Clinical round in OBs & GYNE

Obstetric Physical examination

General Approach

Make sure to always provide **comfort** and sense of **privacy** -

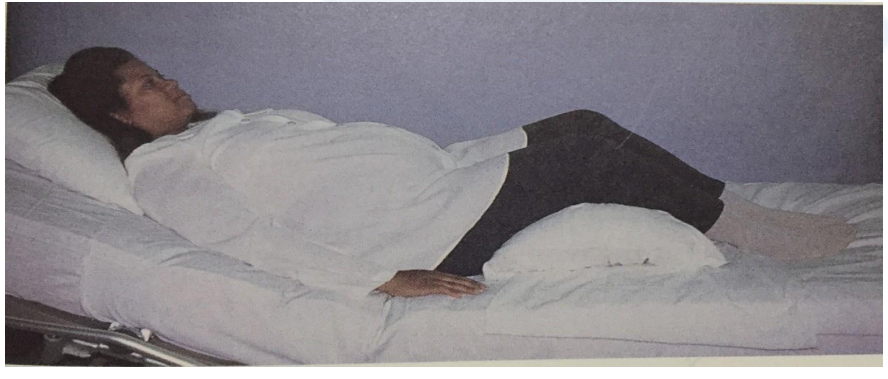
Instruct the patient **to empty her bladder** prior to examination -

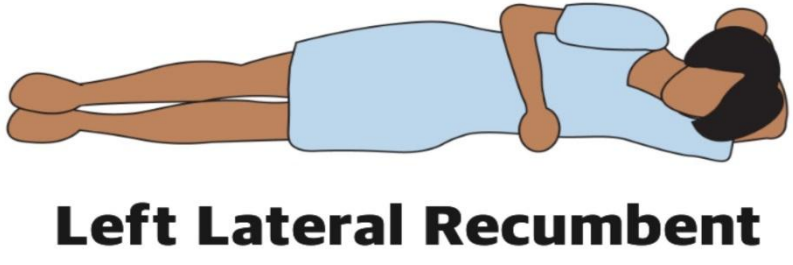
.Exposer from the **symphysis pubis** to the **xiphisternum** -

Positioning

Semi-sitting position with the knees bent supported by a as protection from pillow affords the greatest comfort, as well the negative effects of the weight of the gravid uterus on abdominal organs and vessels.

.In late pregnancy in the **left lateral position**





Left Lateral Recumbent

General examination

Appearance (inspection of overall health, nutritional - status, emotional state, neuromuscular coordination)

- **Weight, Height, BMI**

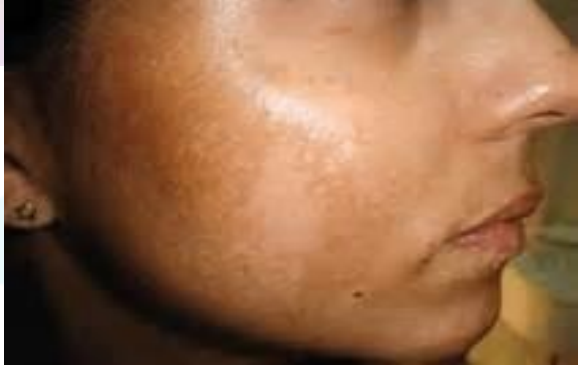
- **Vital signs** (BP, pulse rate, temperature)

Head and Neck

Skin pigmentation changes

CHLOASMA/"MELASMA GRAVIDARUM"

-- irregular brownish patches of varying size appear on the face and neck —the so-called *.mask of pregnancy*



Head and Neck

Hair: note texture, moisture and distribution; dryness, oiliness and .minor generalized hair loss may be noted

Eyes: anemia of pregnancy may cause pallor.

Nose: nasal congestion is common among pregnant women; nose bleeds also common.

Mouth: inspect gums and teeth; gingival enlargement with bleeding is common.

Thyroid: symmetrical enlargement may be expected; marked .enlargement is not normal during pregnancy

Heart

be Palpate the apical impulse; In advanced pregnancy, it may slightly **higher** than normal because of dextrorotation of the heart due to the higher diaphragm

Auscultate the heart; **soft blowing murmurs** are common, reflecting the increased blood flow in normal vessels

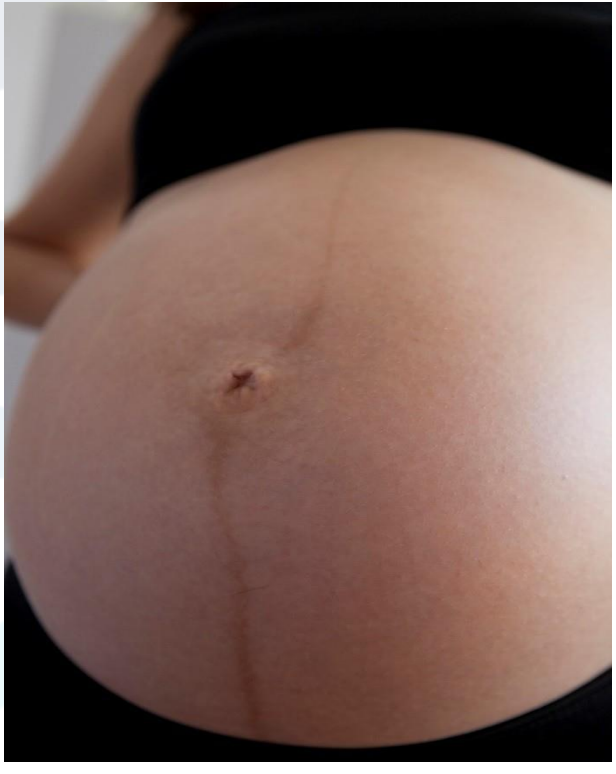
Abdomen

Inspection: skin changes

darkening of the linea alba **Nigra Linea**
abdominal skin from (midline of the
symphysis pubis) xiphoid.

melanophores by increase in melanocyte

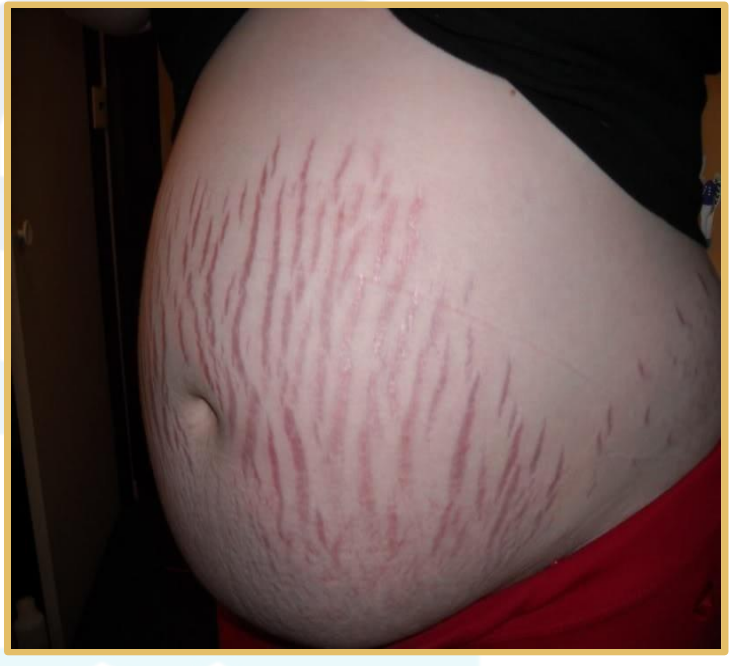
. due to stimulation of stimulating hormone



Abdomen

”Striae gravidarum: “Stretch marks

separation of the underlying collagen tissue (secondary to stretching of the abdomen) and appear as irregular scars



becomes silvery after reddish or purplish delivery

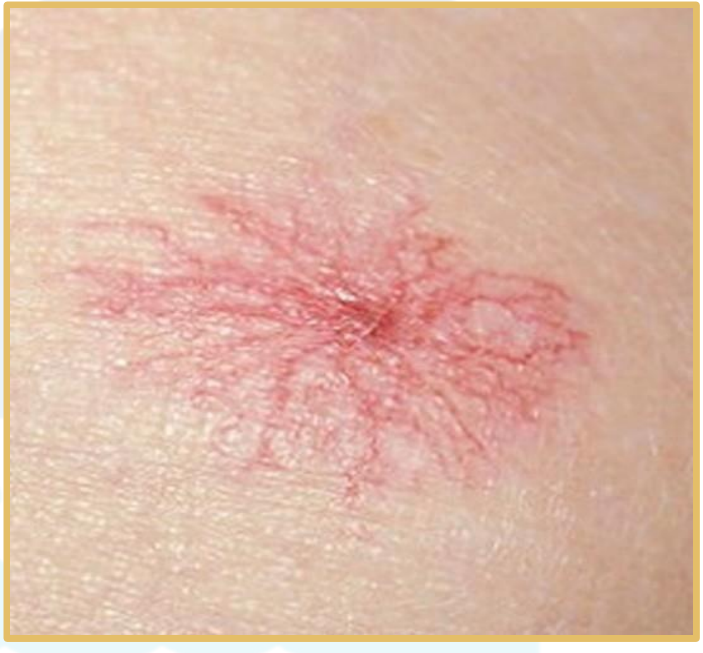
associated **risk factors** are weight gain during pregnancy, younger maternal age, .and family history

Abdomen

Spider telangieactasia:
vascular stellate marks resulting from high levels of estrogen

blanch when pressure is applied

palmar erythema is an associated sign typically develops in face, neck, upper chest and arms

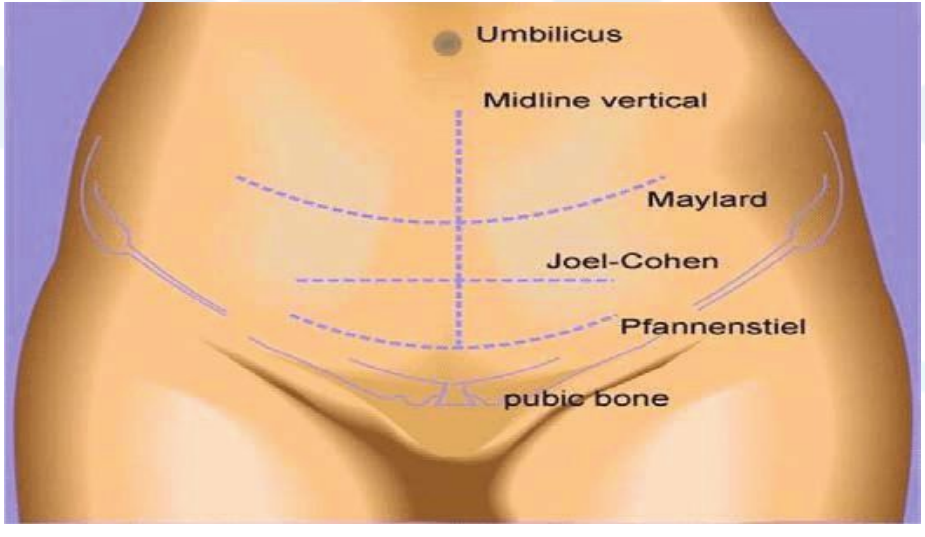


Abdomen

Scars:

Obs: Pfannenstiel, Joel-cohen, below umbilicus midline

Gyne: Above umbilicus midline, Cherny, Maylard, Lap incisions



Abdomen

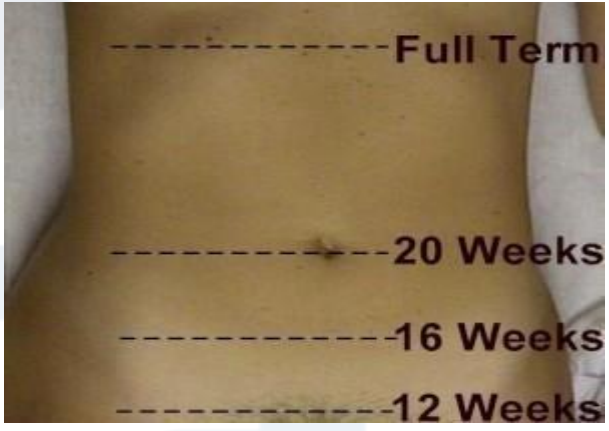
Palpation: **Abdominal Enlargement**

to 12 weeks AOG: uterus is a pelvic organ 0

weeks AOG: uterus at symphysis pubis 12

16 weeks AOG: midway between symphysis pubis and umbilicus

weeks AOG: umbilical level 20



Linear measurement from the symphysis pubis to the uterine fundus on an empty bladder correlates with AOG at 16-32 weeks
example: 20 weeks AOG = 20 cm

:Large for gestational age DDx

Wrong date, polyhydraminos, multiple gestation, fibroid, macrosomia.

Small for gestational age DDx:

Wrong date, oligohydraminos, transverse lie, smoking, PROM, placental insufficiency

Abdomen

Palpation

Perception of **fetal movement** by the examiner

- Examiner may feel fetal movement **after 24 weeks** AOG (felt by the mother around **18 weeks** - "quickening")

:**Uterine contractility**

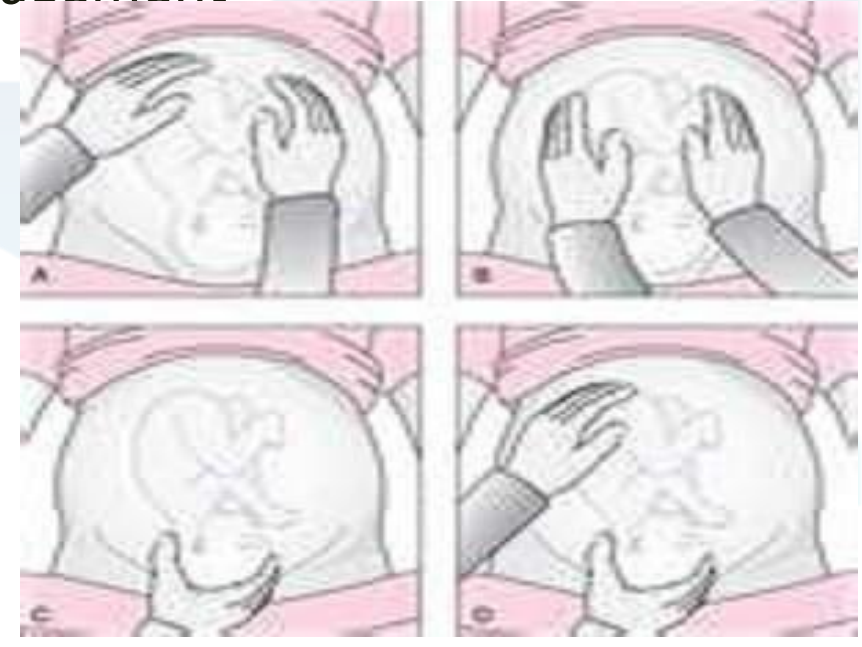
- *abdomen feels tense or firm to the examiner, especially if the patient is in labor, or near term ("Braxton-Hicks contractions")*

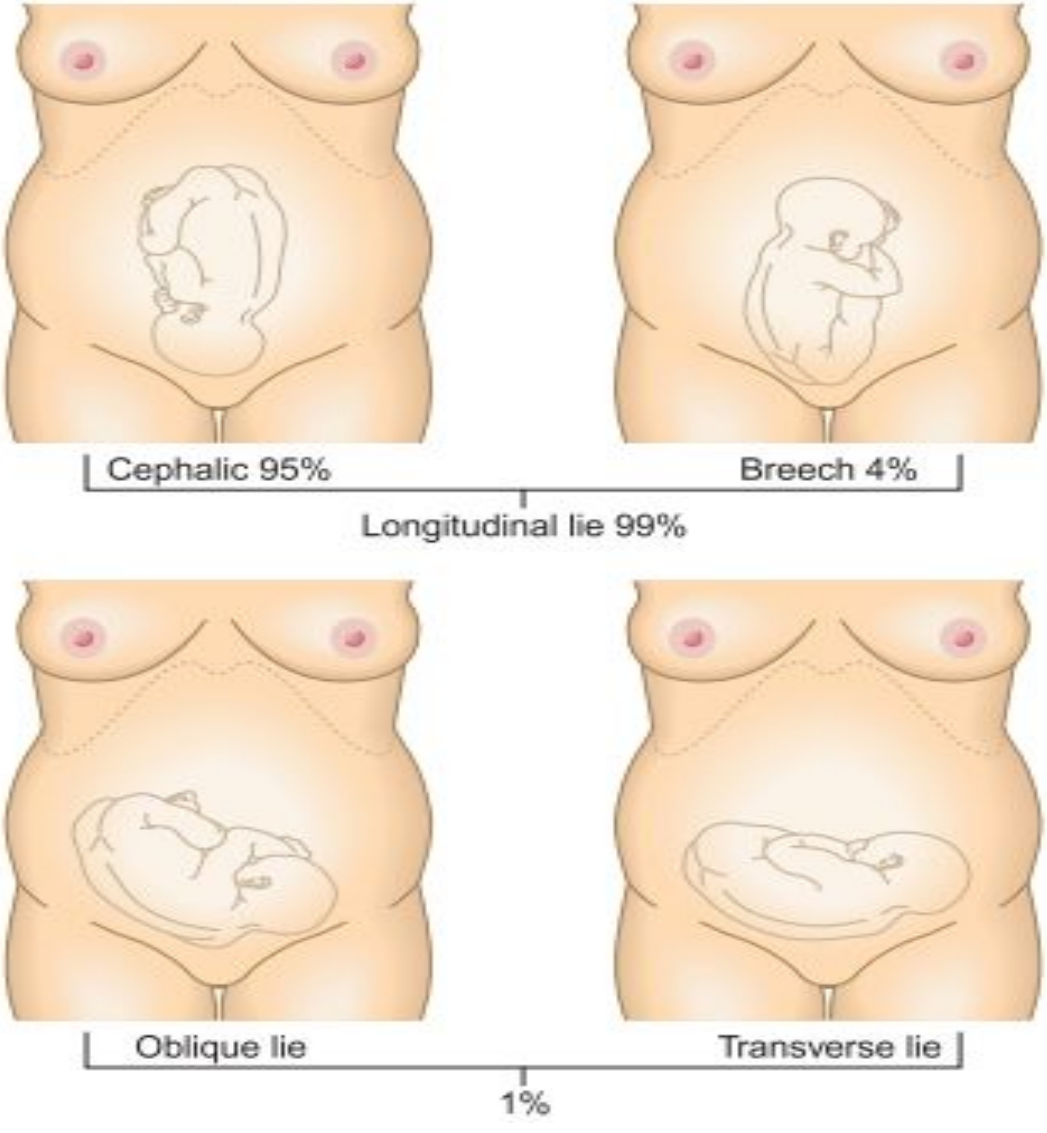
Some fetal parts become palpable, esp if mother is non-obese

Leopold’s maneuver

Palpation

Abdominal exam to determine lie, fetal presentation, .presenting part, and engagement




Cephalic 95%
Breech 4%
Longitudinal lie 99%
Oblique lie
Transverse lie
1%

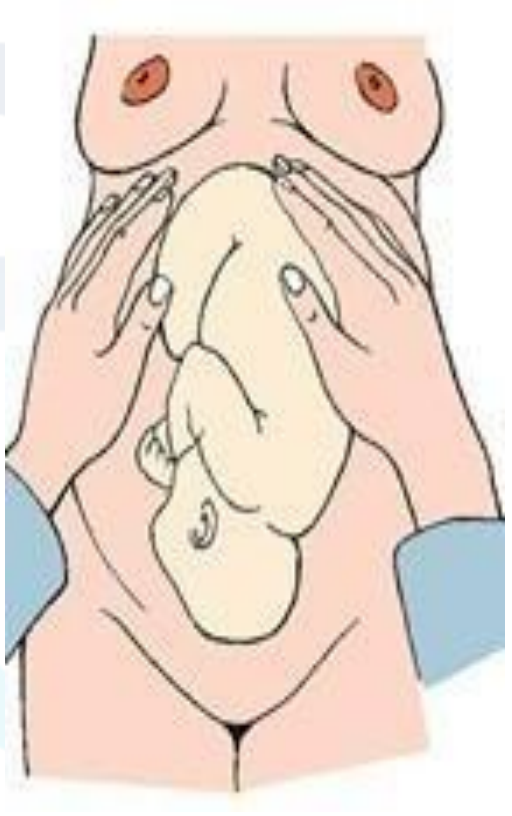
Leopold’s maneuver

1st Leopold’s maneuver
”“Fundal grip

Uterine fundus is palpated to determine which fetal part occupies the fundus

Fetal head should be round and hard, ballottable
Breech presents as a large nodular mass

Also it estimates the liquor volume

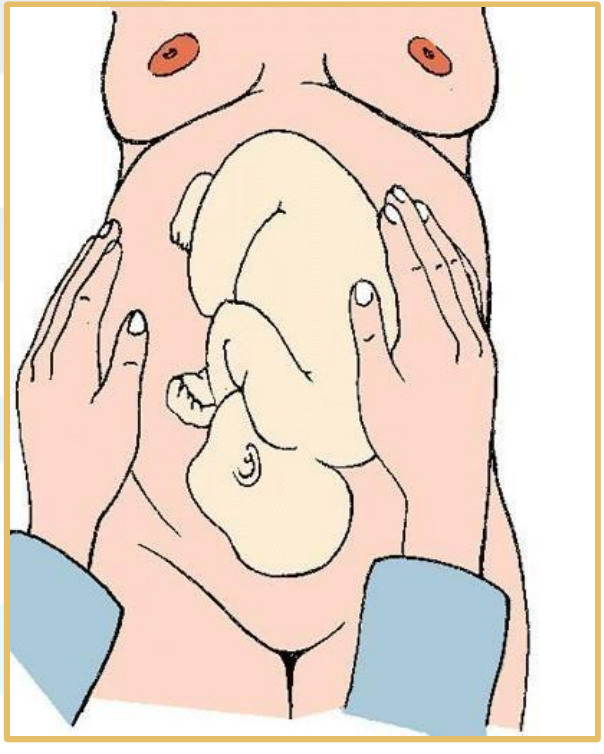


Leopold’s maneuver

2nd Leopold’s maneuver

“Lateral grip”

Palpation of paraumbilical areas or the sides of the uterus to determine which side is the fetal back



Fetal back feels like a hard, resistant, convex structure

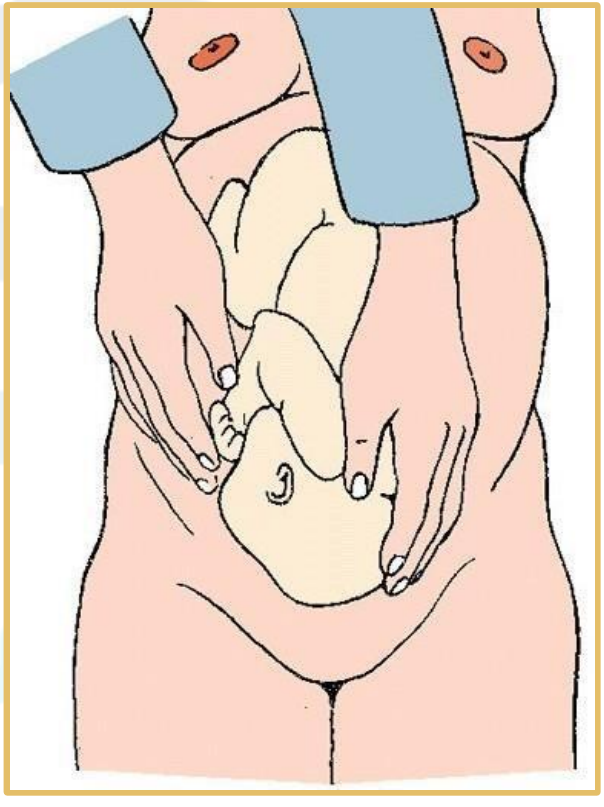
Fetal small parts feel nodular, irregular

Leopold’s maneuver

3rd Leopold’s maneuver
1st pelvic grip

Palpation of the bilateral lower quadrants to determine presentation and presenting part

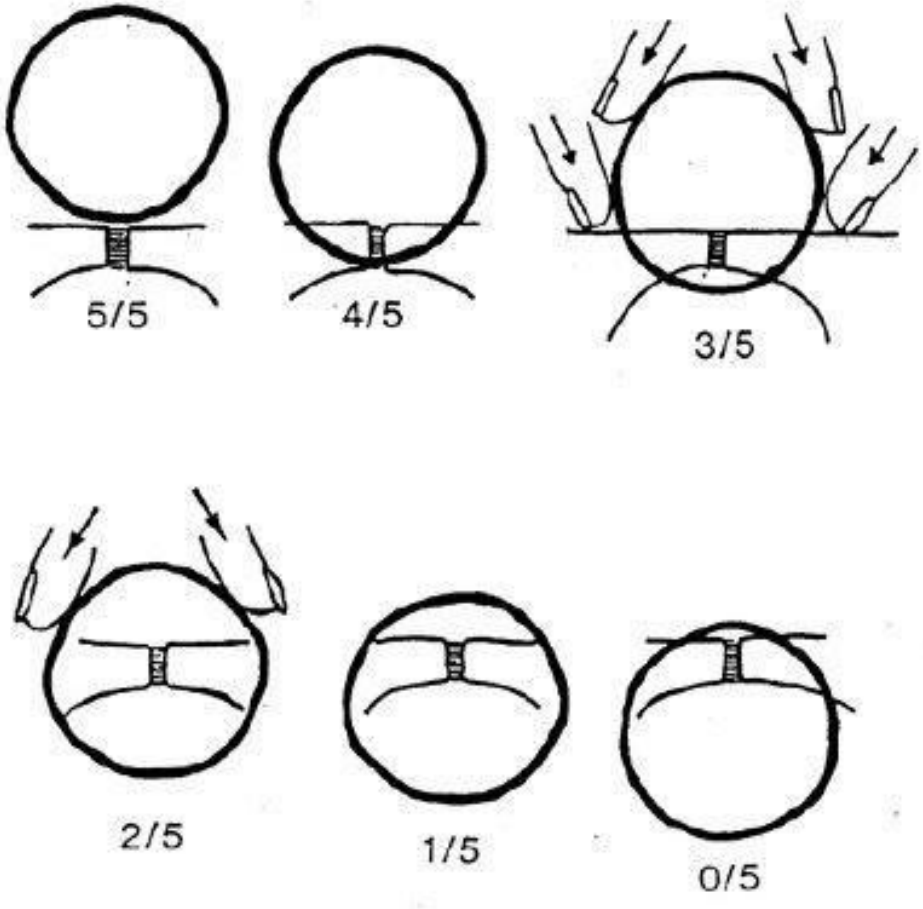
The back of the examiner toward the patient but looking at the patients face for any tenderness



Leopold’s maneuver

4th Leopold’s maneuver
Pawlik’s grip”=2nd pelvic grip

Suprapubic palpation using thumb and fingers just above the symphysis pubis, to *determine engagement* (when the widest diameter of the presenting part passes through pelvic inlet)


5/5
4/5
3/5
2/5
1/5
0/5

Abdomen

Auscultation: Identification of fetal heart beat;

heard between fetal back and head

FHR is usually at a range of 110-150 bpm,

160 if preterm

Detected through stethoscope or fetal Doppler

(sonicaid fetal doppler)

Thank you