BASIC GYNECOLOGY SKILLS MBChB IV

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10 GYNECOLOGY SKILL STATIONS

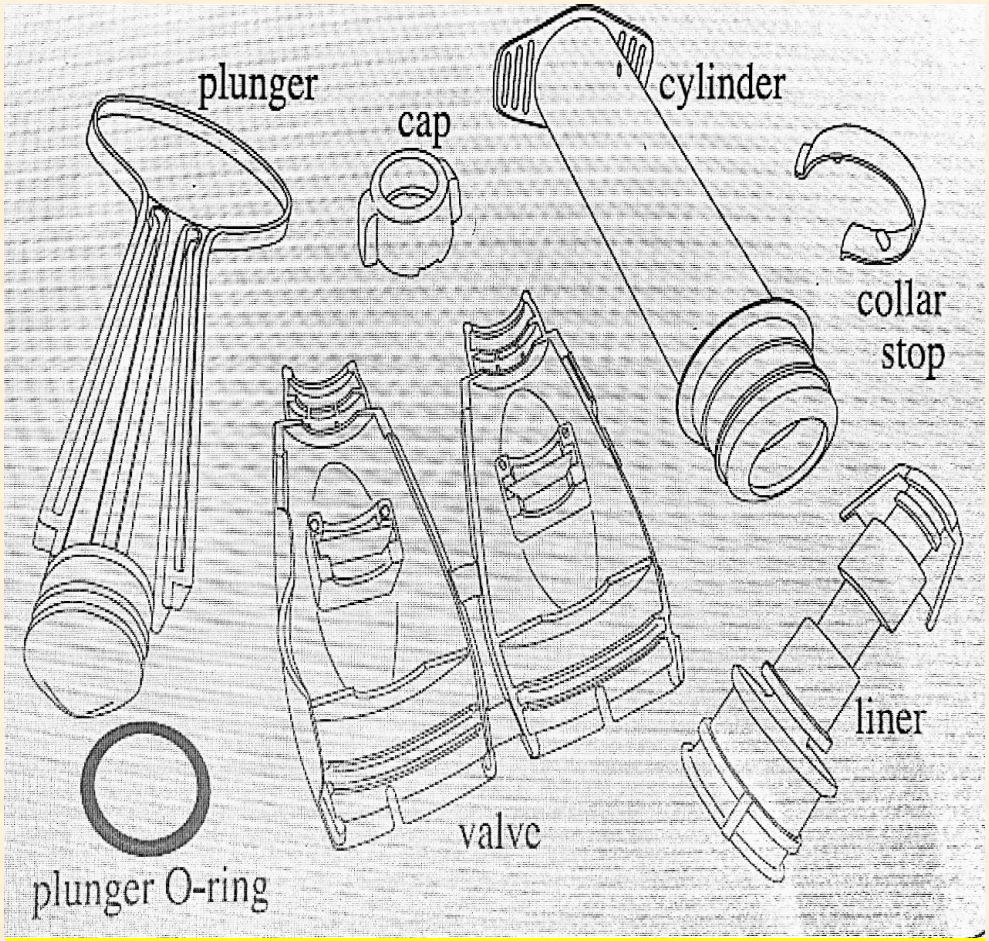
1) **Manual Vacuum Aspiration**
2) Pap smear collection
3) VIA/VILI
4) **Counselling for abnormal cervical screen result**
5) Implant insertion/removal
6) **IUCD insertion/removal**
7) Bimanual examination for pelvic mass/adnexal mass
7) Scrubbing/ Gowning/ Gloving, Abdominal draping and incisions
8) Ectopic Pregnancy, catheterization & IV access
9) High vagina swab & endocervical swab

1) MANUAL VACUUM ASPIRATION- MVA KIT

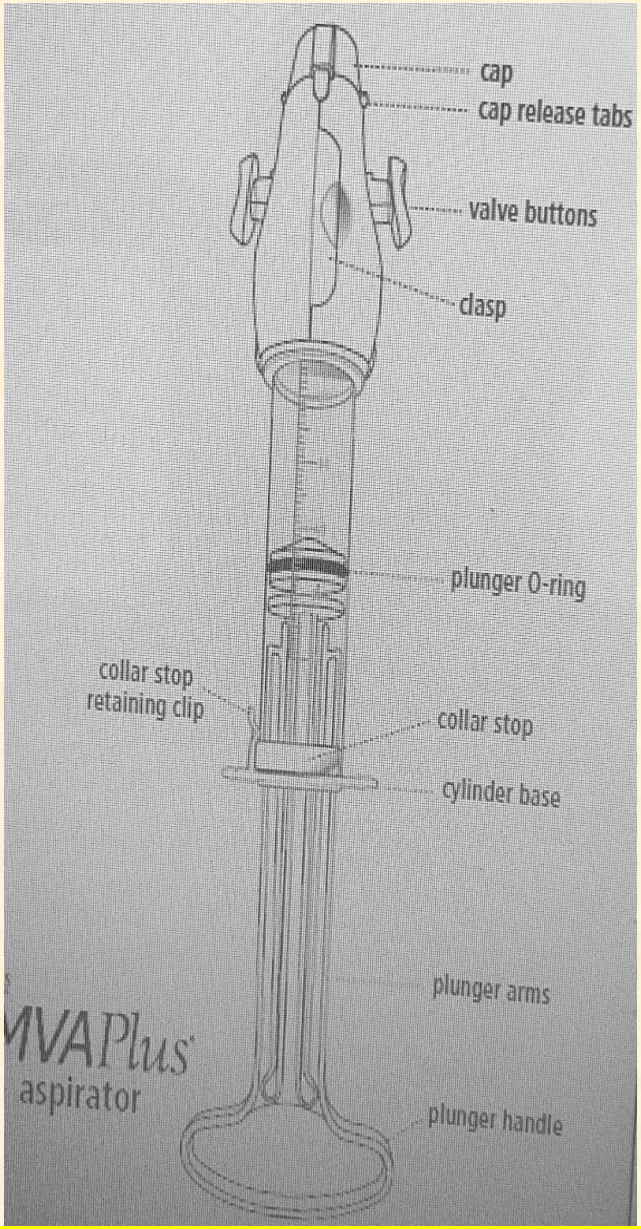
MVA-KIT

- Plunger
- O-rings
- Cap
- Valve set
- Cylinder
- Liner
- Collar stop
- Cannula

CANNULA



MVA PARTS DISASSEMBLED



MVA PARTS ASSEMBLED

MANUAL VACUUM ASPIRATION – PROCEDURE

1) Prepare aspirator/ requirements

✓ Aspirator:

- Position the plunger into the cylinder
- Put collar stop in place with tabs in the cylinder holes
- Push valve buttons down and forward until they lock
- Create vacuum-pull plunger back until arms snap outward and catch on cylinder base

✓ Other requirements

- Drapes, antiseptic
- Sterile gauze
- Ovum/sponge holding forceps
- Tenaculum
- Dilators
- Kidney dish
- Infection prevention supplies: sharps container, buckets,
- Large bore IV cannula
- Specimen bottles
- Cervical block requirements: 1% lidocaine, paracervical needle (or gauge 21 green needle), 10ml syringe
- Gyn bed
- Light source
- Resuscitation tray
- Sanitary pads
- Contraceptive methods

2) Prepare patient

- ✓ Counsel for procedure
- ✓ Confirm gestation ≤12 weeks
- ✓ Confirm diagnosis of incomplete abortion
- ✓ IM diclofenac 75 mg start 30 minutes before the proceedure
- ✓ Prophylactic antibiotics or for treatment if indicated
- ✓ Empty bladder
- ✓ Fix large bore intravenous cannula and assess for IVF or blood
- ✓ Chaperon needed

3) General and abdominal exam

4) Position patient in lithotomy position, clean &drape

5) Sterile pelvic and bimanual exam

6) Insert speculum, visualize the cervical os & check for signs of infection
7) Remove any visible products of conception with ovum forceps
8) Attach tenaculum, at 12 o'clock to steady the cervix and straighten the canal.
   - ✓ Spray 0.5 cc of lidnocain and inject 1% lidocaine before applying the tenaculum at 12 o'clock
9) Para cervical block: 1% lidocain at 8, 10, 2 and 4 o'clock. **Avoid 3 and 9 o'clock –blood vessels**
   - ✓ Inject 2-3 ml at each point just below mucus membrane slowly with aspiration to avoid intravascular injection
10) Applying traction to tenaculum insert the correct size of cannula, dilate if necessary to allow insertion of cannula. Do not insert cannula forcefully
11) Insert cannula to fundus
12) Create vacuum with syringe

13) Suction uterine contents by releasing vacuum and by gently and slowly rotating the cannula 180° in each direction, using an in-and-out motion
14) Expel syringe contents into dish to inspect tissue and measure amount
15) Continue curettage until uterus feels empty: red/pink foaming, gritty feeling, uterus contracts
16) Remove tenaculum, cannula and speculum
17) Reposition patient, reassess for shock
18) Counsel and offer contraception
19) Take specimen for histology if spontaneous, optional for induced and if the patient does not consent
20) Process instruments observing infection prevention principals

2) PAP SMEAR COLLECTION

- **Definition and description:** Pap smear is one of the screening methods for cervical intraepithelial lesions. It involves collection of cells from the squamo-columnar junction of the cervix, followed by cytology.
- **Environment:** This is a clean procedure a Chaperon is required.

2) PAP SMEAR COLLECTION-PROCEDURE

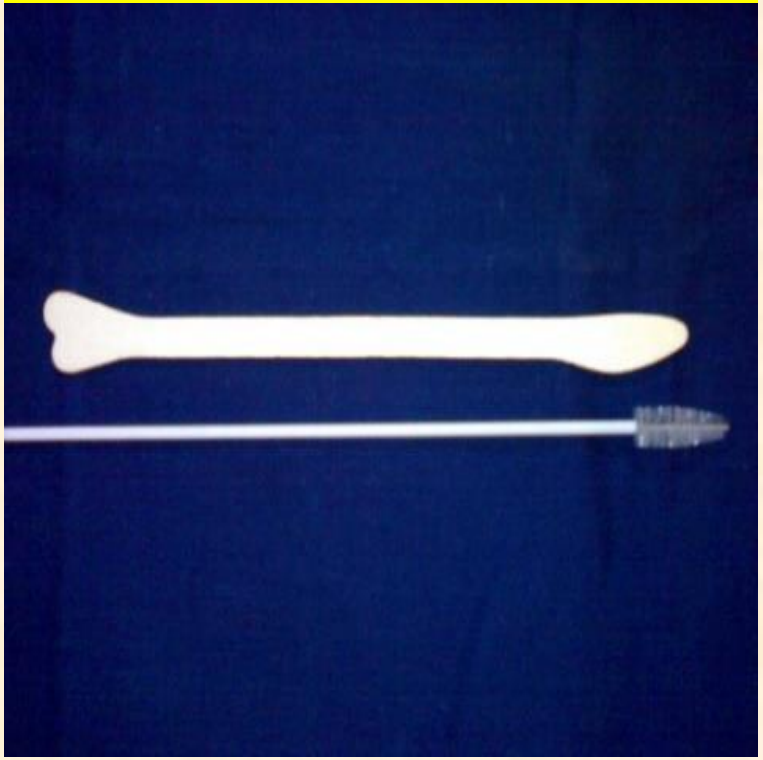
1) Prepare requirements
   - ✓ Examining light
   - ✓ Bivalve speculum
   - ✓ Endocervical broom or Ayre spatula/ endocervical brush
   - ✓ Glass slide
   - ✓ Fixation solution
   - ✓ Pathology request form
   - ✓ Gloves
   - ✓ Cytology request form
2) Prepare patient
   - ✓ Counsel for procedure
   - ✓ LMP
   - ✓ Empty bladder
   - ✓ Ask patient to lie on couch in lithotomy position
   - ✓ Chaperon needed

4) Introduce the speculum and expose the cervical os
5) Obtaining cells from the squamo-columnar junction of the cervical os
   - ✓ For endocervical broom, the central bristles are inserted into the endocervix while the outer will be in contact with the ectocervix. Rotate the broom in the same direction for five times
   - ✓ For ayre spatula and endocervical brush , start with the spatula to scrape the ectocervix, rotate the spatula 360^0 once. Then insert the endocervical brush into the endocervix so that the bristles nearest the examiner are inserted to the level of the external cervical os, rotate the brush 180 degrees
   - ✓ Start with spatula followed by brush minimizes blood in the sample

5) Quickly spread the scrapings evenly on the glass slide and fix by dropping, a drop of the fixative solution or spray evenly allow to air dry
   - ✓Speed is key to prevent drying of cells
6) Discard spatula/brush in waste bin
7) Remove speculum and reposition patient
8) Complete pathology form for Pap smear cytology
9) Counsel and offer contraception
10) Thank client
11) Give return date for cytology result

ENDOCERVICAL BROOM

SPATULA AND ENDOCERVICAL BRUSH



POSSIBLE PAP SMEAR CYTOLOGY RESULT AND ACTION

THE BETHESDA SYSTEM-RESULT	ACTION
✓ Normal	✓ Repeat yearly for 3 years, then 5 yearly ✓ For HIV + annual screens
✓ Low grade squamous intraepithelial lesion (LSIL)	✓ Repeat Pap smear in 6 months
✓ High grade squamous intraepithelial lesion (HSIL) ✓ Recurrent LSIL ✓ Atypical squamous cells of undetermined significance (ASC-US) ✓ Atypical squamous cells – cannot exclude HSIL (ASC-H) ✓ Atypical glandular cells of undetermined significance (AGUS) ✓ Carcinoma in situ	✓ Colposcopy biopsy followed by possible cervical excision procedure by LEEP or cold knife cone
✓ ? Invasive cancer	✓ Investigations to confirm diagnosis

Please Note: CIN classification is for cervical histology <u>NOT</u> cytology

3) VISUAL INSPECTION WITH ACETIC ACID AND LUGOLS IODINE (VIA/VILI)

- **Indication for the procedure:** Screening of cancer of the cervix

1) Prepare requirements

- ✓ Examining light
- ✓ Instrument tray/surface
- ✓ 2 gallipots
- ✓ 3-5% acetic acid
- ✓ Lugols iodine in tightly stoppered brown bottle – light destroys lugols
- ✓ Cotton swabs mounted in an applicator sticks
- ✓ Bivalve speculum
- ✓ K-Y gel
- ✓ Clean gloves
- ✓ Infection prevention: Bucket with 0.5% chlorine solution and container lined with plastic bag
- ✓ Documentation form

Preparation for the procedure

1) Greet the client
2) Reestablish why she wants the test to be done
3) Counsel for procedure
   - ✓ Describe the VIA/VILI and cryotherapy procedure
   - ✓ Tell the woman what the findings might be and what follow-up treatment might be necessary
   - ✓ Take a reproductive health history: Age, parity, LMP, Menstrual pattern, if pregnant, contraceptive use
   - ✓ Ask about breast exam
4) Check eligibility for VIA/VILI
   - ✓ Age: Menopausal women not eligible for VIA/VILI because the TZ (squamocolumnar junction) is in the endocervix; Do Pap smear or refer
   - ✓ LMP: If pregnant, screening can be done up to 20 weeks gestation
   - ✓ Postnatal women: Screening is done from the 6th postnatal visit
5) Ask the client to empty bladder
6) Change to examination gown
7) Ask the woman to undress from waist down, to remove her underwear, and to pull her dress up.
8) Ask patient to lie on couch in lithotomy position
9) Chaperon needed

Procedure steps

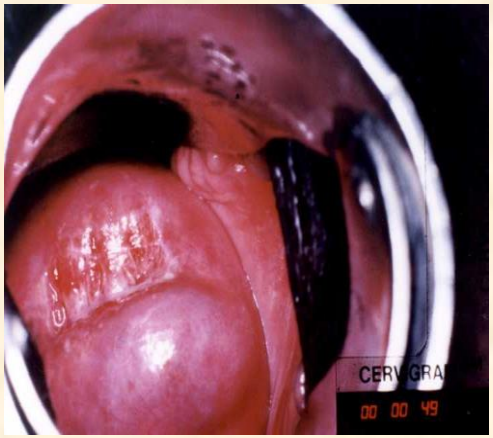
1) **Clean hands with a hand sanitizer or water and soap**
2) **Put on gloves**
3) **Pour enough for one client of acetic acid and lugols iodine to the gallipots**
4) **Inform the woman that you are commencing the procedure**
5) **Start by inspecting the external genitalia for: Papules, vesicles, ulceration, warts, discharge, masses and swelling in the inguinal area**
6) **Apply K-y gel to the speculum**
7) **Tell the woman she will feel some pressure**
8) **Slowly and carefully introduce to the speculum into the vagina without scraping the cervix, adjust so that the whole cervix is centralized and in view**
9) **Adjust light to ensure a clear view of the cervix**
10) **Before applying the acetic acid, look for signs of infection**
    - ✓ Inflamed cervix or vaginal wall
    - ✓ Greenish-yellow or mucopurulent discharge from the cervical os
    - ✓ Thick, white, curdy vaginal discharge
    - ✓ Milky-grey, foul smelling discharge

4) Start by doing the VIA procedure

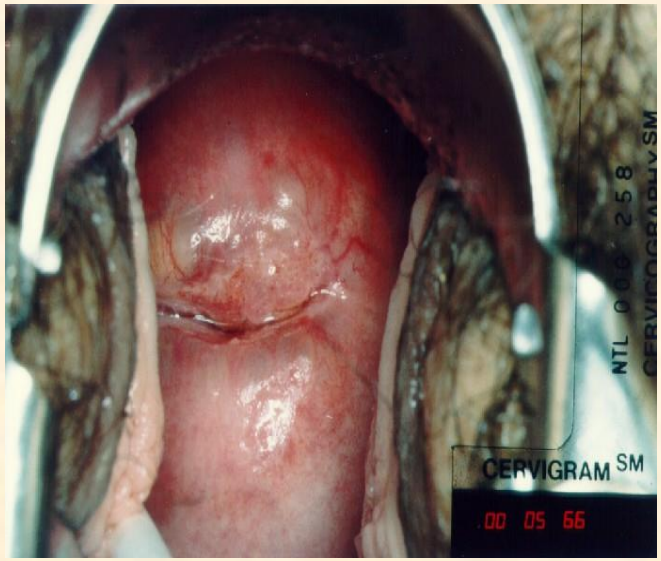
- ✓ Use a dry cotton swab to wipe away any discharge, blood, or mucus from the cervix very gently to avoid causing bleeding
- ✓ Apply 3-5% acetic acid liberally using a cotton mounted swab, ensure the swab covers the entire transformation zone completely
- ✓ Tell the woman she might feel a slight burning sensation
- ✓ Wait for 1 minute for the acetic acid to be absorbed (use a watch)
- ✓ Check the TZ carefully, close to the squamocolumnar junction, for any dense, non moveable acetowhite areas in the epithelium or areas suspicious for cancer
- ✓ Interpret the result (review cervicograms)
  - VIA Negative (Pink)
  - VIA Positive (Acetowhite) - acetic acid coagulates protein in abnormal cells, making them opaque
  - Suspicious for cancer
- ✓ Remove any remaining acetic acid using a dry cotton ball

4) **Followed by the VILI procedures**
   - ✓ Use a fresh lugols iodine for each patient-light destroys lugols
   - ✓ Apply lugols iodine liberally using a cotton mounted swab, ensure the swab covers the entire transformation zone completely
   - ✓ Check the TZ carefully, close to the squamocolumnar junction, for any banana yellow lesions in the epithelium or areas suspicious for cancer
   - ✓ Interpret the result (review cervicograms)
     - VILI Negative (Mahogany black): Normal cell have glycogen that stain black with lugols
     - VILI Positive (Banana Yellow) – abnormal cell have no glycogen hence does not stain with lugols
     - Suspicious for cancer
   - ✓ Remove any remaining lugols iodine using a dry cotton ball
5) **Explain to the patient that the procedure is complete**
6) **Remove the speculum gently and wipe off any remaining k-gel or discharge**
7) **Reposition patient make her comfortable**
8) **Dispose waste and decontaminate equipment as per the infection prevention principals**
9) **Counsel the client on the result**
10) **The following are the actions for each result**
    - ✓ Normal: repeat after 3-5 years, yearly for HIV positive
    - ✓ Positive: Cryotherapy or colposcopy
    - ✓ Suspicious for cancer: Investigate for invasive cancer, refer to tertiary facility
    - ✓ Infection: Treat infection and partners
11) **Counsel and offer contraception or breast examination**
12) **Thank client**
13) **Give a return date**

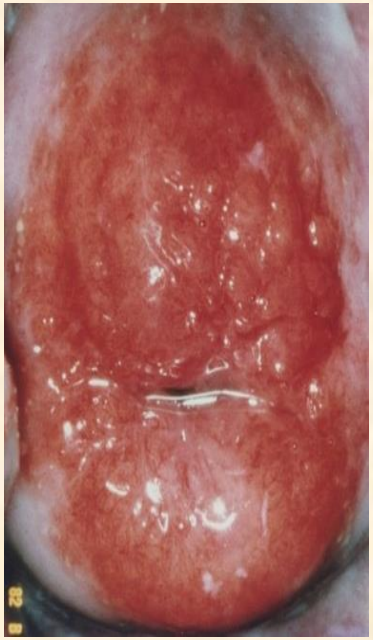
VIA Negative- Parous Os



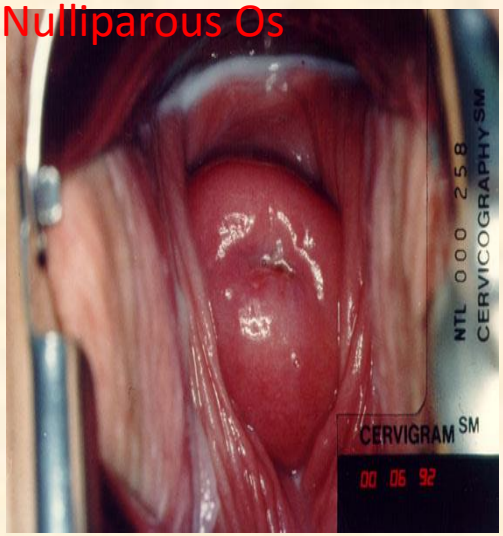
VIA Negative-Nabothian



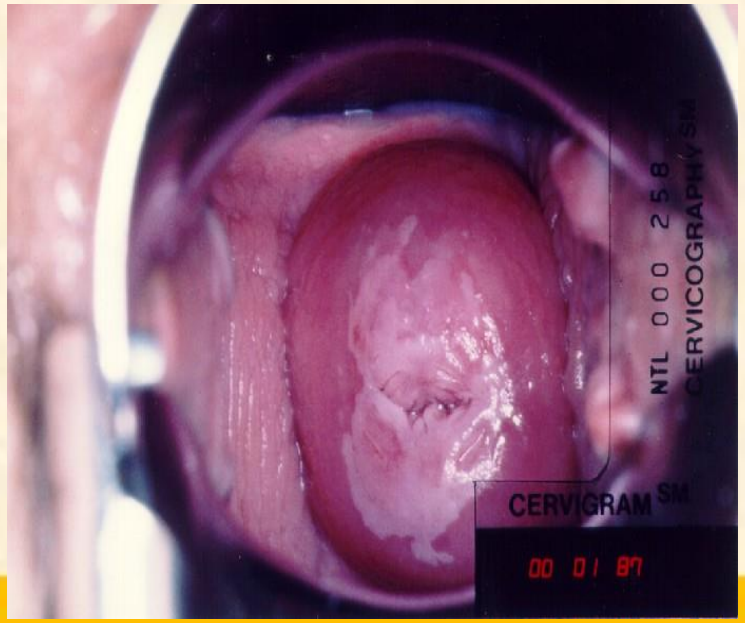
VIA Negative-Ectopy



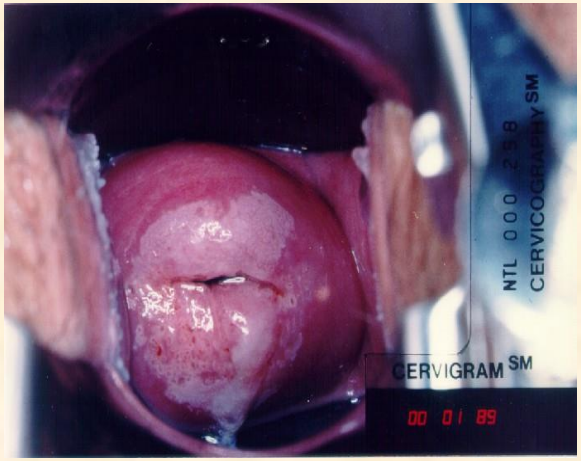
VIA Negative-Nulliparous Os



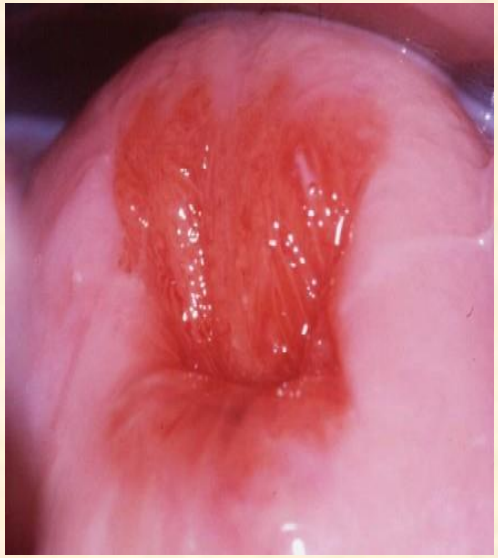
VIA Positive



VIA Positive

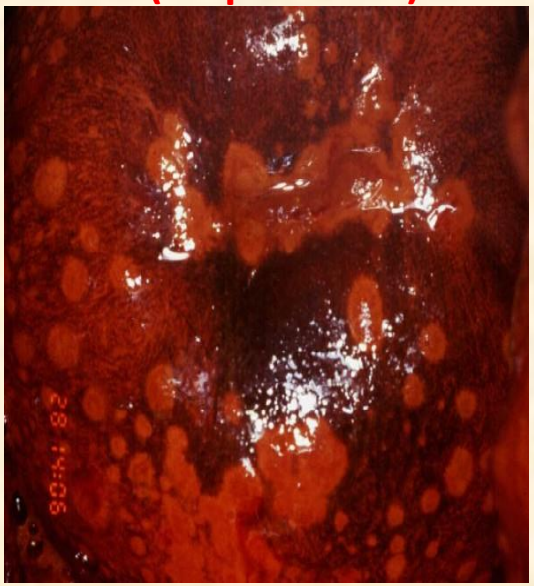


Normal cervix-ectopy

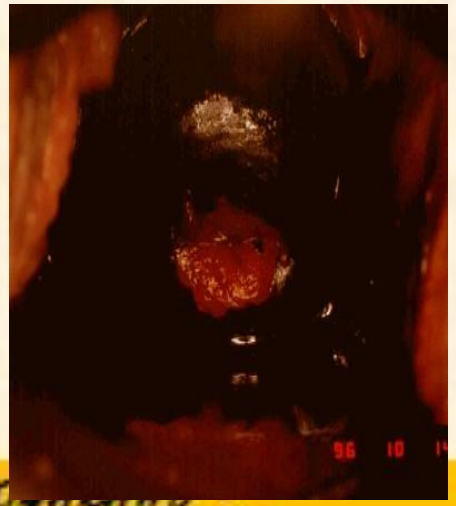


After lugols- VILI Negative-ectopy

VILI Negative – cervicitis (leopard skin)

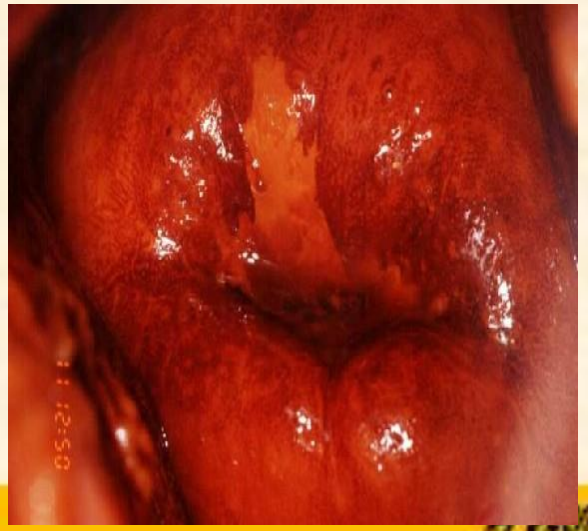


VILI Negative-columnar epithelium has no gycogen

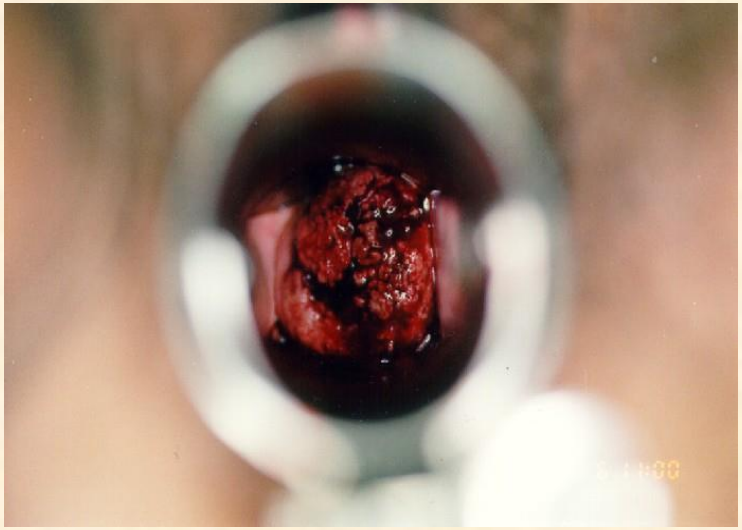


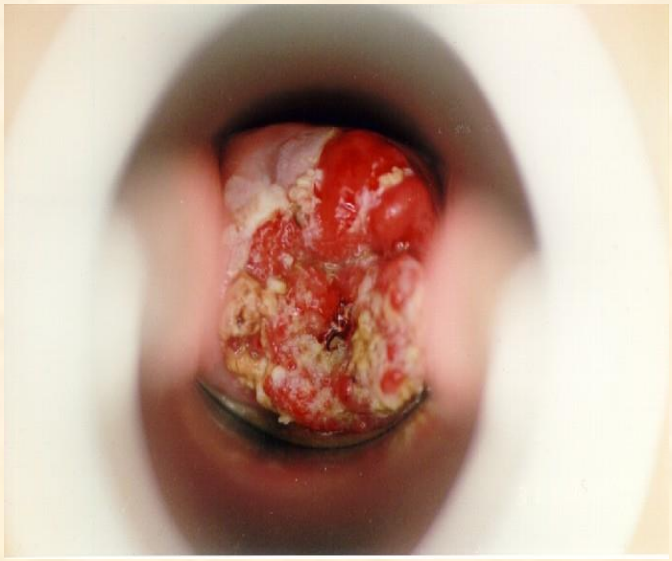
VILI Positive

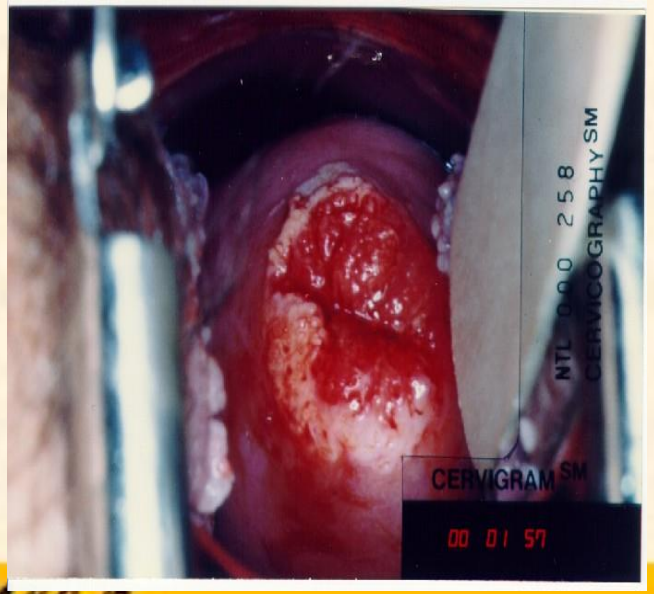
VILI

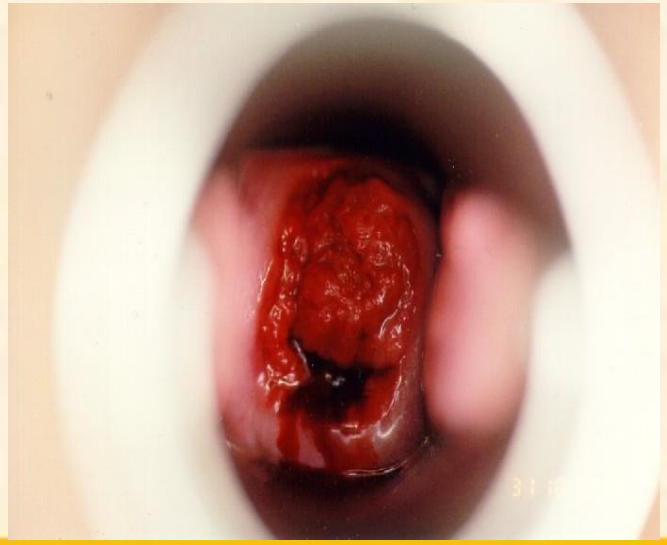


Suspicious for Cancer









4) COUNSELING FOR ABNORMAL CERVICAL SCREEN RESULT

1) **Greet patient, introduce self, sit squarely, open posture, leans forward, eye contact, relax and explain the following to the patient in lay language**
2) **Cancer of the cervix is caused by HPV**
3) **Cancer of the cervix is presided by a pre-cancer stage, with cell abnormalities. Counselling depends on test**
4) **Pap smear results is reported as normal, mild cell abnormalities (LSIL), severe cell abnormalities (HSIL, ASCUS, ASC-H, AGUS) or suspicion for invasive cancer**
   - ✓ Normal results means there were no abnormal cells seen
   - ✓ Mild and severe cell abnormalities are precancerous stages and not cancer
   - ✓ Suspicious for invasive cancer means cancer of the cervix is likely
   - ✓ If normal another Pap smear test will be done after 1 year for 3 years, if all 3 will be normal then Pap smear will be done after 5 years (yearly in HIV +)
   - ✓ If mild cell abnormalities, a repeat Pap smear will be done after 6 months
   - ✓ If severe cell abnormalities colposcopy then treatment will be offered: i) excision of abnormal cells (LEEP or Cold knife cone) or ii) simple hysterectomy. Counselling on the two options will be done to enable you make a choice
   - ✓ If suspicious for invasive cancer more diagnostic test will be performed to confirm diagnosis
   - ✓ Allow patient to ask questions
   - ✓ Thank patient for their time

5) VIA/VILI results is reported as negative, positive and suspicious for invasive cancer

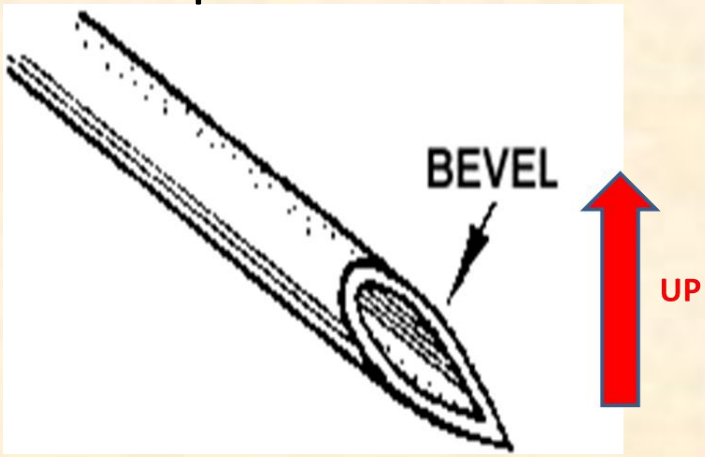
- ✓ Normal means there are no abnormal cells
- ✓ A positive result is a precancerous stage and not cancer
- ✓ Suspicious for cancer means cancer of the cervix is likely
- ✓ If normal a repeat VIA/VILI will be done in 3 years (yearly in HIV +)
- ✓ For positive result treatment can be done by freezing the abnormal cell (cryotherapy) or doing colposcopy biopsy (using a microscope to visualize abnormal cells and take small tissue for investigations), if biopsy shows abnormal cells treatment will be offered depending on result
- ✓ If suspicious for cancer more diagnostic test will be performed to confirm diagnosis
- ✓ Allow patient to ask questions
- ✓ Thank patient for their time

5A) IMPLANT INSERTION- JADELLE LEVONORGESTREL SUBDERMAL IMPLANT

1) **Prepare requirements:**
   - Table for the patient to lie on and rest for her arm
   - Sterile drape with fenestration and sterile tray for the equipment
   - Sterile gloves
   - Sterile Gauze, Antiseptic solution for the skin
   - Local anaesthetic -1% lidocaine, Needle gauge 21 and 5 ml syringe
   - Jadelle, diposable trocar and cannula , Elastoplast
2) **Prepare patient**
   - Counsel client for the method
   - Explain the procedure
   - Explain that the implant will be inserted in the less dominant arm,
   - Ask client to lie on her back so that implant arm is turned outwards and bent at the elbow and is well supported, insertion area is in the inner aspect of the upper arm, between the muscles, about 6–8 cm above the fold in the elbow (measure using your four palm fingers- to be demonstrated)

Procedure steps

1) Prepare clean instrument tray, open sterile instrument pack, open jadelle pouch and drop the rods
2) Wear sterile gloves, clean the insertion area and drape aseptically
3) Infiltrate the local anesthetic under the skin slowly withdrawing to avoid intravascular infiltration. Start by infiltrating the needle entry point to form a small wheal
4) Introduce the trocar under the skin up to the 1st mark with bevel facing up



5) Advance the trocar horizontally under the skin (subdermally) until the 2nd mark
6) Remove cannula
7) Insert 1st rod into the trocar and load it with the cannula by holding the cannula steady and pulling the trocar out up to the level of the 1st mark on the cannula
8) Repeat above and insert 2nd rod in a narrow V shape
9) Remove trocar and cannula
10) Press edges of insertion together and dress with Elastoplast and compress with wrap gauze
11) Check the two rods by cautious palpation, ask the patient to palpate too
12) Answer any questions the client may have, give a return date and thank them

5B) IMPLANT REMOVAL - JADELLE LEVONORGESTREL SUBDERMAL IMPLANT

1) Prepare requirements:
   - Table for the patient to lie on and rest for her arm
   - Sterile drape with fenestration and sterile tray for the equipment
   - Sterile gloves
   - Sterile Gauze, Antiseptic solution for the skin
   - Local anaesthetic -1% lidocaine, Needle gauge 21 and 5 ml syringe
   - 2 mosquito forceps-curved and straight
   - Scalpel 22 mm
   - Elastoplast
2) Prepare patient:
   - Counsel on removal, find out if needs the same method or another method or desires to get pregnant, ask client to lie on her back so that implant arm is turned outwards and bent at the elbow and locate the implants
   - Prepare clean instrument tray, open sterile instrument pack

Procedure steps

1) Wear sterile gloves, clean the insertion area and drape aseptically
2) Infiltrate the local anesthetic under the implants
3) Make a 4-mm incision with the scalpel close to the ends of the implants. Keep the incision small.
7) Push each implant with your fingers gently towards the incision. When the tip is visible in the incision, grasp it with the curved mosquito forceps. Use a scalpel to very gently open the tissue capsule around the implant.
8) Grasp the end of the implant with the second straight forceps
9) Remove the implant gently
10) Repeat the procedure for the second implant
11) Measure the length of the removed implants- the length should be 43 mm
12) After the procedure is completed, close the incision and bandage it as after insertion
13) Show the patient the implants
14) Offer another contraceptive if needed, if jadelle reinsert into the same location
15) The arm should be kept dry for about 3 days
16) Answer any questions the client may have, give a return date and thank them

6A) IUCD INSERTION

1) **Prepare requirements:** Examining light, copper T IUCD, bivalve speculum, tenaculum, uterine sound, sponge holding forceps, scissors, sterile gauze, sterile gloves, sterile drapes, K-Y gel and antiseptic solution
2) **Prepare patient:** Counsel for the procedure, LMP, empty bladder, lithotomy position, chaperone

Procedure steps

1) **Conduct bimanual and speculum pelvic examination to:** Screen for eligibility and determine the position of the uterus, rule out infection
2) **Sound the uterus:**
   - ✓ Clean the cervix with an antiseptic solution
   - ✓ Apply a tenaculum to the cervix at 12 o'clock
   - ✓ Gently pull the tenaculum to align the uterus and cervical opening
   - ✓ Insert the uterine sound into the cervical opening, advance into the uterine cavity until a slight resistance is felt, mark length with sponge holding forceps
   - ✓ Slowly withdraw the sound and assess the uterine length
5) **Load the IUCD:**
   - ✓ Load the IUCD by folding its arms and placing them inside the insertion tube
   - ✓ Set the depth-gauge to reflect the uterine length as measured by the uterine sound
   - ✓ Align the depth-gauge and the folded arms of the T so that they are both in a horizontal plane

6) **Remove the loaded IUCD from the package, keeping it level**

7) **Insert IUD to the uterine cavity:**
   - ✓ Gently grasp the tenaculum (still in place from sounding the uterus) and apply gentle traction
   - ✓ Insert the loaded IUCD, without touching vaginal walls or speculum blades, keeping the horizontal plane
   - ✓ Gently advance the loaded IUCD into the uterine cavity
   - ✓ STOP when the depth-gauge comes in contact with the cervix or light resistance is felt
   - ✓ Hold the tenaculum and white plunger rod stationary, while partially withdrawing the insertion tube - this releases the arms of the IUCD
   - ✓ Gently push the insertion tube until you feel a slight resistance - this step ensures placement high in the uterus
   - ✓ Remove the white plunger rod, while holding the insertion tube stationary
   - ✓ Gently and slowly withdraw the inserter tube from the cervical canal until strings can be seen protruding from the cervical opening
   - ✓ Use sharp Mayo scissors to cut the IUCD strings at 3–4 cm from the cervical opening
   - ✓ Completely withdraw insertion tube with cut ends of strings inside

8) **Gently remove the tenaculum**

9) **Observe the cervix for bleeding and remove speculum**

10) **Reposition patient and make her comfortable**

11) **Counsel woman on checking of strings, complications and give return date**

12) **Thank her for her time**

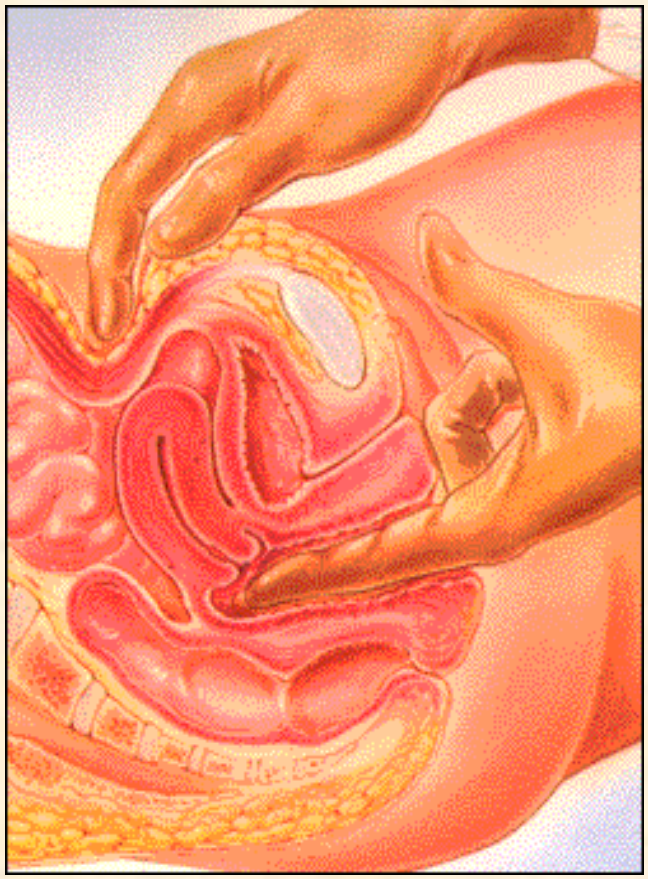
6B) IUCD REMOVAL

1) **Prepare requirements:** examining light, bivalve speculum, sponge holding forceps, sterile gauze, sterile gloves, sterile drapes, K-Y gel and antiseptic solution
2) **Prepare patient:** counsel for the procedure, LMP, empty bladder, lithotomy position, chaperon needed

Procedure steps

1) **Conduct bimanual pelvic exam**
2) **Insert the speculum :** Look for the length and position of strings
5) Swab cervix and vagina with antiseptic
6) Grasp strings close to the cervix and pull gently but firmly to remove IUCD
7) Refer difficult removals
8) Insert a new IUD immediately following removal (if desired) or offer another method
9) Remove speculum
10) Reposition patient
11) Thank the patient

7) BIMANUAL PELVIC EXAMINATION



1) Prepare Requirements

- ✓Gloves
- ✓K-Y gel
- ✓Gauze or tissue paper

2) Prepare patient:

- ✓Great and introduce self to patient
- ✓Explain the procedure
- ✓Ask her to empty bladder
- ✓Chaperon required
- ✓Positon the patient in lithotomy position and expose from waist downwards

Procedure steps

1) Put on gloves
2) If right handed: lubricate index finger and middle fingers of right hand, and explain to the patient that you are about to start the procedure
3) Using the thumb and index finger of the left hand, separate the labia majora then insert the index finger followed by the middle finger into the introitus and advance to the cervix
4) Palpate the vaginal walls as you advance the fingers for obvious abnormalities
5) Using finger tips palpate the cervix: feel for size, shape, mobility and observe for tenderness
6) Bimanually palpate the uterus by pressing it between the right and middle index fingers on the cervix and with your left hand placed on the lower abdomen. At this point feel for any masses
7) Bimanually Palpate the left and right adnexa: note masses and tenderness
8) Note uterine masses will move the cervix during bimanual exam while adnexal masses wont
9) Remove fingers, check glove for discharge/blood
10) Wipe the patient's perineum
11) Remove gloves and dispose gloves
12) Reposition patient and make her comfortable
13) Thank the patient

8) Scrubbing/ Gowning/ Gloving, Abdominal draping and incisions

Scrubbing:

1) Wear surgical cap and mask (eye protection optional)
2) Put on disposable plastic apron
3) Turn on water and get antiseptic
4) Lather hands and arms with scrubbing solution, keeping hands up, wash both palms, between fingers, each finger separately, back of hands X 3
5) Close tap using elbow
6) Dry hands and arms: pick sterile towel, unfold towel, place 1/3 over right hand and 2/3 will be hanging toward left hand then dry left hand and arm. Transfer dry end of towel to left hand, place 1/3 over left hand and 2/3 toward right hand then dry right hand and arm
7) Drop towel to collecting bin

8) Scrubbing/ Gowning/ Gloving, Abdominal draping and incisions

GOWNING:

1) First covering of sterile gown opened by circulating nurse
2) Surgical gowns are folded with the inside facing the scrub person
3) Pick up gown without touching the outside surface with one hand
4) Unfold the gown. Hold the gown away from you, at chest level to facilitate safe handling without break in asepsis
5) Grasp the inside shoulder seams and open the gown with the armholes facing you
6) Slide your arms part way in to the sleeves of the gown, keeping your hands at shoulder level away from the body
7) Hold your hands high so gown does not touch the floor
8) When the fingertips are even with the proximal edge of the cuff, grasp the inside seam at the juncture of gown sleeve and cuff using your thumb and index finger.
9) Be careful that no part of your hand protrudes from the sleeve cuff
10) Circulating nurse will help secure the gown
11) Proceed with sterile gloving

8) Scrubbing/ Gowning/ Gloving, Abdominal draping and incisions

STERILE GLOVING:

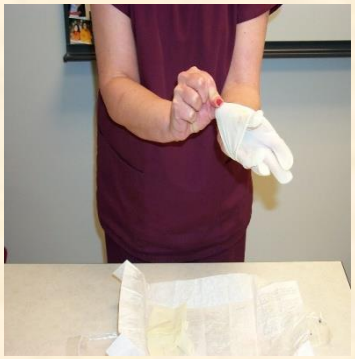
1) After gowning, carefully open the sterile glove wrapper
2) Remove one glove from wrapper by lifting it with one hand without the inside of the glove wrapper
3) Hold the glove by the folded back cuff and slip the hand into the glove, using a smooth upward motion
4) Pick the other glove with the sterile gloved hand
5) Slip fingers of the gloved hand under the cuff of the sterile glove and adjust the glove to fit without touching skin with gloved hand
6) Adjust gloves as necessary by slipping gloved fingers under the sterile fold of the cuff to slide up

(check next page)

Sterile gloving

1

2



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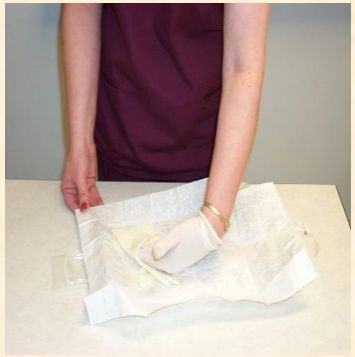


4

5

Technique of removing gloves

1

2

3

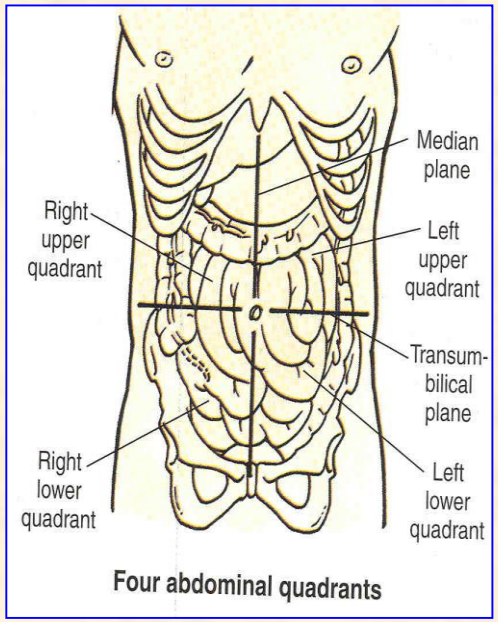
4

1) Insert fingers of one gloved hand under the cuff of the other glove and roll glove off the hand. (glove to glove technique
2) Insert fingers of the bare hand between the cuff of the glove and the wrist to roll glove off hand. (skin to skin technique)
3) Touch only the inside of the gloves during removal

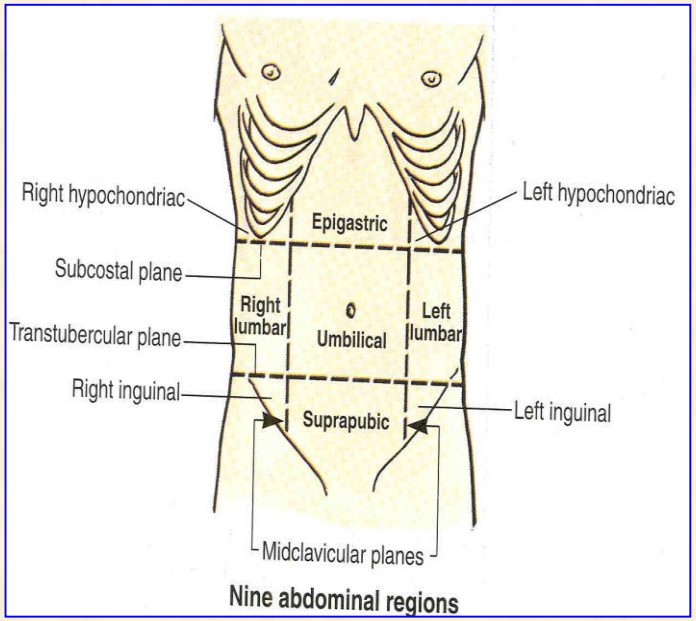
ABDOMINAL DRAPING

1) Depends on the incision site
2) Scrub the abdomen commencing from your incision site work your way outwards with a semi-arc manner
   - ✓ Antiseptic solution X 3
   - ✓ Dry Swab
   - ✓ Povidon iodine x 1
3) Place a plastic drape from the pubic symphysis to the thighs
4) Four small towels:
   - ✓ 1st is placed from the pubic symphysis to the thighs
   - ✓ 2nd is placed from the xiphysternum upwards to cever chest
   - ✓ 3rd and 4th placed loin area outwards
   - ✓ Place 4 towel clips to secure
5) Place the half sheet on top of the first small towel to cover to the foot of the operating table
6) Place the laparotomy sheet (full sheet) with the fenestration at the intended incision site

ANTERIOR ABDOMINAL WALL INCISIONS



Four abdominal quadrants

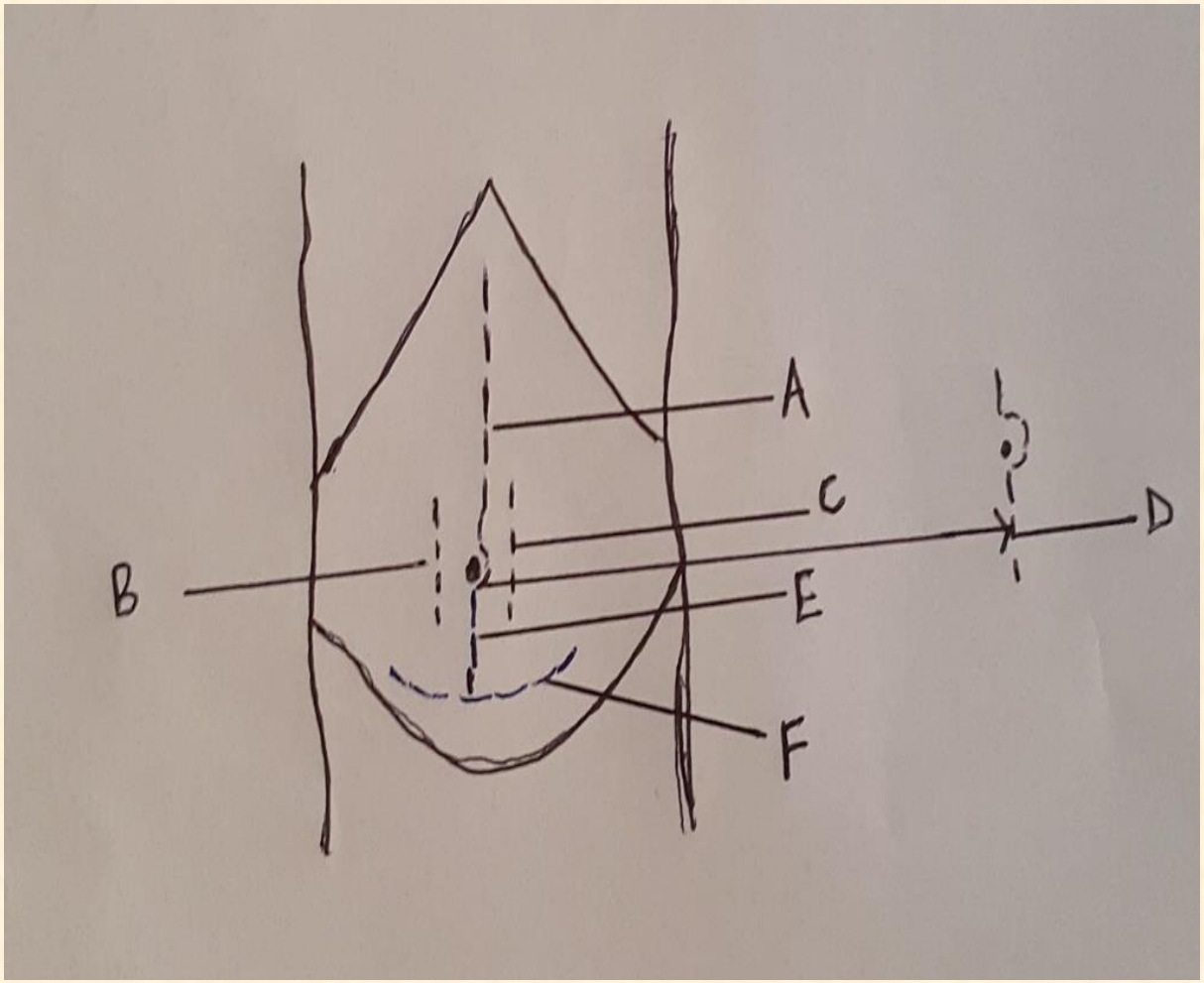


Nine abdominal regions

Choice of incision is determined by:

- ✓ Need for rapid entry
- ✓ Certainty of the diagnosis- location and size of pathology
- ✓ Body habitus
- ✓ Location of previous scars
- ✓ Potential for significant bleeding
- ✓ Cosmetic outcome

ANTERIOR ABDOMINAL WALL INCISIONS

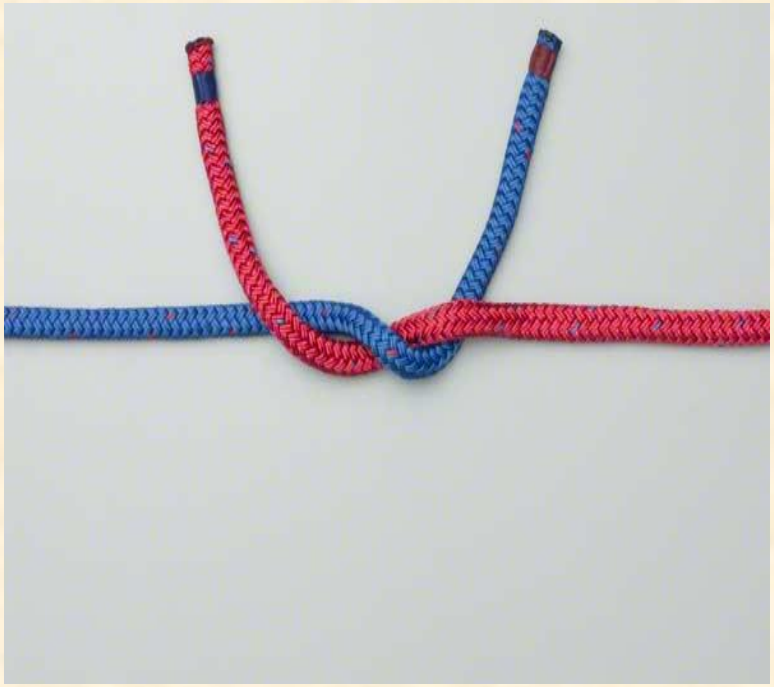


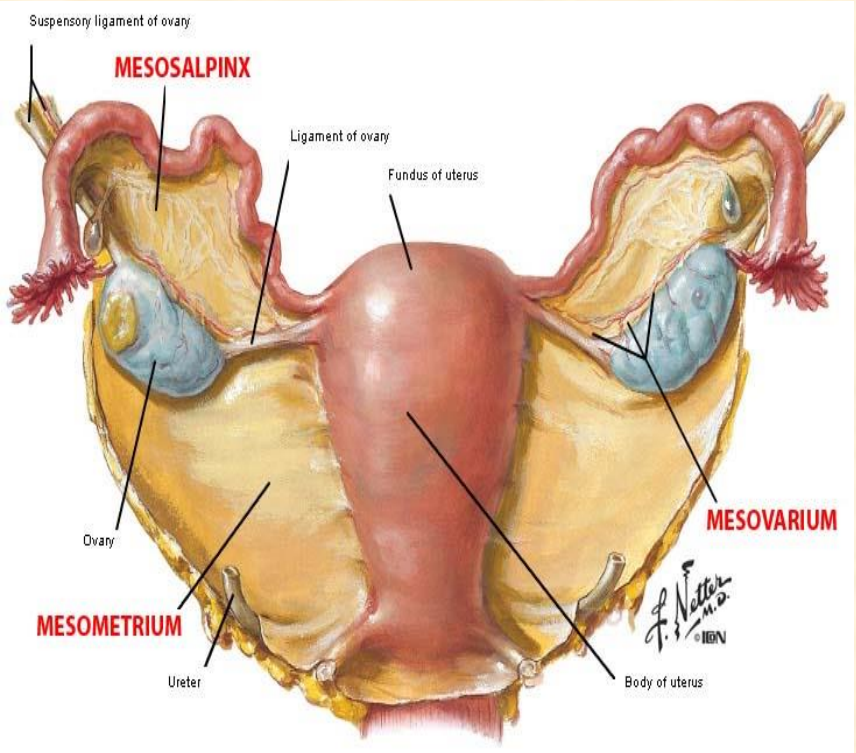
Abdominal incision

A. Midline
B. Right paramedian
C. Left paramedian
D. Extended subumbilical midline
E. Subumbilical midline
F. Pfannenstiel

9A) RUPTURED ECTOPIC PREGNANCY – SALPINGECTOMY

1) A laparotomy is performed through a midline or Pfannenstiel incision
2) The uterus and the fallopian tube with the ectopic pregnancy is identified
3) The ligation of the ovarian pedicle will be demonstrated in this station
4) Place two long curved artery forceps below the ectopic at the level of mesosalpinx making a loop
5) Place a straight artery above the two long curved arteries leaving enough pedicle
6) Using a knife, remove the ectopic by cutting between the straight artery and upper end of the second curved artery
7) Using 2-0 or 3-0 vicryl absorbable suture ligate the pedicle
   - ✓ Anchor the suture and make a reef knot , while the assistant is removing the 1st curved forceps (most distal), as you tighten the knot
   - ✓ Once tight enough, the assistant can remove the second curved artery forceps, knot is tied completely
8) Check to ensure hemostasis is achieved




Suspensory ligament of ovary
MESOSALPINX
Ligament of ovary
Fundus of uterus
MESOVARIUM
Ovary
MESOMETRIUM
Ureter
Body of uterus
F. Netter M.D.

9B) FEMALE URETHRAL CATHETERIZATION

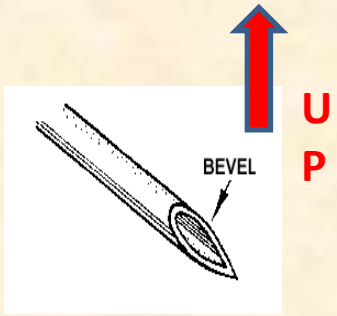
1) **Prepare requirements**
   - ✓ Catheterization pack: kidney dish, gallipot, sterile towel, cotton balls
   - ✓ Foleys catheter size 12-14
   - ✓ Urine bag
   - ✓ Saline
   - ✓ Sterile gloves
   - ✓ K-Y gel
   - ✓ 10ml saline filled syringe
2) **Prepare patient**
   - ✓ Greet
   - ✓ Explain procedure
   - ✓ Verbal consent
   - ✓ Chaperon needed
   - ✓ Position the patient on her back, ask her to put her ankles together and let her knees fall apart
3) Using aseptic technique open the catheterization
4) Wash/dry hands and put on the sterile gloves
5) Using a the towel drape the thigh nearest to you
6) Pour saline to the gallipot

9B) FEMALE URETHRAL CATHETERIZATION

7) Place the kidney dish between the patients legs
8) If you are right handed, with your left hand part the labia
9) Using SALINE soaked cotton balls, gently clean the urethral meatus with single downward movement with each cotton ball X5
10) with the labia still parted apply K-Y gel at the tip of the foleys and insert it into the urethral meatus (do not touch the tip of the foleys)
11) Advance the foleys until urine begins to flow, then inflate the balloon using 10ml of saline
12) Attach the urine bag
13) Gently pull on the catheter until resistance is felt to ensure that the balloon is resting on the urethral opening of the bladder
14) Dispose wastes observing infection prevention
15) Reposition the patient and ensure she is comfortable
16) Thank the patient

9C) IV ACCESS: BRANULA INSERTION

1) Requirement:
   - ✓ Alcohol swab
   - ✓ Gloves
   - ✓ Disposable tourniquet
   - ✓ IV cannula
   - ✓ Plaster
   - ✓ Syringe
   - ✓ Normal saline
   - ✓ Sharps disposal
   - ✓ Alcohol sanitizer for hand washing



2) Patient preparation
   - ✓ Greet the patient and explain the procedure
   - ✓ Make the patient lie or sit down comfortably
3) Sanitize your hands
4) Position the arms of the patient and identify a vein
5) Apply the tourniquet and recheck the vein
6) Put on your gloves
7) Clean patient' skin with alcohol wipe and let it dry
8) Remove the cannula from its packaging and remove the needle cover ensuring not to touch the needle

9C) IV ACCESS: BRANULA INSERTION

9) Stretch the skin distally and the tell the patient to expect a sharp pain prick
10) Insert the needle with bevel upwards at about 30^0
11) Advance the needle until a flush back of blood is seen in the hub at the back of cannula
12) Once this is seen withdraw the needle slightly and advance the cannula further into the vein completely
3) Release the tourniquet
13) Apply pressure to the vein at the tip of cannula
14) Remove the needle
15) Flush with saline and check for patency: if pain, localize tissue swelling or resistance remove the cannula and restart the procedure with a new vein
16) Remove the cap on the needle and cork it at the end of cannula
17) Dispose needle and other wastes
18) Apply plaster to secure the cannula in place and label the date of insertion **(Should not be on more than 72 hours)**
19) Thank the patient

10) HIGH VAGINA SWAB & ENDOCERVICAL SWAB

1) **Prepare requirements**
   - ✓ Sterile gloves
   - ✓ K-Y gel
   - ✓ Sterile bivalve speculum
   - ✓ Swabs
   - ✓ Examining light
2) **Prepare patient**
   - ✓ Greet patient and introduce self
   - ✓ Explain procedure
   - ✓ Chaperon needed
   - ✓ Ask patient to empty bladder
   - ✓ Position patient in lithotomy position
3) Wear sterile gloves
4) Lubricate the speculum and let the patient know the procedure is about to start
5) Advance the speculum to expose the cervix and secure it

10) HIGH VAGINA SWAB & ENDOCERVICAL SWAB

5) For high vaginal swab- if right handed:
   - ✓ Using the right hand, pick up the swab's sample tube and place in your left hand (also holding the speculum) and remove the lid
   - ✓ Take the swab with your right hand
   - ✓ Circle the swab once from lateral fornix to posterior fornix to the other lateral fornix
   - ✓ Insert the swab back to the sample tube and close it
6) For endocervical swab
   - ✓ Steps 1 and 2 same as for high vaginal swab
   - ✓ Place the swab in the endocervical canal and do a full 360^0 sweep
   - ✓ Insert the swab back to the sample tube and close it
8) Remove speculum
9) Wipe patients perineum
10) Reposition patient and make her comfortable
11) Complete the laboratory request form and label specimen
12) Give return date
13) Thank the patient

Gyn OSCE dry run (Five minutes)

SCENARIO

- ✓ During your clinical rotation in the family planning clinic, you were asked to demonstrate insertion of the family planning method label Q

QUESTIONS

1) What is the name of family planning method Q **(Q is Copper T IUCD)**
2) Using the pelvic model provided, uterine sound, tenaculum , demonstrate how to:
   a) Sound the uterus
   b) Loading of Q

End