

Date: 2000, 2022

# MgSO4 DOSES PROTOCOL

1 vial = 10ml = 500mg (5g)

1ml = 50mg, 1g = 2ml

## PITCHARD REGIMEN

### LOADING DOSE

⇒ 4g + 12cc N/S or DISTILLED WATER → IV → 15-20 MINTS  
(8cc) ↓  
TOTAL 20ML (20% MgSO4)

5g I.M ON EACH BUTTOCK ⇒ TOTAL 10g I.M DOSES (50% EACH BUTTOCK)

### MAINTANANCE DOSES

5g DEEP I.M ON ALTERNATE BUTTOCK 4 HRLY (50%)

NOTE: DOSES SHOULD BE CONTINUED 24hr FOLLOWING DELIVERY / LAST SEIZURE, WHICHEVER IS LATER

RECURRENT SEIZURE: REPEAT BOLUS ⇒ 2g MgSO4 OR ↑ INFUSION RATE TO 1.5 OR 2g/hr

MONITORING: HRLY CHECKING DEFEC...

## ZUSPAN REGIMEN

### LOADING DOSE

⇒ 4g IV (20%) IN 100ml FLUIDS GIVEN OVER 5-10 MINUTES (8cc)

### MAINTANANCE DOSES

1g/hr FOR 24hrs THROUGH INFUSION PUMP



2020  
2022

# NICE HYPERTENSION GUIDELINES

(1st line) LABETALOL DOSES (IV)

INDICATION FOR IV THERAPY:- MAP  $\geq 125$  mm Hg

1 vial: 10ml = 50mg, 1ml = 5mg

## LOADING DOSES

$\Rightarrow$  20mg (IV BOLUS) CHECK BP AFTER (4cc)

10-15 mins, IF MAP  $\geq 125$  THEN

40mg (8cc)  $\xrightarrow[15\text{min}]{\text{CHECK BP}}$  80mg (16cc)  $\xrightarrow[15\text{min}]{\text{CHECK BP}}$  80mg (16cc)

UPTO CUMULATIVE DOSES OF 220mg (44cc)

ONCE MAP  $< 125$  mm Hg

## MAINTAINANCE DOSE

$\Rightarrow$  INFUSION @ 40mg/hr (8cc)

DOUBLING DOSE AFTER EVERY

30 mins, IF NECESSARY UPTO 160mg/hr (32cc)

(2nd line) HYDRALAZINE DOSES (IV)

INDICATION FOR IV THERAPY:- MAP  $\geq 125$  mm Hg ( $\frac{2}{3}$  DBP +  $\frac{1}{3}$  SBP)

1 vial: 1ml = 20mg

## LOADING DOSE

1ml Hydralazine + 19cc Distilled water (20mg) = 20ml Solution

5mg IV Bolus  $\xrightarrow[15\text{min}]{\text{CHECK BP}}$  5mg  $\xrightarrow[15\text{min}]{\text{CHECK BP}}$  5mg (1ml = 1mg)

UPTO CUMULATIVE DOSES OF 15mg

WHEN MAP  $< 125$  mm Hg THEN,

## MAINTAINANCE DOSE

$\Rightarrow$  INFUSION @ 10mg/hr, IF NECESSARY

$\uparrow$  DOSE AFTER 30 mins  $\rightarrow$  UPTO 40mg/hr

NOTE:- Colloid should be given to antenatal pt to prevent hypotension & fetal distress





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TOACS – FINAL YEAR MBBS  
Specialty: Obstetrics & Gynaecology



Total Marks: 06

STATION NO: \_\_\_\_\_

25 years old patient in post natal ward delivered via mvd 3 hours ago. She complains of heavy vaginal bleeding, o/e uterus felt boggy, pv bleeding ++, BP=90/60, pulse=102/min

1. What is the diagnosis
2. What are the causes
3. What is management option

(1)  
(2.5)  
(2.5)



Station = 3.

1) Diagnosis = PPH.

2) causes — uterine atony (Macrosomia, Prolonged

• Placenta previa (labour, oxytocin use)

• Coagulation disorder

• Multiple (-section)

• uterine inversion or eruption

3) Management:

• Obstetric hemorrhage Protocol (ABCDE) & call for

help:

• stop uterine bleeding → by • Massage of uterine

• Uterotonic Agent

↳ oxytocin, ↑ dose

Rectal misoprostol

Syntometrine, Repeat ergometrine, carboprostate

• Still bleeding: look for trauma or coagulopathy

Surgical: uterine artery embolization

• Iliac artery ligation

uterine balloon insertion, Hysterectomy





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STATION NO: \_\_\_\_\_

Carefully examine the graph and answer questions

1. Identify the following graph
2. What are different components of graph
3. What are normal values of parameters

(2) 2  
(3) ✓  
(4)



Station 5

1) CTG

2) Baseline HR

• Basal line variability

• Acceleration, Deceleration

3) Basal HR: 110-150 bpm

• B. variability: 10-25 bpm

• 2 acceleration in 20 mins

• NO deceleration

Station: 14/5



STATION No. 14



This 25 years old gentleman has presented with headache and visual disturbances for the last 6 months.

- Q1. What is the diagnosis?
- Q2. Enumerate two specific investigations for the diagnosis.
- Q3. List two relevant treatment options.

Qs. No.5



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• NO deceleration

Mon: 19/5

1: Acromegaly

2. • serum IGF-1

• OGTT

MRI of pituitary

3): TX

Surgical → Transphenoidal  
Surgery

• Medical Mx

octreotide, lanreotide





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STATION NO: \_\_\_\_\_

35 yrs old lady who is G6P5 with 32 weeks POG is complaining of easy fatigability and lethargy which is not associated with any cardiac symptoms. She also complains of perianal itching and her diet is meat

Her current investigations are

Hb : 8g/dl ↓

MCV: 70fl

MCH: 29pg

MCHC: 28g

2.14  
+20  
2.4

1. What is the most probable diagnosis? (1)
2. What investigations would you like to carry? Name any two (1)
3. What are the risk factors of anemia in this patient? Name any two (1)
4. What will be your treatment plan for this period of gestation (1)
5. What would be the treatment plan if this patient would be at 37 weeks of gestation? (2)

3.17

1-16



Station: 1:

1. Iron deficiency anemia (Norm)

2. Investigation: ~~infection~~ infection

• Tape test serum ferritin  
serum iron level, TIBC

• Peripheral smear

• Pelvic examination & vaginal swab

3. Risk factor: Multiparity

• short interpregnancy interval

• ↑ iron requirement in pregnancy

4. Tx:

Oral iron supplement

Dietary counselling

Vitamin C intake

5. If At 37 wks:

↓ Blood-

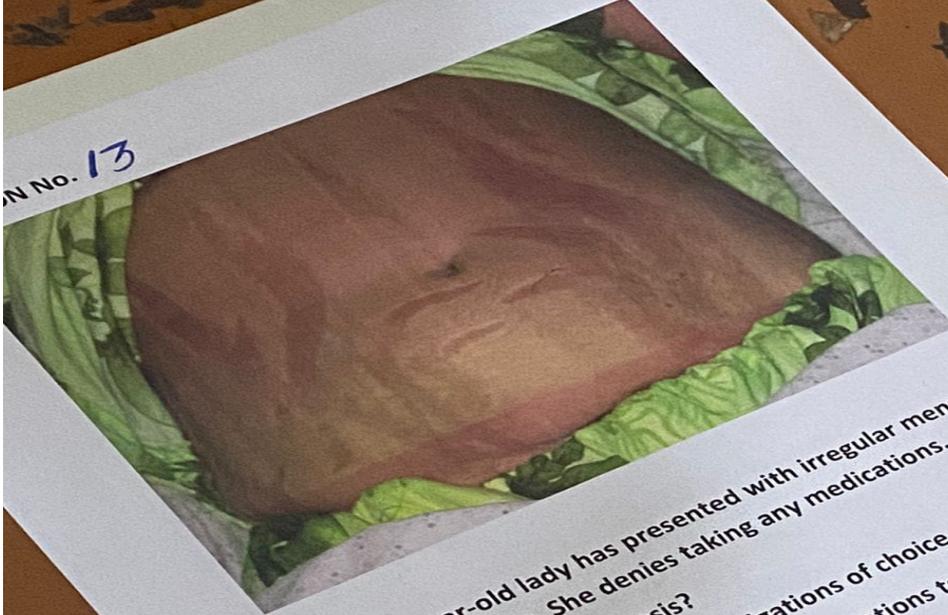
transfusion

• IV iron Therapy (ferric carboxymaltose)

• oral iron supplement iron sucrose



Case No. 13



This 35-year-old lady has presented with irregular menses and weight gain. She denies taking any medications.

Q1: What is the diagnosis?

Q2: List two screening investigations of choice.

Q3: Enumerate two further investigations to confirm the diagnosis.



Station 2

1 = Cushing syndrome

2 = Screening test =

- 24hr - urinary free cortisol
- Dexamethasone suppression test
- late night - salivary cortisol

3 = Further =

• ACTH level

• Pituitary MRI

• CT-scan of adrenal



Station 18

A 45 years old lady presented with swelling in front of neck for long time. look at the picture.

1. Possible D/Ds
2. How will you manage
3. Investigation
4. Treatment



station-18

① DID.

- Thyroid/Goiter
- Thyroglossal cyst, infection
- teratomas
- Terrible lymphoma
- tetatoma
- thymoma

② Management.

- Detail H/O
- Physical Ex
- TFS, USG, FNAC, CT, MRT, chest xray, Blood test

Treatment according to cause

- Investigation: TFS, USG, FNAC, CT or MRT, chest xray, etc

TX: Thyroid nodules → Benign → Follow up  
 → malignant → surgery

• Goiter → Medication

• Cyst → surgical removal

Bacterial vaginosis

→ candidal

• clear



M T W T F S

DATE \_\_\_\_\_

⑩

① Thyroid <sup>life</sup> ~~gates~~, malignancy,

② History <sup>hyperthyroidism</sup> examination, investigation  $\rightarrow$  TFTs  
 $\rightarrow$  USG  
 $\rightarrow$  radioiodine scan  
 $\rightarrow$  FNAC.

③ surgery. thyroidectomy  $\rightarrow$  Lobectomy, drugs  $\rightarrow$  RAI.

⑪

~~Kidney~~ LVU.  $\rightarrow$  stone on right, hydronephrosis

causg- stone. manage. conservation. pain control, antibiotic

if  $\leftarrow$   $< 2\text{cm}$  ESWL  $\rightarrow$   $> 2\text{cm}$  Nephrolithotomy  $\rightarrow$  Lower ureter URS

⑫

Dialysis counseling.

⑬

Minimal change  $\rightarrow$   $60\text{mg}/\text{m}^2/\text{day}$ .

Urine spot test Protein/crea = 20

Preeclampsia  $\rightarrow$  20-25%

Shoulder dystocia  $\rightarrow$  0.2-1%

Breast 3-4%

leomyoma. single 11% multiple 74%

① Cushing disease-

② Low dose dexamethasone test

Late night salivary cortisol test, 24 hr urinary cortisol test

③ High dose dexamethasone test, MRI brain, abdomen  
ACTH levels

$G_3 P_2 + 0 \rightarrow$  Qandeeb



STATION NO: 19

Total Marks:

PG at 8 weeks has presented to you with following blood reports.

- Hb - 8gm%  $\downarrow$   $\downarrow$ h
- P. Smear microcytic hypochromic anemia
- S. ferritin 40pg/l
- Hb electrophoresis
- HB A - 10 %
- Hb A2 - 85 %
- Hb F - 5%

- A. Diagnosis (1)
- B. Next test that you will advise (1)
- C. Risk of transmission of disease to off spring (3)
- a. If only mother is affected.
- b. If both parents are affected.



## A. Diagnosis:

Beta-Thalassemia minor or Intermedia

Microcytic Hypochromic Anemia

Low Hb (6 gm%)

Hb Electrophoresis: ↑ Hb A2 (85%), ↓ Hb A (10%), ↑ Hb F (5%)

## B. Next Test to Advise:

Genetic Testing for Beta-Thalassemia Mutations

Partner's Hb Electrophoresis

Iron Studies to Rule Out Iron Deficiency

## C. Risk of Transmission:

If Only Mother is Affected: Child may be a carrier (50% risk)

If Both Parents Are Affected: 25% risk of Beta-Thalassemia Major, 50% carrier, 25% normal





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**Station Number :** \_\_\_\_\_

- Q.1. 26 Yrs P<sub>1-0</sub> presents in Gynae OPD with the complaint of vaginal discharge for last one week. On per speculum examination, discharge is cruddy white. What is the most likely cause for this discharge?
- Q.2. Name two common predisposing factors for fungal vaginal discharge.
- Q.3. Name organisms responsible for vaginal discharge.
- Q.4. Give Amsel criteria for diagnosis of bacterial vaginosis.

34 / 70



## Vaginal Discharge Case

### 1. Most Likely Cause:

Vaginal Candidiasis (Thrush) – Characterized by curdy white discharge

### 2. Predisposing Factors for Fungal Vaginal Discharge:

Diabetes Mellitus

Immunosuppression (HIV, Steroid Use, Pregnancy, Antibiotic Use)

### 3. Organisms Responsible for Vaginal Discharge:

Fungal: Candida species



Bacterial: *Gardnerella vaginalis* (Bacterial Vaginosis)

Parasitic: *Trichomonas vaginalis*

4. Amsel Criteria for Bacterial Vaginosis (Need 3/4 for Diagnosis):

Thin, homogenous gray-white discharge

Positive Whiff Test (Fishy odor on adding KOH)

Clue Cells on Microscopy

Vaginal pH > 4.5

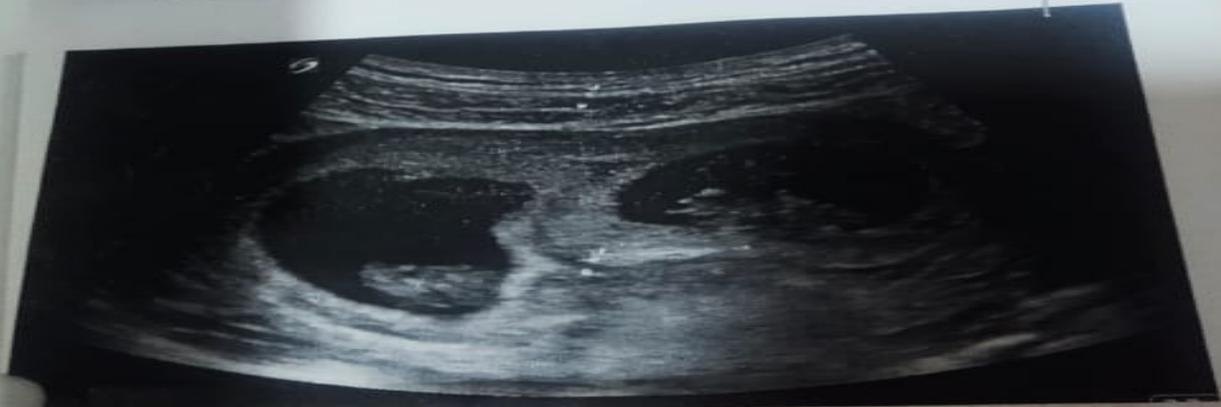




Total Marks: 16

STATION NO: \_\_\_\_\_

1. What is the diagnosis. (1)
2. What are the antenatal fetal complications of this condition. NAME ANY 3 (1)
3. What are the antenatal maternal complications of this condition. NAME ANY 3 (2)
4. What are the features on abdominal examination suggestive of this condition. (2)



Station- 4:

Diagnosis - Twin pregnancy

- 2- Fetal complication.
  - Miscarriage
  - Preterm delivery
  - cord entanglement
  - Twin-Twin transfusion syndrome
  - IUGR.
- 3) Maternal complication.
  - Anemia,
  - Preclampsia,
  - Hypemesis gravidum, Gestation, diabetes, P. Previa, APH

- Abdominal Ex - Finding
  - uterus larger than expected date.
  - 3 or more fetal pole palpable.
- Two F. Heart sound on auscultation



Station (17).

A 50 years old unmarried lady presented with 3x4 cm painless hard lump in upper outer quadrant of right breast for last 6 months now she is also complaining of nipple retraction and blood stain discharge from nipple of right Breast?

1. What your diagnosis
2. How you will Manage
3. Treatment option



Station 1 = Ca of breast (invasive ductal carcinoma)

2 = Triple assessment →

① clinical Ex

② mammography

• USG  
• MRI

③ FNAC  
Trucut biopsy  
incisional  
biopsy

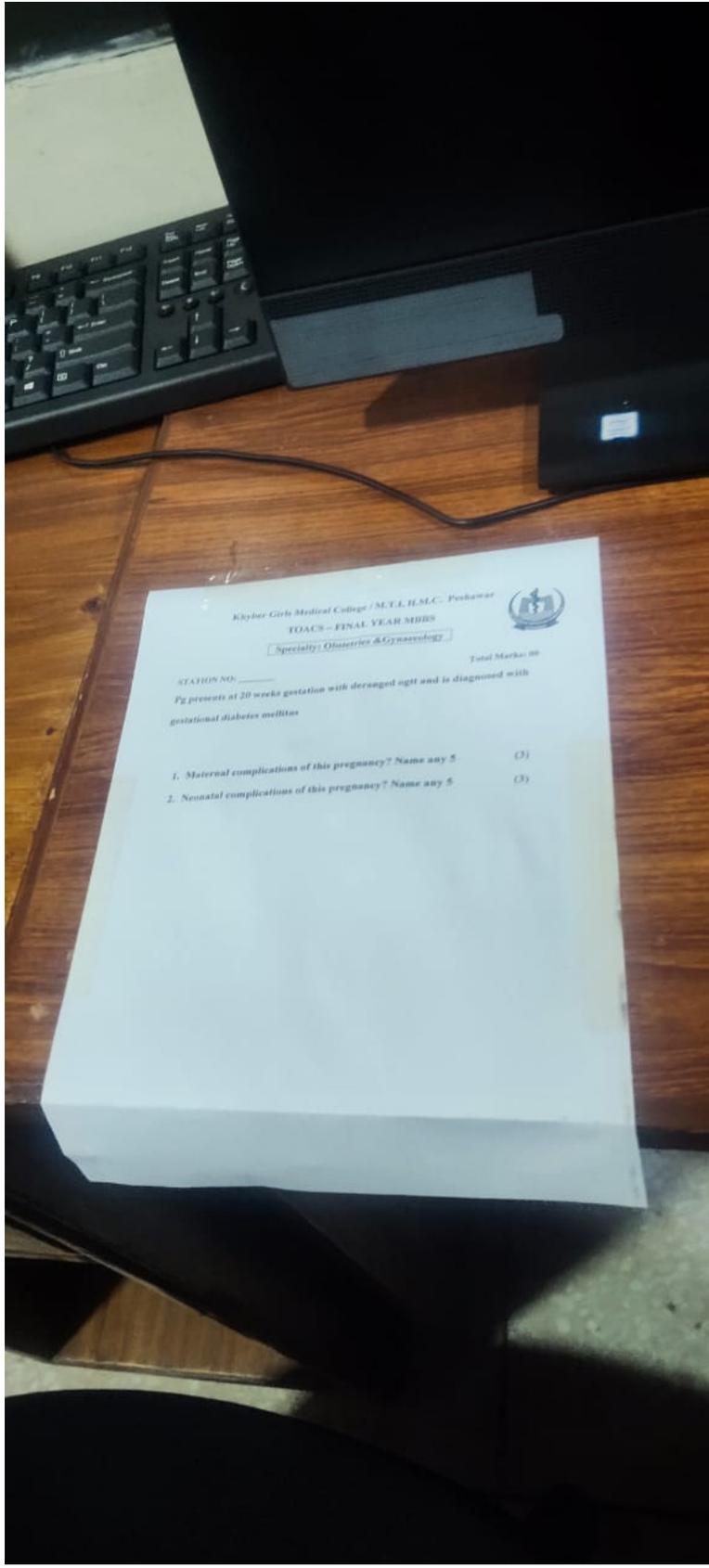
3) = Surgery → Breast conserving surgery

• Mastectomy

• chemotherapy

• Radiotherapy & Hormonal therapy





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FOACS – FINAL YEAR MBBS  
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STATION NO: \_\_\_\_\_ Total Marks: 10  
Pg presents at 20 weeks gestation with deranged sgt and is diagnosed with gestational diabetes mellitus

1. Maternal complications of this pregnancy? Name any 5 (3)
2. Neonatal complications of this pregnancy? Name any 5 (3)



station < 7

1) Diabetes

Maternal complication:

Fetal complication:

- Spontaneous abortion
- congenital anomalies
- Macrosomia
- Preterm birth, PPH, Polyhydramnios
- Oligohydramnios

↓ Pre-eclampsia

↑ risk of infection

PPH, shoulder dystocia

↑ risk of operative delivery

DKA

