Pprom

Preterm Premature Rupture of Membranes (PPROM

Definition:

Rupture of membranes before 37 weeks of gestation before labor onset

Risk Factors:

Infections (e.g., chorioamnionitis, UTI)

Previous PPROM or preterm birth

Multiple gestation

Smoking, poor nutrition

Cervical insufficiency

Diagnosis:

History: Gush of fluid, continuous leakage

Speculum Exam: Pooling of fluid

Nitrazine Test: Alkaline pH (>7.1)

Fern Test: Microscopic ferning pattern

Ultrasound: Oligohydramnios

Complications:

Maternal: Chorioamnionitis, sepsis

Fetal:

Preterm birth, pulmonary hypoplasia, cord prolapse

Management:

<34 weeks:

Corticosteroids (lung maturity)

Antibiotics (latency period)

Tocolysis (if no infection)

Monitoring for infection or distress

≥34 weeks:

Delivery

Group B Streptococcus prophylaxis

External cephalic version interactive

External Cephalic Version (ECV)

Definition:

Manual manipulation of the fetus from breech/transverse to cephalic presentation after 36–37 weeks gestation.

Indications:

Breech or transverse lie at term (≥36 weeks in nulliparous, ≥37 weeks in multiparous).

Contraindications:

Absolute:

Placenta previa

Ruptured membranes

Multiple gestation

Uterine abnormalities

Relative:

Oligohydramnios

IUGR

Prior C-section (risk of rupture)

Procedure:

1. Tocolysis (e.g., terbutaline) to relax the uterus.

2. Ultrasound-guided manipulation of fetal head and buttocks.

3. Fetal heart rate monitoring before and after.

Complications:

Fetal distress → emergency C-section

Placental abruption

Preterm labor

Umbilical cord complications

Success Rate:

40–60%, higher in multiparous women.

Polyhydromnios

Definition:

Excessive amniotic fluid (>25 cm amniotic fluid index [AFI] or >8 cm deepest vertical pocket).

Causes:

Fetal Causes:

Congenital anomalies (e.g., esophageal/duodenal atresia, anencephaly)

Fetal anemia (e.g., Rh incompatibility, fetal hydrops)

Multiple gestation (twin-to-twin transfusion syndrome)

Maternal Causes:

Diabetes mellitus (fetal polyuria)

Infections (TORCH, syphilis)

Idiopathic (~50%)

Symptoms & Signs:

Rapid abdominal distension

Breathlessness, discomfort

Difficulty palpating fetal parts

Preterm labor risk

Diagnosis:

Ultrasound: AFI >25 cm

Glucose testing: Maternal diabetes screening

Fetal anomaly scan

Complications:

Maternal: Preterm labor, uterine atony, postpartum hemorrhage

Fetal: Malpresentation, cord prolapse, stillbirth

Management:

Mild & Asymptomatic: Observation, serial ultrasounds

Severe Cases:

Amnioreduction (amniocentesis)

Indomethacin (if preterm, to reduce fetal urine production)

Delivery planning based on severity

Pre eclampsia

Definition:New-onset hypertension (≥140/90 mmHg) after 20 weeks gestation + proteinuria or organ dysfunction.

Risk Factors:

Maternal:

First pregnancy, advanced maternal age (>35 years)

Obesity, diabetes, chronic hypertension

History of preeclampsia, renal disease

Fetal:

Multiple gestation

Molar pregnancy

Clinical Features:

Hypertension (≥140/90 mmHg)

Proteinuria (≥300 mg/24h or urine protein/creatinine ratio ≥0.3)

Severe Features:

Headache, visual disturbances

Epigastric pain (liver involvement)

Pulmonary edema

Thrombocytopenia (<100,000/μL)

Elevated liver enzymes

Complications:

Maternal:

Eclampsia (seizures)

HELLP syndrome (Hemolysis, Elevated Liver enzymes, Low Platelets)

Stroke, renal failure

Fetal:

Intrauterine growth restriction (IUGR)

Preterm birth

Placental abruption

Management:

Mild Preeclampsia:

Monitor BP, urine protein, fetal growth

Delivery at 37 weeks if stable

Severe Preeclampsia:

Antihypertensives (labetalol, nifedipine, hydralazine)

Magnesium sulfate (seizure prophylaxis)

Immediate delivery if ⩾34 weeks or maternal/fetal distress

breast Ca

Definition:Malignant tumor of breast tissue, most commonly arising from epithelial cells of the ducts or lobules.

Risk Factors:

Non-Modifiable:

Female gender, age >50 years

Family history (BRCA1, BRCA2 mutations)

Early menarche, late menopause

Modifiable:

Obesity, alcohol consumption

Hormone replacement therapy (HRT), nulliparity

Radiation exposure

Types:

Ductal Carcinoma In Situ (DCIS) – Non-invasive

Invasive Ductal Carcinoma (IDC) – Most common (~80%)

Invasive Lobular Carcinoma (ILC) – Less common (~10%)

Triple-Negative Breast Cancer (TNBC) – Aggressive, poor prognosis

Clinical Features:

Painless breast lump (hard, irregular, immobile)

Nipple changes (retraction, discharge, bleeding)

Skin changes (peau d'orange, ulceration)

Axillary lymphadenopathy

Diagnosis:

Triple Assessment:

1. Clinical Examination

2. Imaging: Mammography (first-line for >40 years), Ultrasound (younger women)

3. Biopsy: Core needle biopsy (definitive diagnosis)

Hormone Receptor Testing (ER, PR, HER2)

Staging (TNM System):

T (Tumor size), N (Lymph node involvement), M (Metastasis)

Management:

Surgery:

Lumpectomy (breast-conserving) or Mastectomy

Sentinel lymph node biopsy or Axillary lymph node dissection

Radiotherapy: Post-surgery to reduce recurrence

Chemotherapy: For aggressive tumors or large lesions

Hormonal Therapy:

Tamoxifen (ER/PR-positive)

Aromatase inhibitors (postmenopausal women)

Targeted Therapy: Trastuzumab (HER2-positive tumors)

Prognosis:

Depends on stage, receptor status, and response to treatment

5-year survival varies: >90% in early-stage, <30% in metastatic disease

Urinary Tract Infections (UTIs)

Definition:Infection of any part of the urinary system (kidneys, ureters, bladder, urethra), most commonly caused by bacteria.

Types:

Lower UTI (Cystitis) – Bladder infection

Upper UTI (Pyelonephritis) – Kidney infection

Complicated UTI – UTI with risk factors (pregnancy, diabetes, catheter, structural abnormality)

Uncomplicated UTI – Occurs in healthy individuals without risk factors

Common Pathogens:

Escherichia coli (E. coli) (~80%) – Most common

Klebsiella, Proteus, Enterococcus, Staphylococcus saprophyticus

Risk Factors:

Female gender (shorter urethra)

Sexual activity (honeymoon cystitis)

Poor hygiene

Catheter use

Diabetes mellitus

Urinary stasis (BPH, stones, pregnancy)

Clinical Features:

Cystitis (Bladder UTI):

Dysuria (burning urination)

Frequency, urgency

Suprapubic pain

Cloudy or foul-smelling urine

Pyelonephritis (Kidney UTI):

Flank pain, fever, chills

Nausea, vomiting

Costovertebral angle tenderness

Diagnosis:

Urinalysis (UA):

Leukocyte esterase (+) → WBCs in urine

Nitrites (+) → Suggests Gram-negative bacteria (E. coli)

Bacteria, WBCs, RBCs

Urine Culture:

Confirms diagnosis, guides antibiotic therapy

Significant bacteriuria: $\geqslant 10^5$ CFU/mL (may be lower in symptomatic cases)

Management:

Uncomplicated UTI:

First-line: Nitrofurantoin, TMP-SMX, Fosfomycin

Alternative: Ciprofloxacin, Cephalexin

Complicated UTI/Pyelonephritis:

Oral: Fluoroquinolones (Ciprofloxacin, Levofloxacin)

IV (severe cases): Ceftriaxone, Piperacillin-Tazobactam

Recurrent UTI:

Prophylactic antibiotics (if frequent recurrences

Lifestyle modifications (hydration, post-coital voiding, hygiene)

C section indication types complications

Cesarean Section (C-Section)

Types of C-Section:

1. Lower Segment Cesarean Section (LSCS) – Most common, horizontal incision in the lower uterus.

2. Classical C-Section – Vertical incision on the uterus, used in emergencies or preterm deliveries.

Indications:

Maternal Indications:

Previous C-section (risk of uterine rupture)

Cephalopelvic disproportion (CPD)

Maternal infections (e.g., active genital herpes, HIV with high viral load)

Placenta previa or placenta accreta

Severe preeclampsia/eclampsia

Fetal Indications:

Fetal distress (non-reassuring CTG)

Malpresentation (breech, transverse lie)

Cord prolapse

Multiple pregnancy with complications

Complications:

Maternal:

Intraoperative:

Hemorrhage

Bladder or bowel injury

Anesthesia complications

Postoperative:

Infection (endometritis, wound infection)

Deep vein thrombosis (DVT)

Delayed wound healing

Uterine rupture in future pregnancy

Fetal:

Respiratory distress (transient tachypnea of the newborn)

Birth injuries (lacerations, fractures)

Xanthelasma – Causes

Definition:Yellowish cholesterol-rich deposits on the eyelids, commonly near the inner canthus.

Causes & Risk Factors:

1. Hyperlipidemia (Primary or Secondary):

High LDL (Low-Density Lipoprotein)

Familial hypercholesterolemia

Dyslipidemia (Type II, III hyperlipoproteinemia)

2. Metabolic Disorders

Diabetes mellitus (linked to lipid metabolism dysfunction)

Hypothyroidism (causes lipid accumulation)

Liver diseases (e.g., cholestatic conditions, cirrhosis)

3. Lifestyle & Other Factors:

Obesity

Smoking & alcohol consumption

Genetic predisposition

4. Idiopathic (Normal Lipid Levels in Some Cases)

Undescended testes diagnosis ,surgery name

CRYPTORCHIDISM (UNDESCENDED TESTES)

It is a condition in which testes fail to descend into the scrotum. Incidence at birth is 4% and 80% of these reach the scrotum during the first 3 months of life.

If the testis is not brought down by the age of 1 years, destructive changes occur in the sperm producing cells causing infertility. These changes occur because of high intraabdominal temperature as compared to scrotum. Also there is a 40 fold increase in the risk of malignancy in the undescended testis

Types:

Absent: testes are congenitally absent/ atrophic

Retractile: the testes are mobile and cold. On stroking the thigh causes testes to disappear above. The scrotum is well developed and testes can be brought down by traction. Retractile testes are normal and require no treatment.

Incompletely Descended: the descent is arrested anywhere from abdomen to inguinal canal to the superficial ring.

Ectopic: the testis exits the superficial inguinal ring and goes to these sites: superficial inguinal pouch, perineum, thigh

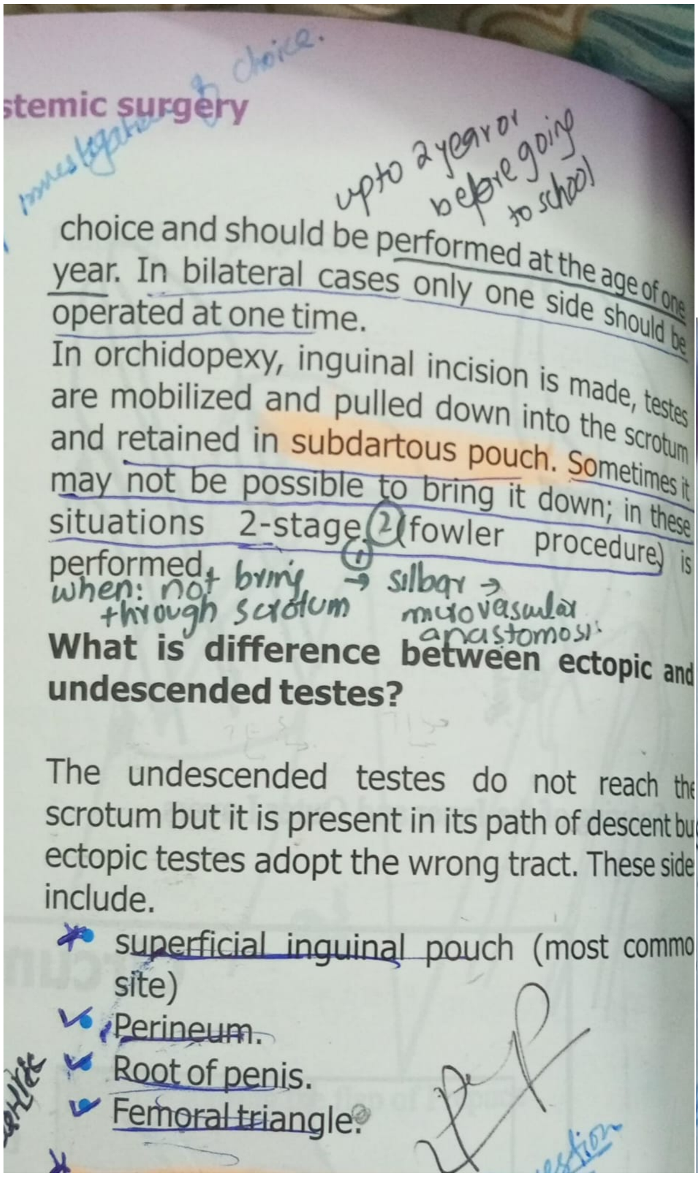
Hazards of incomplete descended testes.

- Sterility in bilateral case.
- Hernia.
- Torsion.
- Trauma.
- Increased risk of malignancy (40 times).
- Atrophy.

Investigation: Investigations are carried out to locate the site of testes, when these are not palpable.

Ultrasonography is helpful but laparoscopy is the investigation of choice.

Treatment: Orchidopexy is the treatment of



stemic surgery

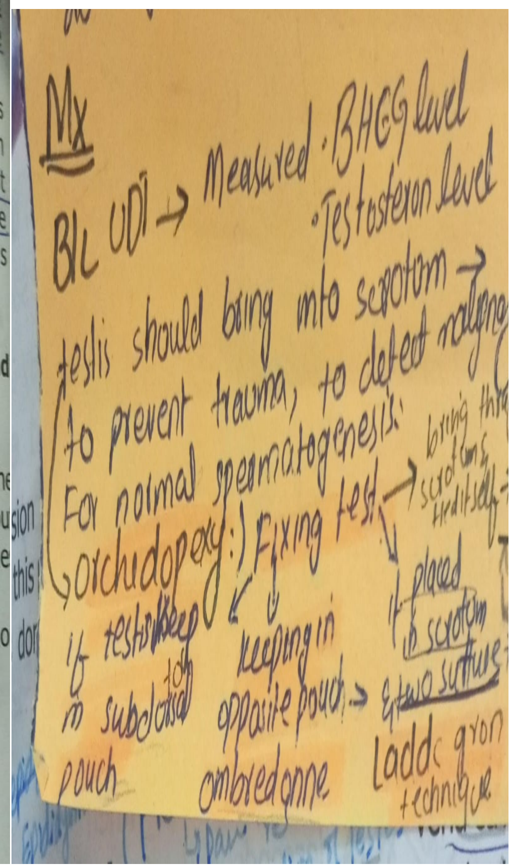
choice and should be performed at the age of one year. In bilateral cases only one side should be operated at one time.

In orchidopexy, inguinal incision is made, testes are mobilized and pulled down into the scrotum and retained in subdartous pouch. Sometimes it may not be possible to bring it down; in these situations 2-stage (fowler procedure) is performed.

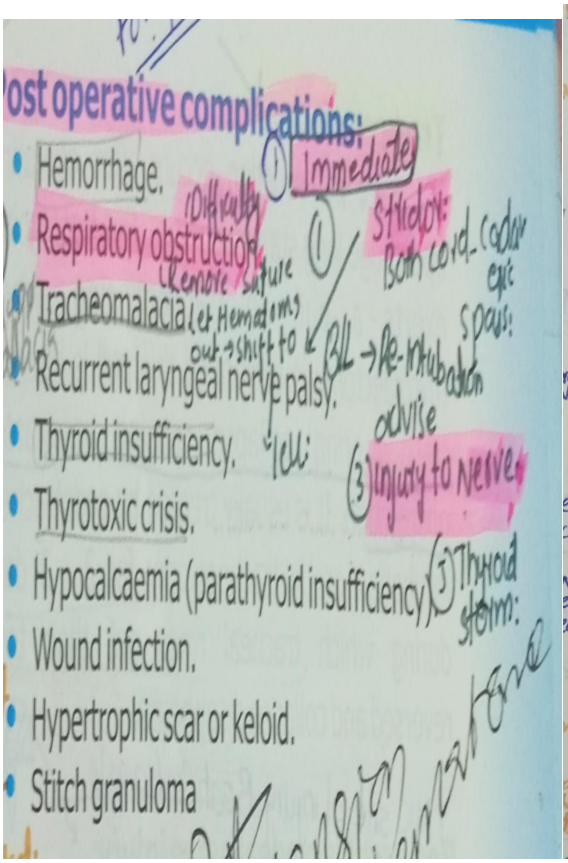
What is difference between ectopic and undescended testes?

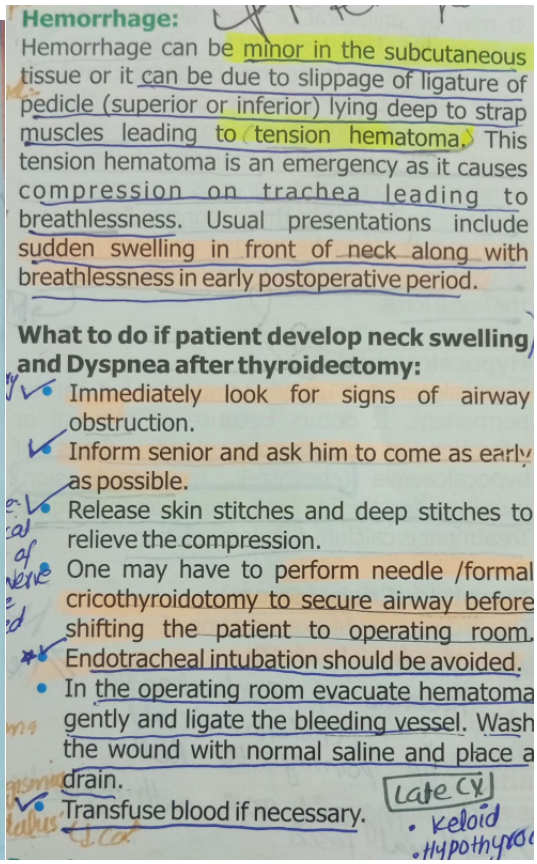
The undescended testes do not reach the scrotum but it is present in its path of descent but ectopic testes adopt the wrong tract. These sites include.

- superficial inguinal pouch (most common site)
- Perineum.
- Root of penis.
- Femoral triangle.



Post thyratectomy complication ,heamatima causes





Hemorrhage:

Hemorrhage can be minor in the subcutaneous tissue or it can be due to slippage of ligature of pedicle (superior or inferior) lying deep to strap muscles leading to tension hematoma. This tension hematoma is an emergency as it causes compression on trachea leading to breathlessness. Usual presentations include sudden swelling in front of neck along with breathlessness in early postoperative period.

What to do if patient develop neck swelling and Dyspnea after thyroidectomy:

- Immediately look for signs of airway obstruction.
- Inform senior and ask him to come as early as possible.
- Release skin stitches and deep stitches to relieve the compression.
- One may have to perform needle /formal cricothyroidotomy to secure airway before shifting the patient to operating room.
- Endotracheal intubation should be avoided.
- In the operating room evacuate hematoma gently and ligate the bleeding vessel. Wash the wound with normal saline and place a drain.
- Transfuse blood if necessary.

Late CX
• Keloid

Duck's soeculum

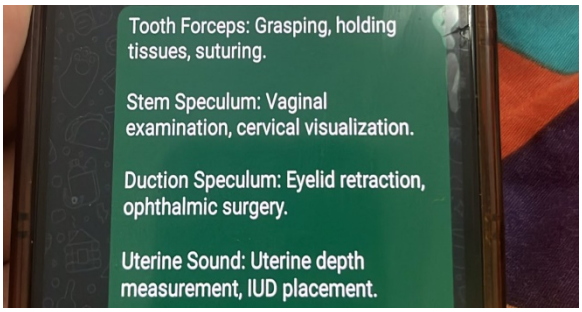
sims speculum

episiotomy scissor

uterine sound

tooth forcep

USES



Perpeural pyrexia causes , risk factors

Risk Factors:

Prolonged labor

Cesarean section

PROM (>18 hrs)

Instrumental delivery

PPH

Retained products

Poor hygiene

Anemia

Obesity

Diabetes

Causes:

Endometritis (most common)

UTI

Mastitis

Wound infection

Thrombophlebitis

Septicemia

Oligohydramnios

Def: AFI <5cm or SDP <2cm.

Causes: ROM, placental insuff, post-term, IUGR, renal anomalies, dehydration, HTN, DM, meds (NSAIDs, ACEi).

Comp: Cord comp, fetal distress, pulmonary hypoplasia, limb deformities.

Dx: USG (AFI/SDP).

Tx: Hydration, AF infusion, delivery planning.

PIH

Def: BP ⩾140/90 after 20wks, no proteinuria.

RiskFactors: Primigravida, FHx, multiple gestation, obesity, DM, renal disease, AMA.

Types: GestationalHTN, preeclampsia, eclampsia.

Comp: IUGR, preterm labor, abruption, HELLP, eclampsia.

Dx: BP monitoring, urine dipstick, LFTs, RFTs.

Tx: Antihypertensives (labetalol, nifedipine, methyldopa), $MgSO_4$ (severe), delivery if indicated.

Hydrops foetalis

Def: Severe fetal edema due to abnormal fluid accumulation in ⩾2 compartments.

Types: Immune (Rh incompatibility) & Non-immune (most common).

Causes:

Immune: Rh/ABO incompatibility → fetal anemia → heart failure.

Non-immune: Cardiac defects, chromosomal anomalies, infections (Parvo B19, CMV), twin-twin transfusion, metabolic disorders.

Comp: Fetal heart failure, polyhydramnios, IUFD.

Dx: USG (ascites, pleural effusion, skin edema), MCA Doppler (anemia).

Tx: Treat cause, intrauterine transfusion (if anemia), early delivery if needed.

Placental abruption

Def: Premature placental separation >20wks.

RiskFactors: HTN, trauma, smoking, cocaine, PPROM, polyhydramnios, previous abruption.

Types: Concealed (internal bleeding) & Revealed (vaginal bleeding).

Sx: Painful vaginal bleeding, uterine tenderness, hypertonicity, fetal distress.

Comp: DIC, hypovolemic shock, IUFD, preterm birth.

Dx: Clinical, USG (retroplacental clot).

Tx: Stabilization, urgent delivery (if severe), corticosteroids (if preterm).

Rhesus isoimmunisation interactive station

Def: Maternal immune response to fetal Rh^+ RBCs → hemolysis in subsequent pregnancies.

Patho: Rh^- mother exposed to Rh^+ fetal blood → anti-D Abs form → cross placenta in next pregnancy → fetal hemolysis.

RiskFactors: Previous Rh^+ pregnancy, blood transfusion, abortion, ectopic, invasive procedures (CVS, amnio).

Comp: Hemolytic disease of newborn (HDN), hydrops fetalis, kernicterus, IUFD.

Dx: Indirect Coombs (maternal Abs), Direct Coombs (fetal RBCs), MCA Doppler (fetal anemia).

Prev: Anti-D Ig (300mcg) at 28wks & within 72hrs of delivery/exposure.

Tx: Intrauterine transfusion (if severe anemia), early delivery if needed.

[[2/26/2025 10:38 AM] Hina 💫: T lambda sign on ultrasound- key: monochorionic twin pregnancy

Post C section headache

Investigation

Treatment

Investigation:

Hx & Exam: Onset, duration, severity, triggers, aura, neuro deficits.

Red Flags: Sudden severe HA, neuro signs, fever, altered LOC, papilledema.

Labs: CBC, ESR/CRP (GCA), BMP, glucose.

Imaging: CT (acute bleed, mass), MRI (chronic conditions, tumor, demyelination).

LP: If SAH suspected but CT negative, meningitis, IIH.

Treatment:

Primary HA:

Migraine: NSAIDs, triptans, antiemetics, prophylaxis (BB, TCA, topiramate).

Tension: NSAIDs, stress mgmt.

Cluster: O_2, triptans, verapamil (prophylaxis).

Secondary HA: Treat underlying cause (HTN crisis, infection, bleed, tumor).

Ectopic pregnancy

Def: Implantation outside uterus, most common in fallopian tube (ampulla).

RiskFactors: PID, tubal surgery, previous ectopic, IUD, ART, smoking.

Sx: Amenorrhea, lower abdo pain, vaginal bleeding, shoulder tip pain (rupture).

Comp: Rupture, hemorrhagic shock, infertility.

Dx: β-hCG (serial rise <53% in 48hrs), TVUS (no IUP, adnexal mass), culdocentesis (if unstable).

Tx:

Stable: Methotrexate (if criteria met).

Unstable/Ruptured: Emergency laparotomy/salpingectomy.

Uterine involution interactive station

Def: Process of uterus returning to pre-pregnancy size & tone post-delivery.

Timeline:

Immediately PP: Fundus at umbilicus.

Day 2: Descends ~1cm/day.

2wks: No longer palpable abdominally.

6wks: Returns to normal size.

Factors Enhancing: Breastfeeding (oxytocin), early ambulation.

Factors Delaying: Multiparity, infection, retained POC, overdistension (polyhydramnios, multiple gestation).

Complications: Subinvolution → PPH, endometritis.

Mgmt: Monitor lochia, uterine tone, treat underlying causes.

Teratogenic drugs

Anticonvulsants: Valproate, phenytoin, carbamazepine → NTDs, facial dysmorphism.

Retinoids: Isotretinoin → CNS, cardiac defects, ear anomalies.

ACEi/ARBs: Renal dysgenesis, oligohydramnios.

Warfarin: Nasal hypoplasia, limb defects, CNS abnormalities.

Tetracyclines: Teeth discoloration, bone growth inhibition.

Aminoglycosides: Ototoxicity.

Methotrexate: Fetal demise, craniofacial defects, limb anomalies.

Thalidomide: Phocomelia (limb shortening).

Sulfonamides: Kernicterus.

Picture of exophthalmos and pritibial myxedema