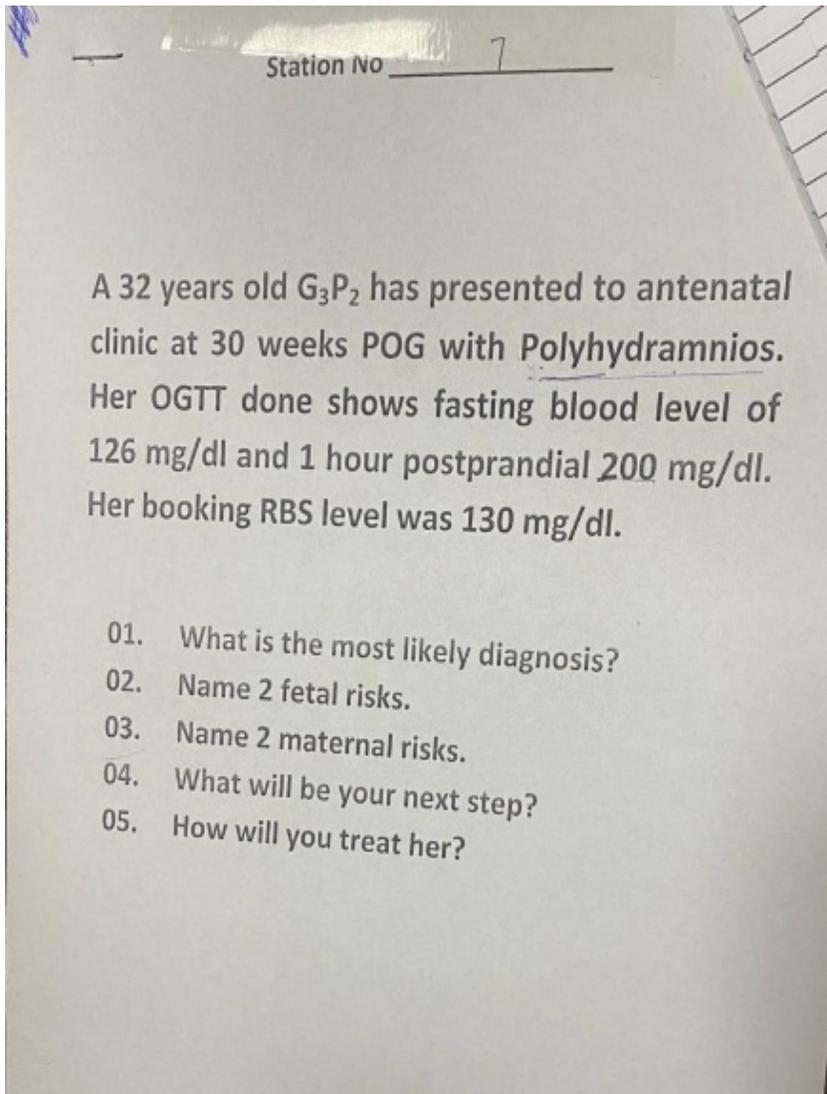
Bladder ultrasound (if needed)



X-ray (in case of doubt)

IN CASE OF OSTRUCTION

SUPRAPUBIC CATHETERIZATION



Station No 7

A 32 years old G<sub>3</sub>P<sub>2</sub> has presented to antenatal clinic at 30 weeks POG with Polyhydramnios. Her OGTT done shows fasting blood level of 126 mg/dl and 1 hour postprandial 200 mg/dl. Her booking RBS level was 130 mg/dl.

01. What is the most likely diagnosis?
02. Name 2 fetal risks.
03. Name 2 maternal risks.
04. What will be your next step?
05. How will you treat her?

**Station 3**

Gestational diabetes with BP in 36 weeks, 126mmhg.

How will you treat



What is the next step in management after diagnosing GDM

Fetal complications

Maternal complications

suprapubic catheterization Test

3 = Gestational diabetes.

2 = Fetal. Miscarriage, caudal regression syndrome, ...  
Maternal risk → CAD, Nephropathy, Retinopathy, ...

: Next steps

Patient education, dietary modification, physical  
Blood glucose monitoring, Pharmacotherapy,  
monitoring, Fetal monitoring

- Tx = Dietary modification, high fiber diet,  
Insulin → two third in morning & one  
evening
- Aim for vaginal delivery at 38-39wk



## Station 4

Pregnant female with easy fatigability weakness hb of 7 g/dl with low mcv, mchc

Diagnosis

Investigation

2 maternal risk

2 fetal risk Treatment

Station No \_\_\_\_\_ State \_\_\_\_\_

A 38 years old G<sub>8</sub>P<sub>7</sub> with 28 weeks POG has presented to antenatal clinic with body aches, easy fatigability and shortness of breath. On investigation she has Hb of 7g/dl, MCV, MCH, MCHC all are decreased. ECG is normal.

01. What is the most likely diagnosis?
02. What next investigation would you order?
03. Name 2 maternal risks associated with it.
04. Name 2 fetal risks.
05. What treatment would you give?

ROLL NO: \_\_\_\_\_  
CLASS YEAR \_\_\_\_\_



Keynote Block: ①

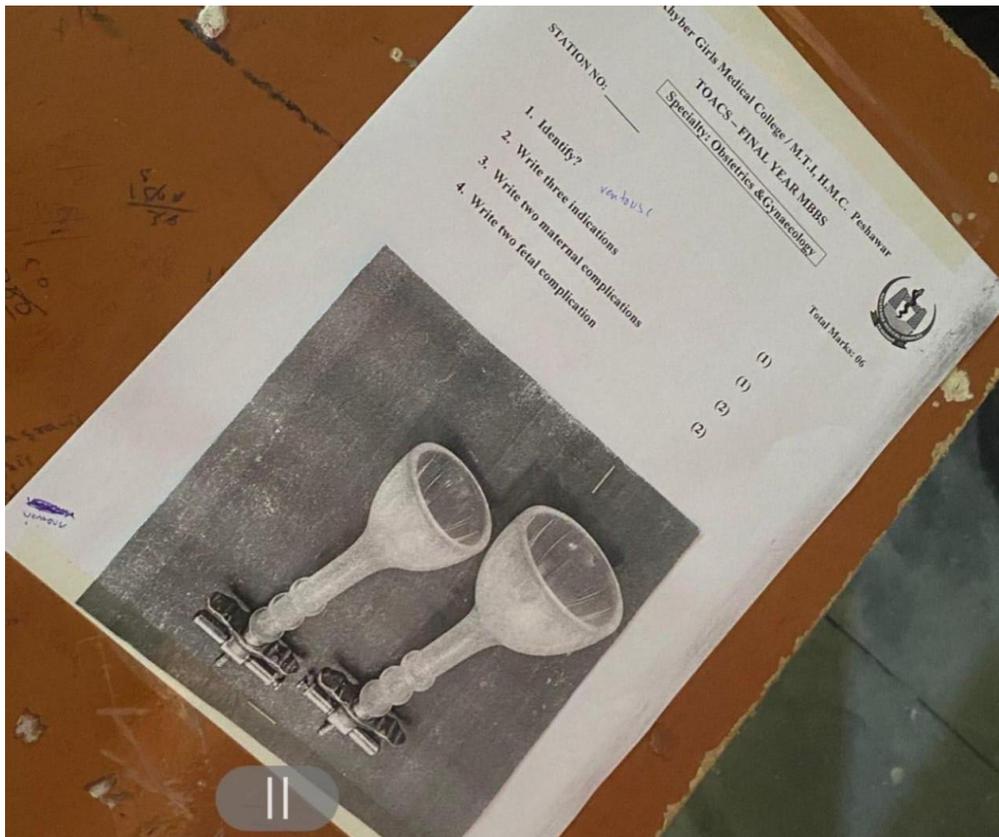
Station = 4

- 1) Iron deficiency anemia
- 2) Lab: Serum Ferritin, serum
- 3) Maternal risk: Fatigue, weakness, ↑ of infection, Preterm labor
- 4) Fetal risk/comp. IUGR, Preterm birth, Neurodevelopment
- 5) Tx: IV Iron therapy (Ferric carboxymaltose or 12)

Station 5



Edit with WPS Office



## Vacuum Extraction

### Indications:

Prolonged second stage

Fetal distress

Maternal exhaustion

### Maternal Complications:

Perineal trauma

Postpartum hemorrhage

### Fetal Complications:



# Cephalohematoma

## Skullfracture

### Station 8

Nephrotic syndrome in child 5 years old

Nephrotic Syndrome in Children

Definition: Kidney disorder causing heavy proteinuria, hypoalbuminemia, edema, and hyperlipidemia.

Causes: Minimal change disease (most common), FSGS, membranous nephropathy.

Symptoms: Generalized edema, frothy urine, fatigue, infections.

Diagnosis: Urinalysis (proteinuria  $>3.5$  g/day), serum albumin  $<2.5$  g/dL, hyperlipidemia.

Complications: Infections, thrombosis, hypovolemia, AKI.

Treatment: Corticosteroids (prednisolone first-line), diuretics, salt restriction, immunosuppressants (if steroid-resistant).



## Station 9

Thyroid viva

Thyroid Important Points

Hormones: T3 (triiodothyronine), T4 (thyroxine),  
Calcitonin

Functions: Metabolism regulation, growth,  
temperature control

Disorders:

Hypothyroidism: Fatigue, weight gain, cold intolerance  
(Common cause: Hashimoto's thyroiditis)

Hyperthyroidism: Weight loss, heat intolerance,  
tachycardia (Common cause: Graves' disease)

Investigations: TSH, Free T3, Free T4, Thyroid  
ultrasound, FNAC for nodules

Complications: Myxedema coma (severe  
hypothyroidism), Thyroid storm (severe  
hyperthyroidism)

Treatment:

Hypothyroidism: Levothyroxine

Hyperthyroidism: Antithyroid drugs (Methimazole,  
PTU), Beta-blockers, RAI therapy, Surgery



## Station 12

Labour viva

-Define labour

-Signs of labour

-define partogram

-time duration of labour in primigravida and multigravida

ANSWER

Process of painful ,regular uterine contractions leading to cervical dilation and effacement that ultimately lead expulsion of fetus And placenta

Labor

Process of regular painful uterine contractions leading to cervical dilation and effacement that ultimately lead expulsion of fetus and placenta

Signs of Labor

True Labor Signs:



Regular, painful uterine contractions  
Progressive cervical dilation and effacement  
Show (blood-tinged mucus discharge)  
Rupture of membranes (water breaking)  
Fetal descent

False Labor Signs:

Irregular, mild contractions  
No cervical changes  
Contractions relieved by rest or hydration

Partogram

Graphical representation of labor progress, monitoring cervical dilation, fetal descent, and maternal-fetal well-being.

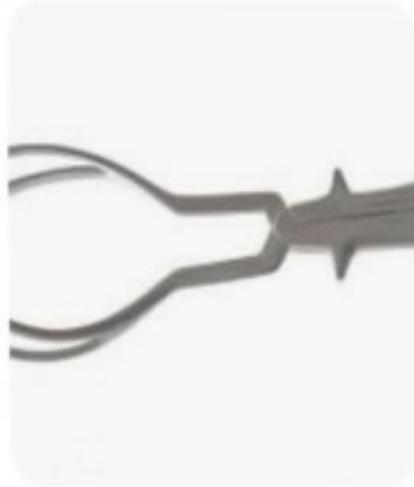
Time Duration of Labor

Primigravida: 12 hours

Multigravida: 8 hours

STATION 13

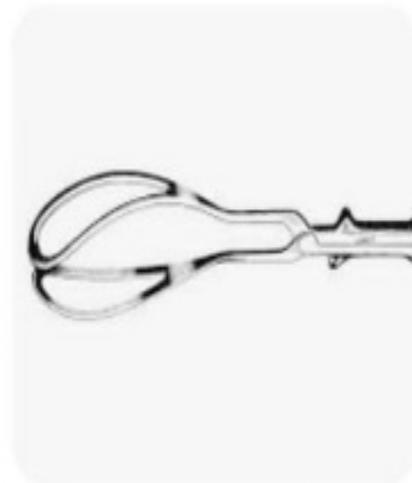




Teleflex Incorporated - Pilling ...



SIMPSON Obstetrical Forceps



Forceps delivery

Name the instrument

3 Indication

3 contraindications

How it is used in vaginal delivery



13 = a) Forcep

b) Indication =

- Prolonged 2<sup>nd</sup> stage
- After coming head of
- Face presentation
- > 36 wks
- Maternal push avoid

13 = contraindication

- Head not fully engaged
- Cervix full not dilation
- CPD

station -

## Station 14





Station -

14 = DCTG

2) Heart Rate 150

2) Baseline line variability

3) No Acceleration

3) No deceleration

4) - corrective step. 1) Mat

2) Oxygen

3) Hydration

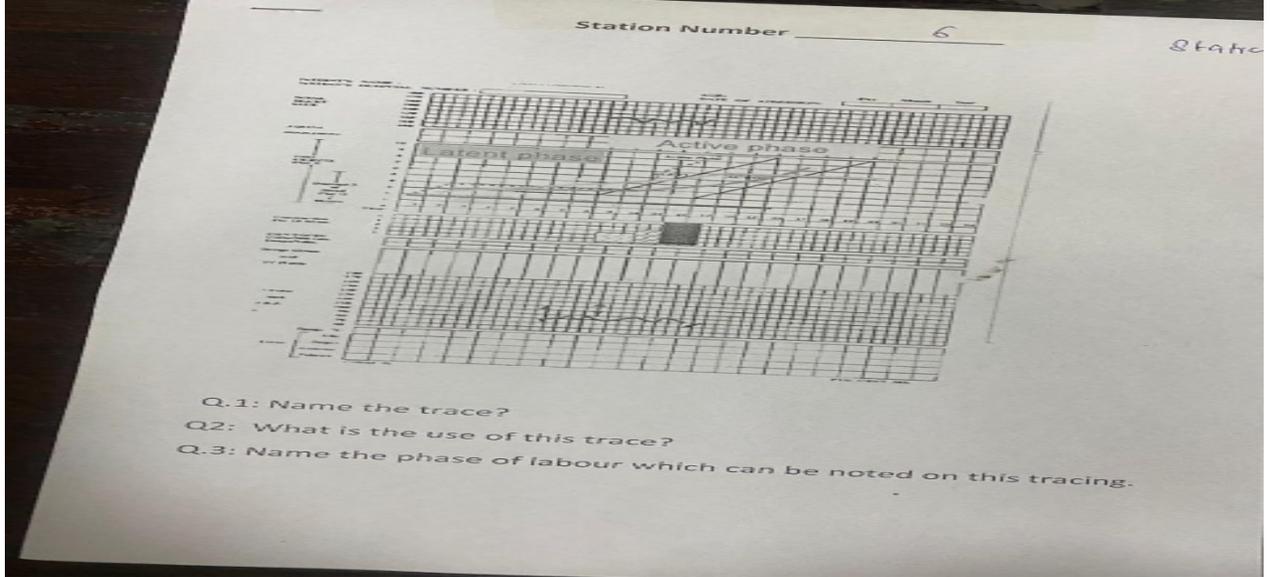
4) Assess

(15) a) Partogram

b) = graphical tool used during  
the

## STATION 15





a) Partogram  
b) graphical tool used during labour to monitor & document the process of childbirth  
c) First stage of labour (latent phase)

1) Cervical dilatation  
2) Hydroamnion  
3) Assess

## Station 16



Station No.



(A)

(B)

1. Enlist only two findings in the given pictures. (2)
2. Enumerate any 4 investigations to confirm the diagnosis? (2)
3. What is your probable diagnosis? (2)

165 95 (Prognathism) (enlarged jaw), enlarge nose  
Thickened lips, coarse feature

- B. Enlarge 4<sup>th</sup> finger
- Thickened

b) Serum Growth hormone level 1) OGTT

3) Serum insulin like growth factor-1 3) Pituitary magmf (

c) Acromegaly



## Station 17

Station 17. a) DKA

b) - urgent investigation

- serum glucose level
- serum ketone
- ABCs

- Serum el.
- urine dipst
- RFTs.

c) Tx:

Fluid resuscitation → start with 0.9% NS.

2) IV insulin

3) Electrolyte correction (Potassium)

3) Bicarbonate therapy

children = 18



## Block P

### 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.

## Station 18

- 3) Electrolyte correction (Potassium)
- 3) Bicarbonate therapy

Station 18

- 1) Preeclampsia
- 2) - 3 symptoms →
  - Severe headache
  - RUQ pain
  - Visual disturbance
- 3) Signs: Hyperreflexia, clonus, Pulmonary edema, severe oliguria or Anuria
- 4) High depend unit or ICU
- 5) - Risk: severe preeclampsia → more chances of recurrence.
  - Early onset preeclampsia (< 34wk)
  - Chronic HTN
  - Multiple pregnancies
  - Obesity
  - Family history



Station Number 10

STATIC

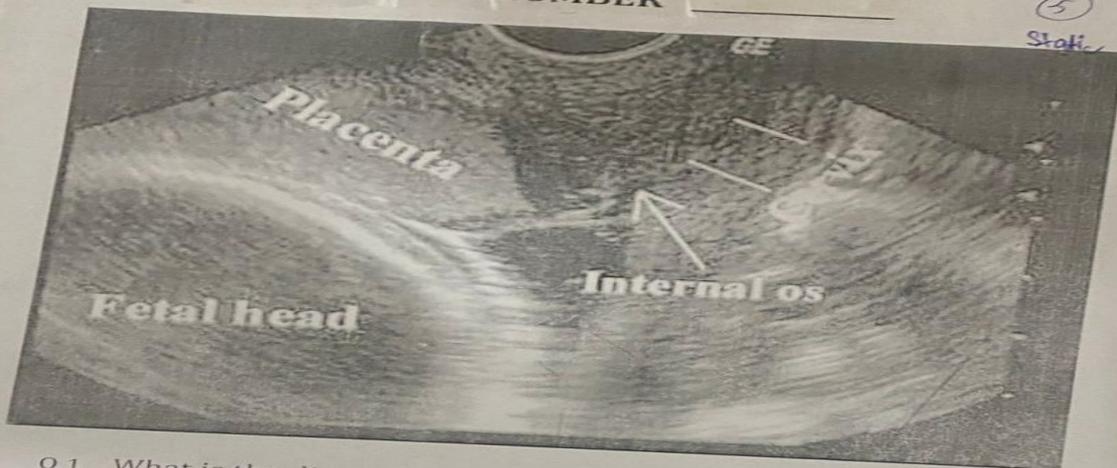
A 30 years old primigravida has presented to labour room at 32 weeks of gestation. She is complaining of headache and blurring of vision. On general physical examination she has B.P of 150/100 mmHg. Her booking B.P was 110/70 mmHg. On urinalysis she has +2 proteinuria.

- Q 1. What is the diagnosis?
- Q 2. Name 3 symptoms of imminent eclampsia?
- Q 3. Name 2 signs of imminent eclampsia?
- Q 4. Where would you manage her?
- Q 5. What is the risk of recurrence in next pregnancy?

**Station 19**



Edit with WPS Office



- Q 1. What is the diagnosis?
- Q 2. How will you diagnose it?
- Q 3. What would be the mode of delivery in this case?
- Q 4. What serious condition would you anticipate if she has previous 3 C/S?

- 1) ~~transvaginal USG~~
- 1) = 1) Diagnosis . Placenta previa
- 2) = Transvaginal USG + clinical symp
- 3) = C-section
- 4) = complication. Placenta accreta spectrum  
Massive hemorrhage

## Station 20

Types of breach delivery

Maternal causes

Fetal causes

Complications

Modes of delivery

ANSWER

Breech Presentation

Types: Frank

Complete

Footling

Causes:

Prematurity

Uterine anomalies

Polyhydramnios



Placenta previa

Complications:

Cord prolapse

Birth asphyxia

Head entrapment

Management: ECV Vaginal delivery (selected cases) C-section (common)

Contraception – Important Key Points

1. Natural Methods

Withdrawal (Coitus Interruptus) – High failure rate

Lactational Amenorrhea – Effective for 6 months postpartum if exclusive breastfeeding

Fertility Awareness – Tracking ovulation (temperature, cervical mucus, calendar)



## 2. Barrier Methods

Male Condom – Protects against STIs, moderate failure rate

Female Condom – Less effective than male condom

Diaphragm/Cervical Cap – Requires spermicide, fitted by a doctor

## 3. Hormonal Methods

Combined Oral Contraceptives (COCs) – Inhibits ovulation, regulates cycles, risk of thromboembolism

Progestin-Only Pills (POPs) – Safe in breastfeeding, irregular bleeding

Injectables (Depo-Provera) – Given every 3 months, may cause weight gain



Implants (Nexplanon) – Effective for 3–5 years, irregular bleeding

Transdermal Patch – Weekly application, increased risk of clots

Vaginal Ring (NuvaRing) – Monthly use, similar to COCs

#### 4. Intrauterine Devices (IUDs)

Copper IUD (Paragard) – Effective for 10 years, non-hormonal, risk of heavy bleeding

Hormonal IUDs (Mirena, Kyleena) – Effective for 3–8 years, reduces menstrual bleeding

#### 5. Emergency Contraception (ECPs)



Levonorgestrel (Plan B) – Within 72 hours

Ulipristal Acetate (Ella) – Within 5 days

Copper IUD – Most effective, can be inserted within 5 days

## 6. Permanent Methods

Female Sterilization (Tubal Ligation, Salpingectomy) – Permanent, irreversible

Male Sterilization (Vasectomy) – Permanent, requires post-procedure semen analysis

## 7. Contraception Failure Rates (Typical Use)

Highly Effective: Implants, IUDs, Sterilization (<1%)



Moderately Effective: OCPs, Injectables, Patch, Ring  
(6-9%)

Less Effective: Condoms, Withdrawal, Natural Methods  
(12-22%)

**Block P day 2**

**Station 1**



Edit with WPS Office

A 28 week pregnant lady visited for antenatal checkup following were the findings on urine RE

Protein nil

Rbc nil

Glucose +++

Pus cells 1-2

Ketones nil

1) what are the findings in this urine RE

2) what further investigations to be done

3) if results are abnormal what treatment to be given

4) what complications it causes in late pregnancy.

Findings in Urine Routine Examination (RE):

Protein: NIL (No proteinuria, ruling out preeclampsia)

RBC: NIL (No hematuria)

Glucose: Positive (Suggestive of gestational diabetes mellitus (GDM))

Pus Cells: 1-2/HPF (Normal, no significant infection)

Ketones: NIL (No ketosis, ruling out starvation or diabetic ketoacidosis)

Further Investigations:



**Oral Glucose Tolerance Test (OGTT) – To confirm gestational diabetes**

**Fasting Blood Sugar (FBS) & Postprandial Blood Sugar (PPBS) – To assess glucose levels**

**HbA1c – To check long-term glucose control**

**Urine Culture – If UTI is suspected despite normal pus cells**

**Renal Function Tests (RFTs) – If suspected kidney involvement**

**Treatment if GDM is Confirmed:**

**Diet & Lifestyle Modification – Low glycemic diet, exercise**

**Blood Sugar Monitoring – Regular self-monitoring of glucose**

**Medical Therapy:**

**First-line: Insulin (if glucose is uncontrolled with diet)**

**Metformin/Glibenclamide (used selectively in some cases)**

**Complications in Late Pregnancy Due to Uncontrolled GDM:**



**Maternal:**

Increased risk of preeclampsia

Polyhydramnios

Increased risk of infections (UTI, candidiasis)

Higher chance of cesarean delivery

**Fetal:**

Macrosomia (leading to birth trauma, shoulder dystocia)

Neonatal hypoglycemia

Respiratory distress syndrome (RDS)

Increased risk of stillbirth

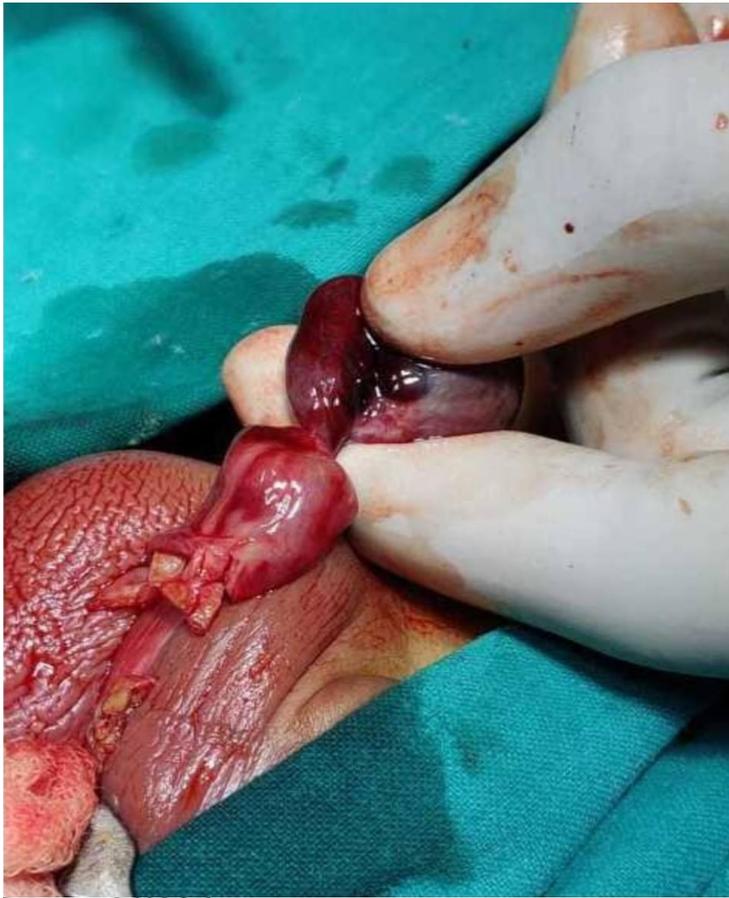
## **Station 2**

Testicular torsion

Diagnosis

Treatment





2. a) Testicular torsion

b) Diagnosis: • clinical

• Doppler USG

• In doubtful case → Exploratory laparotomy within 6hr

ation = (4) a) Preterm labour

b = 4 Fetal or Neonatal

Prematurity, Neonatal sepsis, RDS.

c) - TX:

Surgical Exploration

if testis nonviable

→ orchidectomy

viable → orchidopexy

• Normal testis →

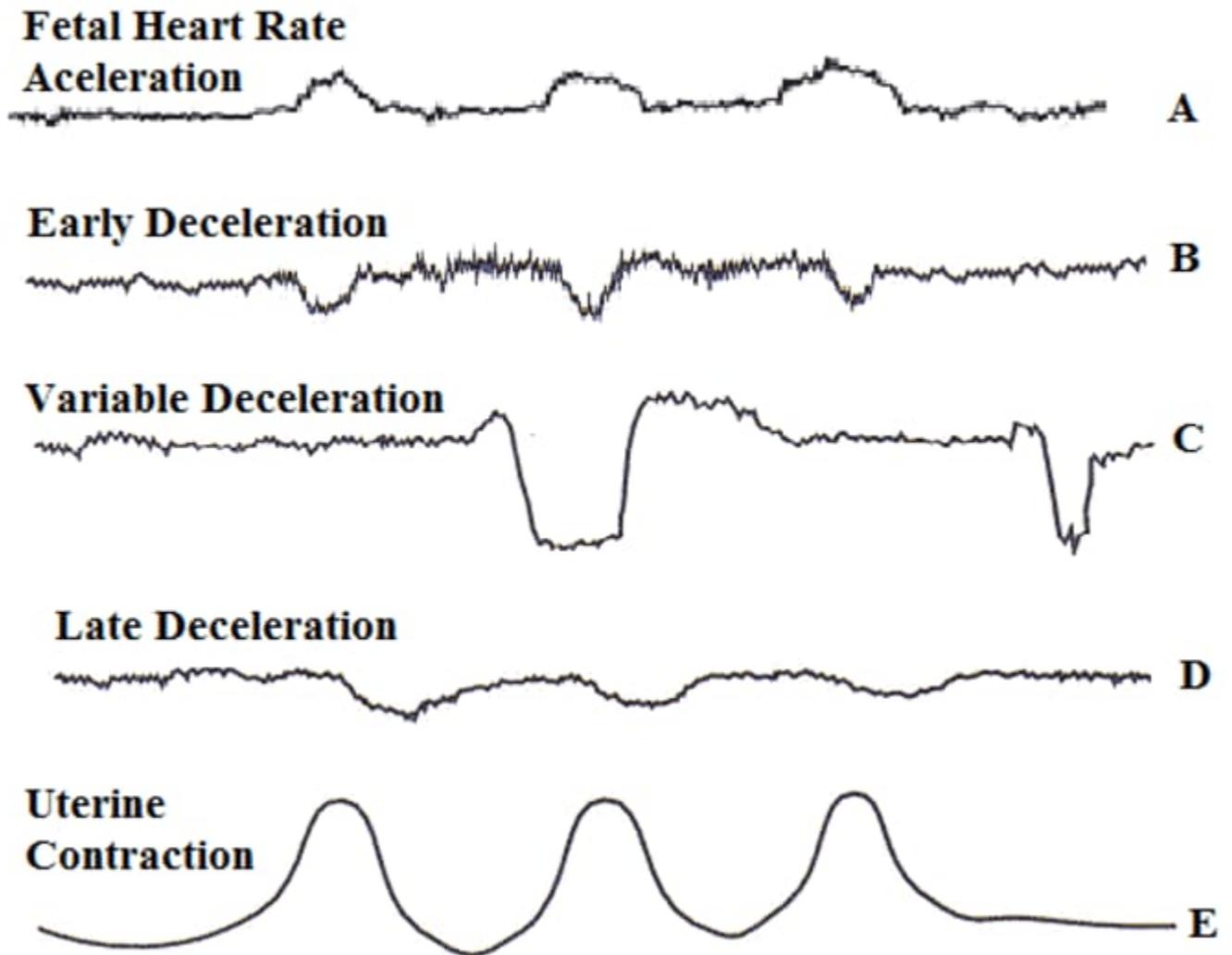
orchidopexy - bcz

risk



### Station 3

Identify the graph, different components of graph, abnormality in graph, different causes of abnormalities.  
( Question was of CTG)



Abnormal CTG Findings



## 1. Baseline

Tachycardia ( $>160$  bpm) → Infection, hypoxia, anemia.

Bradycardia ( $<110$  bpm) → Cord compression, hypoxia, heart block.

## 2. Variability

Reduced ( $<5$  bpm) → Hypoxia, acidosis, CNS depression.

Increased ( $>25$  bpm) → Fetal distress, cord compression.

## 3. Decelerations

Early → Head compression (benign).

Late → Placental insufficiency, hypoxia.

Variable → Cord compression.

Prolonged ( $>2$  min) → Severe hypoxia, cord prolapse.

## 4. Sinusoidal Pattern

Wave-like FHR → Severe fetal anemia, hypoxia.



## Interpretation

Reassuring: Normal baseline, variability, no late/prolonged decels.

Non-reassuring: Tachy/bradycardia, reduced variability, late decels.

Abnormal: Sinusoidal pattern.

## Station 4

G3p1 30-week gestation, regular uterine, cervix, 2 cm dilated, no vaginal bleeding or rupture.

What is diagnosis

4 fetal OR neonatal complications

drugs to stop delivery.

## Answers

### Diagnosis

Preterm labor (30 weeks, regular contractions, cervical dilation).

### 4 Fetal/Neonatal Complications



Respiratory distress syndrome (RDS) (due to surfactant deficiency).

Intraventricular hemorrhage (IVH) (fragile brain vasculature).

Necrotizing enterocolitis (NEC) (intestinal immaturity).

Hypothermia and hypoglycemia (due to immature metabolism).

Drugs to Stop Delivery (Tocolytics)

Nifedipine (Calcium channel blocker).

Indomethacin (NSAID, prostaglandin inhibitor).

Terbutaline (Beta-agonist).

Atosiban (Oxytocin receptor antagonist).

## Station 5

A woman G3p1+1 presents in labor room at 32 weeks gestation with sudden gush of fluid per vagina three hours back.

What is the diagnosis?

Give two differential diagnosis?

give two investigations? Write down the drugs to reduce risk of respiratory distress syndrome.



Station (5) a) PPRM: → UTIs, leucorrhoea

DD: b) = urinary incontinence, normal vaginal secretions  
• vaginal infection

c) = sterile speculum Ex → Pooling +ve  
ds corticosteroids, MgSO<sub>4</sub>

## Station 6

Collapse after vaginal delivery.

Give 6 Differential diagnosis



CULTURE,

- DID • PPH Hypovolemic shock
- Sepsis • Orthostatic Hypotension
- Vasovagal syncope • Eclampsia
- Pulmonary embolus
- Hyperkalemia, AFLP
- Neurogenic shock



## Station 7

Diabetic foot examination

## Station 8

Picture of child with muscle wasting and abdominal distention

What are 2 features in this child

Diagnosis

1 differential diagnosis

Station - 8 :

a) Muscle wasting, A

b) Diagnosis = Kwashiorkor

c) DID =  
• Nephrotic  
• Cirrhosis  
• CHF  
• Cancer & etc



## STATION

Label dimensions?

Diameter which negotiate  
during normal labour?

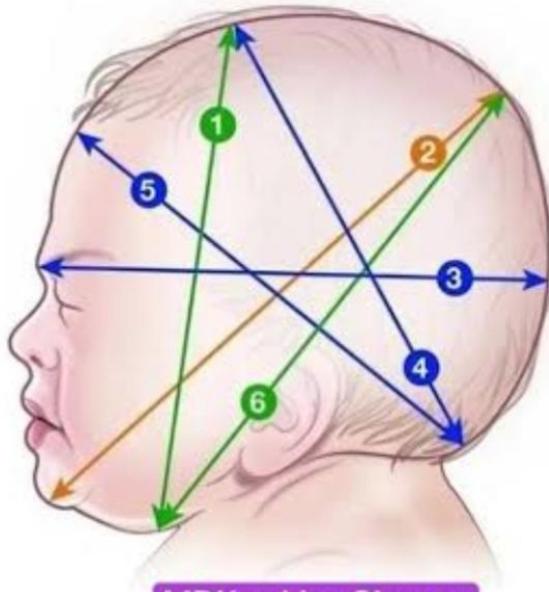
Station 9. at Different dimensions

b) Diameter which negotiate during normal

- Biparietal diameter
- Occipitofrontal diameter



## Fetal skull dimensions



MDKcp Live Classes

	Engaging diameter	Length	Presentation
1	Submentobregmatic	9.5cm	Face
2	Mentovertebral	14cm	Brow
3	Occipitofrontal	11.5cm	Vertex
4	Suboccipitobregmatic	9.5cm	Vertex
5	Suboccipitofrontal	10cm	Vertex
6	Submentovertical	11.5cm	Face

## Station 10





Identify this instrument

What drugs are delivered through this?

What are the complications?

station

a) = Insulin syringe

b) = Drug give by this

1) insulin      2) liraglutide, se

3) growth Hormone      4) HCG

5) Vitam B12      6) cor

c) complication:

- infection
- Insulin lipodystrophy
- Need stick injury
- Hyperglycemia or hypoglycemia
- Needle damage



## Station 11

Logbook - gyne

Ask questions related to the history of the case recorded in the logbook (pre eclampsia)

## Station 12

Partogram component

Components of Partogram

1. Maternal Monitoring:

Temperature

Pulse, BP

Urine output (Protein, Glucose, Ketones)

2. Fetal Monitoring:



**Fetal Heart Rate (FHR)**

**Amniotic fluid (Clear, Meconium-stained, Absent)**

**3. Labor Progress:**

**Cervical dilation (Alert & Action lines)**

**Fetal head descent**

**Uterine contractions (Frequency, Duration, Intensity)**

**causes of labour arrest**



Needle stick injury

Needle damage

Station 12

Labour arrest. Big baby, CPD, Uterine dys  
Secondary uterine infection, deep

### Station 13

Observing station (Viva)



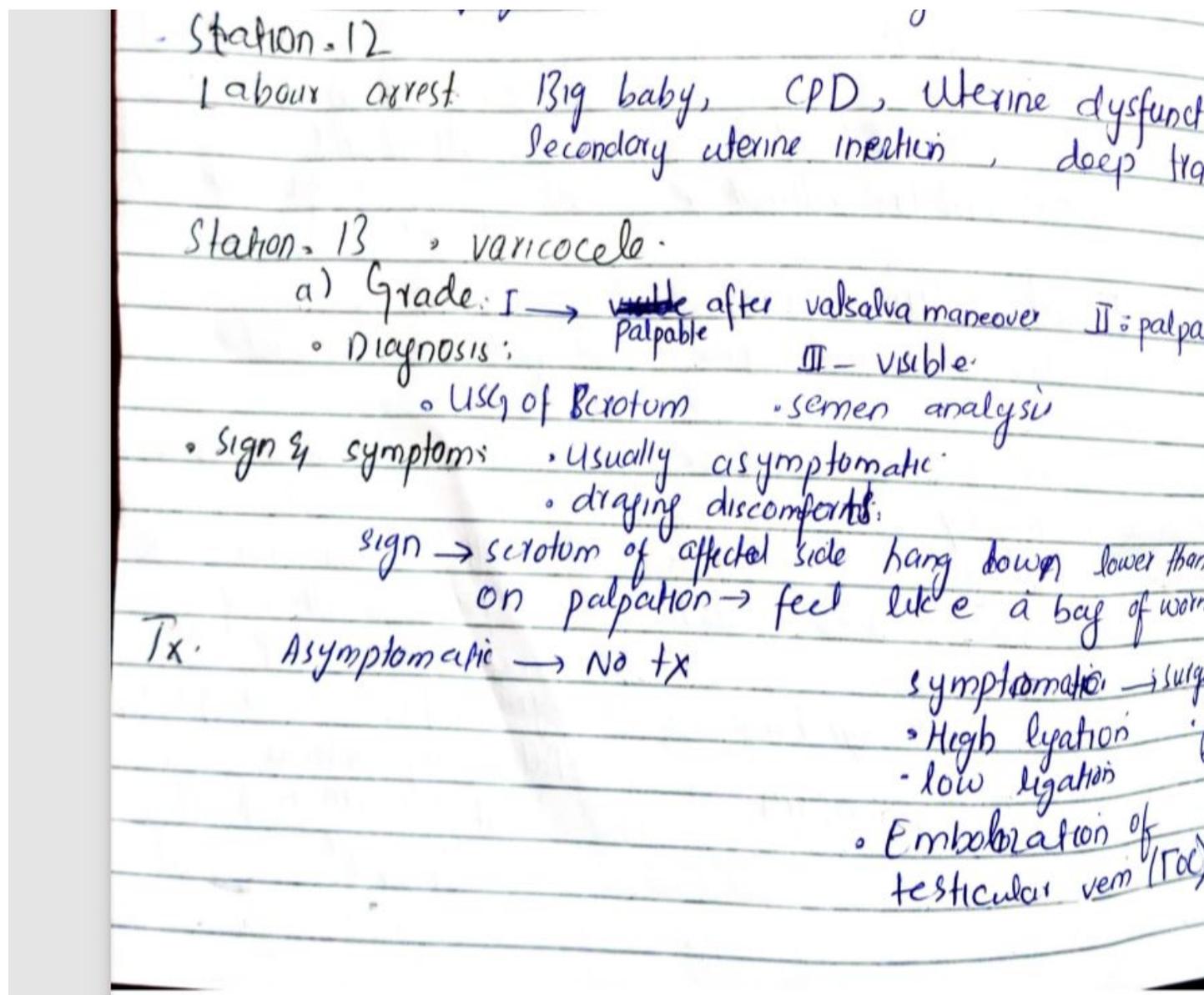
Picture of varicocele

Its grades

Its diagnosis

Signs and symptoms

Treatment options



## Station14

Urology station .....xray of renal tumour identify it first name some renal tumours( renal cell carcinoma , wilms tumour ) ,

name of the surgery (radical nephrectomy and partial )

Surgical approach= OPEN ,LAPROSCOPIC ,ROBOTIC ASSISTED SURGERY

COMmplications of this surgery= Complications of Kidney Tumor Surgery (Nephrectomy for RCC)

### 1. Intraoperative Complications:

Bleeding/Hemorrhage – Due to rich renal vasculature

Injury to Adjacent Organs – Liver, spleen, pancreas, bowel, adrenal gland

Major Vessel Injury – Inferior vena cava (IVC), renal vein thrombosis



**Air Embolism – Rare but possible in laparoscopic surgery**

## **2. Early Postoperative Complications:**

**Infection – Wound infection, urinary tract infection (UTI), pneumonia**

**Acute Kidney Injury (AKI) – Due to reduced renal function**

**Urine Leak/Fistula – After partial nephrectomy**

**Deep Vein Thrombosis (DVT) & Pulmonary Embolism (PE) – Due to prolonged immobilization**

**Adrenal Insufficiency – If adrenal gland is removed**

## **3. Late Complications:**

**Chronic Kidney Disease (CKD) – Due to reduced nephron mass**

**Hypertension – Due to altered renal perfusion and hormonal changes**

**Hernia Formation – At the surgical site (especially in laparoscopic cases)**

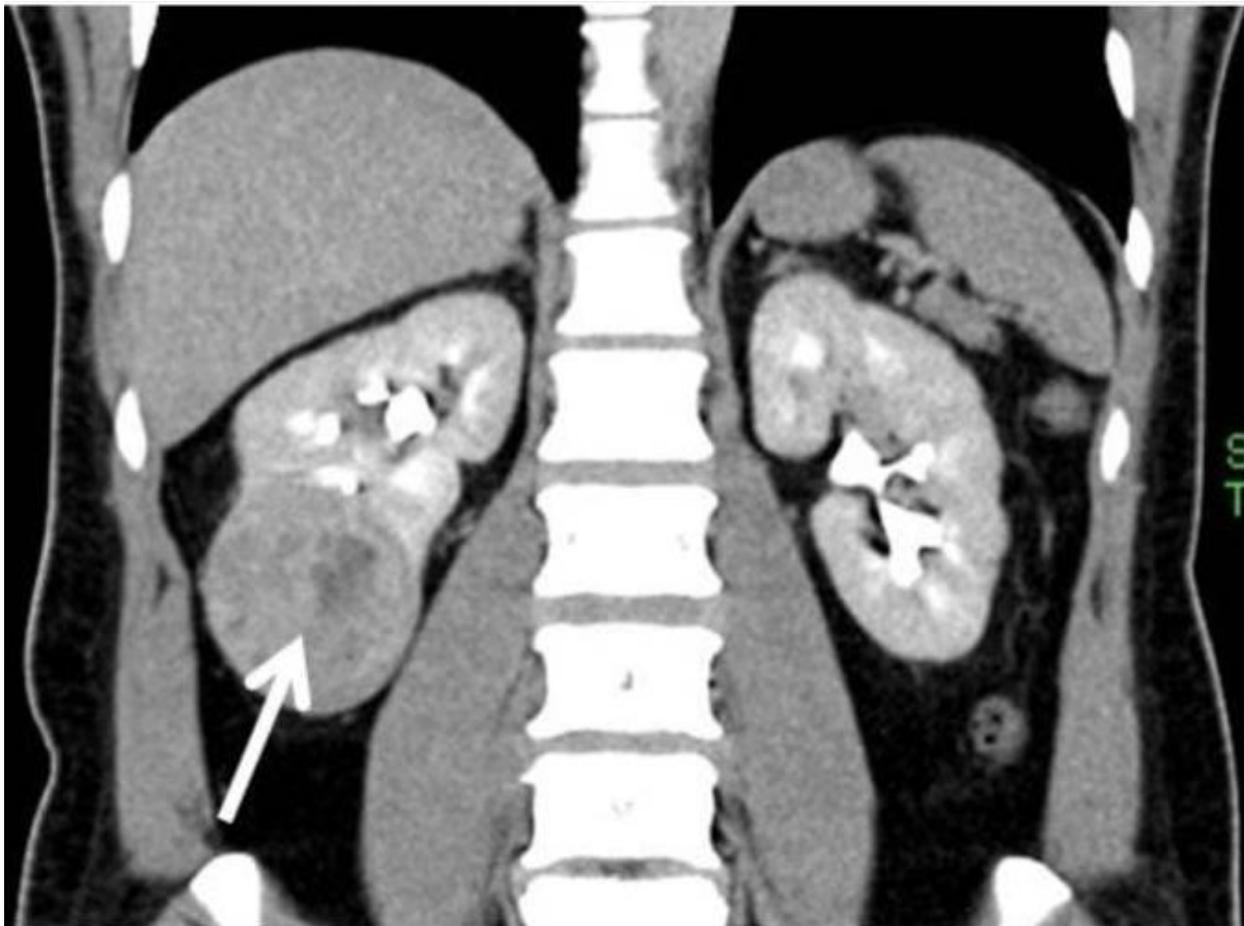
**Local Recurrence or Metastasis – If tumor was not fully excised**



#### 4. Functional & Quality of Life Issues:

Proteinuria & Electrolyte Imbalance – Due to reduced kidney function

Fatigue & Anemia – Due to loss of erythropoietin production  
Psychological Impact – Anxiety and depression post-surgery



#### Station 15

Shoulder dystocia



Edit with WPS Office

Shoulder dystocia is a vaginal cephalic delivery that requires additional ops maneuvers to deliver fetus after head has delivered and genital traction has been unsuccessful in delivering shoulders.

Causes

Treatment

Causes of Shoulder Dystocia:

Fetal macrosomia

Maternal diabetes

Prolonged second stage of labor

Obesity

Post-term pregnancy

Operative vaginal delivery (forceps/vacuum)

Treatment

McRoberts maneuver – Hip flexion & abduction

Suprapubic pressure – Push fetal shoulder downward

Rubin maneuver – Rotate anterior shoulder

Wood's screw maneuver – Rotate posterior shoulder



**Gaskin maneuver – Maternal all-fours position**

**Zavanelli maneuver – Cephalic replacement & C-section (last resort)**

**Clavicle fracture – Deliberate to reduce shoulder width (rare)**



# Shoulder Dystocia Interventions "HELPER"

- H** Call for Help!
- E**valuate for episiotomy
- L**egs (McRoberts maneuver)
- P**ressure (suprapubic)
- E**nter maneuvers
- R**emove posterior arm
- R**oll the client

[archerreview.com](http://archerreview.com)

Station 16



Edit with WPS Office

Nephritic syndrome

Causes

Reason of headache

Diagnosis

Treatment

Nephritic Syndrome - Short Answers

Causes

Post-streptococcal glomerulonephritis (PSGN).

IgA nephropathy (Berger's disease).

Lupus nephritis.

Membranoproliferative glomerulonephritis.

Rapidly progressive glomerulonephritis (RPGN).

Reason for Headache

Hypertension (due to fluid retention and decreased renal function).

Diagnosis

Urinalysis: Hematuria, RBC casts, mild proteinuria.

Blood tests: Elevated creatinine, low GFR, increased ASO titer (if PSGN).



Renal biopsy: If uncertain diagnosis.

Treatment

Blood pressure control: ACE inhibitors, ARBs.

Fluid & salt restriction.

Diuretics (if edema/hypertension).

Corticosteroids (if immune-mediated cause).

Antibiotics (if PSGN with ongoing infection).

## Station17

Nephrotic syndrome

Causes

Investigations

Treatment

Nephrotic Syndrome – Key Points

Definition: Heavy proteinuria  $>3.5\text{g/day}$ , hypoalbuminemia, edema, hyperlipidemia



**Causes:** Minimal Change Disease, FSGS, Membranous Nephropathy, Diabetes, Lupus

**Symptoms:** Generalized edema, frothy urine, fatigue, infections

**Complications:** Infections, Thrombosis, AKI, Hyperlipidemia, Malnutrition

**Diagnosis:** Urinalysis (proteinuria), Serum albumin, Lipid profile, Renal biopsy

**Treatment:** Steroids (Prednisolone), Diuretics, ACE inhibitors, Statins, Immunosuppressants (if resistant)

### **Station 18**

Eclamptic pt collapse with in 2 hr after delivery. Write the general measures.



Station = 18

⇒ ABC, IV line pass

1) Mx = IV MgSO<sub>4</sub>

• IV labetalol or hydralazine

• IV fluid

• Anticoagulation (cf PPH)

• Antibiotic, PPH —

• Pain relief → IV p

## Station 19

At 32 weeks came to hospital for her antenatal checkup



What investigations would you suggest for her during first trimester

When should first anomaly scan be done

When should fetal length ultrasound should be done in high risk pregnancy

### First Trimester Investigations

Blood tests: CBC, blood group & Rh, random blood sugar, thyroid function tests.

Infections: HIV, HBsAg, VDRL, Rubella, TORCH screen (if indicated).

Urine analysis: Routine & culture.

Ultrasound: Dating scan (6–10 weeks), nuchal translucency (11–14 weeks).

Genetic screening: PAPP-A,  $\beta$ -hCG (for Down syndrome screening).

### First Anomaly Scan

Done at 18–22 weeks (mid-trimester anomaly scan).



## Fetal Length Ultrasound in High-Risk Pregnant

Performed in 2nd and 3rd trimesters to monitor fetal growth (28, 32, 36 weeks).

More frequent in IUGR, hypertension, diabetes, multiple gestation cases.

Day 3

### Station 1

peads stations interactive

Scenario of Diabetes insipidus

What is your diagnosis

Causes

Treatment

Diabetes Insipidus (DI) in Pediatrics – Key Points

Types: CentralDI (ADH deficiency) NephrogenicDI (renal resistance)

Causes: Genetic Trauma Tumor Meningitis Medications (Lithium)

Symptoms: Polyuria Polydipsia Dehydration  
Poorgrowth Irritability



Diagnosis: Serum&Urineosmolality  
Waterdeprivationtest Desmopressinresponse

Treatment:

Central DI: Desmopressin (DDAVP)

Nephrogenic DI: Thiazide diuretics, Low-sodium diet,  
Indomethacin

**Station 2** –already done

Diabetic ketoacidosis scenario, questions asked

a) diagnosis

b) management

**Station 3**

My last station was of

Command to perform mechanism of labour on  
dummy...

What is 3rd stage of labour?

How placenta is delivered?

**Station 4**

36 weeks pog presented to er unconscious and



seizures bp 160/110 pulse 90/minute afebrile no A/N  
working done in past on P/A exam 34 weeks  
longitudinal cephalic fhr 140/min bishop <4 what are  
the dds and how will u manage the patient

DDx of Eclampsia:

Epilepsy – No HTN/proteinuria

HTN Encephalopathy – Severe HTN, no proteinuria

ICH – Sudden headache, focal deficits

Meningitis/Encephalitis – Fever, neck stiffness

Metabolic (Hypoglycemia, Hyponatremia) – Seizures,  
altered sensorium

CVT – Headache, papilledema

Drug/Toxin-Induced Seizures – H/o substance use

Management:

ABC, Left lateral, Oxygen

Seizure: MgSO<sub>4</sub>, Diazepam (if needed)

BP: Labetalol, Hydralazine, Nifedipine

Investigations: CBC, LFT, RFT, Coagulation, Urine  
protein

Fluids: Monitor urine, prevent overload



**Delivery: Stabilize, expedite if indicated**

**Postpartum: Monitor BP, urine output, neuro status**

## **Station 8**

### **Breech delivery per vaginal maneuvers**

#### **Breech Delivery Maneuvers**

##### **1. Assisted Breech Delivery (Controlled Assistance)**

**Lovset's Maneuver – Rotate shoulders 180° to deliver arms**

**Mauriceau-Smellie-Veit Maneuver – Support head using fingers in baby's mouth while applying suprapubic pressure**

**Burns-Marshall Maneuver – Allow baby to hang until occiput appears, then flex head for delivery**

**Piper's Forceps – Used to deliver the aftercoming head in difficult cases**

##### **2. Spontaneous Breech Delivery**



No manual assistance, baby delivers naturally with maternal effort

### 3. Total Breech Extraction

Used in emergencies, especially for second twin

Entire fetus is extracted manually

### 4. Emergency Maneuvers

Zavanelli Maneuver – Reinsert fetus into uterus for C-section (last resort)

Duhrssen's Incisions – Cervical incisions for head entrapment

## Station 11

4 year boy with no increase or decrease with pulsations **hydrocele** investigation diagnosis treatment 2 surgical procedures complication of surgery



# Hydrocele

## Investigations:

Clinical Examination – Transillumination test (+ve)

Ultrasound (USG) Scrotum – Differentiate from hernia, tumor, or infection

## Treatment:

Conservative: Observation (if small & asymptomatic)

Aspiration + Sclerotherapy: Temporary relief, high recurrence

## Surgical Procedures:

Hydrocelectomy (Definitive Treatment)

Jaboulay's Procedure – Eversion of tunica vaginalis

Lord's Procedure – Plication of tunica vaginalis (for smaller hydroceles)

Winckelmann's Procedure – Folding tunica vaginalis behind testis

## Complications of Surgery:



Hematoma

Infection

Recurrence

Injury to testis/spermatic cord

Chronic pain

## **Station 12**

Three instruments 2 implications each





**ARTERY FORCEPS:** it is of different sizes (small, medium, large) and different shapes (straight, curve). The smaller version is called mosquito or sinus forceps which is used to open up the abscess cavity, breaking its loculi. Other uses of artery forceps include hemostasis, pedicular clamp for spleen and kidney, to crush the base of appendix during appendectomy etc.

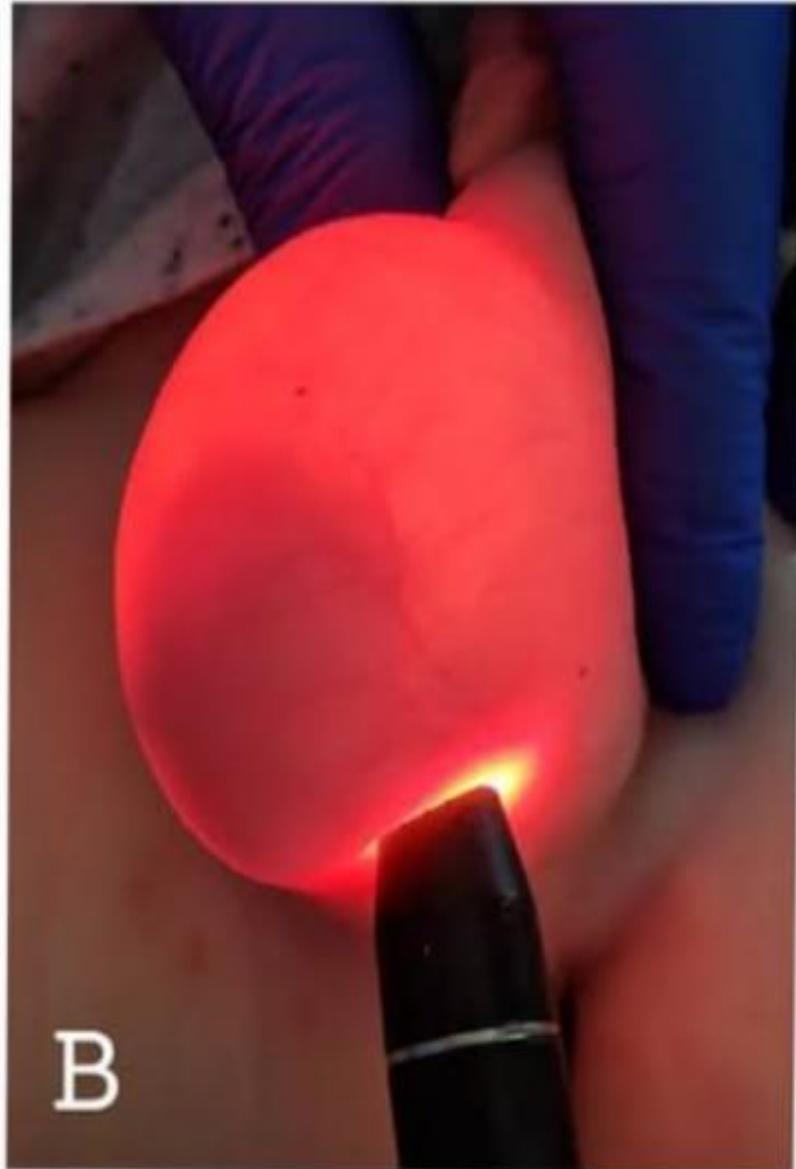


**NEEDLE HOLDER:** This instrument is used to hold the curved needles which are used to suture the parts. A firm grip is essential to apply proper sutures. Needle holder can be confused with artery forceps but it has criss cross serrations on its surface and it may have groove on its inner surface. The needle should be held with its tip at its junction of distal one third and proximal two third.

## Station 13

Elderly with mass Varicocele picture investigations  
treatment options

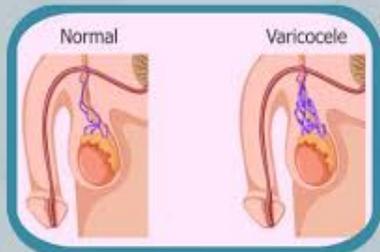




**Station 13: Elderly with Mass (Varicocele)**

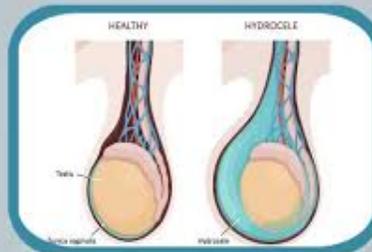


## DIFFERENCE BETWEEN VARICOCELE AND HYDROCELE



**Varicocele**

1. Enlarged veins above the testicle.
2. Faulty vein valves causing blood pooling.
3. Discomfort or pain, especially when standing.



**Hydrocele**

1. Fluid buildup around the testicle.
2. Fluid accumulation due to injury or other factors.
3. Painless swelling like a fluid-filled sac.



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### Investigations:

Clinical Examination: Bag of worms appearance,  
Valsalva maneuver

Ultrasound (USG) Scrotum with Doppler: Confirms



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dilated pampiniform plexus

Abdominal Ultrasound/CT Scan: Rule out renal tumor (especially in elderly)

Semen Analysis: Assess fertility impact

Hormonal Profile: Testosterone, FSH, LH (if infertility suspected)

Treatment Options:

Conservative: Scrotal support, NSAIDs (if asymptomatic)

Surgical:

Varicocelectomy (Open, Microsurgical, Laparoscopic)

Embolization (Percutaneous) – Alternative for high-risk patients

Treat Underlying Cause: If secondary varicocele (e.g., renal tumor)

## Station 14

Moon face striae diagnosis and 2 investigations



## Cushing Syndrome –

### Causes:

Exogenous: Prolonged steroid use

Endogenous: Pituitary adenoma, Adrenal tumor,  
Ectopic ACTH

### Symptoms:

Moon Face, Buffalo Hump, Central Obesity

Purple Striae, Thin Skin, Easy Bruising

Muscle Weakness, Osteoporosis, Hypertension

Hyperglycemia, Mood Changes, Hirsutism, Irregular  
Menses

### Investigations:

24-Hour Urinary Free Cortisol (↑)

Low-Dose Dexamethasone Suppression Test (No  
Suppression)

Late-Night Salivary Cortisol (↑)

ACTH Level: Low (Adrenal), High (Pituitary/Ectopic)

High-Dose Dexamethasone Test: Suppression



(Pituitary), No Suppression (Ectopic)

Treatment:

Steroid-Induced: Gradual tapering

Pituitary Tumor: Transsphenoidal surgery

Adrenal Tumor: Adrenalectomy

Ectopic ACTH: Treat tumor

Medical: Ketoconazole, Metyrapone

## Station15

Menstrual hormones graph 4 what cells produce them  
which one increase the temperature

How many oocytes are present at birth

Oocyte Changes with Age –

Fetal Life: ~6-7 million oogonia, undergo meiosis →  
Primary oocytes (Prophase I arrest)

At Birth: ~1-2 million primary oocytes remain

At Puberty: ~300,000 oocytes left, cyclic recruitment  
begins

Reproductive Age: ~400-500 oocytes ovulated in a



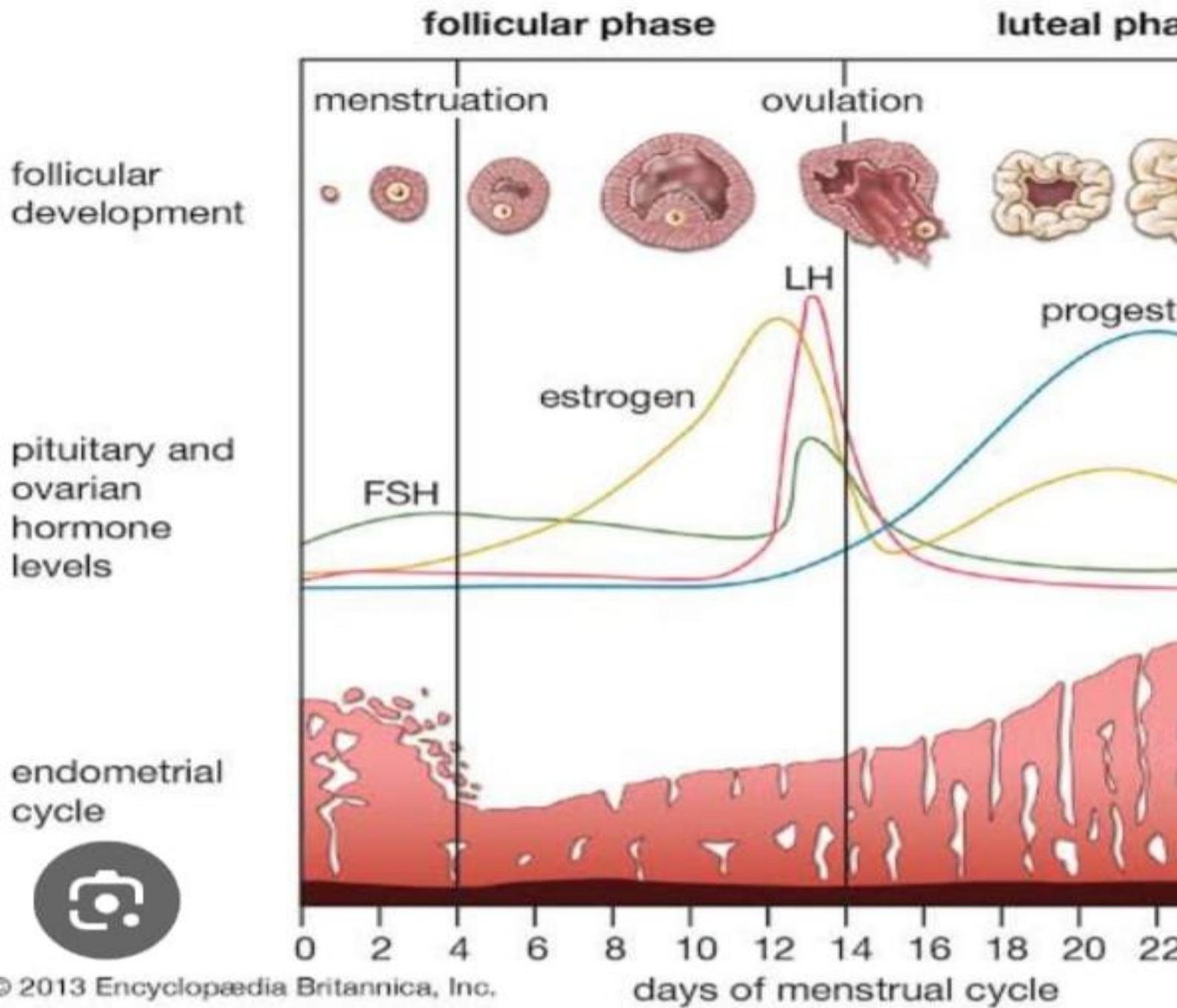
lifetime, quality declines gradually

After 35 Years: Increased aneuploidy risk, decreased fertility

Menopause (~50 years): Ovarian reserve depleted, cessation of ovulation



# The menstrual cycle



## Station16

Female pain dysuria xray kub with stone on right side  
left side normal treatment investigations

Kidney Stones



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## Types:

Calcium Oxalate (Most Common)

Calcium Phosphate

Uric Acid

Struvite (Infection Stones)

Cystine

## Investigations:

Urinalysis: Hematuria, Crystals, pH

Serum Studies: Calcium, Uric Acid, Creatinine

## Imaging:

Non-contrast CT (Gold Standard)

USG (Pregnancy, Hydronephrosis)

X-ray KUB (Radio-opaque Stones)

## Treatment:

Conservative: Hydration, Pain Relief (NSAIDs), Alpha-blockers (Tamsulosin)

Medical Expulsion Therapy: <5mm stones, spontaneous passage

Dissolution Therapy: Uric acid stones (Alkalinization)



with K-Citrate)

**Surgical Options:**

ESWL (Extracorporeal Shock Wave Lithotripsy): <2cm, upper tract stones

URS (Ureteroscopy with Laser Lithotripsy): Mid/Distal Ureteric Stones

PCNL (Percutaneous Nephrolithotomy): >2cm, Staghorn Calculi

Open Surgery (Rare): Large or complicated stones

**Prevention:**

Hydration, Dietary Changes, Treat Underlying Cause

**Station17**

Placenta picture function what hormones it produce 3 abnormalities of placenta



## NORMAL PLACENTA VS. PLACENTA ACCRETA SPECTRUM (PAS)



### **NORMAL PREGNANCY**

*The placenta attaches to a temporary layer in the uterus that's shed at delivery*



### **PLACENTA ACCRETA**

*When the placenta attaches too deeply into the uterine wall*



### **PLACENTA INCRETA**

*When the placenta attaches into the uterine muscle*



### **PLACENTA PERCRETA**

*When the placenta goes completely through the uterine wall, sometimes invading nearby organs like the bladder*

## Hormones Produced by Placenta

1. hCG (Human Chorionic Gonadotropin) – Maintains corpus luteum for progesterone production.
2. Progesterone – Supports pregnancy by maintaining the endometrium.
3. Estrogen (Estradiol) – Promotes uterine growth and blood flow.
4. hPL (Human Placental Lactogen) – Regulates maternal glucose metabolism.



5. Relaxin – Softens cervix and relaxes pelvic ligaments.
6. Corticotropin-Releasing Hormone (CRH) – Regulates fetal stress response.

### Three Placental Abnormalities

1. Placenta previa – Placenta covers the cervix, causing bleeding.
2. Placental abruption – Premature detachment of placenta, leading to fetal distress.
3. Placenta accreta – Abnormal placental attachment to the uterus, causing severe postpartum hemorrhage.

### Functions of the Placenta

Gas Exchange – Transfers oxygen and removes carbon dioxide.

Nutrient Supply – Provides glucose, amino acids, and vitamins.

Waste Removal – Eliminates fetal metabolic waste.

Hormone Production – Secretes hCG, progesterone, estrogen, hPL, relaxin.

Immune Protection – Transfers maternal antibodies (IgG).



Barrier Function – Limits passage of harmful substances.

Amniotic Fluid Regulation – Helps maintain fluid balance.

### Station 18

New born with mass attach on external genitalia maybe congenital perineal lipoma

Investigations. Treatment Clitoral enlargement pic  
....one month infant with severe vomiting... diagnosis,



4:11 PM



50



1. what is the diagnosis?

2. treatment options?

3. which test will you perform?



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# Congenital perineal lipoma: an unusual presentation

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## DESCRIPTION

We report a case of a male newborn, the second of triplets, from non-consanguineous parents who conceived using in vitro fertilisation. It was an uneventful pregnancy and ultrasounds were normal revealing a



**Figure 1** Neonate with a spherical pedunculated mass in the perineal region, with 13.8 mm of greater axis, with a cylindrical 5mm form attached.



**Figure 3** Spherical pedunculated mass in the perineal region, at the age of 6 months.

dichorionic triamniotic pregnancy. A caesarean section was performed at 34 weeks of gestation. The Apgar score was 9/10, weight 2423 g and physical examination revealed a congenital malformation in the perineal region with 13.8 mm of greater axis, spherical pedunculated and soft, with a cylindrical 5 mm form attached, similar to an accessory penis and scrotum (figure 1).

The neonate underwent an ultrasound displaying normal structures with an external malformation consistent with an accessory testicle, while MRI showed a complex structure, compatible with type 1 sacrococcygeal teratoma (figure 2). At 6 months of age (figure 3), the mass was locally excised, without complications. Postoperative histological examination however, revealed a subcutaneous lipoma.

Isolated congenital perineal lipomas are rare lesions that can lead to a misdiagnosis of an accessory scrotum in men, in particular because these two conditions can be associated in over 80% of cases.<sup>1-2</sup> The differential diagnosis is mainly an accessory scrotum, sacrococcygeal teratoma, fetus in fetu, haemangioma, haematoma or lipoblastoma.<sup>2</sup> A complete evaluation of the urogenital and anorectal tract is recommended, taking into account related anomalies described such as renal agenesis, anorectal malformations, scrotum and penile anomalies.<sup>1-2</sup> These isolated lesions are usually benign and the standard treatment is local excision.<sup>2</sup>

## Station20

Bishop scoring: What is bishop of this patient

What are components of bishop.,importance of bishop scoring



	Score			
	0	1	2	3
Position	Posterior	Middle	Anterior	--
Consistency	Firm	Medium	Soft	--
Effacement	0-30%	40-50%	60-70%	80%+
Dilation	Closed	1-2cm	3-4cm	5+cm
Station	-3	-2	-1/0	+1/+2

Additional factors: +1 point for each previous vaginal birth, -1 point for first time birth givers]

Add the score for each factor.

Scores lower than 5 suggest labour will not begin without induction.

Scores 9 and higher indicate labour will likely begin spontaneously.

Scores 3 and lower may indicate that an induction would not be successful

## Station 2

### Apgar score calculation



# APGAR SCORING SYSTEM

	0 Points	1 Point	2 Points	Points totaled
Activity (muscle tone)	Absent	Arms and legs flexed	Active movement	↓
Pulse	Absent	Below 100 bpm	Over 100 bpm	
Grimace (reflex irritability)	Flaccid	Some flexion of Extremities	Active motion (sneeze, cough, pull away)	
Appearance (skin color)	Blue, pale	Body pink, Extremities blue	Completely pink	
Respiration	Absent	Slow, irregular	Vigorous cry	

Severely depressed	0-3
Moderately depressed	4-6
Excellent condition	7-10

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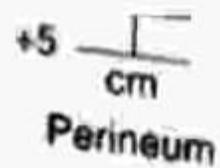
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## Station 3

Labour and steps of labour



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# Labour

## Definition & Stages:

- It is defined as, process by which regular painful contractions and dilatation of the cervix and descent of the presenting part leads to the
- The onset of labour is defined as <sup>strong</sup> regular <sup>painful</sup> contractions with cervical change.
- It is divided into three stages:

*total duration*

*primi → 12  
Multi → 8*

### Stage-I:

- It is the stage from the onset of labour to full dilatation of the cervix.
- It is divided into two phases:

#### The Latent Phase:

- It is the time between the onset of labour and the onset of active phase.
- In this phase cervical effacement takes place. Cervical length shortening as it becomes indistinguishable from the uterine segment.
- It lasts about 3-8 hours, being shorter in multiparae.

*one or two (hours) of bloody mucus*

#### The Active Phase:

It is the time between the end of latent phase and the onset of second stage.

- Time of involuntary expulsive
- The fetal head is relatively high in the pelvis
  - There is no maternal urge to push.
- A passive stage is usually

cond  
= > 3hr →  
al consider

### ○ The Active Second Stage:

- The fetal head is low in the pelvis (engaged)
- Therefore there is a maternal urge to push

### (iii). Stage-III:

- It is the time from delivery of fetus(s) until the delivery of placenta
- It is normally < 30 minutes with active management and management (discussed later).



## Clinical Pearl

### Labour Duration:

- Prolonged Labour is labour of > 12 hr duration in primiparous women and > 8 hr duration in multiparous women
- Precipitous Labour is defined as expulsion of fetus within 3 hours from the onset of regular uterine contraction

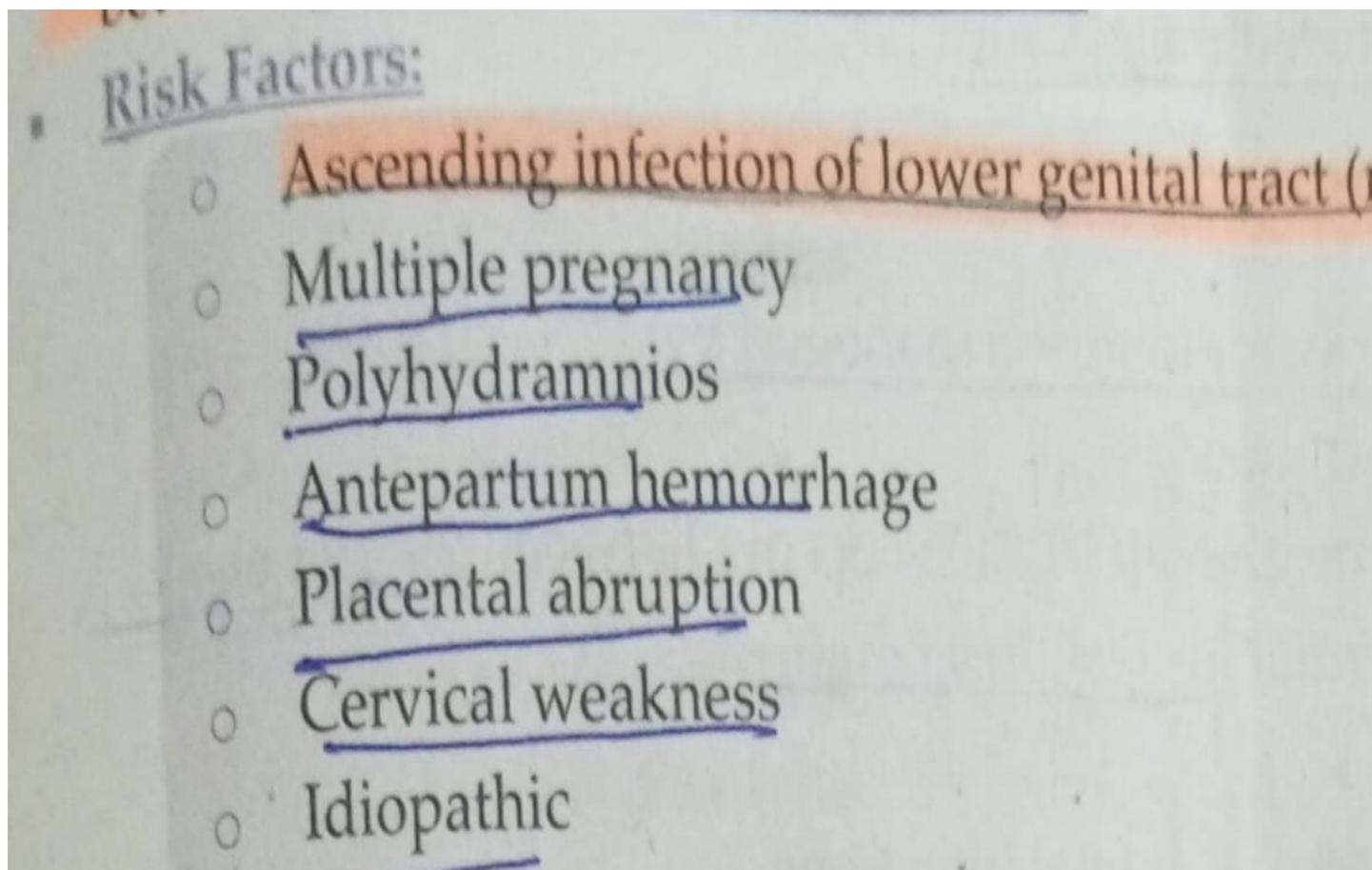


## Station 4

Pprom

Incidence 2-3 %

Causes



## Station 5

Breach

**Incidence 3%**

causes, risk factors [already discussed]

## Station 6

Ocp and pop moa

OCP (Oral Contraceptive Pills) – Mechanism of Action

Combined OCP (Estrogen + Progesterone):

Inhibits Ovulation – Suppresses LH & FSH release

Thickens Cervical Mucus – Prevents sperm penetration

Endometrial Atrophy – Prevents implantation

Alters Tubal Motility – Delays sperm/egg transport

Progesterone-Only Pills (POP):

Thickens Cervical Mucus – Blocks sperm entry

Inhibits Ovulation – Suppresses LH surge (not consistently)

Endometrial Changes – Reduces implantation likelihood

Slows Tubal Motility – Delays fertilization



VACCUM DELIVERY=



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- (A) = Ask For help, Address patient, Anesthetist
- (B) = Bladder empty, Backup plan
- (C) = Cervix fully dilated, cervix effaced
- (D) = Determine fetal head position
- (E) = Equipment ready
- (F) = Apply cup over sagittal suture in relation to posterior fontanel

Flexion-point



centre of cup should be 3cm - anterior to posterior fontanel: The edge will be over posterior fontanel (Most cup and 6cm from anterior fontanel. 5-7cm)

Flexion point is important for maximum traction & minimizing detachment of cup

(G)

Gentle traction = traction should be apply at right angle to plan of cup: Rocky movement avoid bc2 it lead cookie fraction: 15 minutes of application.

and with each pull.

As head extend, Vacuum will rise

twice.

From horizontal to

vertical • Traction should be good traction the office



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<Untitled>



How to apply cups:  
 Vertex is wiped clean of blood  
 and fluid: Labia are separated  
 cup is compressed & inserted: A finger is  
 swept around cup to make sure that  
 maternal tissue is not trapped  
 The pressure gauge is calibrated  
 into yellow & green area



Ventouse Cup

(ii). Prerequisites & Rules:

Manometer

Prerequisites:

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List (mnemonic: FORCEPS)

## Station11

Episiotomy types, early and late complications



## Episiotomy & Perineal Injury

### I. Episiotomy:

#### (i). Introduction:

- It is a surgical incision of the perineum made to increase the diameter of the vulval outlet during childbirth.
- It is equivalent of perineal injury grade-2 (see below).
- WHO recommends an episiotomy rate of 10% for normal deliveries.
- WHO indications for episiotomy are:
  - Fetal distress
  - Complicated vaginal delivery:
    - Breech
    - Shoulder dystocia
    - Forceps
    - Ventouse
  - Lower genital tract scarring:
    - Female genital mutilation
    - Poorly healed 3<sup>rd</sup> or 4<sup>th</sup> degree tears

#### (ii). Types & Procedure:

- Episiotomy is performed by two different techniques:

<u>Midline Episiotomy</u>	<u>Mediolateral Episiotomy</u>
<ul style="list-style-type: none"><li>▪ It extends from the <u>fourchette</u> towards the anus.</li><li>▪ It is associated with:<ul style="list-style-type: none"><li>○ <u>Less blood loss</u></li><li>○ <u>Easier to repair</u></li><li>○ <u>Heals quickly</u></li><li>○ <u>Less pain in postpartum period</u></li><li>○ <u>Anal sphincter injury</u></li><li>○ <u>Reduced incidence of dyspareunia</u></li></ul></li></ul>	<ul style="list-style-type: none"><li>▪ It extends from the fourchette towards the anus.</li><li>▪ It is associated with:<ul style="list-style-type: none"><li>○ <b>Reduced risk of anal sphincter injury therefore the recommended incision</b></li><li>○ More blood loss</li><li>○ Difficult to repair</li><li>○ Delayed healing</li><li>○ More pain in postpartum period</li></ul></li></ul>



### (iii). Complications:

- Bleeding
- Hematoma
- Pain
- Infection
- Scarring
- Dyspareunia
- Fistula formation (rare)



## Station14

Peas congenital hypothyroid viva





Original



Photo



Docs



Clear



Color

A 2-week-old boy presents with constipation and jaundice. He is sluggish (hypotonia) and excessive sleepy. On physical examination, he has mild jaundice with a distended abdomen. He has a large tongue, a large anterior and posterior fontanel, an umbilical hernia, and a coarse dry skin. Plasma  $T_4$  is decreased and TSH is raised. No ossification center at knee X-ray. Isotope and ultrasound scanning showed no thyroid tissue.



## **Congenital Hypothyroidism – Key Points**

### **Causes:**

**Thyroid Dysgenesis (Most Common) – Agenesis, Ectopy, Hypoplasia**

**Thyroid Dyshormonogenesis – Enzyme defects, Iodine transport defects**

**Maternal Factors – Iodine deficiency, Anti-thyroid drugs, Autoimmune diseases**

### **Clinical Features:**

**Prolonged Jaundice**

**Poor Feeding, Lethargy**

**Constipation**

**Macroglossia, Puffy Face**

**Hypotonia, Large Anterior Fontanelle**

**Dry Skin, Hoarse Cry**

### **Investigations:**

**Newborn Screening: ↑ TSH, ↓ T4**

**Serum TSH & T4 Levels**



Thyroid Ultrasound/Scan – Identify gland abnormalities

Treatment:

Levothyroxine (Lifelong) – Early treatment prevents intellectual disability

Monitor TSH & T4 Regularly

## Station15

Graves disease scenario

Graves' Disease – Key Points

Cause:

Autoimmune Hyperthyroidism – TSH receptor antibodies (TRAb) stimulate thyroid

Clinical Features:

Hyperthyroidism Symptoms: Weight loss, Heat intolerance, Palpitations, Tremors

Goiter: Diffuse, Non-tender, Bruit may be present

Eye Signs (Thyroid Eye Disease): Exophthalmos, Lid lag,



**Diplopia**

**Dermopathy: Pretibial myxedema**

**Cardiac: Tachycardia, Atrial fibrillation**

**Investigations:**

**TSH ↓, Free T4/T3 ↑**

**TRAb (TSH Receptor Antibodies) Positive**

**RAIU (Radioactive Iodine Uptake) Scan: Diffuse increased uptake**

**Treatment:**

**Anti-thyroid Drugs: Methimazole, Propylthiouracil (PTU in pregnancy)**

**Beta-Blockers: Symptom control (Propranolol)**

**Radioactive Iodine Therapy: Preferred for long-term control**

**Surgery (Thyroidectomy): Indicated in large goiter, malignancy suspicion, or drug failure**



## Station17

Liver anatomy, segments and blood supply viva

Liver Anatomy

Divided into 8 segments (Couinaud classification).

Right lobe (Segments 5-8), Left lobe (Segments 1-4).

Caudate lobe (Segment 1) has independent vascular supply.

Liver Blood Supply

Dual supply:

Hepatic artery (25%) – Oxygenated blood from the celiac trunk.

Portal vein (75%) – Nutrient-rich blood from GI tract.

Venous drainage: Hepatic veins → IVC.

## Station18

60 years old diabetic man unconscious with increase pulse and tachycardia ...he is on oral hypoglycemic glibenclamide also missed his breakfast ...diagnosis and management



## Unconscious Hypoglycemia Management – Key Points

### Immediate Actions:

ABC Assessment – Airway, Breathing, Circulation

Positioning – Lateral position to prevent aspiration

### Treatment:

IV Dextrose 50% (25–50 mL) – Rapid glucose correction

If No IV Access: IM/SC Glucagon 1 mg

Monitor Blood Glucose – Repeat dextrose if needed

### Post-Recovery:

Identify & Treat Cause – Insulin overdose, adrenal insufficiency, sepsis

Prevent Recurrence – Adjust medications, dietary counseling

Hospital Admission – If recurrent or severe episodes





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