

## HISTORY AND EXAMINATION IN OBSTETRICS

### **I. History:**

- ◆ PATIENT DEMOGRAPHIC DATA
  - ◆ PRESENT COMPLAINTS/DURATION
  - ◆ HISTORY OF CHIEF COMPLAINTS
  - ◆ MENSTRUAL HISTORY
  - ◆ PRESENT PREGNANCY
  - ◆ PREVIOUS OBSTETRIC HISTORY
  - ◆ MEDICAL HISTORY
  - ◆ SURGICAL HISTORY
  - ◆ FAMILY HISTORY
  - ◆ SOCIAL HISTORY
  - ◆ GYNECOLOGICAL HISTORY
  - ◆ CONTRACEPTION
  - ◆ RISK FACTORS
- 
- ◆ **PATIENT DEMOGRAPHIC DATA**
    - Name
    - Age
    - Nationality
    - Marital status
- 
- ◆ **PRESENT COMPLAINTS/DURATION**
  - ◆ **HISTORY OF CHIEF COMPLAINTS**
  - ◆ **MENSTRUAL HISTORY**
    - Date & certainty of Last menstrual period (LMP)
    - Regularity of menstrual cycle
    - Recent contraception if any
    - Calculate Expected Date Of Delivery (EDD)
      - Formula: (280 days from LMP)
      - LMP- date/month/year
      - $EDD = LMP + 7\text{days} / 9\text{ months}$
      - Example: LMP, 11-1-2015  
EDD, 18-10-2015

#### ◆ **PRESENT PREGNANCY**

- Last menstrual period
- Expected Date of Delivery
- Gestational age
- Symptoms of pregnancy
  - Amenorrhea
  - Nausea & vomiting
  - Frequency of micturition
  - Lassitude
  - Breast tenderness & heaviness
  - Fetal movement (Quickening)
    - At 20 weeks for PG
    - At 18 weeks for MG
  - PICA (desire/craving for a particular food)
  - Pseudocyesis (pregnancy test negative)
  - Heart burn
  - Constipation
  - Back pain

#### ◆ **PREVIOUS OBSTETRIC HISTORY**

- **It Is Important To Differentiate Between Gravidity & Parity.**
  - **GRAVIDITY**- Indicates the number of times the woman has been pregnant.
  - **PARITY**- Indicates the number of = or >24-week births (including viable and non-viable; i.e., stillbirths) pregnancies consisting of multiples, such as Twins or Triplets, count as one birth for the purpose of this notation.
  - **PRIMIGRAVIDA**- Being Pregnant for the 1<sup>st</sup> time.
  - **MULTIGRAVIDA**- Woman who is pregnant and has been pregnant at least once before.
  - **NULLIPAROUS**- Being a female that has not borne offspring
  - **PRIMIPARA**- Woman bearing the first offspring
  - **MULTIPARA**- Giving birth of more than one infant as a result of more than one pregnancy.
  - **GRANDPARA** - Giving birth of 5 infants or more as a result of more than one pregnancy.
- **Detailed Information Of Previous Pregnancy & Delivery + Miscarriage**
  - Length of gestation
  - Antenatal complications
  - Detail of labor e.g. spontaneous or IOL

- Length of labor
- Method of delivery
- Puerperinium complication such as; PPH infection, thrombosis, psyche etc
- Condition of each infant at birth.
  - Birth
  - Weight
  - Sex
  - Needs for NICU admission
  - Any abnormalities ,alive/dead

◆ **MEDICAL HISTORY**

- Medical disease (DM,HTN,Renal, Cardiac disorder etc)
- Thrombo-embolism
- Psychiatric disease
- Blood transfusion
- Allergy
- Medication

◆ **SURGICAL HISTORY**

- Surgical procedure
- Anesthetic difficulties
- Previous Caesarean Section, Dilatation Curettage
- Cervical cerclage.

◆ **FAMILY HISTORY**

- Hypertension history
- Diabetes history
- Congenital/genetic disorder
- Multiple pregnancy

◆ **SOCIAL HISTORY**

- Marital status
- Lifestyle status
- Vices (smoking, alcohol, drugs etc)

◆ **GYNECOLOGICAL HISTORY**

- Regularity of the cycle
- Length of the cycle
- Duration of menstrual flow
- Intermenstrual bleeding; post coital bleeding

- Sex disorder; dyspareunia (difficult or painful sexual intercourse) etc.
- ◆ **CONTRACEPTION**
  - Details of contraceptive method used .
  - Was the pregnancy planned?
  - Length of time planning to conceive?
- ◆ **RISK FACTORS**
  - Any factor liable to increase maternal or fetal morbidity should be highlighted in the case sheet.

## **II. Examination In Obstetrics**

- ◆ PRIMARY EXAMINATION
- ◆ THE SUBSEQUENT ANTENATAL EXAMINATION
- ◆ **PRIMARY EXAMINATION (THE FIRST EXAMINATION)**  
At the initial visit; complete physical examination should be undertaken.
  - i. **Height and Weight**
  - ii. **Blood Pressure**
  - iii. **Head & Neck**
    - Inspect skin pigmentation (CHLOASMA)
  - iv. **Breast**
    - Increased vascularity
    - Montgomery's gland enlarged
  - v. **Abdomen (skin)**
    - Striae gravidarum (stretch mark)
    - Linea negra
  - vi. **Limbs**
    - Varicosities
    - Edema
    - Shortening
  - vii. **Back**
    - Kyphosis
    - Lordosis (pregnancy associated with lumbar lordosis)
  - viii. **Abdominal Exam**  
Important to ascertain:
    - Size of the uterus
    - Fetal size
    - Fetal lie; presentation & attitude

- A auscultation of FH
- Presence of abnormal condition such as excess of Amniotic fluid (hydramnios); multiple pregnancy (twins ,triplets & quadruplet)

ix. **Pelvic Exam**

- To rule out the abnormalities & infection
- Confirmation of pregnancy
- Speculum exam and Pap smear
- Digital examination
- Assessment of pelvic bone

x. **Obstetric Ultrasound**

- For gestation age & viability

◆ **SUBSEQUENT ANTENATAL EXAMINATION**

i. **General Exam**

- Blood pressure
- Weight
- Urine analysis (to check for protein, sugar & ketone)

ii. **Abdominal Exam**

- Inspection
  - Size
  - Fetal measurement
  - Pigmentation
- Palpitation
  - Level of the fundus  
By symphysis pubis up to the fundus ,1cm= 1 week
  - Amount of fluid
  - Fetal parts
  - Fetal lie
  - Fetal presentation
  - Fetal position
  - Engagement
- Auscultation of the fetal heart.
  - Pinard fetal stethoscope
  - Doppler sunicad

**What The Examiner Should Identify?**

1. Is The **FUNDAL HEIGHT** consistent with the estimation of gestational age?
2. Is the **LIE** longitudinal?

3. Is the **PRESENTATION** breech or Cephalic?

4. Is the **CEPHALIC PRESENTATION** a **VERTEX**? This depends on the **ATTITUDE** of the fetus i.e. the relationship of its different parts to each other. The normal attitude is **FULL FLEXION**.  
In full flexion, every fetal joint is flexed.; This gives a **VERTEX** presentation, the only normal presentation.  
Sometimes the head may be extended. This gives a **FACE** presentation, which is highly abnormal

5. What is the **POSITION** of **VERTEX**?

The position is the relationship of the presenting part to the mother's pelvis.

6. Is the **VERTEX ENGAGED**?

Engagement means the descent of the biparietal diameter through pelvic brim.

If the vertex is at the level of the ischial spines, the head must be engaged unless there is caput formation.

Engagement can only be diagnosed with certainty by vaginal examination.

### iii. Vaginal Examination In Pregnancy

Bimanual examination is no longer a routine part of antenatal examination but still sometimes required:

1. To assess maturity in early pregnancy
2. To exclude suspected abnormalities such as incarcerated retroversion of the uterus or ovarian tumor.
3. To identify a presenting part this cannot be confidently identified abdominally.
4. To exclude or confirm gross degrees of contraction (in very small patients).
5. To assess the ripeness of the cervix near term.
6. To assess pelvic cavity.

## DEFINITIONS

**Presentation** is that part of the fetus in the lower pole of uterus overlying the pelvic Brim. Only a Cephalic is normal.

- Cephalic, (normal)
- Breech,
- Shoulder

**Attitude** is the posture of the fetus

- Flexion
- Deflexion
- Extension

**Lie** of the baby is the relation of the long axis of the fetus to the mother. Only a longitudinal lie is normal.

- Longitudinal (normal)
- Transverse
- Oblique

**Position** of the baby is the relationship of the presenting part to the mother's pelvis. It is conveniently expressed by referring to the position of one area of the presenting part known as **denominator**.

**Pelvis** is divided into (8) eight parts for the purpose of description:

**Denominator** is an arbitrary part of the presentation;

- Occiput in vertex presentation
- Sacrum in breech presentation
- Mentum in face presentation

**Chloasma**- irregular brownish or blackish spots especially on the face that occur sometimes in pregnancy and in disorders of or functional changes in the uterus and ovaries.

**Montgomery's gland**- the apocrine gland in the areola of the mammary gland.