UNIVERSITY OF LEICESTER

Reproductive Health

Student Handbook: 2026 -7

Including Student Workbook

Updated August 2026

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Introduction

Welcome to the Reproductive Health Block. We hope you will find your time with us challenging (in a good way), rewarding and enjoyable.

Learning Outcomes. Aims and Objectives

Throughout Phase 2, you will work towards the learning outcomes of the **Leicester Medical School Curriculum** (see the Phase 2 Curriculum Guide), to attain the core knowledge, skills and behaviours defined in the **Medical Licensing Assessment (MLA) Content Map** and to achieve the **GMC Outcomes for Graduates**. You should refer to these documents and resources regularly to guide your learning.

The aims and objectives listed below support these outcomes and align with the Leicester Medical School Curriculum, MLA Content Map and GMC Outcomes for Graduates. They show how you can use your Reproductive Health Placement to achieve these outcomes and goals.

Aims and Objectives

- Develop basic clinical skills in history taking, clinical examination and problem solving in Obstetrics & Gynaecology and GUM
- Recognise common presentations in Obstetrics & Gynaecology and GUM, assess patients and formulate appropriate management plans
- Understand the principles of routine antenatal, intra- and postpartum care
- Understand the principles of national screening programs in Obstetrics & Gynaecology
- Gain an understanding of available methods of fertility control and the ability to counsel patients accordingly
- Develop an insight into social, ethical and legal aspects of medical care and safeguarding in Obstetrics & Gynaecology and GUM

For a more detailed list of outcome objectives, please see specific Obstetrics & Gynaecology and GUM Workbook sections.

Achieving Aims and Objectives

To achieve the course objectives, you should take advantage of the following learning opportunities:

- Clinical teaching offered at your designated teaching unit, attendance at clinical areas as timetabled, and on-calls/night shifts as appropriate.
- Participation in clinical work and taking advantage of educational opportunities as they arise in clinical areas during your placement.
- Online lectures and tutorials for all Block students (usually on Teams or Blackboard), and any structured teaching offered at your designated unit.
- Self-directed learning, including use of the Workbook and Reproductive Health Blackboard resources.

Code of Conduct and Consent

General Conduct

Courtesy to patients, their partners and families, and to members of staff reflects your professionalism. You must introduce yourself adequately in all clinical areas, and dress appropriately to the local hospital dress code.

Please follow any specific infection control guidance at your unit, including Bare Below the Elbow and hand hygiene, as well as use of PPE.

Your identity badge must be worn at all times; members of staff may deny you access to clinical areas if you are not wearing an ID.

Attendance

The code of conduct for Phase 2 clearly states that 100% attendance of time-tabled sessions is expected. In that respect, your clinical attachment is to be treated in the same way as full-time paid employment. This is backed up by your MKM, and attendance at any teaching arranged centrally (tutorials etc). Your attendance may be graded as unsatisfactory if you MKM is sparsely populated, and/or you do not attend central teaching.

For any virtual teaching, **YOUR CAMERA NEEDS TO BE ON**. Otherwise, your attendance will not be considered.

Unavoidable absence (sickness etc) during the block should be notified to the relevant Undergraduate Coordinator, and Medical School Policy on absences should be followed. Unauthorised absence will also result in an unsatisfactory grade for attendance.

Consent & Intimate Examinations

As a general rule, you should introduce yourself by your name and role to all patients whose care you will be observing or participating in.

During the course, you should learn to assess patients presenting with symptoms of gynaecological conditions. Apart from appropriate history taking and general examination, you should learn to perform pelvic and speculum examinations competently and sensitively. Intimate examinations require explicit consent from the patient and must only be carried **under direct supervision by a qualified doctor (or midwife on labour ward)**.

In outpatients, where your tutor considers it appropriate for you to perform a speculum or pelvic examination, they will introduce you and obtain verbal consent on your behalf.

You will also be taught to perform intimate examinations in theatre, where patients are anaesthetised. **The consent for examination under anaesthesia MUST be written and obtained before the patient is transferred to theatre.**

You must attend the pre-operative ward round to have the opportunity to take a history from the patient and build a rapport with them. Your tutor may feel that, as a senior student, it is appropriate for you to obtain such consent yourself, but they will confirm that you have done this in an appropriate way. In that case you must ask the patient for permission to perform a pelvic examination whilst they are anaesthetised, and document in their notes that consent has been given.

Some units will provide a specific consent form for this purpose, but it is good practice to also make an entry in the notes that the patient has given consent.

Where a specific form is not provided, insert the following in the patient's notes, and ask them to sign and print their name, and date the entry:

I give my consent to …… (*student's name to be inserted*)…… to perform a supervised pelvic and speculum examination whilst I am under anaesthetic, as part of their medical training.

Patient's Signature:…… Date:……

Patient's Name (To be written clearly in block capitals)……

Course Structure

Your block will run over six or seven weeks, depending on university timetable.

Introductory sessions

On the first day of the block, a general (virtual) introduction will be held in the morning for all students. Please check your emails from the Undergraduate co-ordinator to find out when your sessions will be taking place. You will be expected to attend the general block introduction, regardless of the location of your placement.

Online material and resources

There are online recorded lectures, slides and further resources available on Blackboard. The Online Learning folder has been set up so that lectures and exercises are grouped into particular areas of O&G. You will find the resources MBChB Year 4 Reproductive Health folder on Blackboard.

Clinical Attachment

In some units you will be attached to a specific Consultant team and follow their clinical timetable. In other units, you may be rotating through a range of clinical areas and meet periodically with a designated supervising Clinician to monitor your progress.

Additional Clinical Activities

In addition to your work with your team, arrangements will be made for you to gain experience on Labour Ward and to be on call for Gynaecological Emergencies.

Labour Ward

When on-call for labour ward you should introduce yourself to the Midwife in charge and the Obstetric Team. A midwife will usually be appointed to be responsible for you and guide you through your clinical activities on labour ward. Ideally, you should observe one-two full labours, two normal vaginal deliveries, and other clinical activities.

Labour ward experience should be recorded on MKM.

Tutorials

There will be a program of virtual tutorials that should be accessed by students from all sites. Additionally, local tutorials may take place at each site. A list of suggested tutorial topics is enclosed in Appendix 1. However, this is for guidance only and you may wish to discuss additional topics with your tutors.

For all virtual teaching, YOUR CAMERA NEEDS TO REMAIN ON THROUGHOUT, otherwise your attendance won't be considered.

My Knowledge Map

There will be a number of items to complete on MKM during your course. MKM fulfils a number of functions:

- It allows you to focus your learning activities on important content
- It provides your tutor with information on what you need to see and do
- It allows us to review your clinical exposure and attendance

This includes activities in clinics, theatre sessions and Labour Ward, as well as any patients you discussed with the supervising Clinician.

There are also assessment forms that need to be completed during the latter part of the block.

It is your responsibility to ensure all relevant sections on MKM are completed, with sign off where appropriate, otherwise your attendance and over all block performance may be graded as unsatisfactory.

Workbook

You will be expected to complete the Reproductive Health Block Workbook cases during your attachment. It is a problem-based study guide spanning the curriculum- you may use it as a basis for discussion with your clinical team or for group work with your colleagues.

The Workbook forms a part of your assessment and must be reviewed and signed off on MKM by your supervising Clinician. Failure to do so will result in an 'unsatisfactory' grade for the Workbook component at the end of the block.

Plagiarism will not be tolerated, and anyone suspected of submitting a Workbook that is not their own work will be referred to the Director of Studies at Leicester Medical School.

Assessment

You will be assessed on a number of criteria:

1. A satisfactory attendance record
2. Completed MKM
3. Completed Workbook (submitted/presented on time and graded by Consultant)
4. Formative assessment forms (MKM) signed by Consultant
5. Satisfactory performance in the end-of-block formative examination (SBA, SAQ, observed consultations)

Formative Assessment Forms

The MKM End of Block forms contain sections on Attendance, Professionalism, Workbook, and Consultation skills. These have to be completed by the clinical team.

End Of Block Forms

Reproductive Health - End of Block Formative Assessment form
Reproductive Health - End of Block Formative Assessment Form - Consultation Skills

In the Consultation skills section, grades should be awarded 'live' in clinical areas, for example you can ask for an observed assessment in an antenatal clinic or on a gynae emergency on-call. The grades have to be awarded by a Consultant or an experienced trainee (ST3 or above).

You will not be awarded an overall 'satisfactory' grade for clinical performance if your formative assessment suggests otherwise (or if it is unavailable), regardless of your performance in the exit exam.

Exams SBA , SAQ, observed OSCE consultation

You will sit an SBA and SAQ paper on Examsoft, in an invigilated setting, and undertake 1-2 formal observed consultations in exam settings.

See Appendix 2 for Exam guidance and sample questions.

Results and Feedback

OSCE station feedback is completed by the examiner and given to you before you leave the exam premises at the end of your session.

Assessment results will be recorded on MKM, usually within two-three weeks of the end of the Block.

You will also be offered an opportunity to receive individual face to face or telephone/virtual feedback on your exam performance if you wish. Appointments may be made via the Undergraduate Co-ordinator.

Support

Problems with the lecture programme and centrally organised sessions should be notified to the Undergraduate Co-ordinator.

Local problems at your designated unit should be discussed in the first instance with your Consultant/Clinician or the local Undergraduate Co-ordinator. If your problems cannot be addressed locally, please contact the Block Lead *(Contact numbers on page 116).*

If you are experiencing any health, personal or financial problems or any problems at all, don't try to cope alone. Please talk to us or relevant members of staff at Medical School so you can get help.

Prizes in Obstetrics and Gynaecology

RCOG prizes:

The Royal College of Obstetricians and Gynaecologists awards a number of prizes to medical students, including a number of **Case History Prize**, a **Medical Student Elective Award** and a **Women's Visiting Gynaecological Club** Prize.

You can find the details and application forms on the RCOG website:
RCOG grants & prizes

Should you wish to apply, please discuss this with your Block Tutor or with the Reproductive Health Block Lead, to ensure you get adequate support for your application.

Obstetrics and Gynaecology Workbook

Obstetrics and Gynaecology Workbook

This workbook is designed as a study guide.

In this section you will receive an introduction to specific outcome objectives, history taking and a number of case scenarios for self-directed learning in a guided discovery fashion.

We have not duplicated factual information here that you can find in books and web resources, however working through the cases should help you cover most of the curriculum.

Gynaecology

History taking

By the end of the course, you should be able to

- Take a full gynaecological and sexual history, paying attention to risk factors for and symptoms of gynaecological disorders
- Take a focused history in specific presentations
- Recognise physical, psychological and social aspects of gynaecological disorders and sexually transmitted disease
- Appreciate the impact of gynaecological disease on the individual as well as the wider public health implications of these conditions

In taking a gynaecological history, it is usual to focus initially on the presenting complaint, but this should then be set in the context of the patient's age and overall reproductive history.

A major feature of gynaecological practice is to be aware of the possibility of malignant or pre-malignant disease of the reproductive tract so that diagnosis and treatment can be instituted as early as possible.

Basic structure of Gynaecological History:

- ✓ Demographic and reproductive identifiers
    - Patient's name, age, parity and occupation.
- ✓ Presenting complaint: elaborate on the presenting complaint and assess impact on quality of life and normal functioning.
    - Common presenting complains in gynaecology include
        - Heavy/painful/irregular, frequent or absent periods
        - Acute or chronic pelvic pain
        - Painful intercourse
        - Urinary incontinence
        - 'Something coming down' (prolapse)
        - Infertility
        - Request for sterilisation
        - Bleeding and/or pain in early pregnancy
        - Postmenopausal bleeding
        - Postcoital bleeding
        - Vaginal discharge
        - Vulval skin symptoms
- ✓ Menstrual history
    - First day of last menstrual period (LMP)
    - Number of days of bleeding and flow (i.e. flooding, heavy, light)
    - Length and Regularity of cycle (e.g. a 28 day regular cycle, a 32 day regular cycle, a 21 to 60 day irregular cycle)
    - Any abnormal bleeding patterns: intermenstrual or post coital bleeding
    - Menarche (age at first period)
- ✓ Contraception
    - Current method of contraception and duration of use.
    - Previous methods of contraception
    - Any problems with any contraception used to date

- ✓ Cervical smear
    - When was last smear taken and what was the result
- ✓ Reproductive/Obstetric history
    - Gravidity, parity, pregnancy outcomes (births, miscarriages, ectopic pregnancies, terminations), birth weights and modes of delivery where relevant
- ✓ Previous gynaecological history
    - Past gynaecological problems, their investigations and treatment.
    - Previous gynaecological operations
- ✓ Past medical history, drug history /allergies, family history and social history and a systems inquiry are taken as usual.

Clinical activities in Gynaecology

MKM includes a number of clinical activities you should try and undertake during the block.

- *Case presentations and Cased based discussion*: You should take a full gynaecological history from patients in outpatients, but also from elective and emergency admissions to the ward. You should then formulate a problem list for each patient, and a management plan including investigations and treatment options.

Aim to take histories from patients with the following presenting complaints where possible, and then present them to members of your Clinical Team:

Presenting complaint
Heavy or painful periods
Pelvic/lower abdominal pain in a non-pregnant woman
Postmenopausal bleeding
Urinary incontinence and or prolapse
Vulval pain or pruritus
Excessive vomiting in the first trimester of pregnancy
Vaginal bleeding and/or pain in the first trimester of pregnancy
Infertility

- *Theatres*:
    - You should attend the preoperative ward round, introduce yourself to patients, and liaise with the Consultant Gynaecologist before approaching patients to obtain written consent for examination under anaesthesia.
    - In Theatre, aim to observe common gynaecological procedures, including, amongst others:
        - Hysteroscopy and curettage
        - Diagnostic laparoscopy
        - Operative laparoscopy (ovarian cystectomy, endometriosis treatment, myomectomy, hysterectomy)
        - Open hysterectomy or myomectomy
        - Pelvic floor repair

- *Outpatients*:
    - Attend gynaecology clinics, including special clinics (Early Pregnancy, Colposcopy etc) where available.
    - Observe consultations with different presenting complaints and take and present histories.
    - Your tutor/clinical team may consider it appropriate for you to examine suitable patients in Clinic, where consent is given.
    - Observe outpatient procedures such as Pipelle endometrial biopsy, smear taking, STD screening, Coil insertion and Hysteroscopy.

- Wards:
    - Attend ward rounds with members of the clinical team
    - Review your inpatients where possible, and note their progress daily, observing postoperative care
    - Take histories from emergency admissions with the on-call doctor and observe the approach to their assessment and management.
    - Look at drug and fluid charts (paper or electronic) to familiarise yourself with commonly prescribed medicines and fluids in the speciality.

NICE/RCOG and national guidelines in Gynaecology:

Ectopic pregnancy and miscarriage:
https://www.nice.org.uk/guidance/ng126/chapter/Recommendations

Heavy Menstrual Bleeding:
https://www.nice.org.uk/guidance/ng88/chapter/Recommendations

Menopause:
https://www.nice.org.uk/guidance/ng23/chapter/Recommendations

PMOS:
PMOS guidelines summary
https://www.nice.org.uk/guidance/indevelopment/gid-ng10436

PID:
BASHH Guidelines PID

Urinary Incontinence:
https://www.nice.org.uk/guidance/ng123/chapter/Recommendations

Pelvic pain:
https://www.rcog.org.uk/media/muab2gj2/gtg_41.pdf

Infertility:
nice.org.uk/guidance/ng257 Fertility

Vulval conditions:
www.bashh.org/_userfiles/pages/files/bashh_vulval_guidelines_2024.pdf

Termination of pregnancy:
https://www.nice.org.uk/guidance/NG140

Endometriosis
https://www.nice.org.uk/guidance/ng73

Gynaecological Cases

The following cases should help you cover a broad range of topics in Gynaecology and GUM. We have not duplicated factual information here that you can find in books or on the O&G web-resources but try problem-solving each case using multiple resources. You may wish to discuss aspects of the cases with your clinical team, who may provide a different perspective.

Menstrual disorders

By the end of the course, you should be able to

- **Describe the physiology and endocrinology of the normal menstrual cycle**
- **Take a menstrual history, taking into consideration physical, psychological and social consequences of abnormal menstruation**
- **Recognise conditions associated with abnormal menstruation and their physical signs, including PMOS, fibroids, endometriosis, endometrial and cervical polyps, endometrial hyperplasia and genital tract infections**
- **Appreciate psychological and social burden of pre-menstrual dysphoric syndrome**
- **Recognise symptoms associated with the climacteric and describe the endocrine changes of the menopause and their physical, cognitive and emotional impact**
- **Competently perform a physical examination, including an abdominal, pelvic and speculum examination, in women presenting with menstrual disorders**
- **Suggest appropriate first line and further investigations of irregular, absent, painful or excessive menstruation as per NICE guidance**
- **Appropriately interpret investigation results and counsel patients accordingly**
- **Suggest conservative and operative management strategies for the treatment of menstrual disorders, commensurate with severity of symptoms and taking into account the circumstances of the person, as per NICE Guidance**
- **Understand drugs and therapeutics used in menstrual disorders and menopause, their mechanisms of action and side effects**

CASE 1

A 46 year old shop assistant, who is married with four children, is referred by her GP to the Gynaecology clinic. She was investigated for tiredness and lethargy and was diagnosed with anaemia. Her GP suspects that her periods may have caused the anaemia. Her cycles are 7/29, and there is no intermenstrual or postcoital bleeding. Her partner uses condoms for contraception.

1.1. Visit the NICE.org.uk website, and read the Quick Reference guidance on Heavy Menstrual Bleeding (HMB)

1.2. Suggest two questions you could ask the patient to quantify her menstrual loss, and two questions to assess impact on her quality of life.

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1.3. You decide that the history does suggest heavy menstrual bleeding. What features of a general physical examination might be helpful in your differential diagnosis?

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You examine the patient and find her generally well, with a normal-size mobile uterus and no adnexal masses.

1.4. What is the most likely diagnosis and what features of history and examination support your view?

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1.5. Suggest first line investigations, including the rationale (NICE) for your recommendation.

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1.6. Outline the medical management options for this patient, starting with the simplest and least invasive treatment first.

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1.7. Explain to the patient the advantages and disadvantages of two of your suggested medical treatments.

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1.8. Describe the mechanism of action in two commonly used **non-hormonal** therapeutics in the management of heavy menstrual blood loss.

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1.9 What operative interventions are available if medical management fails, and what are their commonest complications?

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Menstrual Cycle Quizz- Geeky Medics

Heavy Menstrual Bleeding Patient info video

CASE 2

A 35 year old nulliparous patient presents with painful periods. She was sterilised aged 30 and discontinued the Pill at that point. Over the past four years her periods have become increasingly painful; the pain starts a few days before onset of menstruation and resolves by the end of the period. Her cycles are 3/28, and there is no intermenstrual or post coital bleeding. Her periods can be heavy occasionally, although this does not concern her as much as the pain. She does have to take time off her work as a carer occasionally because of the pain.

2.1 From the history given, draw up a list of possible causes for the patient's symptoms.

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Endometriosis video

Endometriosis stories

2.2 What additional questions would you like to ask the patient specifically about her presenting complaint and why?

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2.3 On examination, you find that the patient is mildly overweight; her abdomen is soft with no obvious masses. On vaginal examination you find a normal-sized, fixed retroverted uterus, and there is tenderness in the posterior vaginal fornix. Both adnexa appear normal. What differential diagnoses would you consider based on these signs?

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2.4 How might you investigate this patient? Please explain how the information from each test will help you with your differential diagnosis.

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2.5 Suggest management strategies for dysmenorrhoea, grouping available treatments by underlying cause.

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Patient information leaflet on endometriosis

2.6 Describe the mechanism of action of two different hormonal therapeutics you might use, their mode of administration, and their side effects.

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How do GnRH anlogues work?

Ryego new medication for Endometriosis

Yselty new medication for Endometriosis

CASE 3

A 55 year old nulliparous woman is referred to you by her GP because of vaginal bleeding. Over the past year her periods have become increasingly prolonged and heavy, and she is now bleeding virtually every day. There is no significant pain. Her GP felt she might be perimenopausal and tried to regulate her periods using HRT, but this did not help. Her Hb was checked two weeks ago, and it was reported as 82 g/l. Her past medical history includes Diabetes mellitus, Hypertension, a fractured ankle 12 years ago, and a cholecystectomy aged 45.

3.1 What features of this patient's history raise your concerns as possible red flag symptoms and why?

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3.2 Suggest possible causes for the patient's symptoms.

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Endometrial Hyperplasia Patient Information

3.3 Describe the constituents of Hormone Replacement Therapy and explain why there is a need for different regimens. You should also consider the different modes of administration available.

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HRT Fact Sheet

3.4 What are the benefits and risks of HRT?

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HRT Risks & Benefits fact sheet

Risks & Benefits British Menopause Society

You examine the patient. Her BMI is 45, and her BP is 155/95 mm Hg.

Abdominal and pelvic examinations are difficult to interpret because of the patient's habitus.

3.5 What would be your suggested first line investigations, and describe how these would help your differential diagnosis.

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3.6 Discuss endometrial hyperplasia and its causes and consequences.

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Urinary Incontinence and Prolapse

By the end of the course, you should be able to

- **Take a relevant history from a patient presenting with urinary symptoms, and make a clinical distinction between the common types of female urinary incontinence**
- **Take a relevant history from a patient with symptoms of uterovaginal prolapse**
- **Understand the anatomical structures involved in different manifestations of uterovaginal prolapse**
- **Appreciate risk factors for uterovaginal prolapse and urinary incontinence**
- **Appreciate physical, psychological and social consequences of urinary incontinence and prolapse**
- **Recognise the different causes of urinary incontinence, including UTI, overactive bladder, genuine (urodynamic) stress incontinence, retention with overflow**
- **Understand the signs to be sought on physical examination**
- **Suggest appropriate first line and further investigations of urinary incontinence**
- **Appropriately interpret investigation results and counsel patients accordingly**
- **Suggest appropriate conservative and surgical management strategies for the treatment of female urinary incontinence and uterovaginal prolapse**
- **Understand drugs commonly used in female urinary incontinence, their mechanism of action, and their contraindications and side-effects**

4 CASE 4

A 55 year old woman with two grown-up children is referred to the Gynaecology clinic because she has been complaining of urinary leakage for the past two years, and her symptoms have become worse recently. Her medical history is unremarkable, with the exception of asthma for which she requires intermittent steroid treatment. She smokes 10 cigarettes per day; her alcohol intake is low, and she drinks up to 10 cups of coffee per day. She works as domestic staff and lives with her disabled husband.

4.1 Describe normal physiology of urinary continence.

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4.2 What other symptoms/history would you ask the patient about the presenting complaint?

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4.3 Suggest questions to ask the patient to assess the impact of her symptoms on her quality of life.

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4.4 What signs would you look for on examination and why?

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You examine the patient; she is obese, with a BMI of 38. General examination is unremarkable, and on pelvic examination there is no evidence of prolapse.

4.5 Visit the NICE website and look at the recommendations in the Guideline on Urinary Incontinence

4.6 Outline your plan for first line investigations and suggest some further investigations which may need to be considered in due course.

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Bladder Diary 'How To'

4.7 What lifestyle advice would you offer the patient to reduce the severity of her symptoms?

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Bladder training advice

4.8 The patient returns six weeks later and tells you that her GP prescribed Duloxetine in the meantime. What is this drug, what is the rational for using it in urinary incontinence, and what are its side effects?

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4.9 Despite taking Duloxetine she is no better and wishes to have surgery.

List two common surgical procedures for this condition and their complications.

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5 CASE 5

An 80 year old retired cook is referred to the Gynaecology clinic because she has been complaining of 'something coming down'. She feels uncomfortable, and finds it difficult to empty her bladder and open her bowels, and coping with her daily life has become more difficult. She lives on her own.
Her past medical history includes Ischaemic Heart Disease, and she is on Atenolol and Simvastatin.

5.1 Define the anatomical supports of the uterus, with a schematic drawing.

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You examine the patient and find that she has a second degree uterovaginal prolapse, with a moderate cystocele and small rectocele.

5.2 Describe the definition and anatomical basis of cystocele, rectocele and enterocele. Describe the difference between first, second and third degree uterine prolapse.

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5.3 Describe the range of symptoms that can be associated with uterovaginal prolapse.

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5.4 What first line management option would you consider for this patient, and why? What would be the advantages and disadvantages of your proposed management?

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Pelvic Floor Exercise Videos

5.5 What other options are available to this patient, and what are their risks and benefits?

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5.6 The patient decides to have surgery, and you are seeing her in Preoperative-Assessment clinic. Given her history, how would you adequately assess her before surgery?

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Pelvic pain

By the end of the course, you should be able to

- **Take a relevant history from a patient presenting with acute or chronic pelvic pain, including social and sexual history where appropriate.**
- **Appreciate common factors in the aetiology of acute and chronic pelvic pain**
- **Understand common causes of acute pelvic pain in the pregnant and non-pregnant woman, including pelvic inflammatory disease, functional and pathological ovarian cyst complications and non gynaecological causes**
- **Recognise the multifactorial nature of chronic pelvic pain, including psycho-sexual factors, and the need for a multidisciplinary approach**
- **Suggest appropriate investigations in a woman presenting with acute pelvic pain and interpret the results**
- **Suggest appropriate investigations in a patient presenting with chronic pelvic pain**
- **Develop a management plan for a patient with acute pelvic pain**
- **Propose a management strategy for a patient with chronic pelvic pain, taking into consideration the psycho-social impact of chronic pain**

6 CASE 6

A 19 year old student is referred to the Gynaecology admissions unit because of severe right iliac fossa pain for the past 24 hours. She is on Depo Provera® for contraception, and has been amenorrhoeic for the past 18 months. On admission her BP is 100/65 mm Hg, her pulse is 104 bpm and her temperature is 37.1°C. On physical examination she appears in pain, despite having been given intramuscular Opiates on arrival. Her abdomen is generally tender with maximum tenderness in the right lower abdomen; there is guarding with rebound tenderness. Pelvic examination reveals marked cervical excitation and right adnexal tenderness.

6.1 List the four most relevant differential diagnoses, and describe the salient presenting features and examination findings for each of these:

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6.2 Suggest the first line investigations that would help you narrow down your list of differentials.

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Further investigations confirm the diagnosis of a torted right ovarian cyst, and the patient undergoes a laparoscopic oophorectomy.

6.3 Draw on available resources to explore causes of adnexal masses; consider the types of ovarian cysts likely to present in the reproductive age-group (including functional ovarian cysts).

Visit RCOG website for learning regarding management of pre and post-menopausal ovarian cyst.

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The patient is discharged home, and makes a good recovery. She discontinues hormonal contraception, as she is concerned about side effects. Her periods resume and are regular, with a cycle of 4/28.

Eight months later she misses her period by 10 days and a home pregnancy tests is positive. She presents to her GP to discuss the option of Termination of Pregnancy.

6.4 Under what circumstances can a pregnancy be lawfully terminated in England? Review Abortion Law and summarise key points below.

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6.5 What methods are available for safe Abortion Care?

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7 CASE 7

A 29 year old housewife has been referred to the Gynaecology clinic because of recurrent lower abdominal pain. She has had pelvic pain since the age of 18. She underwent four laparoscopies between the ages of 18 and 23 to investigate the pain; all were normal. At the age of 24, after the birth of her only child, she underwent a total abdominal hysterectomy at her own request, because her symptoms failed to resolve. The operative notes suggest that her pelvis was normal at the time. Subsequently she felt her symptoms had improved, although she remained on pain killers. Over the past two to three years, her pain has been increasingly difficult to control. It is constant, bilateral, and appears to be exacerbated cyclically, although it is worse at times of stress. The patient is requesting to have her ovaries removed, and her GP is supporting her request.

Visit RCOG website Green top Guideline on chronic pelvic pain

See Visual Summary for Chronic Pain (NICE)

7.1 Consider possible physical and psychosexual causes of chronic pelvic pain. Analyse this patient's history, considering the likelihood of organic disease.

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7.2 Describe the effect of surgical menopause on women, with particular consideration of long-term health risks.

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7.3 What approach to this patient's management would you suggest?

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Pelvic Pain-What next? Patient Information

7.4 Discuss the ethical dimension of patient choice, when a procedure is requested that you, in your professional opinion, do not consider justifiable against the background of medically unexplained symptoms.

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Early Pregnancy

By the end of the course, you should be able to

- **Take a relevant history from a patient presenting with bleeding, pain, or excessive vomiting in early pregnancy**
- **Understand causes of sporadic and recurrent early pregnancy loss**
- **Request appropriate investigations in women presenting with suspected miscarriage**
- **Diagnose and suggest management of early pregnancy complications such as miscarriage or molar pregnancy**
- **Counsel women about management option for early miscarriage in an empathetic, sensitive way, using lay language**
- **Recognise and manage life-threatening complications of early pregnancy, such as ectopic pregnancy or pregnancy of unknown location**
- **Investigate and manage women with hyperemesis gravidarum, with particular attention to the prevention of life-threatening complications**
- **Understand safe drug prescribing in early pregnancy**
- **Investigate a couple with recurrent miscarriages**
- **Appreciate ethical and legal framework of the Abortion Act 1967, and principles of safe access to abortion care**
- **Understand benefits of pregnancy planning and principles of contraception**

8 CASE 8

A 39 year old secretary, who is nulliparous, attends the Early Pregnancy Assessment Clinic with light, painless vaginal bleeding. Her LMP was nine weeks ago; her cycles are 5/30. She has not used condoms for approximately four months prior to her LMP, because she was trying to conceive. On examination she appears well, and her uterus is just palpable above the symphysis pubis.

Her past history includes a pulmonary embolism 10 years ago, following a long-haul flight whilst taking the COCP. She was on Warfarin for six months subsequently.

The patient and her partner are extremely anxious and concerned.

8.1.Describe the journey of the zygote from fertilisation until a urinary pregnancy test becomes positive.

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8.2.Based on the history and examination above, what would be your working diagnosis?

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8.3. When (at what gestation) is the uterus usually palpable per abdomen? What possible causes might there be for a large-for-dates uterus in the first trimester?

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8.4. What investigations would you offer this patient and why?

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8.5. The Patient has βHCG test taken, and it is repeated after 48 hours. If found to have suboptimal rise of less than 66% and an empty uterus on USS, what would be the potential differential diagnoses? How would you differentiate between these early pregnancy complications?

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NICE recommendation- ectopic pregnancy and miscarriage

Why do miscarriages happen?

Two weeks later an ultrasound scan reveals an intrauterine gestational sac with a viable singleton of 11 weeks gestation. The patient is reassured by this, but discloses that she has had three miscarriages in the past, occurring at approximately 12-14 weeks gestation. The most recent miscarriage was five years ago. You conclude that she probably had missed miscarriages.

8.6. Describe possible causes of recurrent miscarriages, and consider, given the history above, what the likely cause might be in this patient.

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Recurrent miscarriage video

8.7. Given the causes you described above, outline how you would investigate a couple presenting with recurrent miscarriages.

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Recurrent miscarriage- patient information

The patient returns three days later with further vaginal bleeding and pain. On examination her BP is 120/78 mm Hg, her pulse is 88 bpm and there is moderate vaginal bleeding. On pelvic examination the cervical os is open.

An ultrasound scan is arranged and reveals that the gestational sac is no longer present and there is an area of approximately 40x20 mm in the uterine cavity which could represent retained products of conception.

8.8. What is the diagnosis and how can the patient's pregnancy loss be managed?

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8.9. Suggest an empathetic way of explaining the diagnosis and your proposed management to the couple, using lay language. Discuss what steps you would take to provide appropriate support to the couple during the consultation.

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8.10. The patient opts for a surgical evacuation of the uterus. Please complete the enclosed consent form with the relevant information.

CONSENT FORM FOR INVESTIGATION OR TREATMENT FOR COMPETENT ADULTS

Patient Details:

Unit Number:	……
Patient's surname:	……
Patient's first name:	……
Date of Birth:	……

Name of proposed procedure or treatment (include brief explanation if medical term not clear)	…… ……
Statement of Health Professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)	I've explained the procedure to the patient. In particular, I have explained: **The intended benefits**:…… …… **Serious or frequently occurring risks**…… …… …… …… Any extra procedures which may become necessary during the procedure: ☐ blood transfusion…… ☐ other procedure (please specify)……. The procedure will involve: ☐ general/regional anaesthesia ☐ local anaesthesia ☐ sedation

8.11. Following the procedure, you are called to the ward to prescribe postoperative analgesia. You go to see the patient; she is experiencing mild to moderate pain. She has no known allergies.

What three drugs would be appropriate as postoperative analgesia? State generic name, dose, frequency and route of administration for each.

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Infertility

By the end of the course, you should be able to

- **Take a relevant history from a couple presenting with infertility, taking into consideration contributory lifestyle and health issues, and the psychosocial impact of infertility**
- **Understand causes of primary and secondary female infertility**
- **Understand causes of male infertility**
- **Request appropriate investigations in couples with infertility**
- **Interpret test results, including semen analysis, female endocrine tests, and results of tubal patency testing**
- **Counsel patients about the relevant test results and their implications**
- **Suggest appropriate management strategies for couples with primary or secondary infertility**
- **Appreciate and respect life choices of LGBTQ couples presenting to the infertility services**
- **Understand drugs used to treat female infertility, the rationale for their use, mode of action, and side effects**

9. CASE 9

A patient is referred to the Gynaecology outpatients because she has been trying to conceive for two years without success. She is a 31 year old customer service manager; she has been married for five years and neither she nor her partner have any children from previous relationships. Her partner is 29 years old and is self-employed, working from home most of the time.

9.1. Visit the NICE website and read the summary recommendations in the guideline on Infertility.

9.2. Define infertility, and differentiate between primary and secondary infertility

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9.3. Outline the main aetiological groups for female infertility.

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The patient's periods have been irregular since menarche, with cycles as long as four months. The duration of her periods is 3-7 days; occasionally they are heavy, but there is no significant pain. Until she started trying to conceive, she was regulating her periods successfully by using the COCP.

Her past medical history includes an appendicectomy aged 9.

You examine the patient; her BMI at 40 and she also appears to have a moderate amount of facial hair. There are no other significant findings.

9.4. Based on the above, what is the likely reason she has not yet conceived?

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9.5. Suggest investigations that could confirm your suspicion of the underlying disorder.

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9.6. Given that the patient is presenting with infertility, what other relevant investigations would you request and why?

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9.7. Describe the findings of a normal semen analysis, based on WHO normal values.

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9.8. What information obtainable through history would be helpful if you suspected tubal factor infertility?

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9.9. The patient's investigations reveal an anovulatory disorder. How could you induce ovulation? ……

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9.10. Describe the side effects of ovulation induction.

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9.11. If the patient was to get pregnant what implications would her BMI have on her pregnancy and labour? See:

Care Of Women with Obesity in Pregnancy

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Gynaecological Oncology

By the end of the course, you should be able to

- **Demonstrate understanding of existing women's health related screening programmes**
- **Interpret cervical screening results and explain them to the patient appropriately, including first line management**
- **Understand epidemiological, environmental, genetic and physical risk factors for gynaecological cancers, including conditions that are associated with increased cancer risk, such as endometrial hyperplasia, CIN and lichen sclerosus et atrophicus**
- **Recognise red flag symptoms and signs of endometrial, cervical, ovarian, and vulval cancer**
- **Understand the significance of postmenopausal bleeding and investigate patients appropriately**
- **Understand basic principles of treating gynaecological malignancies**
- **Appreciate the need for multidisciplinary management and psycho-social support in patients with gynaecological cancer**

10. CASE 10

A 30 year old nulliparous woman attends her GP's surgery for the first time. She recently arrived in the UK from an area of conflict in Sub Saharan Africa, a region with limited health care resources.

As part of the consultation, she is informed of the cervical screening program, which she is happy to participate in. A cervical smear is taken, and the patient is informed that she will be notified of the result in due course.

10.1. Visit the national cervical screening website and review the National Cervical Screening programme.

NHS Screening – patient information video

Screening patient information video

Cervical screening website

10.2. What specific **condition** does the cervical screening programme screen for?

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10.3. What risk factors for cervical malignancy may this patient have based on the case history? Name two.

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10.4. Describe additional risk factors for cervical malignancy. Suggest 6 risk factors from at least three domains.

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10.5. Describe the association of cervical cancer with the HPV virus, and discuss the implications of this association for prevention, including vaccines.

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10.6. What categories of smear results are there, and how can they be appropriately managed?

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10.7. Whilst taking the smear, it is noted that the patient had undergone female genital mutilation. What is FGM and what are the different types/grades?

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10.8. What are short- and long-term complications of FGM?

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10.9. What steps would you take in the management of this patient with regards to FGM and why?

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10.10. Please outline UK law on FGM, with particular emphasis on your specific professional obligations as a doctor.

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FGM Flowchart & Reporting Tool

10.11. This patient arrived in the UK from an area of conflict, having had limited opportunities to access healthcare. What challenges face refugees and asylum seekers in terms of their health care needs being met in the UK and other European countries?

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Women in War- the price of violence (video on women's reproductive health issues in areas of conflict, please scroll down linked page for video)

Health needs of asylum seekers and refugees

Obstetrics

History taking

When presenting an Obstetric case, it is useful to start by giving five pieces of background information that help the listener to focus on the major features of the case:

1. Patient's name
2. Age
3. Gravidity and Parity. *A Gravida is a woman who is pregnant. Gravidity refers to the number of pregnancies a woman has had, including current pregnancy. Parity is a description of the number of deliveries of 24 weeks or more plus those ending before 24 weeks where there was a sign of life. For example, a woman who is pregnant in her third pregnancy and who has had a previous miscarriage and a live birth is recorded as: G3 $P1^{+1}$*
4. Maturity of pregnancy, expressed in weeks gestation
5. The presenting problem(s).

Examples:

Mrs Anywoman is a 36 year old primigravida who is presenting at 28 weeks gestation with an antepartum haemorrhage.

Ms Anotherwoman is a 19 year old Gravida 2 Para 1 who is attending the Labour Ward at 37 weeks gestation for an External Cephalic Version because of a breech presentation.

Miss Anotherotherwoman is a 41 year- old Gravida 3 Para 0 who has been referred to the Antenatal Assessment Area by her community midwife because of hypertension and proteinuria at 32 weeks gestation.

✓ Dating/menstrual history

The purpose of taking a menstrual history is to define the gestational age and the expected date of delivery (EDD). The basis for this is that ovulation occurs 14 days before the next expected menstrual period and that delivery will occur approximately 38 weeks after ovulation. The following points should be ascertained:

- The first day of the last menstrual period. Is the patient sure of this date?
- Was the last period normal?
- Did the last period occur when expected?

- The normal interval between the first day of one period and the first day of the next (in days)
- Regular cycles?
- Was the patient using hormonal contraception? (This can interfere with the resumption of regular ovulation)

✓ History of current pregnancy

Once the presenting complaint has been described, the nature of follow up questions will depend on the patient's specific problem. The history of the current pregnancy should be then taken in depth.

The easiest way to do this would be to go through the pregnancy chronologically and ask about care routinely offered as well as any problems the patient might have experienced:

- 1st trimester
    - Preconceptual counselling (important in women with medical problems, on medications etc) and Folic acid intake
    - Dating (see menstrual history), booking USS (timing and result), routine blood results, blood group, any antenatal screening offered
    - Any additional tests offered/advised
- 2nd trimester
    - Second trimester screening for aneuploidy
    - Detailed USS? Result?
    - Any additional tests/problems?
- 3rd trimester
    - Any concerns by patient/midwife/doctors
    - Any additional testing undertaken (e.g. GTT, fetal growth scans...etc)

Clinical activities in Obstetrics

Your Logbook will list a number of clinical activities you should try and undertake during the course.

- History taking and Case presentations: You should take a full obstetric history from patients in clinics and wards, Labour Ward and, where available, obstetric admissions unit/triage. Aim to take a least one history per week. You should then formulate a problem list for each patient, and a management plan including investigations and treatment options.

Aim to take histories from patients with the following presenting complaints where possible, and then present them to members of your Clinical Team:

Presenting complaint
Normal pregnancy
Pre-eclampsia
Small-for-gestational-age baby
Diabetes in pregnancy
Obstetric Cholestasis
Breech presentation at term
Multiple pregnancy
Reduced fetal movements
Previous Caesarean section
Antepartum haemorrhage
Threatened Preterm Labour

- Antenatal Clinic:
    - Take histories, and perform antenatal checks (BP, urinalysis, obstetric abdominal palpation).
    - Familiarise yourself with the structure of a routine booking visit or antenatal visit.
    - Familiarise yourself with layout and content of handheld obstetric notes.
    - Observe consultations and approach to different presenting complaints.

- Observe counselling about antenatal screening.

- Day care /Antenatal assessment areas/Ultrasound:
  - Attend obstetric ultrasound session.
  - Observe diagnostic procedure such as amniocentesis or CVS, including pre-test counselling.

- Maternity admissions unit
  - See emergency admissions
  - Take and present histories and perform abdominal palpation

- Labour Ward
  - Attend ward rounds with members of the clinical team.
  - Observe normal and abnormal labour, and operative delivery.
  - Observe an induction of labour.
  - Look at patients' partograms and learn to interpret them.
  - With help from midwifery and medical staff, interpret fetal heart rate patterns in patients on continuous electronic fetal monitoring.
  - Manage a normal labour including first, second and third stage under supervision.

- Ante- and postnatal wards
  - Review patients you observed in labour
  - Take histories from inpatients and present them to members of your clinical team.
  - Speak to midwives about breast feeding support.
  - Review drug charts to help you understand prescribing in pregnant and breast-feeding women.

NICE guidelines in Obstetrics:

Antenatal Care: Antenatal Care NICE Antenatal and Postnatal Mental Health: http://www.nice.org.uk/guidance/cg192 Caesarean section: https://www.nice.org.uk/guidance/ng192 Hypertension in pregnancy: https://www.nice.org.uk/guidance/ng133 Intrapartum Care: Intrapartum care Postnatal Care: http://www.nice.org.uk/guidance/cg37 Obstetric Cholestasis: https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.17206

Maternity Safety:

Saving Babies Lives Care Bundle	https://www.england.nhs.uk/long-read/saving-babies-lives-version-3-2/
Ockenden 7 Actions	https://www.youtube.com/watch?v=QIk08bvgwGk
MBRRACE 2025	Summary

Obstetric Cases

The following cases should help you cover a broad range of topics in Obstetrics; each case is designed to cover multiple aspects of antenatal and postnatal care of mothers and babies. We have not duplicated factual information here that you can find in books or on the O&G web-resources but try problem-solving each case using multiple resources. You can consult the recommended reading list and links given in each section.

Normal pregnancy and Labour

By the end of the block you should be able to:

- **Take a full obstetric history considering physical, psychological and social/lifestyle aspects of women's health, as well as risk factors in relation to pregnancy**
- **Identify and refer safeguarding concerns (for example Vulnerable adult or child, Domestic violence, Female genital mutilation)**
- **Diagnose and date pregnancy and recognise factors affecting accurate dating**
- **Understand physiological changes occurring in pregnancy**
- **Counsel patients about routine antenatal care and antenatal screening for fetal abnormalities and diagnosis methods available to them**
- **Counsel patients about results of antenatal tests and screening for fetal abnormalities and explain their implications**
- **Identify and manage common issues in pregnancy, such as anaemia, reflux, pelvic girdle dysfunction**
- **Perform competently an antenatal examination of the pregnant woman, with special reference to obstetric abdominal examination, and recognise deviations from norm**
- **Manage normal labour, delivery and puerperium under supervision**
- **Recognise deviation from normal labour patterns such as delay in first and second stage of labour, and retained placenta**
- **Identify appropriate method of fetal monitoring and advise patient accordingly; recognise abnormal fetal heart rate patterns and suggest management options**
- **Understand and describe indications for and methods of induction of labour**
- **Appreciate the need for identification of perineal trauma and its consequences**
- **Understand physiology and maternal and infant benefits of breast feeding**
- **Understand available maternity services**
- **Appreciate importance of team working and multidisciplinary co-operation to achieve good outcomes for mothers and babies**
- **Be aware of main findings and recommendations of Ockenden and MBRRACE reports, and of the Saving Babies Lives Care Bundle**

11. CASE 11

A 24 year old nurse is arranging an appointment with a midwife, as she has just had a positive pregnancy test. Her last Menstrual Period was on 1st of September 2019; her cycles are usually regular at 4/28. This is her first pregnancy, and she has no significant medical or surgical history. She's in a long-term, stable relationship.

11.1. Visit the NICE.org.uk website and look at the main summary points of the guideline on Antenatal Care in low-risk pregnancy.

Antenatal Care- summary of latest NICE GUIDELINES

Antenatal tests

11.2. Outline routine blood tests that should be performed at the booking visit, and why.

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11.3. Describe the Naegele rule, and calculate the patient's Expected Date of Delivery (EDD) using that method.

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The patient works with adults with learning disabilities. She wishes to have information on screening available to her during the pregnancy, with particular reference to Down Syndrome.

11.4. Counsel the patient about screening tests for Down syndrome available in the first and second trimester respectively and explain how the results are interpreted.

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Screening tests for you and your baby video

11.5. Describe the physiological changes in the cardiovascular system in pregnancy.

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Her pregnancy progresses normally to 38 weeks gestation. She telephones Labour Ward at $38+^{6}/40$ concerned that her membranes may have ruptured. She is not experiencing any contractions, and fetal movements have been normal. The midwife asks her to come in so that it can be established whether or not her membranes have ruptured.

11.6. How can you confirm pre-labour rupture of membranes?

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11.7. What are maternal and fetal risks of pre-labour rupture of membranes?

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11.8. Given your response above, how would you manage the patient if her membranes are confirmed to have ruptured?

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The assessment on Labour Ward confirms that the patient's membranes have ruptured. It is noted that a high vaginal swab performed earlier in pregnancy revealed Group B Streptococcus. Two hours after admission the patient starts contracting and appears to be going into labour.

11.9. Review the RCOG guideline on the management of GBS in pregnancy and labour, and summarise it below.

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11.10. What methods of Intrapartum fetal monitoring are available? Describe each method and its indications, and then suggest how this patient's baby should be monitored during labour and why.

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Intrapartum fetal monitoring NICE

The patient is examined two hours after admission, and her cervix is found to be 4 cm dilated. Four hours later she is re-assessed, and her cervix is 5 cm dilated.

11.11. Discuss reasons for delay in the first stage of labour and how it could be managed.

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11.12. Describe the pharmacokinetics and –dynamics of synthetic Oxytocin, and its side effects.

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11.13. Discuss methods of intrapartum analgesia with their risks and benefits, starting in early labour at home through to advanced labour and delivery.

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Pain relief in labour options- video

Complicated pregnancy

By the end of the block you should be able to

- **Identify women at particularly high risk of developing complications in pregnancy**
- **Identify life-threatening problems of pregnancy, such as obstetric haemorrhage, venous thromboembolism, sepsis and maternal collapse, and conduct appropriate initial assessment and suggest first line management**
- **Counsel women about management options in term breech presentation**
- **Advise women about the benefits and complications of operative delivery and about Vaginal Birth After Caesarean (VBAC)**
- **Recognise abnormal patterns of fetal growth and amniotic fluid volume, and their causes, and propose an appropriate management plan**
- **Appreciate underlying causes of reduced fetal movements and intrauterine death, and their management**
- **Appreciate the added risk of multiple pregnancy and advise women on best pregnancy surveillance**
- **Identify and participate in the management of abnormal labour and puerperium, including prematurity, prolonged labour, suspected fetal compromise, and retained placenta**
- **Understand the importance of maternal mental health problems in pregnancy and puerperium**
- **Recognise and discuss ethical dilemmas in Obstetrics**

CASE 12

A 38 year old nullipara is attending the Early Pregnancy Clinic after eight weeks amenorrhoea with light, painless spotting *per vaginam*. She has known polycystic ovaries, and her periods can be up to six months apart. She became pregnant following ovulation induction.
The ultrasound report suggests two gestational sacs with viable fetuses of approximately eight weeks gestation.

11.14. Outline the concepts of zygosity and chorionicity.

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The patient returns for an ultrasound at 12 weeks gestation to confirm chorionicity. It appears that her twins are dichorionic and diamniotic.

11.15. Describe complications of pregnancy which are more common with twins and higher order pregnancy than in singletons.

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11.16. Given your response above, outline to the patient how her pregnancy will be monitored from now on.

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At 27 weeks gestation the patient presents at the hospital draining clear fluid per vaginam. There are no contractions. Preterm prelabour rupture of membranes (PPROM) is confirmed.

She is advised that it would be best to temporise to gain maturity.

11.17. What are fetal and maternal complications of PPROM, and what measures can you take that will help you to either detect these complications early, or prevent them altogether?

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11.18. Explain the risks of prematurity to the patient.

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11.19. Use the internet or library resources to find out about the ORACLE trial and describe its main findings.

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11.20. What two evidence-based therapeutic interventions would you instigate to increase latency from PPROM to delivery and reduce the impact of prematurity?

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The patient is admitted to the ward for surveillance. She remains well, but two weeks later she experiences moderately heavy blood loss *per vaginam*. The midwife attending to her estimates approximately 500ml of blood loss.

The patient is sent to the Labour Ward urgently. She appears in pain, and on examination her BP is 90/65 mm Hg and pulse is 116 bpm. On the CTG, Twin I appear to be having unprovoked decelerations, whilst Twin 2's heart rate pattern is normal.

11.21. What are the main causes of antepartum haemorrhage, and how might you be able to differentiate between them clinically?

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11.22. What immediate investigations would you request whilst you assessing the patient, and why?

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11.23. Given the history and examination findings above, what would be your proposed management plan? Please give details.

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11.24. The patient is delivered by Caesarean section. About one hour after the operation you are called to see her because she is bleeding heavily *per vaginam*. Her BP is 80/45 mm Hg and pulse is 146 bpm. What would be the immediate management of her post-partum haemorrhage, including drug therapy?

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12. CASE 13

A 45 year old nulliparous patient attends antenatal clinic at 32 weeks gestation to discuss mode of delivery. She has a poor obstetric history, having had several miscarriages between 12- and 14 weeks gestation, and a late miscarriage at 18 weeks. Given her history and maternal age, the decision was made to offer her an elective Caesarean section at 38 weeks gestation.

12.1. Explain the risks and benefits of Caesarean section to the patient.

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12.2. The patient is scheduled for a Caesarean section and is to return at 36 weeks for pre-assessment. However, one week later she presents to the Maternity Assessment Unit with a 24-hour history of reduced fetal movements.
Review the recommendations on Reduced Fetal Movements and then summarise the significance of the patient's presentation.

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12.3. What history would you take from a patient with altered fetal movements?

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12.4. How would you manage a patient with altered fetal movements at 33 weeks gestation, and what factors would you take into consideration when making a management plan? Use the guideline above to form your answer.

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12.5. The patient undergoes emergency caesarean section and her estimated blood loss is 2000 ml due to atonic PPH. On the third postoperative day you are called to see her because she is complaining of breathlessness. She appears well, but her pulse is 128 bpm, and her respiratory rate is 28 bpm. What is the suspected diagnosis, and what are other likely differential diagnoses?

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12.6. What risk factors for your suspected diagnosis are present and what others would you enquire about?

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12.7. How would you investigate?

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12.8. If your suspected diagnosis is confirmed, how would you treat the patient? Please specify dosage, mode of administration, and treatment duration.

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12.9. Explain the principles and methods of thromboprophylaxis in Obstetrics, with advantages and disadvantages of each method.

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Medical problems in pregnancy

By the end of the block you should be able to

- **Appreciate the impact of maternal medical problems arising in pregnancy on both maternal and fetal health, with special reference to disorders such as pre-eclampsia, obstetric cholestasis, Gestational diabetes mellitus, and VTE**
- **Understand the impact of pregnancy with its physiological changes on the course of pre-existing medical conditions such as asthma, epilepsy, diabetes mellitus and cardiac disease**
- **Appreciate the need for multidisciplinary working in the care of women with complex medical or psycho-social needs**
- **Understand safe prescribing in pregnancy, including drugs used to treat common medical conditions such as asthma, epilepsy, anaemia, hypertension, diabetes and thrombo-embolic disorders**
- **Understand impact of systemic and blood borne infection on pregnancy, including Rubella, CMV, Parvovirus, Chickenpox, Influenza, Syphilis, Zika HIV and COVID-19**

13. CASE 14

A 17 year old unemployed primigravida lives with her 44 year old partner, who is also unemployed. She presents for booking at 20 weeks gestation. Her BMI is 16; she smokes 20 cigarettes per day and uses occasional recreational drugs.
Her past medical history includes epilepsy. She is stable on Carbamazepine and has been seizure free for over a year. Initial booking blood tests reveal mild iron deficiency anaemia, but are otherwise normal.

13.1. Had the patient consulted you for preconceptual counselling regarding her epilepsy, what advice would you have given her on her medication, and on risk reduction in pregnancy?

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Epilepsy in pregnancy video

13.2. Discuss the potential impact of low socio-economic status and other items in the patient's history, on her pregnancy.

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13.3. Apart from routine antenatal care, what additional tests do you think this patient should have during the course of her pregnancy?

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The patient is found to be anaemic on her booking bloods with a HB of 82 g /l.

13.4. What are the clinical consequences of anaemia in pregnancy, labour and purperium?

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13.5. What investigations would you perform to determine the nature of her anaemia?

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The patient contacts her midwife at 24 weeks gestation. She is too distressed to talk on the phone, and the midwife therefore arranges a home visit. She finds the patient with bruises on her face and her arm in a sling. It appears that her partner has been arrested for assaulting her.

13.6. Review the following publication:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442136/

13.7. Having read the article or used other resources, please outline the impact of domestic violence on pregnancy.

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The patient's partner is remanded in custody, and she is now unsupported as she does not have family or friends locally. At 32 weeks gestation her neighbour calls an ambulance, as he finds her collapsed outside her front door. The actual collapse was unwitnessed. S he is brought to hospital by ambulance. The admitting team assume that she had an epileptic seizure. On arrival she is more alert and complains of a headache and epigastric pain. Her BP is 166/100 mm Hg.

13.8. What would be your main differential diagnosis?

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13.9. What investigations would you request to confirm or refute your suspected diagnosis?

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Whilst you are assessing the patient; you note that her BP has risen to 170/124 mm Hg, and you are more certain of the diagnosis. The fetal heart is normal.

13.10. Describe how you would manage the patient and why.

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13.11. What are potential maternal and fetal complications of the condition this patient has?

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13.12. Describe three different drugs from three different therapeutic groups that may be used to treat hypertension in pregnancy, including mode of action, usual dosage regimens, routes of administration, contraindications and side effects.

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13.13. Describe methods of induction of labour and the relevance of the Bishop Score

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Inducing Labour- patient information

CASE 15

A 28 year old woman with a history of depression stops taking her medications on her own accord when she finds out she is pregnant with her second child. She plans to have a home-birth.
Her antenatal care is uneventful until 34 week of gestation.

15.1. At 34 weeks of gestation she reports to her midwife that she developed pruritus on palms her hands and soles of her feet. There is no visible rash.

What tests will you offer this patient at this point?

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15.2. What abnormalities in the blood tests would you expect with Obstetric Cholestasis?

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15.3. What would be the differential diagnoses to consider?

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15.4. If Obstetric cholestasis is confirmed, how would you manage the rest of her pregnancy?

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A diagnosis of Obstetric cholestasis is made and the patient is offered induction of labour at 38 weeks gestation. She ends up having a difficult forceps delivery in theatre with post-partum haemorrhage, requiring a blood transfusion.
Postnatally, she was noted to be withdrawn and lethargic, with a low mood, which was attributed to her delivery. She was discharged home after 3 days.
Two weeks later, the health visitor noted that the patient had a very low mood, was uncommunicative and complained of hearing voices. Her baby was severely malnourished and showed signs of neglect.

15.5. What would be your main differential diagnosis?

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15.6. What risk factors in the patient's history would support your differential diagnosis?

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15.7. What management steps should be taken? Please consult the NICE guideline on Antenatal and postnatal Mental health.

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Maternal Mental Health information

Patient experience videos (scroll down web page)

16. CASE 16

A 27 year old woman has just had a caesarean section at term for pre-eclampsia. She and the baby are well. Her Blood pressure is well controlled on Labetalol 200 mg bd. She is also on Lamotrigine for her epilepsy, which is well controlled. She wishes to breastfeed her baby.

16.1 Describe the physiology of breastfeeding and the composition of breast milk.

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16.2 How can women be supported toward successful breastfeeding?

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Lactation for New Mums

Breastfeeding_advice UHL

16.3 List three common drugs that are contraindicated with breastfeeding.

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16.4 On Day 3 post partum the patient complains of pain and bleeding from her right nipple. What features would you look for in the examination of her breast?

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16.5 She is diagnosed as having mastitis. Please describe your initial management plan and what advice you would give the patient.

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INTEGRATED SEXUAL HEALTH WORKBOOK

Learning opportunities in Integrated Sexual Health

- Lectures/Tutorials
- Self-directed learning
- Observed clinics where available
- Case notes review of the patients seen during clinic sessions

History and Examination

By the end of this placement, you should be able to

- Take a full sexual history to assess risk for sexually transmitted infections (STIs) and to communicate this risk to individual patients in a sensitive, non-judgemental manner
- Take a contraceptive and reproductive health history to assess risk for pregnancy and contraceptive need
- Recognise risk factors for HIV and recommend HIV testing for patients presenting with these risk factors or where HIV is part of the differential diagnosis
- Perform male and female genital examinations skilfully including testicular examination, speculum and pelvic examination
- Respect patient dignity, confidentiality and exhibit cultural sensitivity; appreciate need for chaperones

Sexually transmitted disease

- Take a sexual history from male and female patients in a non-judgemental and empathic manner
- Perform blood borne virus (BBV) risk assessment, discuss this with the patient and recommend testing as appropriate
- Understand the relevance of taking samples for testing that are appropriate to the patient's symptoms and risk factors
- Advise appropriate tests for asymptomatic STI screening
- Recognise the common presentations of STIs
- Manage and counsel patients with common STIs including fungal, viral and bacterial diseases
- Understand the importance of partner notification
- Have knowledge of risk factors, natural history and basic principles of management of HIV
- Request appropriate HIV test and discuss relevant issues related to HIV testing including window period
- Describe effective ways of preventing or reducing the risk of BBVs including vaccinations, pre- and post-exposure prophylaxis (PEPSE and PrEP)
- Understand the role of the MDT and be able to sign post patients accordingly

Contraception

- Demonstrate basic knowledge of currently available common contraceptive methods and be able to communicate to clients the mechanism of action and failure rate
- Describe to a client methods of emergency contraception and indications for use

GUM Cases

The following cases should help you cover a broad range of topics in GUM. You should problem-solve each case using multiple resources. You may wish to discuss aspects of the cases with your clinical team, who may offer a different perspective.

17. CASE 17

An 18-year-old female presents to the sexual health clinic with a one-week history of abnormal vaginal discharge.

She split up from her long-term partner 4 months ago and reports two casual partners in the last three months.

17.1 What additional information would you like to obtain from the patient, with emphasis on sexual history taking?

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You examine the patient. Her abdomen is soft. Speculum examination reveals a thin smelly homogenous discharge. Bimanual examination is normal.

Microscopic examination of a Gram-stained smear of vaginal discharge in clinic identifies epithelial cells covered with small Gram-negative/Gram-variable rods.

17.2 What further microbiological and serological tests for STIs should be offered?

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17.3 What would be your working diagnosis?

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17.4 A week later she is recalled to the clinic to see the Nurse/ Health Adviser (HA) for treatment of genital chlamydia. What additional information should be obtained from the patient before treatment?

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17.5 Suggest 2 recommended treatment regimens for genital chlamydia.

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1/7.6 What further advice and follow up will you arrange?

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She returns 10 days later having completed her antibiotics, feeling unwell, with bilateral lower abdominal pain, post-coital bleeding and deep dyspareunia.

On examination she is normotensive, pulse of 78 bpm, temperature 37^{o}C. On abdominal palpation there is bilateral tenderness in the lower abdomen. On bimanual examination there is cervical excitation and bilateral adnexal tenderness.

17.7 What is your differential diagnosis?

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17.8 Describe the investigations you consider necessary in this case.

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17.9 What would be your working diagnosis?

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17.10 What are the short term and long-term complications of this diagnosis for this 18-year-old if it remains untreated?

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17.11 How would you treat this patient should your working diagnosis be correct? (See https://www.bashhguidelines.org/media/1217/pid-update-2019.pdf)

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17.12 What other steps/interventions would you consider (including advice to patient)?

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18. CASE 18

A 24-year-old MSM (men who have sex with men) presents to the sexual health clinic with a two-week history of burning pain on passing urine. His job requires him to travel abroad regularly. He has been with his regular male partner for the last 4 months and this is his first visit to the clinic.

18.1 What other genital symptoms will you ask about?

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18.2 What additional information would you like to obtain to identify any risk taking behaviour, with emphasis on sexual history taking and BBV risk assessment?

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18.3 He admits to 'Chemsex'. What do you understand by this term and which drugs are usually implicated?

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On examination, the patient has a muco-purulent discharge from the urethra. Testicular examination is normal.
Microscopic examination of a Gram-stained smear of urethral discharge in clinic identifies gram-negative intracellular diplococci in polymorphonuclear leukocytes

18.3 What further microbiological and serological tests for STIs will you offer in this case?

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18.4 What is your working diagnosis?

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18.5 Explain the diagnosis to the patient using jargon-free language that you would use to explain this to the patient.

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18.6 Suggest a recommended treatment regimen for this patient, based on your working diagnosis.

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18.7 What additional risk reduction measures and other key advice will you offer?

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He returns 2 weeks later complaining of redness, pain and swelling of the right epididymis and testicle.

On examination he is normotensive, pulse of 80 bpm, temperature 37.6^{o}C. Right testicle and epididymis are tender on palpation with erythema and oedema of the scrotum. Genital examination is otherwise normal.

The patient receives appropriate treatment, and is asked to see the Health Advisor prior to leaving clinic.

18.8 What are the differential diagnoses?

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18.9 What immediate test will you perform in the clinic?

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18.10 What further laboratory tests would you consider?

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18.11 How would you treat this patient should your working diagnosis be correct? (See https://www.bashhguidelines.org/media/1242/eo-2019.pdf)

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The patient receives appropriate treatment. However, he presents to the clinic 2 weeks later. He reports that the treatment was effective but some of his symptoms have returned over the last 2 days.

18.12 What key facts would you ascertain from the patient?

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18.13 How would you manage this patient?

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18.14 Comment on the usefulness of an ultrasound scan in this patient.

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19. CASE 19

A 28 year old woman returns to the sexual health clinic with some questions regarding her management. She has been recently tested positive for HIV. She is keen to try for a baby. She is otherwise well.
Her partner has been tested negative and is aware of her status.

19.1 What is the risk of vertical transmission (%) if HIV is untreated?

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19. 2 What antenatal, intrapartum and postnatal measures are recommended to reduce the risk of vertical transmission?

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19.3 Does she need to start antiretroviral medicines, and if so, when?

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19.4 Can she have a vaginal delivery?

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19.5 Will the baby require any treatment after birth? If yes, for how long?

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19.6 Can she breastfeed?

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19.7 How can she reduce the risk of transmitting the infection to her negative partner?

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19.8 Does she have to inform all staff looking after her during pregnancy, labour and postnatal period of her HIV status?

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19.9 What special precautions will she require during delivery?

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19.10 'I have read about U=U on the internet' the patient informs you. How a discussion regarding this statement can give her reassurance? Explain.

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20. Case 20

A 22-year-old bisexual man attends the sexual health clinic with a 3-day history of pain on urination. His underwear has been stained for the last 2 days.
He has had several new partners over the last few months. He last had sex 4 days ago. You take a detailed sexual history.

20.1 What additional risk factors will make an STI more likely?

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Genital examination shows a watery clear discharge within the urethral meatus (without the need to milk the urethra).

20.2 What would be your differential diagnosis?

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20.3 What immediate diagnostic test would you perform in the clinic?

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20.4 What additional tests/ samples will you consider and why?

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Gram stain smear from the urethra shows the presence of > 5 polymorphonuclear leucocytes (pus cells) per high power field with absence of intracellular diplococci in several fields.

20.5 What is your working diagnosis?

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20.6 What are the current recommended treatment options, and what are the challenges of providing treatment?
(See https://www.bashhguidelines.org/current-guidelines/urethritis-and-cervicitis/ngu-2015)

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20.7 What further advice and follow up will you arrange before he leaves the clinic?

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The patient receives appropriate treatment. However, he presents to the clinic one month later. He reports that he noticed an ulcer on his penis 7 days ago which is not painful.
On examination, he has a single non-tender ulcer on the shaft of his penis with swollen inguinal lymph nodes. He also has maculopapular rash on the palms and the soles of his feet. The rash is not itchy or painful.

20.8 What is your working diagnosis?

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20.9 What other infective and non-infective agents may cause ulcer/s on the penis?

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20.10 What immediate test will you perform in the clinic?

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20.11 What further laboratory tests would you consider?

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The patient receives appropriate treatment with a single intramuscular injection of benzathine penicillin.

20.12 What additional advice and follow up will you arrange?

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21. Case 21

An 18 year old female presents to the sexual health clinic requesting contraception advice. She has heard about “contraceptive pill” but not aware of any other contraceptive methods.
She is otherwise fit and well. She has been using condoms for contraception.

21.1 List different methods of contraception available to her in the UK?

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21.2 What is the biggest difference between condoms and other methods of contraception?

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21.3 How likely is she to get pregnant on the Pill versus using a condom alone?

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She feels that the birth control pill is a simple and convenient way to prevent pregnancy.
Therefore, she decides to start the combined oral contraceptive pill.

21.4 How does the combined oral contraceptive pill (COCP) work?

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21.5 What assessment would you consider before initiating a COCP and why?

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21.6 Describe three major health risks associated with using the COCP.

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She returns 3 months later for a review. She has been forgetting to take her pill and would prefer contraception that does not need to be taken every day.

21.7 Which contraceptive methods can you suggest that would not require her to remember to use every day?

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21.8 She wants to know the key differences between Nexplanon and Mirena. (Please explain using the language you would use when explaining this to the patient)

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22. Case 22

A 20 year old female attends sexual health clinic requesting the “morning after pill”. She got drunk at a party and cannot remember using a condom during sexual intercourse.

22.1 What other information do you need before deciding to offer emergency contraception (EC)?

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22.2 What types of EC is available in the UK?

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22.3 Why is taking emergency contraception not the same as having an abortion?

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She had unprotected sex about 36 hours ago. She has a predictable 28-day cycle and her last normal period started 12 days ago. She has not had any other acts of sex in this cycle. She is not on any regular medication and has no allergies.

22.4 What method of EC do you feel would be most suitable for her and why?

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22.5 What are three key differences between Ulipristal Acetate (known as ellaOne) and the copper IUD?

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She decides to take ellaOne in the clinic. She is also keen to start a progestogen only pill (POP).

22.6 When can she start taking the POP after ellaOne and why?

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22.7 What other advice can you give her after taking ellaOne?

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Reading List

RECOMMENDED BOOKS

1.	Collins S, Arulkumaran S, Hayes K, Jackson S, Impey L. Oxford handbook of obstetrics and gynaecology. Fourth edition. Oxford: Oxford University Press; 2023. View online.
2.	Symonds IM and Arulkumaran S. Essential Obstetrics and Gynaecology. 6th edition, Elsevier, 2020 View online
3.	Kenny L, Myers JE. Obstetrics by ten teachers. 20th edition, Taylor and Francis 2017 View online
4.	Bickerstaff H, Kenny LC. Gynaecology by ten teachers. 10th edition, Taylor and Francis, 2017 View online
5.	Hamilton-Fairley, D. and Chamberlain G. Obstetrics & Gynaecology (Lecture Notes). 3th edition, Blackwell, 2009 (Library)
6.	Pitkin J, Peattie A, Magowan B. Obstetrics and Gynaecology: An illustrated colour text. Churchill Livingstone 2003 (ISBN 044305035X) View online
9.	Impey L, Child T. Obstetrics and gynaecology. 5th edition, Chichester: Chichester : Wiley-Blackwell; 2016
10.	Rogstad KE. ABC of Sexually Transmitted Infections. 6th edition, BMJ books, 2011 View online
11.	Aiken, C.E.M. et al. Self-assessment in obstetrics and gynaecology by ten teachers. 2nd ed, Hodder Arnold; 2012 View online

REFERENCE BOOKS

1.	Magowan B, Owen P, Thomson A. Clinical Obstetrics and Gynaecology. 4th edition, Elsevier, 2018 http://ezproxy.lib.le.ac.uk/login?url=https://www.clinicalkey.com/#!/browse/book/3-s2.0-C2016003512X
2.	James DK, Steer PJ, Weiner CP, Gonik B. High Risk Pregnancies: Management Options. Elsevier Saunders 1999 (ISBN 0702022233)
3.	Arulkumaran S. Oxford desk reference. Obstetrics and gynaecology. Arulkumaran S, editor. Oxford: Oxford: Oxford University Press; 2011 https://ebookcentral.proquest.com/lib/leicester/detail.action?docID=797721
4.	Oats J, Abraham S. Llewellyn-Jones Fundamentals of Obstetrics and Gynaecology 10th edition, Elsevier, 2017
5.	Enkin, Murray et al. Guide to Effective Care in Pregnancy and Childbirth. Third Edition, Oxford University Press 2000 (ISBN 019263173X)
6.	Chamberlain G. Turnbulls Obstetrics. Third Edition. Churchill Livingstone 2001 (ISBN 0443063656)
7.	Shaw R et al. Gynaecology. 4th edition, Churchill Livingstone, 2011

8.	Lees C, Bourne T, Edmonds K. Dewhurst's textbook of obstetrics & gynaecology. 9th edition, Chichester, U.K. : Wiley-Blackwell; 2018 https://ebookcentral.proquest.com/lib/leicester/detail.action?docID=822611
9.	Sonnex C. A General Practitioner's guide to genitourinary medicine and sexual health. Cambridge University Press, 1996 (ISBN 0521556562)
10.	Wisdom A, Hawkins DA. Sexually transmitted diseases: diagnosis in colour. 2nd Edition, Mosby, USA 1997 (ISBN 0723424969)

FURTHER RESOURCES

Journals

1. British Medical Journal www.bmj.com
2. BJOG: An international journal of obstetrics and gynaecology www.blackwellpublishing.com/journal.asp?ref=1470-0328
3. Sexually Transmitted Infections www.sextransinf.com
4. International Journal of STDs and AIDS www.roysocmed.ac.uk/pub/std.htm

Websites

1. Royal College of Obstetrician & Gynaecologists www.rcog.org.uk
2. Cervical screening: https://www.gov.uk/guidance/cervical-screening-programme-overview
3. Saving mothers lives : https://www.npeu.ox.ac.uk/mbrrace-uk
4. SIGN guidelines: https://www.sign.ac.uk
5. e-medicine O&G resource new address: https://emedicine.medscape.com/obstetrics_gynecology
6. British Association for Sexual Health and HIV (BASHH) www.bashh.org
7. Information on HIV and AIDS: is this now www.aidsmap.com
8. General Practice notebook: is this now www.gpnotebook.com

Contact Numbers

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Appendix 1

This is a list of suggested topics that may be used as the basis for teaching sessions in outpatients, ward based teaching and/or tutorials.

Early pregnancy complications
Antenatal screening and diagnosis
Normal and abnormal labour and puerperium
Operative delivery (Caesar/Instrumental delivery)
Medical disorders in pregnancy
Obstetric haemorrhage
Preterm birth
Fetal growth disorders (SFD/IUGR/Macrosomia)
Fetal monitoring in labour
Multiple pregnancy
Menstrual disorders
Acute and chronic pelvic pain (PID, endometriosis)
Urinary incontinence and prolapse
Menopause & HRT
Cervical screening
Infertility
Contraception

Appendix 2: End-of-block exam

The Reproductive Block Examination

There is an end-of-block examination following the reproductive block; this consists of an SBA and SAQ paper, and observed consultations in OSCE format.

General examination guidelines and university regulations apply, so please ensure you are familiar with these prior to entry into the exam.

PLEASE READ!

As a minimum, the following guidance must be observed:

- If you require **extra time for written examinations**, please confirm this with block administrator know at the beginning of the block so we can make arrangements ahead of the exam to accommodate you.
- Late arrivals with more than 30 minutes delay will not be admitted to the examination. If you arrive less than 30 minutes late you may be able to sit the exam but **YOU WILL NOT BE GIVEN ADDITIONAL TIME**, you will have to end the exam at the same time as all other students (or extra time students, if you require extra time).
- The papers may be delivered electronically via Examsoft and will be invigilated.

Short Answer Question (SAQ) paper

-You will have six SAQ questions to complete, in one hour.

Sample SAQ

Question 1

A 21-year-old nulliparous woman has been diagnosed as having a left sided Ectopic pregnancy. She is going to have a laparoscopic left salpingectomy.

a) *You have been asked to obtain informed consent for the procedure. Please list four operative complications that you will have to talk to the patient about.*

b) The patient would like to know the cause of her Ectopic pregnancy. What is the leading cause in the UK?

c) The patient undergoes surgery; the surgeon converts to an open procedure because of multiple adhesions. On the third postoperative day you are asked to see her because of increasing abdominal pain and abdominal distension. She looks unwell, her temperature is 38.5^{o}C, and her pulse is 124 bpm. What are your differential diagnoses?

d) Prior to discharge, the patient wishes to receive contraceptive advice. Please provide two items of information relevant to her situation.

Question 1

Candidate Initials:…….

Candidate Obs & Gynae No: …….

(a)	

(b)	

(c)	

(d)	

Sample Answers

a)

i. anaesthetic risk
ii. haemorrhage
iii. infection
iv. visceral/vascular injury

b) chlamydial PID

c)

i. Bowel injury
ii. Peritonitis
iii. Pelvic haematoma

d)

i. avoid IUCD
ii. avoid progestogen only contraception

Single Best Answer Paper (SBA)

The paper consists of 40 questions. You will have one hour to complete the paper (unless you have special arrangements). Each SBA question consists of a vignette (case history) a lead-in statement (your instruction what to do), and a list of options (answers). You are required to choose the best option from the "option list" for each case. The options may be lists of diagnostic tests, diagnoses, treatments, or drugs. There is no negative marking.

For examples see below.

Sample SBA

1. A 30-year-old G3 P2 presents for a routine Antenatal Clinic visit at 22 weeks gestation. She is very well and the pregnancy has been progressing in a satisfactory fashion. Her last recorded pre-pregnancy blood pressure was 138/85 mm Hg. Today her BP is 88/50 mm Hg.

   Please select the RELEVANT PHYSIOLOGICAL ADAPTATION MECHANISM from the option list.

   OPTIONS:

   A. Increase in plasma fibrinogen
   B. Rise in cardiac output
   C. Inhibition of gonadotrophin secretion
   D. Decrease in peripheral vascular resistance
   E. Venous compression by enlarging uterus

2. A 42-year-old G1 P0 seeks your advice regarding antenatal screening and diagnosis. She is currently nine weeks pregnant. She would like to know whether or not her baby has Down's syndrome, and would like a test at the earliest possible opportunity.

   Select the MOST APPROPRIATE TEST from the option list.

   OPTIONS:

   A. Amniocentesis
   B. Nuchal translucency screening
   C. Chorionic villous sampling
   D. Second Trimester Triple Test
   E. Serum AFP

3. A 27-year-old nulliparous woman is undergoing investigations for infertility. Her doctor wishes to perform a blood test to confirm ovulation.

   Please select the most appropriate HORMONE TEST from the option list.

OPTIONS:

A. Progesterone
B. Oestradiol
C. Follicle stimulating hormone
D. Sex-Hormone-Binding-Globulin
E. Luteinising hormone

Sample SBA Answers

1. **Correct answer: I decreased peripheral vascular resistance**
   This is a healthy woman in the second trimester of pregnancy. Her low blood pressure is the result of peripheral vascular dilatation. Whilst the rise in cardiac output compensates to a degree for the drop in vascular resistance, the net effect is usually a reduction in blood pressure, with a nadir in the second trimester. BP tends to increase again in the third trimester.

2. **Correct answer: C Chorionic villous sampling**

   This patient wants to know whether or not her baby is affected, that means you need to offer her a diagnostic rather than a screening test. She wishes to have a test as soon as possible; a chorionic villous sample (CVS) can be taken after 10 weeks gestation, whereas an amniocentesis is offered from 15 weeks onwards. An earlier CVS carries a risk of limb reduction defects, whereas an amniocentesis performed before 15 weeks has a higher risk of miscarriage.

3. **Correct answer: A Progesterone**

   If ovulation occurs, the corpus luteum begins to secrete Progesterone; a rise in plasma Progesterone levels in the midluteal phase is therefore suggestive of an ovulatory cycle. In longer cycles the best timing for the test is one week before expected menstruation.

Observed Consultations

Aside from the written exam, we conduct an OSCE style observed consultation.

This usually takes place on the last Friday of the block, but timing may vary depending on room availability and you will be notified of the date and time of the exam by the Undergraduate Co-ordinator.
The exam is conducted under usual examination rules and regulations.

Our current format includes one Obstetric and one Gynaecology station. You have one minute reading time, followed by a five minute consultation station.
The content can be drawn form the entire Reproductive Health curriculum, and may consist of history taking, results explanation (including results that may be upsetting to the patient), outlining management, counselling about a common test or procedure, or performing an examination on a model.
Handwritten feedback by examiners is given to individual students prior to the group leaving the exam premises.

Exam results for OSCE and written are released together once marking is completed, usually within two weeks of block end.

Sample Observed Consultation:

A 33 year old Gravida 5 Para 4 has been referred to hospital by her community midwife because of an unstable lie at 38 weeks gestation. You've been asked to see her to explain management.

Consultation station- Sample Marksheet

O&G OSCE MARK-SHEET
Unstable lie - Counselling

Marking scheme	**0**	**1**	**2**
Introduction (1), establishes what patient has been told so far (1)			
Explains unstable lie correctly (1) and that presentation must be confirmed by USS (1)			
Should malpresentation be confirmed, there are some risks (higher perinatal morbidity, perinatal mortality, cord prolapse, Emergency delivery by CS) 1 mark for 2 correct answers, 2 marks for 4 correct answers			
Explains fetus may turn spontaneously (1) but chances at term are small (1)			
Explains option of External cephalic version (1) and risks (failure, discomfort, risk of abruption/fetal compromise, baby may turn back) (1 for any two correct)			
Explains option of elective Caesarean section at 39 weeks (1) and higher maternal but lower fetal risk (1) (accept student giving two risks of section for mark)			
Explain why to stay in till delivery of baby (2)			
Offers appointment after USS once presentation confirmed and placenta previa is excluded (2)		[redacted]	
Offers consultation with more senior doctor if oblique lie is confirmed (2)			
Systematic and concise approach (2)			

Please circle **ONE** global score category:

Fail	**Borderline**	**Pass**	**Good**	**Excellent**

Comments:

End of Block Grades

The grades awarded at the end of the block will be in the following domains:

1. **Professionalism:** **Satisfactory/Unsatisfactory**

   This will include elements of professionalism and attendance

2. **Academic:** **Excellent/good/pass/borderline/fail**

   This will include the SAQ and SBA papers and the Workbook assessment

3. **Clinical:** **Excellent/good/pass/borderline/fail**

   This will include formal observed consultation plus formative assessment

4. **Overall Impression:** **Excellent/good/pass/borderline/fail**

Formative Assessment and Feedback

It is your responsibility to ensure that your assessment on MKM is completed in a timely manner. You should clarify your tutor's availability in the last two weeks of the course (weeks six and seven) to ensure that you don't have any difficulties getting the assessment and feedback form signed off. Your tutor may be able to nominate an appropriate delegate if he/she will be on leave.

During the block, you need to be assessed on the following:

1. **Workbook:** Your tutor will review your workbook to assess that you have worked through all the cases, and may ask you questions about a random selection of cases to ensure your understanding.
2. **Clinical assessment:** This grade is based on direct observation of your clinical skills, and should be signed off by a Consultant or senior trainee (ST3 or above) who has directly observed your skills. Ideally, you should request a sign off whilst you are working on the wards or in clinics in the last couple of weeks of the block.
3. **Attendance:** May be marked by your tutor but can be overridden by Course Lead if you MKM does not reflect good attendance, or you don't attend tutorials
4. **Professionalism**: May be marked by your tutor, but can be overridden by Course Lead if there is cause for concern