First ever book conceptualized for giving One Touch to Obstetrics and Gynecology by

Flowcharts • Tables • MCQs • One-Liners

ONE Touch Obstetrics & Gynecology

For NEET/NEXT/FMGE/INI-CET

Sakshi Arora Hans

Special Features

- Written and Compiled by a Leading Faculty and Subject Expert of OBG
- Enriched with Latest Updates up to March 2023
- Entire theory covered in just 200 pages in Flowcharts, Tables and One-Liners format
- **250+** MCQs of Recent Exams covered up to March 2023
- All important Images/Illustrations covered

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26. ABRUPTIO PLACENTA

History

Patient gives H/O Trauma or Has High BP
+ PAIN IN ABDOMEN
+ Bleeding P/V in T3
- Blood dark red in color
- Not recurrent
- No warning hemorrhage

Types

Abruption is premature separation of normally situated placenta:
1. **Revealed variety:** Whatever bleeding occurs = Comes out
2. **Concealed type:** Blood collects in uterus behind placenta giving rise to couvelaire uterus (Bruised uterus) (Image 36)
3. **Mixed type** (M/c)

P/A Finding

- Ht of uterus>POG
- Uterus is tensed tender and rigid
- FHS = Not heard
- Fetal part: Not palpable

BLEEDING IN LATE PREGNANCY: ABRUPTIO PLACENTA:

PAGE = Classification
GRADEO = Retrograde
GRAD 1 = Pain + bleeding + FHS (N)
GRAD 2 = Fetal distress seen
GRAD 3 = Fetal death maternal shock ± DIC seen

Placental separation releases Thromboplastin which initiates contraction + leads to DIC

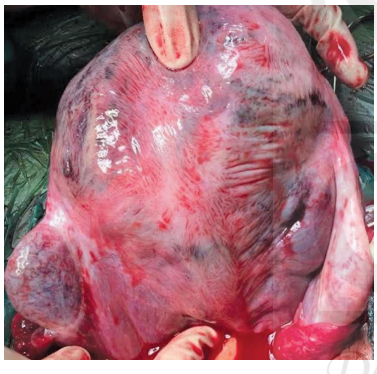


Image 36: Couvelaire uterus

P/V Examination
Not C/I in Abruptio but should be done after ruling out previa

Investigation
TVS = Not diagnostic
- Abruptio is a clinical diagnosis
- On TVS =
  1. See placenta in upper segment
  2. Retroplacental clot
  3. **Jello sign:** Shimmering of placenta on maternal movement.

Management

1. Abruptio + fetal distress/maternal condition unstable: Emergency C/section
2. Abruptio + fetal death + mother unstable or DIC = Emergency C/section
3. Abruptio + fetal death + mother stable = IOL for vag delivery
4. Abruptio + DIC: Correct DIC f/b C/section
5. Abruptio + No emergency condition: If gestational age <34 weeks = Continue pregnancy
6. If gestational age ≥34 weeks = IOL f/b vaginal delivery.

Remember

A patient of abruptio may present as preterm labor
∴ whenever in a patient of PTL → uterus is tensed and tender always rule out abruptio

For obstetric causes of DIC and investigations done in DIC = See Table 5 and 6.

28. INFECTIONS IN PREGNANCY

Based on History of Patient

H/O eating Raw/undercooked Meat/coming in contact with cat feces → TOXOPLASMA

- Maximum transmission = T_3
- Most severe malformation occurs = T_1 transmission
- Leads to: Triad of **Intracerebral calcification + chorioretinitis + Hydrocephalus** (along with IUGR)

T/t: For known infection: Pyrimethamine and sulfadiazine
To prevent vertical transmission — Spiramycin

H/O contact with Toddler → CYTOMEGALOVIRUS

Leads to periventricular calcification

- Chorioretinitis
- Microcephaly
- SNHL

- M/C congenital viral syndrome
- M/C cause of congenital deafness

H/O contact with school-going children (Slapped cheek appearance) → PARVOVIRUS B19 Infection (Fifth disease)

Mother: Polyhydramnios
Fetus:

- Hydrops fetalis
- Anemia
- Abortion
- It doesn't lead to teratogenicity
- Parvovirus is cytotoxic to fetal RBC

Infections in Pregnancy

Rubella

- Most Teratogenic
- **Congenital Rubella Syndrome** occurs if infection occurs less than 20 weeks (≃ <16 weeks)
- TRIAD
  - Cataract
  - SNHL (M/C)
  - Congenital Heart defect: (M/C patent ductus arteriosus followed by pulmonary stenosis)
  - Others
    Blueberry muffin rash

Note:

1. Congenital rubella is an indication for MTP
2. Rubella IgG is done in all pregnant females
3. Rubella vaccine is C/I in pregnancy
4. Pregnancy is C/I for 1 month after Rubella vaccine
5. If patient conceives in this one month then MTP is not done.

Varicella Zoster

- If a pregnant female is exposed to VZ: Within 96 hours VZIG should be given
- **Teratogenic pd: 12–20 weeks, leads to congenital varicella syndrome:**
  Microcephaly, cataract zigzag cicatricial skin lesions and limb Hypoplasia
- **Neonatal VZ syndrome**
  Seen if mother gets infection 5 days before delivery or 2 days after delivery.
- Neonate has hepatitis, pneumonitis meningoencephalitis and cicatricial skin rash (Image 40)

Zika Virus

Only vector borne teratogen

Female Mosquito = Aedes borne Teratogen (Image 41)
Receptor = TIM-1
TAM-XL
Transplacental transmission occurs through Hofbauer cells
Fetus:

- Microcephaly
- Calcification
- ↑tone of Limb
- Clubfoot
- Seizures

Leopold Fourth Maneuver/Deep Pelvic Grip (Image 68)

Examiners hand on the pelvic area. Both hands are used and kept parallel to inguinal ligament.

It (1) Confirms finding of pawlik grip (2) Attitude of fetus.

Important Points

- To know head has entered the pelvis or not- Fingers of both hands are brought below the head.

If both hands converge: Below the head → means head has not entered the pelvis.

If both hands diverge: Means head has entered the pelvis.

46. SOME IMPORTANT CONCEPTS

True Labor Pain vs False Labor Pain

	True labor pains	False labor pains
1. Uterine contraction		
a. Nature	Regular rhythmic (On and off)	Irregular, continuous
b. Progressive	↑Intensity, ↑Frequency, ↑Contraction	It is not progressive
2. Cervical dilatation	Leads to progressive dilatation	Does not lead to dilation of cervix
3. Site of pain	Lower abdomen + Radiating pain to the thigh and back	Localised to abdomen
4. Show	Blood + mucus discharge seen	Absent
5. Bag of membranes	Felt	Absent
6. Relieved by	Not relieved by anything	Relieved with sedation and enema

Note:

Oxytocin → Produces rhythmic and regular contraction, and maintains polarity of the uterus → can be used in induction and augmentation.

Ergometrine on the other hand cannot be used as it doesn't maintain the polarity and cuts off blood supply to fetus.

Uterus Contractions

Begin @ cornua of uterus and spread to entire uterus at 2 cm/sec

Entire uterus is depolarized in 15 seconds

Adequate uterine contractions:

- 3 contractions in 10 minutes (Frequency).
- Each contraction lasts for 45 seconds (Duration).
- Generating a pressure of 65–75 mm Hg or 200–250 montevideo (MV) units (Intensity).

Tachysystole: ≥5 contractions in 10 minutes.

Hyperstimulation: Tachysystole can cause fetal distress

Tachysystole can occur in spontaneous labor and with use of oxytocin or misoprost

On CTG: It appears as prolonged deceleration

Station of Fetal Head

- It is described with respect to its position above or below ischial spine
- If fetal head is above ischial spine: Positive station
- If @ level of ischial spine = zero station

If below ischial spine: Negative station.

+2 means = 2 cm above ischial spine

−3 means = 3 cm below

Important Landmark Ischial Spine

- It is the site for internal rotation of fetal head
- Site for deep transverse arrest
- Site for giving pudendal block (ligament pierced while giving pudendal block is sacrospinous ligament)
- Origin of levator ani muscle

53. IMPORTANT POINTS RELATED TO THIRD STAGE OF LABOR

Important points related to third stage of labor

Who recommends:
Active management of third stage of labor (AMTSL)
- It decreases the duration of third stage
- Decreases blood loss
- Decreases chances of PPH
- AMTSL is the best method to prevent PPH

Steps in AMTSL
1. Inj. uterotonic within 1 minute of delivery of baby or immediately after delivery of anterior shoulder of baby (most imp step)
2. Delayed cord clamping (clamping cord in 1–3 mins of delivery)
3. Delivery of placenta by controlled cord traction (Modified (Brandt Andrews technique)
4. Intermittent assessment of uterine tone (earlier: uterine massage)

Note: Early cord camping is not a part of AMTSL

Uterotonics
Recommended by WHO:
Oxytocin: 10 IU I/M or in infusion
If oxytocin is not available following can be given
1. Methyl ergometrine: (methergine) 0.2 mg I/M
   Never given I/V as it can lead to hypertension
2. Syntometrine: Fixed dose combination of 5U oxytocin and 0.5 mg methyl ergometrine
3. Carbetocin- Synthetic oxytocin 100 mcg Slow IV
4. Misoprost PGE 1
   600 mcg oral, sublingual or P/V for AMTSL (400–600 mcg)
   WHO recommends misoprostol distribution to pregnant females to prevent PPH

Carboprost = PG F-2d is used for management of PPH and not AMTSL

Conditions of early cord clamping
(clamping cord within 1 minute of delivery)
1. Birth asphyxia
2. If neonatal resuscitation is needed
3. K/C/O congenital heart disease
4. If in RH negative female: Indirect coomb's test is negative (nonisoimmunized pregnancy)

HIV + pregnant females (as per NACO guidelines)
but ACOG : Delayed cord clamping
In case of RH negative pregnancy: If indirect Coombs test is positive, where maternal antibodies are already formed against fetal Rh antigen, early cord clamping is of no use: Delayed cord clamping

In preterm infants.
In COVID 19 + patients.
In macrosomic babies.
In post term cases.
— Delayed cord clamping

All you need to know on oxytocin
- Natural oxytocin is nonapeptide
- Synthesized by para ventricular nucleus of hypothalamus
- Stored in posterior pituitary = T1/2 = 3–5 mins
- Can be given = I/M or I/V infusion
- Never given as I/V bolus as it leads to hypotension/cardiac arrest
- Infusion should be prepared in RL and not D-5% as it can lead to water intoxication
- It is the Hormone responsible for milk ejection

Note: In all those conditions where methylergometrine is C/I, oxytocin can be used

54. DRUGS USED IN AMTSL PPH

Methylergometrine

Leads to tetanic contraction of uterus
Can lead to hypertension
C/I:
T = After delivery of first twin
O = Organic heart disease
P = Preeclampsia
E = Eclampsia
R = Rh negative female
Relative C/I: HIV positive female on protease inhibitor

Prostaglandins
Misoprost (PGE_1)

Available as tablet
Routes: Oral/sublingual/P/R or P/V
Never: I/V or I/M
Water and heat soluble
Side effect: Hyperthermia
T 1/2 = 20–40 minutes

Carboprost: PGE2α Dinoprost/hemabate:

Available as injection:
Route: I/M
Absolute C/I
- Asthamatics
- Pulmonary HT
- Suspected amniotic fluid embolism

Relative C/I = Preeclampsia, renal disease, liver disease
Side effect = Diarrhea
Carboprost: Is best drug to manage PPH but is not used for AMTSL

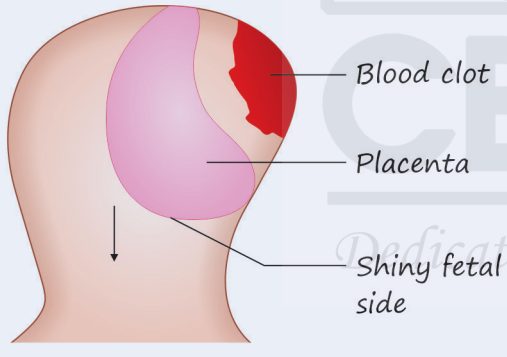
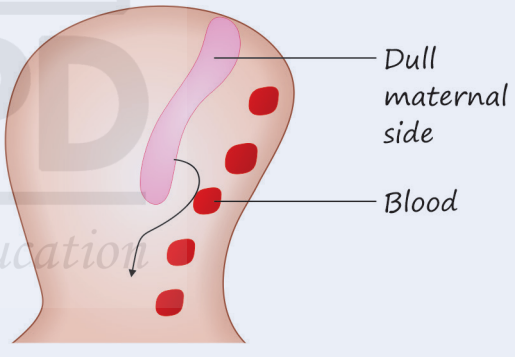
Carbetocin

Synthetic oxytocin analogue octapeptide
T 1/2 = 85–100 minutes
Dose = 100 mcg slow I/V

Syntometrine

5U oxytocin + 0.5 mg methylergometrine highly patient.
Not readily available, expensive

55. METHODS OF PLACENTAL SEPARATION

Schultz method	Duncan's method
	
Images 73: Methods of placental separation	
• Placental separation begins from the center	• It begins from periphery
• Blood collects behind the uterus and bleeding is apparent only after complete separation of placenta	• External bleeding begins with separation
• Formation of retroplacental clot	• No retroplacental clot formed
• Total blood loss is less	Total blood loss is more
• Shiny fetal side presents at vulva (**S** for Shiny, **S** for Schultz)	Dull maternal side presents at vulva (**D** for Dull, **D** for Duncan
• M/C (seen in 80% cases)	Seen in 20% cases

Note: Separation of placenta is along parts of decidu (intermediate spongy layer of the decidua basalis)

Table 23: Important radiological signs in pregnancy

Sign	Significance
Bagel sign	Gestational sac in adnexa with a hyper echoic ring USG sign in Tubal ectopic
Intra decidual sign	1st USG sign of pregnancy
Double decidual sac sign	It indicates intrauterine pregnancy. Inner ring is decidua capsularis and outer ring — decidua parietalis.
Double bleb sign	It indicates intrauterine pregnancy. One bleb is for yolk sac and other for amniotic sac.
Lambda sign	USG sign seen in Dichorionic pregnancies. (d/t presence of chorionic tissue in between membranes of twins.
T sign	USG sign seen in monochorionic twins
Lemon sign	Frontal bossing seen in spina bifida
Banana sign	Abnormal anterior curvature of cerebellum d/t associated Arnold chiari malformation. Seen in spina bifida.
Clover leaf skull	Seen in craniosynostosis.

Table 24: Basics of placenta

Fetal side of placenta formed by = Chorion Fundosum
Maternal side of placenta formed by = Decidua Basalis
Primary villi = Formed by D13 (only trophoblastic shell)
Secondary villi = Formed by D16 (Has mesodermal core)
Tertiary villi = Formed by D17 (Has fetal capillary)
Volume of blood in villi = (Fetal blood) = 350 mL
Volume of blood in inter villi space = (Maternal blood) = 150 mL
Volume of placenta @ term = 500 mL
Weight of placenta @ term = 500 gms
Ratio of weight of placenta: fetus = 1:6
POG at which weight of placenta = weight of fetus = 17 weeks
Maternal spiral A's open in IVS on = D15
Utero placental circulation — established by = D17; value = 500–750 mL/min
Fetoplacental circulation — established by = D15; value = 400 mL/min; Fetal blood flow @term = 125 mL/kg

Differential Diagnosis

	Fibroid	Polyp	Adenomyosis (endometrium inmation)
Age	Reproductive age (25–35 years) Nulliparous females	Any age With increasing age, chances of polyp increase	≥40 years (4th–5th decade) Multiparous female
M/C complain	Heavy menstrual bleeding	**In premenopausal/ Reproductive age:** • Intermenstrual bleeding • Irregular bleeding	M/C = HMB 2nd M/C = 2° dysmenorrhea Usually pt C/O both
Other	2° dysmenorrhea Infertility Pelvic pressure symptoms	**In postmenopausal female:** • Postmenopausal bleeding	
P/A examination	Uterus is enlarged and irregualr and may reach up to 20 weeks' pregnancy size	—	—
Gross appearance	Fibroid has a whorled appearance, white in color and is surrounded by a pseudocapsule • Blood vessels supplying fibroid are present in pseudocapsule • Cut surgace: irregular/ uneven and arises from broad base (Image 122)	Mucosal outgrowth • Fleshy, red in color • Has a smooth surface and hangs from a narrow base in uterine cavity (Image 123)	• Symmetrically enlarged uterus = globular uterus cut surface shows multiple hemorrhages (Image 124)
P/V examination uterus:	• Enlarged • Irregular • Nontender	• Normal in size • Anteverted	• Size of uterus: 10–12 weeks pregnant size • Uterine tenderness present (**Halban sign**)
Adnexa:	—	—	• No adnexal mass • Adnexal tenderness may be present
IOC	**USG** For submucous fibroid: Saline infusion sonography (Image 125)	**USG** = 1st IX On USG: Feeder vessel sign seen (Image 126) **IOC:** Hysteroscopy **Management:** **Endometrial Polyp:** Removed by Hysteroscopic polypectomy **Cervical polyp:** Removed with a help of polypectomy hook	**MRI** • Junctional zone ≥12 mm in thickness

88. IMPORTANT IMAGES OF FIBROID, POLYP AND ADENOMYOSIS

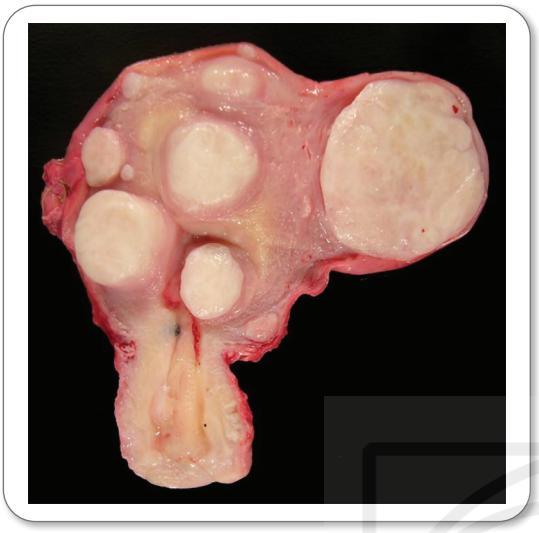


Image 122: Cut surface of fibroid Showing whorled appearance

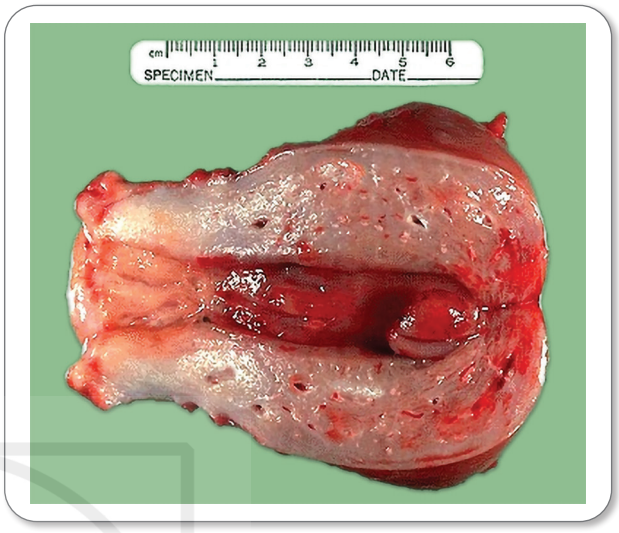
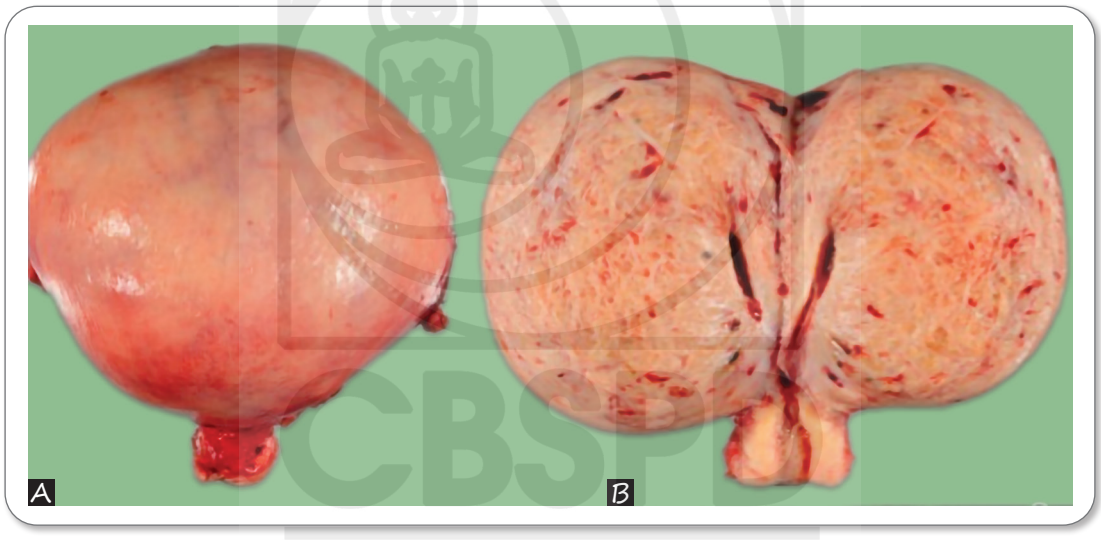


Image 123: Specimen of polyp Red fleshy mass



Images 124A and B: **A.** Adenomyosis gross showing uniformly enlarged uterus; **B.** Cut surface showing multiple haemorrhages

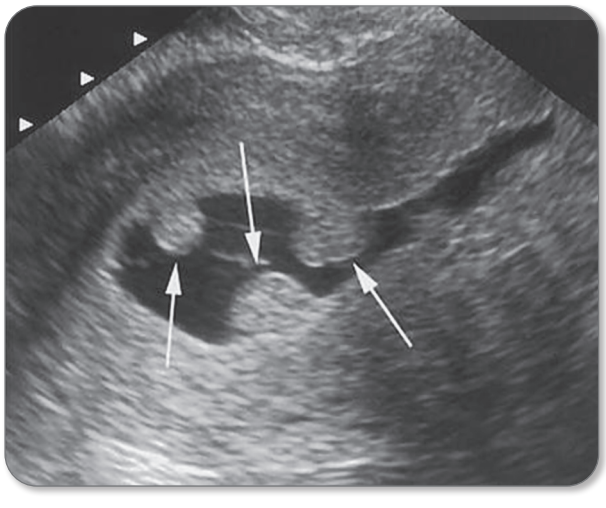


Image 125: USG of fibroid Showing echogenicity same as myometrium and arising from broad base

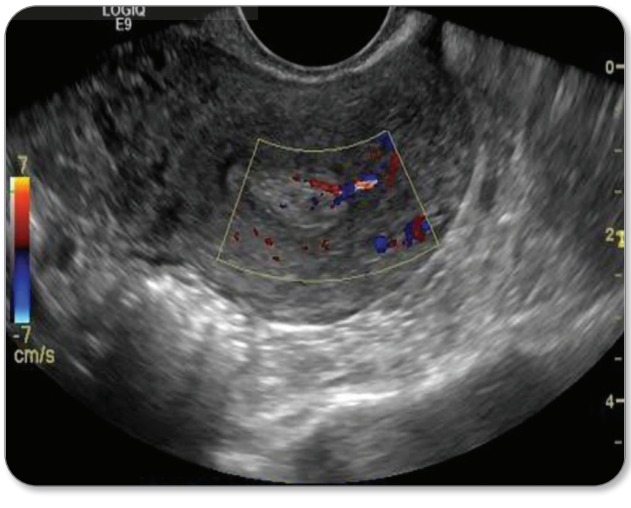


Image 126: **USG of polyp:** Showing feeding vessel sign

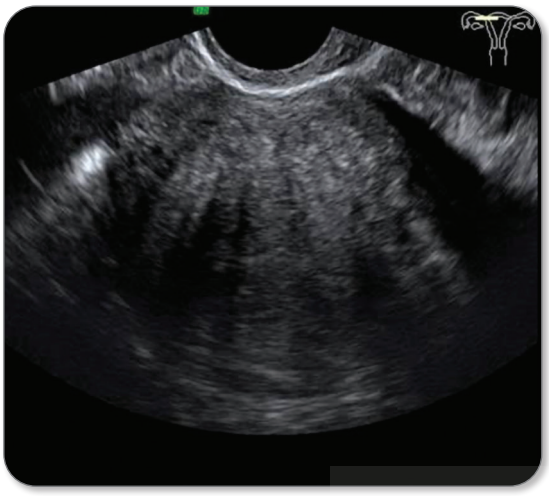


Image 127: **USG image of adenomyosis:** Venetian blind appearance

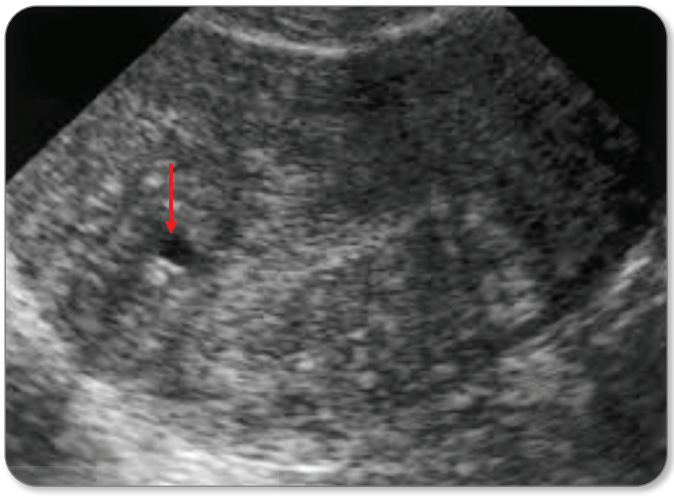


Image 128: USG showing myometrial cyst in adenomyosis

Leiomyoma	Adenomyosis
Asymmetric enlargement of uterus	Symmetric enlargement/globular uterus
Nontender uterus	Tender uterus C/a Halban sign
Uterus is firm	Soft uterus
Menorrhagia is chief complaint	Menorrhagia with dysmenorrhea is chief presentation
Uterus can grow to huge size even up to 20 weeks pregnant uterus size	Uterus usually does not grow beyond 12 weeks size

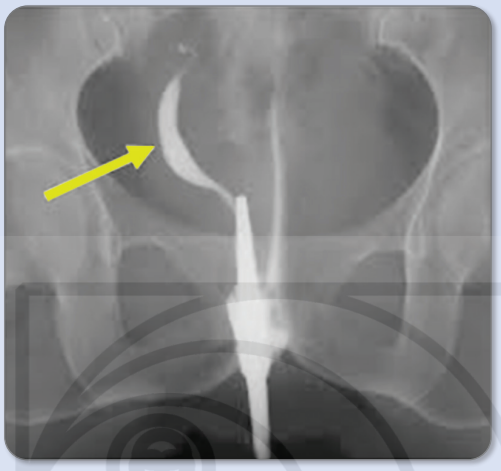
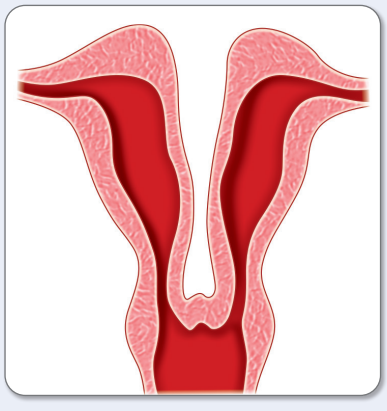
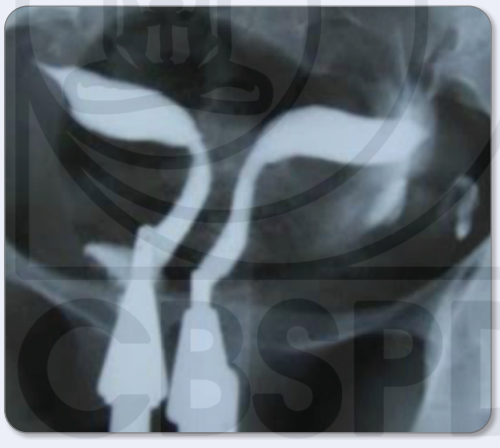
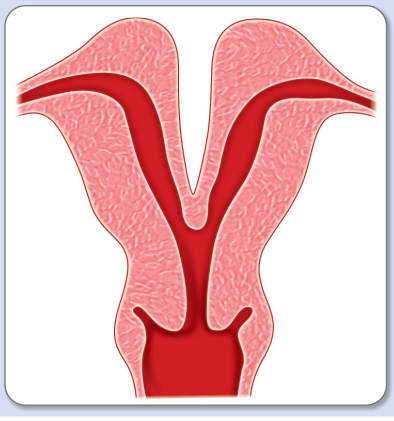
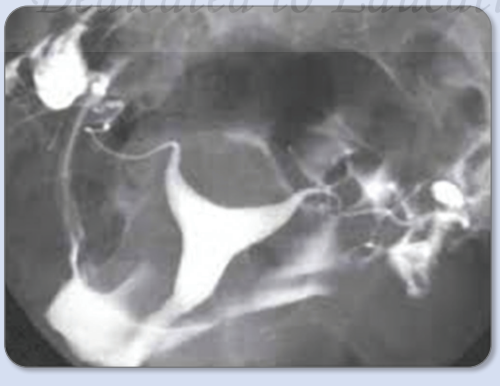
USG Appearances of Adenomyosis

1. Asymmetrical myometrial thickness.
2. Myometrial cyst (blood collection in myometrium) (Image 128).
3. Myometriual island (large collection of blood).
4. Venetian blind appearance (Image 127).
5. Irregular junctional zone.
6. Increased vascularity of junctional zone.

Diagnosis and Management of Adenomyosis

- USG or MRI imaging shows a diffusely symmetrically enlarged uterus with cystic areas found within the myometrial wall.
- The only definitive diagnosis is by histologic confirmation of the surgically excised tissue.
- **Management:** Medical treatment includes the levonorgest (LNG)-releasing intrauterine system, which may decrease heavy menstrual bleeding.
- Surgery in the form of hysterectomy is the treatment of choice.

Mullerian Malformations

CLASS	HSG Image	Comment
Class I: Mullerian agenesis	–	• Both MD Absent • Ovary present as it arises from genital ridge
Class II: Unicornuate uterus	 Image 151: Unicornuate uterus	• Single MD • Single fallopian tube **On HSG** • Single FT • Half of uterus • Half of cervix and • Half of upper vagina • Banana shaped uterus (Image 151)
Class III Uterus Didelphys 	 Image 152: Uterus didelphys	• Both MD are present but fail to fuse. Hence 2 vagina seen • It is the only condition where 2 vagina are present • Hence on HSG 2 Leech Wilkinson Cannula used (Image 152)
Class IV: Bicornuate Uterus (Grossly = fundus of uterus is divided into 2 parts) 	 Image 153: HSG of bicornuate Uterus • Angle between uterine horns: obtuse • Distance between horns ≥4 cm	• MD Start fusing but fusion is incomplete. • There are two uterine horns and single vagina. • Cervix could be one or two 1. If there is single cervix = Unicollis 2. If 2 cervix = Bicollis

Contd...

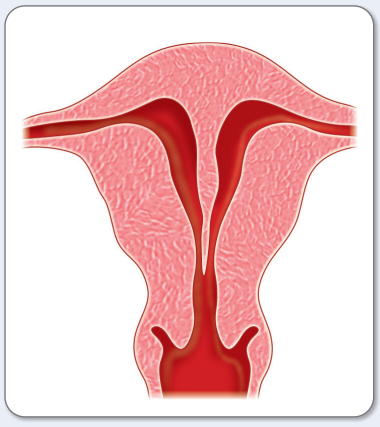
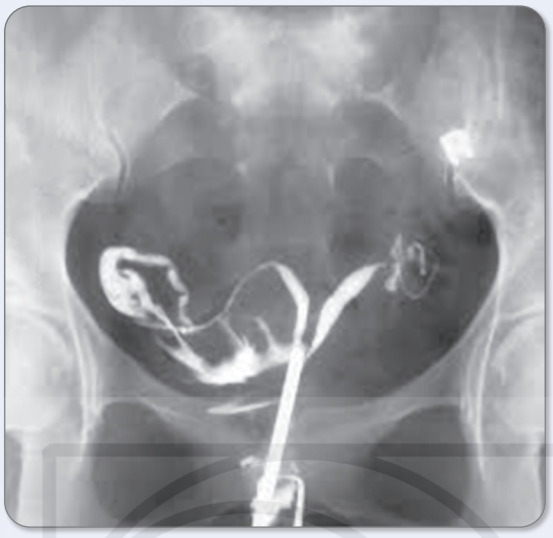
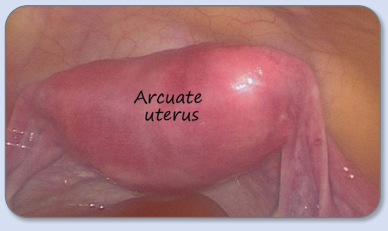
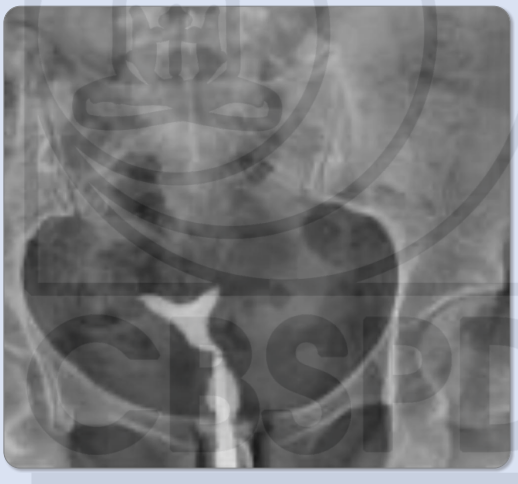
CLASS	HSG Image	Comment
Class V: Septate Uterus (Grossly = fundus of uterus is not divided)  **Note:** Fundus of uterus fused in septate uterus.	 Image 154: Septate uterus • Angle between uterine horns: Acute • Distance between horns <4 cm	• Both MD fuse • Septa is formed • But Septa fails to resolve • There are 2 uterine horns and single vagina 1. On HSG: It is difficult to differentiate between septate and bicornuate uterus 2. To differentiate between them fundus of uterus should be visible **In bicornuate:** Fundus is divided **In septate:** It is not divided
Class VI: Arcuate uterus 	 Image 155: Arcuate uterus	• Flat topped uterus or there is slightly dipped fundus • Best reproductive outcome
Class VII: In utero exposure to Diethylstilbestrol (DES)		• M/C malignancy a/w DES: Clear cell cancer of cervix and vagina • M/C uterine malformation a/w DES: Hypoplastic uterus • Most specific uterine malformation a/w DES: T shaped uterus • DES exposure does not lead to renal anomalies in female fetuses.

Table 33: Absolute contraindication of OCPs

WHO Category 4:	
Mnemonic	Banks have various schemes to provide home loans during May.
Banks:	Known/suspected case of **breast** cancer.
Have:	**Uncontrolled hypertension:** severe (≥160/110) (Medically controlled hypertension, in a female who is nonsmoker, of any ange: Not a C/I for OCPs).
Various	Undiagnosed **vaginal** bleeding.
Schemes:	**Smoker** ≥ 35 years of age.
To:	Known or suspected case of **thromboembolism** or family history of idiopathic thromboembolism in parent or sibling or h/o CVA/MI, or conditions predisposing to it (Risk factor for thromboembolism, e.g., malignancy, lupus anticoagulant present, prolonged immobility due to trauma or surgery → **absolute contraindication**).
Provide:	**Pregnancy** or h/o **peripartum cardiomyopathy**.
Home:	Severe hypercholesteremia, hypertriglyceridemia
Loans:	Presently impaired liver function/ liver cancer/acute or chronic cholestatic liver disease.
During:	Diabetes with vasculopathy
May:	Migrane with Aura.
OCP:	Also C/I in breast feeding and post partum females (<21 days)]

Table 34: LARC methods

Long Acting Reversible Contraceptives
1. Injection: DMPA
2. Implants
3. IUCD

Table 35: DMPA Injection

- Included in NFP by name of:- ANTARA
- Dose = 150 mg
- I/M
- Repeated every 3 months
- Window period = 4 weeks

Method of Action: (Anovulation)

- Advantages
  - Decreases seizure frequency
  - Decreases sickling in SCA
- Disadvantages
  - Delayed return of fertility
  - Decreased bone mineral density
  - Leads to irregular bleeding

Table 36: IUCD Generations

IUCD: Generations	
1st generation	Inert like Lippes Loop
2nd generation	Contain Cu - e.g., Cu T 380A (Image 165); multi load 375 (Image 166)
3rd generation	Contains progesterone MIRENA (Image 167); Progestasert (Outdated)

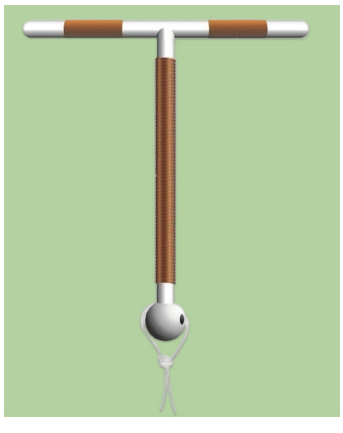


Image 165: CuT 380A

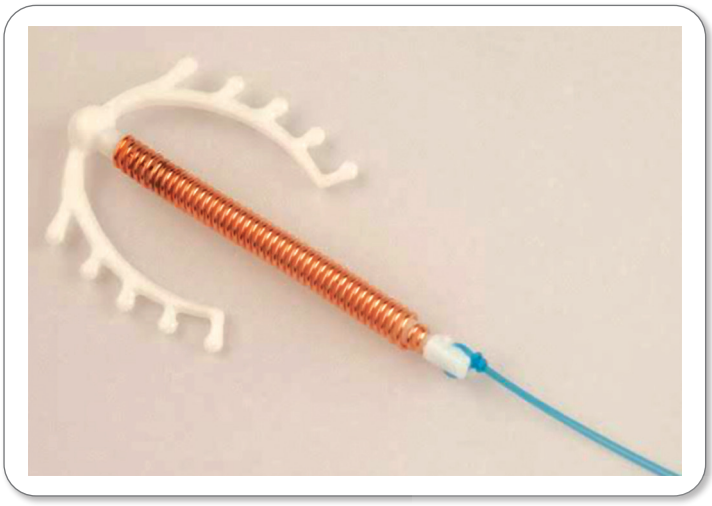


Image 166: Multiload 375

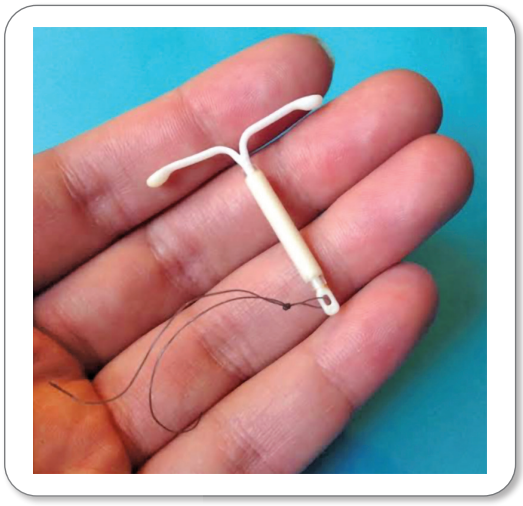


Image 167: Mirena

Table 37: Important IUCD

Important IUCD's	
1. Cu T 380A: PARAGUARD (Image 165)	• T shaped device • Has copper wire on vertical stem and horizontal arms (∴ A) • Surface area of copper wire: 380 mm^2 (∴ Number = 380) • Small ball which prevents perforation • Releases 50 mcg of copper/day • It can release Cu up to 12 years but approved life span is 10 years.
2. Multiload 375 (Image 166)	• Not T shaped and no copper on arms. • Arms are bent and have spurs on arms which lessens expulsion • Nylon thread present • Life span: 5 years
3. MIRENA/LNG IUCD (Image 177)	• Not copper containing • Contains progesterone = Levonorgestrel 52 mg. • Mirena releases 20 mcg per day (∴ called as LNG-20 also.) • Releases LNG for 7 years but approved for life span of 5 years.

Table 38: Comparison of CuT 380 and Mirena

CuT 380	Mirena
• Acts by preventing fertilization	• Acts by preventing implantation
• Releases 50 mcg of Cu per day	• Releases 20 mcg of LNG per day
• M/C side effect is bleeding	• It helps in reducing bleeding so in pts of AUB it is used
• Increased risk of infection (PID) @ time of insertion	• Makes cervical mucus thick and decreases PID
• Causes Ect pregnancy incase failure occurs	• Chances of Ectopic pregnancy more if failure occurs
• Can be used as emergency contraceptive	• Cannot be used as an emergency contraceptive.

128. IMPORTANT INSTRUMENTS IN GYNAE

Image 186: Sims' speculum

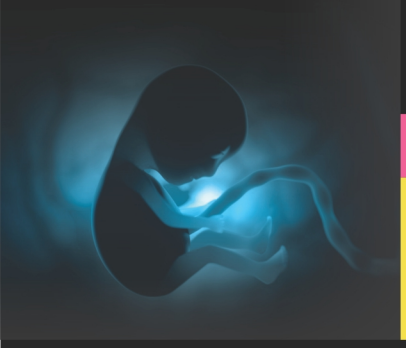
Image 189: Uterine sound

Image 187: Cusco's speculum

Image 190: Myoma screw

Image 188: Blunt and sharp curette

Image 191: Myoma clamp



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Sakshi Arora Hans, *MBBS, DGO from MLN Medical College, Allahabad* possesses a vast experience of teaching for more than a decade. She is famous for her 'Simplified Approach' toward Obstetrics and Gynecology. She has been playing an instrumental role in shaping the careers of thousands of medicos and nursing students in the country and abroad. She is popularly known as "Your Midwifery Madam". She excels at helping students clear the entrance exams, and also widely known for her dedication and impeccable work ethics. She is a leading author of two most popular titles among PGMEE aspirants for the last 16 years. She is a national level faculty for Marrow & Nursing Next Live.

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