LSU OBGYN

STUDENT GUIDE

WELCOME TO YOUR OBGYN ROTATION!

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COMMON ABBREVIATIONS

1°LTCS- primary low transverse cesarean section
AFI- amniotic fluid index
AROM- artificial rupture of membranes
BPP- biophysical profile
BSO- bilateral salpingo-oophorectomy
BTL- bilateral tubal ligation
CKC- cold knife conization
D&C- dilation and curettage
EAB- elective abortion
EDC- estimated date of confinement (due date)
FAVD- forceps assisted vaginal delivery
FHT- fetal heart tones
FM- fetal movement
FTP- failure to progress
G #P# noted as G2P1001
G (Gravida)- # times they've been pregnant
P (Para)- divided into TPAL
T (Term)- # full term births
P (Preterm)- # preterm deliveries (20- 36 6/7 weeks)
A (Abortions)- #spontaneous or elective abortions before 20 WGA
L (Living)- # children still alive
GDM- gestational diabetes mellitus
HLIV- hep-lock IV
Hystero- uterus
IUFD- intrauterine fetal demise
LAVH- laparoscopic assisted vaginal hysterectomy
LEEP- loop electrocautery excision procedure LMP- last menstrual period
LOF- leakage of fluid
NST- nonstress test
NSVD- normal spontaneous vaginal delivery
NT/NE- non-tender/non-engorged (breast exam)
PIH- pregnancy-induced hypertension
PMP- previous menstrual period
PNC- prenatal care
POC- products of conception
PPROM- preterm premature rupture of membranes
PROM- premature rupture of membranes
PTL- preterm labor
RLTCS- repeat low transverse cesarean section
RTC- return to clinic
SAB- spontaneous abortion
SLIUP- single live intrauterine pregnancy
SROM- spontaneous rupture of membranes
TAH- total abdominal hysterectomy
TLH- total laparoscopic hysterectomy
TOA- tubo-ovarian abscess
TOD- time of delivery
TVH- transvaginal hysterectomy
US- ultrasound
VAVD- vacuum assisted vaginal delivery
VB- vaginal bleeding
VBAC- vaginal birth after cesarean
VFI- viable female infant
VMI- viable male infant
WGA- weeks gestational age
Buff chart - start discharge paperwork/ prescriptions

COMMON PRESCRIPTIONS

Azithromycin 1 gram Disp: 1 pill Sig: 1 po x 1 dose	Lortab 7.5/500mg Disp: #30 (Thirty) Sig: 1-2 po q 4-6 hours prn pain No refill
Colace 100mg (give to those on iron BID/TID) Disp: #60 Sig: 1 po BID prn constipation Refill x 6	MOM (Milk of Magnesia) 30mL Sig: 1 po q 6 hrs prn constipation
Ceftriaxone 150mg Sig: 1 IM x 1 dose	Motrin 800mg & Anaprox DS Disp: #20 Sig: 1 po q 8 hours prn pain Refill x 1
Dulcolax suppository 10mg Sig: 1 per rectum x 1 dose	Mylicon 80mg Sig: 1 po q 6 hrs prn gas
Fergon 325mg Disp: #30/60/90 Sig: 1 po daily/BID/TID Refill x 6	Percocet 5/325mg Disp:#30 (Thirty) Sig: 1-2 po q 4-6 hours prn pain No refill
Flagyl 500mg Disp: #14 Sig: 1 po BID x 7days	Prenatal vitamins Disp: #30 Sig: 1 po daily Refill x 6

OBSTETRICS

What is a normal morning like on OB? (Times/experiences may differ depending on location)

- You will round and write progress notes on post-op and post-partum patients in the morning. Residents will tell you when to have your notes done by. Be timely with your notes. The first year resident has to see all patients after you.
- Always introduce yourself to the nurses. They can help you so much.
- Check the orders section every morning to see if something new has been ordered. Make sure you check labs every morning- f/u cultures, etc.
- For Baton Rouge:
    - Residents will want notes done by 6am, but you are not allowed to get to the hospital before 5 am and cannot go into a patients room before 5:30. This leaves you rushed to see your patient(s), get the vitals and medicine records from the nurses, and write your note and have in the chart in 30 minutes.
    - You can go on the computer in the residents lounge, and look up your patient before you see them, all the vitals/any new labs will be there. So basically, get there at 5 am, look up your patient on the computer and write down vitals and changes in meds, new labs, etc. so that when you go see your patient(s) and write your note, you'll already have that information.
- **If a patient complains of chest pain, SOB, leg pain, etc., speak with resident before writing it in the chart.** (chest pain could be heart burn and most pregnant women feel short of breath normally)
- Have your notes ready and in the chart before the resident. Make a copy of your note on the copy machine (usually one at the nurse's station), so you have a copy for rounds, and place your note in the chart.
- Begin working on discharge papers when you start seeing the patient. Discharge work is very helpful for your residents
- Have prescriptions written: check with staff, usually Percocet, iron tablets, colace (stool softener)
- After you write your note, meet for rounds. You will present your patient to staff. Ask your resident/staff if they want the full soap note presentation or the

pertinent information.

- If you are on call that day, you should follow the on-call team at the hospital starting at noon. However, the on-call team may not have anything to do and may tell you go to clinic and they will call you if something comes up.
- After clinic, back to the hospital for check-out (where the day team tells the night team about the current patients in hospital). Then home. If on call, follow the night team after check-out.

What are good questions to ask a post-op/post-partum patient in the morning?

- How do you feel today? etc.
- Have you been up moving around (basically are you ambulating?)
- Have you passed gas or had a bowel movement? (if they had a c-section)
- Are you cramping?
- Are you having any vaginal bleeding (lochia)? If so, is it less than, equal to, or greater than your normal period?
- Dizzy? Fatigued? Lightheaded upon standing? Palpitations? Shortness of breath? (looking for s/s of anemia)
- Are you breast feeding?
- Are you having pain in your breasts? Are they engorged?
- What kind of birth control are you taking? Do you plan on using birth control, and if so, what kind?
- Are you sore? Itching? Painful urination? Increased frequency? Blood in urine? (make sure to check before you see the patient if she had an episiotomy or if she still has a catheter)
- Headaches? Vision changes?
- On physical exam, extra things:
    - Feel for fundus of the uterus- and put on note: uterus is at the umbilicus, or how many centimeters below the umbilicus
    - Lochia (vaginal bleeding): Less than normal menses

- Check for calf tenderness (DVT)

How do I manage a post-partum patient?

- Learn how to buff the chart- fill out discharge summary and write prescriptions. You can do this at any time after the patient delivers. Have someone teach you how to do this.
- On C-section patients with pfannensteil incision (bikini cut), you can remove their bandage on POD#1 and remove staples on POD#3 before the patient goes home. Have someone show you how to do this. Apply benzoin and steri-strips. Counsel the patient that they may shower and use dove/dial antibacterial soap to clean it. It should heal within 2 weeks. They should keep it dry and clean. They may remove the steri-strips in the shower after 7 days.
- POD#1 orders for C-section patients (write these on the order sheet and have a resident sign them, also different now with EMR):
  1. Discontinue foley
  2. Activity: Ambulate TID with assistance; Patient may shower
  3. Diet: Advance as tolerated
  4. Heplock IV when tolerating po
  5. Discontinue IV/IM pain meds when tolerating po, then switch to po pain meds:
     Lortab 7.5/500mg 1 po q 4 hours prn pain level 1-5
     Lortab 7.5/500mg 2 po q 6 hours prn pain level 6-10
     Also can use Percocet 5/325mg
     Motrin 800mg 1 po q 8 hours prn pain
     MOM 30 ml po q 6 hours prn constipation
     Mylicon 80mg po q 6 hours prn gas
     May have Toradol 30 mg IV/IM q 6 hours prn pain (Max 4 doses)
- For 3rd and 4th degree tears we add:
  Colace 100mg 1 po BID prn constipation
- If patient wants OCP's write prescription to start 6 weeks postpartum b/c increased risk of blood clots. Patients with high BP do not get OCP's.
- If patient is breastfeeding, use micronor or Depo provera (at discharge) - Micronor is Progesterone only; can be started at discharge.
- Please be on time for writing notes in the morning as the intern needs to write a note on every patient after you and needs the chart.
- Before entering the patient room, review type of delivery and hospital day. Go into the room and introduce yourself as student doctor. Ask if they had any problems overnight. Listen to their heart and lungs and abdomen. Check the fundus- it will be near or below the umbilicus (should be firm). Make sure breasts are not engorged. Check pad for bleeding (wear gloves)- should be slow ooze. Write your note. On PPD#1/POD#1 include baby information (male/female; apgars; weight).

How should I organize and write my post-partum note?

L3 Postpartum Note (Vaginal Delivery)
X yo GxPxxxx s/p SVD PPD#1 of VMI/VFI 6# with apgars of 9/9 on date and time with x laceration. Pt. desires OCP/Patch/Depo for birth control. Pt. is bottlefeeding, breastfeeding or both. PNC at LSU (or other clinic). Pt. tol po and ambulating with no complaints.
VS: Tmax Tcurrent BP P RR
Gen: A&Ox 3, NAD
CV: RRR
Lung: CTAB
Breast: NT/NE
Abd: Soft, NTND +BS
Fundus: Firm, non-tender, below the umbilicus
Lochia: Minimal
Ext: No C/C/E
Labs: Pre-delivery CBC and Postpartum CBC, Blood type, RPR, Rubella
A/P: Xyo GxPxxxx s/p SVD PPD#1- Doing well

1. Routine postpartum care
2. Bottlefeeding- bind breasts or Breastfeeding
3. Birth control plan
4. Will d/c after 48 hours if afebrile and f/u at 6 weeks postpartum in clinic

L3 Postpartum Note (Cesarean Delivery)
X yo GxPxxxx s/p 1LTCS or RLTCS b/c of (indication) POD#1 of VMI/VFI 6# with apgars of 9/9 on date and time with x laceration. Pt. desires OCP/Patch/Depo for birth control. Pt. is bottlefeeding, breastfeeding or both. Pt. had PNC at LSU (or other clinic). Pain well controlled. Pt. tol ice chips, +/- Flatus, +/- Bowel movement. Patient has not ambulated yet.
VS: Tmax Tcurrent BP P RR Urine output
Gen: A&Ox 3, NAD
CV: RRR
Lung: CTAB
Breast: NT/NE
Abd: Soft, NTND +BS (BS very important in post-op patient)
Incision: C/D/I (clean/dry/intact)- pull off bandage on POD#1
Fundus: Firm, non-tender, below the umbilicus
Lochia: Minimal
Ext: No C/C/E No calf tenderness, SCD's and/or TED's in place
Labs: Pre-delivery CBC and Postpartum CBC, Blood type, RPR, Rubella
A/P: Xyo GxPxxxx s/p SVD PPD#1- Doing well

1. Advance to POD#1 orders
2. Bottlefeeding- bind breasts or Breastfeeding
3. Birth control plan
4. Encourage ambulation
5. Will d/c after 72 hours if afebrile and f/u in 2 weeks for incision check.

How do I present a patient on rounds?

Patient presentations should be focused, in the format of an H&P and GOAL DIRECTED.

HPI: This is Postpartum/Post operative Day #1 for Ms. Jones who is S/P RLTCS/ BTL (for h/o previous C/S*2) of VFI w/ Apgars 8/9. No complaints this AM. +Flatus. Tolerating PO. Bottle-feeding.

Vital Signs: T: 98 BP: 120/80 P: 78 R: 16 Uop~45cc/hr

Exam: Gen-AO*3; CV: RRR; Lungs: CTAB; Breast: Nontender/Non Engorged; Abd: Soft +BS; Incision: C/D/I (+staples or +steri-strips in place); Uterus: Firm/ below the umbilicus; Lochia: moderate rubra; Ext: No clubbing/cyanosis/edema/ calf tenderness.

Labs: Bld type/screen; Rubella status, HIV status, Hepatitis status, GBBS status, any pertinent labs.

Assessment/Plan: PP/postop day #1 for Ms Jones, doing well- Will advance to POD #1 orders.

(same type of presentation is expected on GYN Patients).

How do I evaluate a patient in triage/L&D?

- Triage is our mini emergency room. OB triage is run by the intern and supervised by the 2nd year resident. Here we are trying to determine if the patient needs to be admitted or can go home.
- Follow the intern/resident initially to get oriented. If it is really busy, offer to start the H&P on the patient and then present to the intern/resident (see Triage H&P note). Do the physical exam but wait to do the vaginal exam with the intern/ resident. **DO NOT write the following in your note:** chest pain (it may just be heartburn), SOB (most pregnant patients feel this way normally), weakness, dizziness or leg pain until you have spoken to the intern or resident first (this

applies to all notes while on this rotation).

- **Important question for ALL obstetric patients (5 common questions)**: vaginal bleeding? vaginal discharge? leakage of fluid? contractions- if so, how often? fetal movement?
- To learn cervical exams, grab a pair of gloves when the intern or resident checks the patient. It is best to teach you the cervical exam once the patient has an epidural.
- You can all help by trying to help gather supplies for the patient exam. Ask the resident/ intern or nurse for the location of the following:
    1. Culture swabs: Gonorrhea/Chlamydia culture, Group B strep culture
    2. Wet prep: Q-tips, slide, slide cover slip, and normal saline ampulle
    3. Sterile speculum
    4. Bed pan and chux pad
    5. Light
- Many of the patients have been seen in clinic or in triage before. The nurse will pull out the patients chart in the file cabinet. Use CLIQ (ILH/UMC) or Soarian (Touro) to get prenatal labs and ultrasound info.
- If they've had a previous c-section find out the indication and print the operative report.

What are the most common complaints presented at triage/L&D and how are they managed?

1. **Rule out active labor in a full term patient:** This patient may only need a cervical check and monitoring to determine if they are in labor. If the cervical exam is 4cm dilated, they will likely get admitted. You should also make sure that the patient has **consents** (blood transfusion, vaginal delivery and cesarean section).
    a. **Specific questions to ask:** quality of pain, location, dysuria, nausea/ vomiting?

2. **Rule out preterm labor (<37 weeks pregnant):** Most common cause is **infection.** This patient will need a cath UA, cultures and a wet prep- start collecting the supplies (as above). They may also perform a fetal fibronectin test. If they are in PTL, they will require IVF's, tocolysis, steroids and antibiotics. Read about this and understand why they use them.
    a. **Specific questions to ask:** PTL in prior pregnancy, dysuria, substance

abuse?

3. **Rule out rupture of membranes:** There are 3 test to confirm this: (1) pooling of fluid in vagina, (2) nitrazine test- test pH (amniotic fluid- blue), and (3) ferning test. You can help by collecting the supplies with an additional slide for the ferning test. If they are ruptured, they will be admitted.
    a. **Specific questions to ask:** time of rupture, color of fluid, urinary incontinence?

4. **Evaluation of high blood pressure:** The patient will need lab work (LFT's, CBC, CMP, LDH, Uric acid and UA (urine dip done first for protein). We are working up the patient for pre-eclampsia. Check their DTR's on exam. This patient may require blood pressure management and magnesium sulfate for seizure prophylaxis. Read about this topic, eclampsia and HELLP syndrome!
    a. **Specific questions to ask:** headache, vision changes, RUQ pain, h/o HTN or PIH, recent tobacco or drug use?

5. **Evaluation of trauma in a pregnant patient:** This patient will need an US to rule out abruption, a speculum exam and monitoring for contractions as well as a CBC and type & screen.
    a. **Specific questions to ask:** description and time of trauma, direct abdominal trauma, abuse, drug use?

6. **Evaluation of nausea and vomiting in pregnancy (rule out hyperemesis gravidarum):** Depending on the severity, the patient may need labs drawn- LFT's, CMP, Amylase, Lipase, UA (check for ketones), CBC- and will also have to tolerate p.o prior to discharge. Don't forget to consider other disorders of the GI tract: appendicitis, pancreatitis, hepatitis, cholecystitis, UTI, pyelonephritis or fatty liver of pregnancy.
    a. **Specific questions to ask:** duration, abdominal pain, fever/chills, last time ate or drank something, weight loss.

7. **Evauluation of vaginal bleeding (rule out placenta previa/abruption):** Vaginal spotting is often caused by labor/PTL/ROM/ prior cervical exam/sex/STD. No matter what the cause, US will be done to evaluate for previa/abruption.
    a. **Specific questions to ask:** onset, amount, last intercouse, trauma, prior C/S, drug or tobacco use, h/o prior abruption, Rh status, exam earlier that day?

8. **Decreased fetal movement:** The patient will get an NST and US for BPP if necessary. NST is a FHR tracing where we look for 2 accelerations of 15 beats above the baseline lasting for 15 seconds- if so the baby is reactive (reassuring). A BPP is where we check the amniotic fluid index, the baby's tone, flexion/

extension, breathing and NST. Each category gets 2 points and if 10/10, considered reassuring.

   a. **Specific questions to ask:** accurate gestational age, trauma, contractions, bleeding?

9. **Fever:** The patient will need a cath UA to r/o pyelonephritis, CBC, and may need further workup depending on symptoms (CXR, etc.)

How should I organize and write my note for a triage H&P?

This format can be used for all H&P's in OBGYN.

The hardest part of writing an H&P on an OB patient is to figure out how they are dated. Is it by LMP alone (no US), LMP consistent with an US (need documented US), or by US only and inconsistent with their LMP? Your intern/resident will help you to determine this. The patient usually does not know, but it will be in their chart if they have been seen in clinic or triage before.

Date/Time
CC: Contractions
HPI: 36 yo G3P2012 @ 39 6/7 WGA by LMP c/w 10 wk US presents with complaints of (Ctx, ROM, VB, decreased FM, dysuria, abd pain, trauma). Pt. denies vaginal bleeding, vaginal discharge, ROM, occ. ctx, positive fetal movement. Prenatal care with LSU (or other clinic).
PMHx. HTN/DM/Asthma?
PSHx: C/S? If gyn surgery, ask if it was laparoscopic or open, indication (especially in hysterectomy), do they still have their tubes and ovaries?
Meds: PNV/Fe? Other meds, if so put dosage/frequency/etc.
Allergies: to meds? what reaction?
POBHx:
Year of delivery/NSVD or C-section or forceps (reason for c-section)/vacuum/weight/ male or female/preterm or fullterm/complications/hospital
(ex: 2003 1LTCS for failure to progress 6# fullterm no complications ILH)
PGYNHx: (1) Menarche/Time between cycles/Cycle duration
(2) Abnormal pap, if so when and did they ever have biopsies, cryotherapy (freezing)
or surgery on their cervix (CKC/LEEP)? Were their follow-up pap smears normal?
(3) STD's, if so when and if treated? Make sure you name them all:
(GC/Chl/HIV/Herpes/Hepatitis/Trichomonas/Syphilis), LMP, sexual history
(ex: 12/28day/7days; no abnormal paps; h/o chlamydia this

pregnancy- treated)
SocHx: Tob/EtOH/Drugs?
FamHx: health problems, birth defects, multiple births?
Vital Signs: pay attention to elevated BP
Gen: A&O x 3, NAD
CV: RRR (normal to hear flow murmur)
Lungs: CTAB
Abd: Gravid, NT, nl BS
Ext: No C/C/E (normal to have mild edema); DTR
EFM (external fetal monitor): baseline HR/accelerations?/decelerations?
Toco: ctx? if so, how frequent?
Cvx: Dilation/Effacement/Station (ex. 4/50%/0)
Labs: List all prenatal labs (Type & Screen, CBC, Sickle cell, HIV, Hep B, GC/Chl, Rubella, RPR, Group B strep, Urine culture, pap, O'Sullivan-1hr glucose)
Ultrasound: The intern/resident will do this. You can help fill out the report page.
A/P: 36yo G3P2012 with IUP @ 39 6/7 WGA with _____
You will formulate the plan with the intern/resident.

What are the most common reasons people are admitted?

- PTL- Ask the patient about contractions daily. If there is any concern, the resident will check the patients cervix. They may go home if they are stable. Know her last cervical check. Some patients need to stay until they are 34 weeks.
- Pyelonephritis- You will need to know how many hours the patient has been afebrile. Check for CVA tenderness every morning. Check the urine culture results every morning.
- DM control- Know her accuchecks each morning- ask the nurse if you don't see them in the chart. Have the resident discuss how we adjust insulin. Make sure she has a nutrition consult and diabetic teaching.
- Rule out pre-eclampsia- Ask the patient if she has a headache, vision changes, or RUQ pain. Know her BP's. Check her 24 hour urine results. Know the results of all her labs (CBC, CMP, LDH, Uric Acid, UA).

How do I deliver a baby?

1. Babies are coming out whether you are ready or not! Try to get dressed as fast as you can so that you can participate. Ask someone where to find boots, hat and mask with faceshield so that you aren't scrambling for it at the last minute.
2. Make sure that you put your sterile gloves and gown on the delivery table. Don't expect someone to get it for you.
3. Pick up the gown on the sterile field with your bare hands- the part of the gown

that touches you is not sterile. Put your hands in the sleeves but not past the white cuffs. Pick up the right glove with our left hand (which is still covered by the gown), place the glove on the right hand. Now your right hand is sterile and you can put on the left glove. Have someone tie the back of your gown and help you turn. Now you're ready! (If this process is confusing, have someone go over it with you when nothing is going on.)

4. Place the bottom drape under the patient and leg drapes.
5. Place fingers at the head of the baby.
6. Instruct mom to push while contracting- i.e. be a cheerleader counting 1-10/ breath 3 times during a contraction. Support the perineum with a raytek and apply upward pressure while the head crowns with one hand while supporting the head on top with the other hand so to deliver the head slowly and minimize perineal trauma.
7. As the head delivers, apply pressure to the head downward to deliver the head. Pancake the babies head between your two hands. Once the head is out, continue with downward pressure to deliver the anterior shoulder. Tell mom to stop pushing!!
8. Look for a nuchal cord. If there is one, try to reduce it over the baby's head. If it is tight or a double nuchal cord, the resident will clamp it and cut it.
9. Suction out the babies mouth then nose with the bulb suction.
10. Now deliver the posterior shoulder by elevating the head using both of your hands and lift upwards. The resident will be protecting the perineum as you do this. As the body delivers, use one hand to support the head and the other to guide the rest of the baby out.
11. Deliver the baby onto the mother's belly or your arm. Make sure the baby doesn't fall!! Congratulate the mom. The resident or you will place two clamps on the cord and cut in between. You can let the father cut the cord.
12. Pass the baby off to the nurse. Be careful...the baby is slippery!
13. The resident will obtain cord blood sample.
14. Deliver the placenta by gentle traction downward on the cord with one hand and at the same time applying suprapubic pressure with the other hand. Keep moving the clamp towards the perineum as you get more slack. Normal placental delivery can take up to 30 minutes. Don't pull too hard as you can avulse the cord or invert the uterus.
15. After the placenta is delivered, the resident or you will massage the uterus to ensure firmness and may sweep the uterus if necessary to remove clots.
16. The cervix is inspected for tears with the ring forceps. Then the vagina/perineum is examined for tears and repaired by the resident if necessary. You can help by blotting or helping to provide exposure for the resident.
17. Next the patient is cleaned, the laps are counted and the sharps are disposed.
18. Wash your hands and now help with filling out delivery note and postpartum order forms.

What is my role as a student in a Cesarean section or tubal ligation procedure?

A student scrubs in for C-section and tubal ligation. You will act as an assistant- help hold bladder blade and if you have practiced, help sew the skin. Also, have the resident teach you to write post-op orders.

How do I write up post-op orders?

C/S Postoperative Orders:

Is different now that Soarian is at Touro

**Same inpatient orders apply for GYN cases (ie TAH- total abdominal hysterectomy)

1. Transfer to Recovery, then to 3west (postpartum) when stable
2. Diagnosis: s/p Repeat C-Section
3. Condition: Stable
4. Vitals: Per Routine
5. Allergies: NKDA
6. Activity: Bedrest
7. Nursing: Per routine; Foley to gravity with accurate I's&O's
8. Diet: NPO with ice chips OR clears and advance as tolerated
9. IV Fluids: LR@125cc/hr
10. Meds: **ILH— Pain Management Per Anesthesia
    **Touro: PCA per Anesthesia
    **UMC: Demerol 50mg IV every 4 to 6 hrs prn pain
    Phenergan 25mg IV every 4 to 6hrs prn pain
    Toradol 30mg IV every 6hrs *4doses for breakthrough pain
11. Labs: CBC in AM @0500
12. Call HO if T>100.4; SBP>140 <90; DBP> 90 <60; Pulse > 105 <50; RR >22 <12; UOP <30cc *2 consecutive hours or Any concerns
13. Incentive Spirometer @bedside with instruction (10X's/ hour while awake)

D&C Post Op Orders

Write these out without being asked

**Same outpatient orders apply for other minor cases (i.e. CKC, laparoscopy, hysteroscopy, lap tubals, Bartholins marsupualization)

1. Transfer to Recovery, then D/C to home when stable
2. Diagnosis: s/p D&C
3. Condition: Stable
4. Vitals: Per Routine
5. Allergies: NKDA

6. Activity: Pelvic rest * 4 weeks
7. Nursing: Per routine
8. Diet: As tolerated
9. Meds: Lortab 7.5/500mg 1 to 2 po every 4 to 6hrs prn pain #20
   Methergine 0.2mg po every 6hrs *3 doses #3 (after D&C)
   In One Day Stay:
   Phenergan 25mg IV/IM every 4 to 6hrs prn pain
   Toradol 30mg IV/IM every 6hrs *4doses for breakthrough Pain

10. Call HO if T>100.4; SBP>140 <90; DBP> 90 <60; Pulse > 105 <50; RR >22 <12; UOP <30cc *2 consecutive hours or Any concerns
11. Follow Up with GYN in 3weeks

GYNECOLOGY/GYNECOLOGY ONCOLOGY

What should I do to prepare for a GYN surgery?

- The day before surgery, find the O.R. schedule for the next day (usually in a binder in clinic or ask a resident). Make copies of the schedule for all the residents who are on GYN and give it to them before the next day. (ask the residents if they want you do this before)
- Divide the surgeries between the students (1 surgery per student), and when you go home that night, learn your patient's history and recent labs (know H/H) (will be on the OR schedule)
- Learn what surgery you will be scrubbing in on. Techniques and review anatomy (they always pimp on anatomy)
- If your surgery is first, pre-op the patient. Always introduce yourself to your patient prior to the surgery. 1 student (or more for UH gyn) present for surgery at a time – usually the other students can study during the other surgeries.
- After your surgery, text the other student for next operation and they will come down and pre-op
- In the OR:
    - Know the residents and staff glove size
        - Have the gloves pulled before they come to the OR
    - Help the residents set up the bed.
    - After helping set up, be the first to scrub unless told not to, they don't want to wait for the student to finish scrubbing so they can scrub.
    - Know everything about your patient
    - After the surgery, help with clean-up, always follow your patient into the recovery room.
- Certain days are assigned for reading time. Make sure to tell your residents you have assigned reading time that day. They don't know your schedule, so they may tell you to go to clinic after surgeries. Just inform them you have scheduled study hours and it shouldn't be a problem (not true for NO rotation).

How do I manage a Gynecology/Gynecology Oncology patient?

- These patients are much like C-section day #1 patients. Write the same orders on post op day #1 (in uncomplicated cases).
- Take off the bandage on POD#2 and take out staples on pfannensteil incisions (bikini) on POD#3. Vertical midline staples come out day 7-10.
- Be sure to ask all abdominal surgery patients about flatus and bowel movements daily.
- Read the patients H&P and know this info as well as the indication for the surgery. Check the order section each time you open the chart to see if

something new has been ordered and needs to be followed up.

- Write a PM note daily unless the resident has already written one.
- Reasons patients are admitted are s/p gyn surgeries, for anemia with menorrhagia to receive blood transfusion (will have CBC 6 hours after transfusion), missed abortions for cytotec treatment and possible D&C, PID or TOA's, etc.
- If you are not scrubbed into a surgery, ask the intern or resident to show you how to write post-op admit orders to the GYN service if this is a major case (TAH/TVH). Remember the pneumonic: **ADCVANDISMAL**. (see next page: How do I write admit orders? All are on EMR now.)
- When the patient is put to sleep in the OR, you should put on a pair of gloves and help position the patient. Then change your gloves and get ready to examine the patient under anesthesia. When the surgery is over, put on gloves again to help move the patient. Get patient stickers for the residents. The resident will fill out the operative report. You can help write orders and prescription (for those going home). Keep prescriptions on you at all times!

<u> Orders are more detailed when you rotate on ONCOLOGY - Check with the residents before writing orders on the chart to learn the additional items that need to be included. **</u>**

How should I organize and write my post-op GYN note?

L3 Gyn Note (Post-op note)
34yo G2P2 with uterine fibroids s/p TAH/BSO/Cysto POD#1. Pain relief adequate, no complaints, no flatus, no BM, tolerating ice chips, no ambulation yet. No N/V.
VS: Tmax Tcurrent BP P RR Urine output
Gen: A&Ox 3, NAD
CV: RRR
Lung: CTAB
Abd: Soft, NTND +BS (BS very important in post-op patient)
Incision: C/D/I (clean/dry/intact)- pull off bandage on POD#2
Ext: No C/C/E, No calf tenderness, SCD's in place
GU: Foley to gravity with clear urine
Labs: Pre-op CBC and Post-op CBC
A/P: 34yo G2P2 s/p TAH/BSO/Cysto POD#1- Doing well

1. Advance to POD#1 orders- good urine output
2. Encourage ambulation and incentive spirometry.

How do I write admit orders?

No matter what rotation you are on, you will need to know how to write admit orders! **Remember ACDVANDISMAL!!** You are not expected to always write them, but to learn how and offer to write them. Ask the resident to teach you and help you write them!

Example Admit orders (for use after C/S, hysterectomy, major operations):
Consider a 23 yo G1P1001 s/p TAH/BSO/CYSTO

1. Admit to 3 West- LSU GYN
2. Condition: Stable
3. Diagnosis: s/p TAH/BSO/CYSTO
4. Vitals: per routine
5. Allergies: NKDA
6. Nursing: per routine, foley to gravity, accurate I/O's (ins and outs), SCDs to bilateral lower extremities until ambulating
7. Diet: NPO except ice chips
8. IVF: LR @ 125 cc/hr
9. Special: none
10. Meds: PCA per anesthesia or IV meds of choice (ask resident for their preference)
11. Activity: bedrest
12. Labs: CBC in AM (0500)

Call MD if: temp > 100.4, BP >140/90 or <90/60, RR >22 or <12, Pulse >120 or <60, UOP<30cc/hr x 2 consecutive hours

What do routine post-op orders (Day #1) look like?

Routine Post op Day #1 Orders (for use after C/S, hysterectomy, major operations):

1. Discontinue Foley
2. Activity: Ambulate TID with assistance; Patient may Shower
3. Diet: Advance as tolerated
4. Heplock IV when tolerating PO
5. Discontinue IV/IM pain meds when tolerating PO, then switch to PO pain meds:
   Lortab 7.5/500mg 1 PO every 4 to 6hrs prn pain
   Lortab 7.5/500mg 2 PO every 4 to 6hrs prn pain
   **also can use Percocet 5/325mg
   Motrin 800mg 1 PO every 8hrs prn pain
   MOM 30ml PO every 6hrs prn constipation
   Mylicon 80mg PO every 6hrs prn gas
   May have Toradol 30mg IV/IM every 6hrs prn pain (Max 4doses)

6. IS to bedside use 10x/hour while awake

What are the most common causes of post-operative fever?

Fever is defined as an increase in temperature 100.4 on 2 occasions at least 4hrs apart, excluding the 1st 24hrs OR temperature >101.5.

-If a patient has a fever, the most likely cause is determined by the postoperative day (POD). Remember the 7W's: Wind, Water, Womb, Wound, Walking, Wonder Drugs, and Watermelons (Breast) — useful tools when following post-op patients (i.e. C-section or Gyn surgery)

POD 1-2: Wind (Atelectasis): often causes fever secondary to inadequate deep breathing after surgery and incisional pain on deep breathing. Treated with Incentive Spirometery b/c deep breathing prevents atelectasis.

POD 3-5: Water (Urinary tract infections): secondary to Foley catheters.

Womb (Uterus): secondary to endometritis. Predisposing factors: C/S, prolonged labor, PROM, Chorio, Internal Monitors, Multiple vaginal exams, meconium, manual placenta extraction, anemia, poor nutrition.

Watermelons (Breast): Always check breasts during each exam. Keep breasts bound if not breast feeding.

POD 4-6: Walking (Deep Venous Thrombosis): due to venous stasis. Venous compression devices or low dose heparin reduce the incidence of venous thromboembolization. Early ambulation of the patient on POD#1 is the best way to prevent this complication.

POD 5-7: Wound: Most wound infections occur during this period, especially in obese patients. Preoperative antibiotics are important to prevent or reduce the risk of infection.

POD 7: Wonder Drugs: If all other sources of fever are ruled out after careful physical exam and laboratory evaluation. Check the meds that the patient is taking. Also, look at the temperature chart for characteristic spiking pattern. (CBC may show elevated eosinophils)

CLINIC

What is my role as a student in clinic?

- You will see patients and present to your staff. DON'T CHART SHOP!! (pick up the first chart in the stack, don't go through the charts and pick one that interests you…they notice that and hate it!)
    - If new patient: you need to get a full history
    - If follow up: look patient up on the computer and write down any recent lab results before seeing the patient
- Follow a resident in clinic until you feel more comfortable seeing patients alone.
- You can work up a patient: write the H&P and also do the physical exam except the pelvic and breast exam. You will need a chaperone for these exams.
- OB Visit:
    - Questions to ask :
        - Are you having any contractions?
        - Vaginal bleeding?
        - Leakage of fluid?
        - Fetal movements?
        - RUQ pain, headache, vision changes (s/s of pre-eclampsia)?
    - On physical, do fetal heart tones, and measure fundal height
    - Print out a chart of the labs/vaccinations/screening tests needed during each trimester visit (good one in blueprints) and carry it in your pocket (so when you present to staff your assessment/plan for the patient, you will know what labs need to be ordered for this visit
    - Some people still use the pregnancy wheel - they have numerous apps for iPhone that calculate gestational age for you!
- GYN visit:
    - There are too many different diagnoses to narrow down a question list
    - But always ask: Last menstrual period and methods of birth control

What should I include in my prenatal clinic note?

- Read the nurses assessment at the top of the page. Review the patient's problem list and prenatal labs. Use your wheel to determine how far along the patient is pregnant. Then enter the room, introduce yourself and start your H&P.

1. Use the prior note as a guide. The patient only needs a full H&P on the initial OB visit. Have a resident show you how to fill out all of the paperwork.
2. Labs: Initial OB labs at first visit. Screen at 15-18 weeks. O'Sullivan (1 hr GTT) at 28 weeks. GBBS culture at 35-37 weeks. Reorder CBC and RPR in 3rd trimester.
3. Prenatal patients only need cervical checks at their initial visit and if they c/o pain or contractions and every visit from 37 weeks until delivery.

Sample Prenatal Note

21 yo G3P2002 at 30 6/7 WGA by LMP c/w 12 wk US for OB visit. Pt. without complaints. +FM, no LOF, no VB, no Ctx.
VS: weight BP HR
Urine dipstick results- Protein/Glucose/Nitrite
FH (fundal height)- use tape measure (i.e. 30cm)
FHT- (fetal heart tones)- use Doppler (i.e. 140's)
A/P: 21 yo G3P2002 at 30 6/7 WGA by LMP c/w 12 wk US.

1. S = D (size equals dates)
2. Note anything from problem list and how it is being managed (i.e. GDM, CHTN)
3. h/o C/S x 2 for repeat C/S
4. Continue PNV and iron
5. Kick counts/ PTL or Labor precautions (the nurses will give patient instruction sheets).
6. RTC in ___ weeks (<28 WGA: 4 week appt., 28-37 WGA: 2 week appt., >37 WGA: 1 week appt till delivery)

What should I include in my GYN clinic note?

1. Read the nurses assessment at the top of the page. Then enter the room, introduce yourself and start your H&P.
2. Use the prior note as a guide. Have a resident show you how to fill out all of the paperwork.
3. Be sure to review Health Maintenance- pap smears, self breast exams, mammograms, colonoscopy, fecal occult blood, calcium/Vit D supplementation.
4. Many appointments are for annual exams- get these charts! You are able to do everything on these patients. Get a resident to help with your first few exams until you are comfortable.
5. For menstrual period complaints make sure you ask if they are regular or irregular, how many pads per day, how many days of bleeding, hormonal therapy use, any medicines used and if they worked. Any patient over 35 with menometorrhagia (heavy periods and bleeding between periods) will likely require an EMB (endometrial biopsy) to rule out pathologic source.

When you finish your note, review it with a resident and have them sign behind you. After, you can present to staff. Read your note when you present- don't leave anything out

COMMON PIMP QUESTIONS

- Know the 3 signs of placental separation.
- Stages of labor.
- Know how to read the fetal monitor – fetal heart tones.
- Normal fetal heart rate, accelerations and 3 different types of decelerations on fetal monitor
- Guidelines for pap screening and mammogram screening.
- What arteries supply the ovaries.
- Layers of the abdominal wall.