UNIVERSITY OF NARIOBI

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICINE

DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

MBCHB EXAMINATION THURSDAY 19TH SEPTEMBER 2013

Obstetric osce 1 Station 3

Instructions for Candidate

THIS IS AN INTERACTIVE SESSION WITH THE EXAMINER ON AN ANTENATAL PATIENT.

You will be required to respond the questions and perform an obstetric examination palpation. Marks will be awarded for the correct palpation and the correct findings

SCEANARIO

Mrs GH comes to labour ward as an emergency with history of reduced fetal movements at a gestation of 32 weeks.

You are expected to answer the following questions.

1. What further history would you like to obtain from her?
2. During the obstetric examination how will you confirm fetal viability?
3. You are required to perform an obstetric examination on this patient. Prepare for the examination
4. Perform the obstetric palpation (Leopold's maneuvers), and you will be awarded marks for correct procedure and correct findings. You are NOT required to report the inspection findings.
5. With regards her history of reduced fetal movements what further investigation will you request from and specify what parameters are most important in this investigation.

The remaining questions will be asked by the examiner

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OSCE 3

OBSTETRIC 3

INTERACTIVE STATION

SCENARIO

Achieng' delivered 2 hours ago and you are called to review her because of heavy per vaginal bleeding.

Questions

1. What is the most likely diagnosis?

2. Demonstrate how you will go about managing the patient.

    a. General management
    b. Specific management

End

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tion 3 Obstetrics 3 Date: October 2016

me of student: Registration number:

	Question	Expected answers	Score	Max Sco
	What is the most likely diagnosis?	- Primary post-partum haemorhage		2
	What are the sequence of management options would you employ in this situation?	- Introduce self to midwife/patient - Examine abdomen to check fundus and rub up contraction if necessary - Demonstrate correct procedure for Bimanual compression - Briefly ask about the history of the pregnancy and labour - Ask about placenta completeness - Ensure 2 large bore i.v. line(s) inserted(1) and take bloods for FBC(1), cross-match(1), coagulation profile(1), baseline u/e/cr(1) - Start iv fluids - May want to check pulse and BP him/herself - Vaginal examination expels clots(1), insert catheter(1) - Ensure input and output well documented - Discuss the use of syntocinon and ergometrine, other uterotonics - Involve the anaesthetist, may need CVP - Inform senior staff and take patient to theatre for EUA - Discuss the 4 Ts: tone, trauma, tissue, thrombin (clotting) - Surgical management if above fails: - • B-Lynch suture - Uterine artery ligation - • Hysterectomy - • Postoperative ICU/HDU care - • Mention Sheehan's syndrome - • Debriefing the patient important -		25
3	What are the possible causes of this condition in this patient?	- Twin gestation, uterine overdistention, uterine atony, trauma, retained placenta/membranes		5
TOTAL MARKS				32

%.....

Examiner

1. _____ signature _____

2. _____ signature _____

HECKLIST FOR COMPRESSION OF THE ABDOMINAL AORTA

To be used by the **Participant** for practice and by the **Trainer** at the end of the course)

a "✓" in case box if step/task is performed **satisfactorily**, an "X" if it is **not** performed **satisfactorily**, or if not observed.

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Observed: Step or task not performed by participant during evaluation by trainer

RTICIPANT _____ **Date Observed** _____

CHECKLIST FOR COMPRESSION OF THE ABDOMINAL AORTA
(Many of the following steps/tasks should be performed simultaneously.)

STEP/TASK	CASES				
ETTING READY					
Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.					
Provide continual emotional support and reassurance, as feasible.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
:OMPRESSION OF THE ABDOMINAL AORTA					
1. Place a closed fist just above the umbilicus and slightly to the left.					
2. Apply downward pressure over the abdominal aorta directly through the abdominal wall.					
3. With the other hand, palpate the femoral pulse to check the adequacy of compression.					
4. Maintain compression until bleeding is controlled.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POSTPROCEDURE TASKS					
1. Monitor vaginal bleeding, take the woman's vital signs and make sure that the uterus is firmly contracted.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

CHECKLIST FOR BIMANUAL COMPRESSION OF THE UTERUS

(To be used by the **Participant** for practice and by the **Trainer** at the end of the course)

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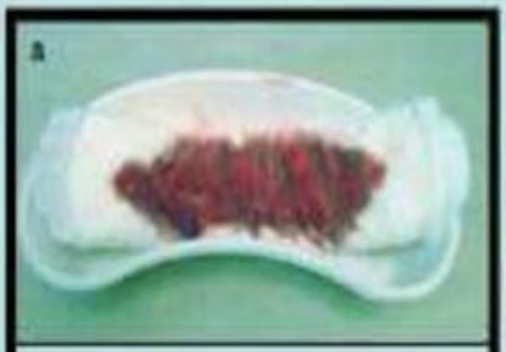
PARTICIPANT _____ **Date Observed** _____

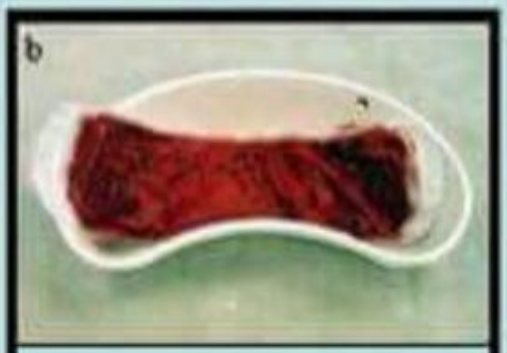
CHECKLIST FOR BIMANUAL COMPRESSION OF THE UTERUS (Many of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	**CASES**					
GETTING READY						
1. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.						
2. Provide continual emotional support and reassurance, as feasible.						
3. Put on personal protective barriers.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
BIMANUAL COMPRESSION						
1. Wash hands thoroughly and put on high-level disinfected or sterile surgical gloves.						
2. Clean the vulva and perineum with antiseptic solution.						
3. Insert fist into anterior vaginal fornix and apply pressure against the anterior wall of the uterus.						
4. Place other hand on abdomen behind uterus, press the hand deeply into the abdomen and apply pressure against the posterior wall of the uterus.						
5. Maintain compression until bleeding is controlled and the uterus contracts.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
POSTPROCEDURE TASKS						
1. Remove gloves and discard them in leakproof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.						
2. Wash hands thoroughly.						
3. Monitor vaginal bleeding, take the woman's vital signs and make sure that the uterus is firmly contracted.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						

A Pictorial Reference Guide to Aid Visual Estimation of Blood Loss at Obstetric Haemorrhage: Accurate Visual Assessment is Associated with Fewer Blood Transfusions

Dr Patrick Bose, Dr Fiona Regan, Miss Sara-Paterson Brown



Soiled Sanitary Towel
30ml

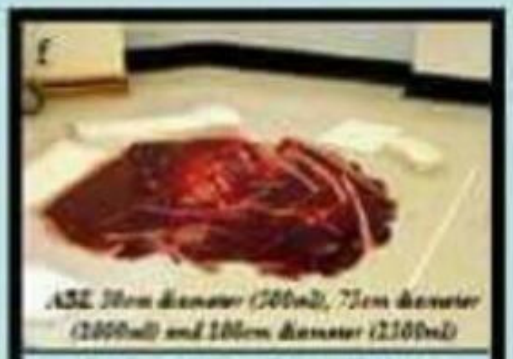


Soaked Sanitary Towel
100ml

Small Soaked Swab 10x10cm
60ml

Incontinence Pad
250ml

Large Soaked Swab 45x45cm
350ml*



100cm Diameter Floor Spill
1500ml*

PPH on Bed only
1000ml

PPH Spilling to Floor
2000ml

Full Kidney Dish
500ml

***Multidisciplinary observations of estimated blood loss revealed that scenarios (e-f) are grossly underestimated (> 30%)**

For Further Information please contact Miss Sara Paterson-Brown
Delivery suite, Queen Charlottes Hospital, London

UNIVERSITY OF NAIROBI, COLLEGE OF HEALTH SCIENCES, SCHOOL OF MEDICINE, DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

OSCE 1

OBSTETRIC 1

NON INTERACTIVE STATION

SCENARIO

You are called to review Josephine who is in second stage of labour with a malpresentation.

Questions

1. Identify the malpresentation?
2. Conduct the delivery.
3. What are the potential complications?

End

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Station 1 Obstetrics 1 Date: October 2016

Name of student: **Registration number:**

Q	Question	Expected answers	Score	Max Score
1	Identify the malpresentation	- Breech presentation		2
2	What other information would you like to get from the patient?	- LMP (1), Maturity of the current pregnancy (1), antenatal history (1). Previous obstetric history: mode of previous deliveries (1), birthweights of previous deliveries (1), status of the babies (1). Maternal Vital signs (1). Duration of labour (1), FHR (1), cervical dilatation (1).		10
3	How would you conduct her delivery vaginally?	- Determines type of breech - Determines contraindications to vaginal breech delivery - Explains to the mother about the diagnosis(1), and gets maternal consent(1) - Determines cervical dilatation - Observes no touch technique till the umbilicus is visible - Loosens loop of cord - No touch till nape of neck is visible - Does not use traction but supports and guides the baby - Keeps sacrum and baby back anterior - Delivers arms by sweeping them across the chest/abdomen - Delivers head appropriately by, Maurice au smellie veit manoeuvre(1) or forceps(1) - Avoids pulling the jaw and understands the importance of keeping the head flexed(1) with malar pressure(1) - Checks baby after delivery - Checks perineum for tears - Checks placenta for completeness		18
TOTAL MARKS				**20**

%.....

Examiner

1._____ **signature** _____

2._____ **signature** _____

CHECKLIST FOR BREECH DELIVERY

(To be used by the **Participant** for practice and by the **Trainer** at the end of the course)

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PARTICIPANT _____ **Date Observed** _____

CHECKLIST FOR BREECH DELIVERY (Many of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	**CASES**					
GETTING READY						
1. Prepare the necessary equipment.						
2. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.						
3. Provide continual emotional support and reassurance, as feasible.						
4. Ensure that the conditions for breech delivery are present.						
5. Put on personal protective barriers.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
PREPROCEDURE TASKS						
1. Wash hands thoroughly and put on high-level disinfected or sterile surgical gloves.						
2. Clean the vulva with antiseptic solution.						
3. Catheterize the bladder, if necessary.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
BREECH DELIVERY						
Delivery of the Buttocks and Legs						
1. When the buttocks have entered the vagina and the cervix is fully dilated, tell the woman she can bear down with contractions.						
2. Perform an episiotomy, if necessary.						
3. Let the buttocks deliver until the lower back and shoulder blades are seen.						
4. Gently hold the buttocks in one hand.						
5. If the legs do not deliver spontaneously, deliver one leg at a time.						
6. Hold the newborn by the hips.						

CHECKLIST FOR BREECH DELIVERY
(Many of the following steps/tasks should be performed simultaneously.)

STEP/TASK	CASES				
Delivery of the Arms					
7. If the arms are felt on the chest, allow them to disengage spontaneously.					
8. If the arms are stretched above the head or folded around the neck, use Lovset's maneuver.					
9. If the newborn's body cannot be turned to deliver the arm that is anterior first, deliver the arm that is posterior.					
Delivery of the Head					
10. Deliver the head using the Mauriceau Smellie Veit maneuver.					
11. Complete steps for active management of the third stage of labor.					
12. Following childbirth, check the birth canal for tears and repair, if necessary. Repair the episiotomy, if one was performed.					
13. Provide immediate postpartum and newborn care, as required.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POSTPROCEDURE TASKS					
1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.					
2. Place all instruments in 0.5% chlorine solution for decontamination.					
3. Remove gloves and discard them in a leakproof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.					
4. Wash hands thoroughly.					
5. Record procedure and findings on woman's record.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

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Station 2 Obstetrics 2 Date: October 2016

Name of student: **Registration number:**

Q	Question	Expected answers	Score	Max Score
1	What is the most likely diagnosis?	- Shoulder dystocia		2
2	Demonstrate on the mannequin how you would proceed	- HELPERR acronym(1) - H Call for help, midwife, anaesthetist, pediatrician(4) - E. Evaluate for episiotomy and extend if possible(3) - L. Legs McRoberts manoeuvre (hyperflexion of the hips)(3) - P. Suprapubic Pressure, external pressure, understanding of the direction of pressure, i.e. the posterior aspect of the shoulder(3) - E. Enter Wood's Screw Manoeuvre(2) - R. Rotate posterior shoulder to anterior(2) - R. Roll over onto all fours(2) - Continue each manouvre for 30 seconds before moving onto the next (1). - Understands the importance of moving the shoulder anteriorly across the abdomen to narrow the diameter. Pushing it in the opposite direction increases the diameter(2) - Salvage manouvres: fracture clavicle(1), symphysiotomy(1), caesarean section		25
3	What are the predisposing factors for the above condition?	- GDM - High BMI - Large baby - Post maturity - 50% occur with a normal weight		5
OTAL MARKS				32

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Examiner

1. _____ **signature** _____

2. _____ **signature** _____

CHECKLIST FOR VACUUM EXTRACTION

(To be used by the **Participant** for practice and by the **Trainer** at the end of the course)

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PARTICIPANT _____ **Date Observed** _____

CHECKLIST FOR VACUUM EXTRACTION (Many of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	**CASES**					
GETTING READY						
1. Prepare the necessary equipment.						
2. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.						
3. Provide continual emotional support and reassurance, as feasible.						
4. Ensure that the conditions for vacuum extraction are present.						
5. Make sure an assistant is available.						
6. Put on personal protective barriers.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
PREPROCEDURE TASKS						
1. Wash hands thoroughly and put on high-level disinfected or sterile surgical gloves.						
2. Clean the vulva with antiseptic solution.						
3. Catheterize the bladder, if necessary.						
4. Check all connections on the vacuum extractor and test the vacuum.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
VACUUM EXTRACTION						
1. Assess the position of the fetal head and identify the posterior fontanelle.						
2. Apply the largest cup that will fit.						
3. Perform an episiotomy, if necessary, for placement of the cup.						
4. Check the application and ensure that there is no maternal soft tissue within the rim of the cup.						
5. Have assistant create a vacuum of negative pressure and check the application of the cup.						

CHECKLIST FOR VACUUM EXTRACTION (Many of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	CASES					
6. Increase the vacuum to the maximum and then apply traction. Correct the tilt or deflexion of the head.						
7. With each contraction, apply traction in a line perpendicular to the plane of the cup rim and assess potential slippage and descent of the vertex.						
8. Between each contraction, have assistant check fetal heart rate and application of the cup.						
9. Continue the "guiding" pulls for a maximum of 30 minutes. Release the vacuum when the head has been delivered.						
10. Complete birth of newborn and delivery of placenta.						
11. Following childbirth, check the birth canal for tears and repair, if necessary. Repair the episiotomy, if one was performed.						
12. Provide immediate postpartum and newborn care, as required.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
POSTPROCEDURE TASKS						
1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.						
2. Place all instruments in 0.5% chlorine solution for decontamination.						
3. Remove gloves and discard them in a leakproof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.						
4. Wash hands thoroughly.						
5. Record procedure and findings on woman's record.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						

AVD

A – Ask for Help

B – Empty the bladder

C – Cx dilation - Fully

D - Decent at Station 0 or 1

E – Equipment Working

F – Flexion Point

G – Gentle Traction

H – Halt ⟵ Cup slips twice
⟵ No decent ≥ 3 good Pulls
⟵ Procedure should not exceed 20mins

I – Incision / selective episiotomy

J – Jaw delivery release Vacuum, support the Perineum deliver normally.

Aldo Vacca, MB BS, FRACOG, FRCOG, GO (FNGI), GCEd

5-Step Vacuum Technique

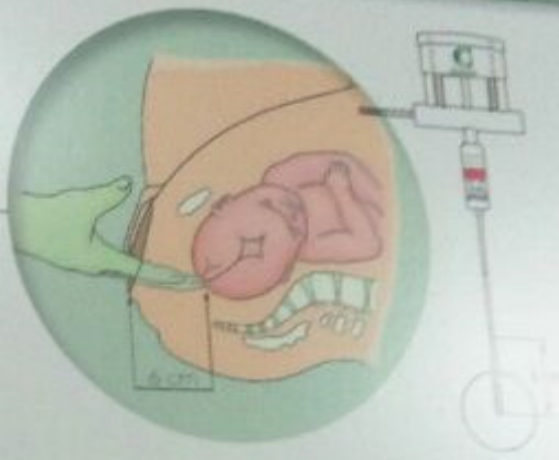
Courtesy of Vacca A. Handbook of Vacuum Delivery in Obstetric Practice, 3rd Ed.

Kiwi OmniCup PalmPump

Complete Vacuum Delivery System

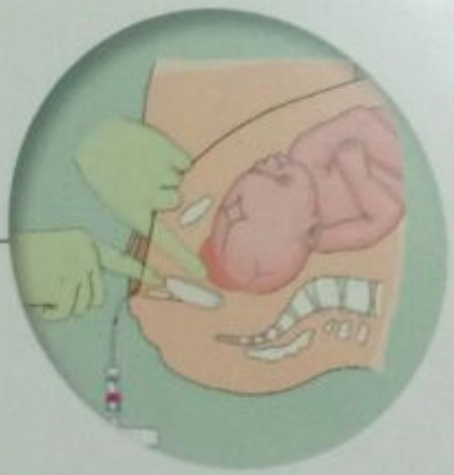
1 Locate Flexion Point, Calculate Cup Insertion Distance

Refer to reverse side for more information.



2 Hold & Insert the Cup

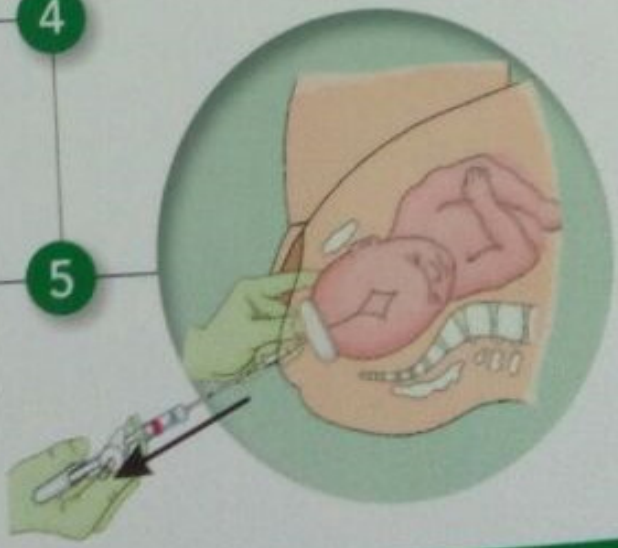
Best Practice – Insert with groove at 12 o'clock



3 Maneuver Cup Toward and Over Flexion Point

4 Create Vacuum and Exclude Maternal Tissue

Best Practice: 600mmHg



5 Using Finger Tip Traction and Finger/Thumb Technique, Pull Along Axis of the Pelvis

CLINICAL INNOVATIONS

747 West 4170 South Murray, Utah 84123 USA
Phone: 801-268-8200 • Fax: 801-266-7373
Toll Free: 888-268-6222 • www.clinicalinnovations.com

P/N 056-0077 Rev.

SKILLS STATION 1:
NORMAL VAGINAL DELIVERY

Apgar Scoring System

Indicator		0 Points	1 Point	2 Points
A	Activity (muscle tone)	Absent	Flexed arms and legs	Active
P	Pulse	Absent	Below 100 bpm	Over 100 bpm
G	Grimace (reflex irritability)	Floppy	Minimal response to stimulation	Prompt response to stimulation
A	Appearance (skin color)	Blue; pale	Pink body, Blue extremities	Pink
R	Respiration	Absent	Slow and irregular	Vigorous cry

0-3 SEVERELY DEPRESSED

4-6: MODERATELY DEPRESSED

>7-10: EXCELLENT CONDITION

CHECKLIST FOR CONDUCTING A CHILDBIRTH

(To be used by the **Participant** for practice and by the **Trainer** at the end of the course)

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PARTICIPANT _____ **Date Observed** _____

CHECKLIST FOR CONDUCTING A CHILDBIRTH (Many of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	**CASES**					
GETTING READY						
1. Prepare the necessary equipment.						
2. Allow the woman to push spontaneously.						
3. Allow the woman to adopt the position of choice.						
4. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.						
5. Provide continual emotional support and reassurance, as feasible.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
CONDUCTING THE CHILDBIRTH						
1. Put on personal protective barriers.						
2. Wash hands thoroughly and put on high-level disinfected or sterile surgical gloves.						
3. Clean the perineum with antiseptic solution.						
4. As the perineum distends, decide whether an episiotomy is necessary and perform as necessary.						
5. After crowning, allow the head to gradually extend and feel around the newborn's neck for the cord: • If found, slacken the cord to allow the shoulders to pass through, or clamp and cut the cord.						
6. Allow restitution and external rotation of the head to occur.						
7. Apply gentle downward traction on the head to allow the anterior shoulder to slip beneath the symphysis pubis.						
8. Guide the head and trunk in an upward curve to allow the posterior shoulder to escape over the perineum.						
9. Grasp the newborn around the chest to aid the birth of the trunk and lift it toward the woman's abdomen.						

CHECKLIST FOR CONDUCTING A CHILDBIRTH

(Many of the following steps/tasks should be performed simultaneously.)

STEP/TASK	CASES				
Note the time of birth.					
Dry the newborn quickly and thoroughly with a clean, dry towel/cloth immediately after birth.					
Wipe the newborn's eyes with a clean piece of cloth.					
Place the newborn in skin-to-skin contact on the mother's abdomen and cover with a clean, dry towel/cloth.					
Observe the newborn's breathing (see **Learning Guide for Newborn Resuscitation**).					
. Clamp, cut and tie cord.					
». Palpate the mother's abdomen to exclude second newborn and give oxytocin intramuscularly.					
7. Apply gentle but firm traction to the cord during a contraction, while at the same time applying counter traction abdominally.					
8. Wait for the next contraction and repeat, if the maneuver is not immediately successful.					
9. Cup the placenta in both hands, when it is visible.					
20. Use a gentle upward and downward movement or twisting action to deliver the membranes.					
21. Check that the uterus is well contracted.					
22. Inspect the lower vagina and perineum for lacerations/tears and repair, if necessary.					
23. Repair episiotomy, if one was performed.					
24. Examine the maternal surface of the placenta and membranes for completeness and abnormalities.					
25. Note the insertion of the cord and examine the cut end of the cord.					
26. Dispose of the placenta by incineration (or place in a leakproof container for burial). Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.					
27. Place all instruments in 0.5% chlorine solution for decontamination.					
28. If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for decontamination. If disposing of needle and syringe, place in puncture-proof container.					
29. Remove gloves and discard them in a leakproof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.					
30. Wash hands thoroughly.					
31. Record all findings on woman's record.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA

(To be used by the **Participant** for practice and by the **Trainer** at the end of the course)

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ot Observed: Step or task not performed by participant during evaluation by trainer

ARTICIPANT _____ **Date Observed** _____

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA
(Many of the following steps/tasks should be performed simultaneously.)

STEP/TASK	CASES				
GETTING READY					
1. Prepare the necessary equipment.					
2. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.					
3. Provide continual emotional support and reassurance, as feasible.					
4. Have the woman empty her bladder or insert a catheter.					
5. Give anesthesia.					
6. Give prophylactic antibiotics.					
7. Put on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
MANUAL REMOVAL OF PLACENTA					
1. Wash hands and forearms thoroughly and put on high-level disinfected or sterile surgical gloves (use elbow-length gloves, if available).					
2. Hold the umbilical cord with a clamp and pull the cord gently.					
3. Place the fingers of one hand into the uterine cavity and locate the placenta.					
4. Provide counter-traction abdominally.					
5. Move the hand back and forth in a smooth lateral motion until the whole placenta is separated from the uterine wall.					
6. Withdraw the hand from the uterus, bringing the placenta with it while continuing to provide counter-traction abdominally.					
7. Give oxytocin in IV fluid.					
8. Have an assistant massage the fundus to encourage atonic uterine contraction.					
9. If there is continued heavy bleeding, give ergometrine by IM injection or prostaglandins.					

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA (Many of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	CASES					
10. Examine the uterine surface of the placenta to ensure that it is complete.						
11. Examine the woman carefully and repair any tears to the cervix or vagina or repair episiotomy.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
POSTPROCEDURE TASKS						
1. Remove gloves and discard them in a leakproof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.						
2. Wash hands thoroughly.						
3. Monitor vaginal bleeding, take the woman's vital signs and make sure that the uterus is firmly contracted.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						

CHECKLIST FOR REPAIR OF CERVICAL TEARS

(To be used by the **Participant** for practice and by the **Trainer** at the end of the course)

Place a "✓" in case box if step/task is performed **satisfactorily**, an "X" if it is **not** performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

PARTICIPANT _____ **Date Observed** _____

CHECKLIST FOR REPAIR OF CERVICAL TEARS (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Prepare the necessary equipment.					
2. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.					
3. Provide continual emotional support and reassurance, as feasible.					
4. Have the woman empty her bladder or insert a catheter.					
5. Give anesthesia, if necessary.					
6. Put on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
REPAIR OF CERVICAL TEARS					
1. Wash hands thoroughly and put on high-level disinfected or sterile surgical gloves.					
2. Clean the vagina and cervix with an antiseptic solution.					
3. Grasp both sides of the cervix using ring or sponge forceps (one forceps for each side of tear).					
4. Place the first suture at the top of the tear and close it with a continuous suture, including the whole thickness of the cervix each time the suture needle is inserted.					
5. If a long section of the rim of the cervix is tattered, under-run it with a continuous suture.					
6. Use ring forceps if the apex is difficult to reach and ligate.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POSTPROCEDURE TASKS					
1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.					

CHECKLIST FOR REPAIR OF CERVICAL TEARS (Many of the following steps/tasks should be performed simultaneously.)						
STEP/TASK	**CASES**					
2. Place all instruments in 0.5% chlorine solution for decontamination.						
3. Remove gloves and discard them in a leakproof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.						
4. Wash hands thoroughly.						
5. Record procedure on woman's record.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						

(Participant for practice and by the **Trainer** at the end of the course)

Place a "✓" in case box if step/task is performed **satisfactorily**, an "X" if it is **not** performed satisfactorily, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

PARTICIPANT _____ **Date Observed** _____

CHECKLIST FOR EPISIOTOMY AND REPAIR
(Many of the following steps/tasks should be performed simultaneously.)

STEP/TASK	CASES				
GETTING READY					
1. Prepare the necessary equipment.					
2. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.					
3. Provide continual emotional support and reassurance, as feasible.					
4. Ask about allergies to antiseptics and anesthetics.					
5. Put on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
MAKING THE EPISIOTOMY					
1. Wash hands thoroughly and put on high-level disinfected or sterile surgical gloves.					
2. Clean the perineum with antiseptic solution.					
3. Administer local anesthetic.					
4. Perform episiotomy when perineum is thinned out and newborn's head is visible during a contraction.					
5. Insert two fingers into the vagina between the newborn's head and the perineum.					
6. Insert the open blade of the scissors between the perineum and the fingers. Make a single cut in a mediolateral direction.					
7. If delivery of the head does not follow immediately, apply pressure to the episiotomy site between contractions.					
8. Control delivery of the head to avoid extension of the episiotomy.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

CHECKLIST FOR EPISIOTOMY AND REPAIR

(Many of the following steps/tasks should be performed simultaneously.)

STEP/TASK	CASES				
REPAIRING THE EPISIOTOMY					
1. Clean the woman's perineum with antiseptic solution.					
2. Repeat local anesthetic, if necessary.					
3. Use a continuous suture from the apex downward to repair the vaginal incision.					
4. At the vaginal opening, bring the cut edges together.					
5. Bring the needle under the vaginal opening and out through the incision and tie.					
6. Use interrupted sutures to repair the perineal muscle, working from the top of the perineal incision downward and to bring the skin edges together.					
7. Place a clean cloth or pad on the woman's perineum.					
POSTPROCEDURE TASKS					
1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.					
2. Place all instruments in 0.5% chlorine solution for decontamination.					
3. If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for decontamination. If disposing of needle and syringe, place in puncture-proof container.					
4. Remove gloves and discard them in a leakproof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.					
5. Wash hands thoroughly.					
6. Record procedure on woman's record.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

UNIVERSITY OF NAIROBI, COLLEGE OF HEALTH SCIENCES, SCHOOL OF MEDICINE, DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

MBCHB LEVEL 4 FINAL YEAR EXAMS OCTOBER 2016

OSCE 1

GYNECOLOGY 2

NON INTERACTIVE STATION

Instructions to examiner

1. This is a ten minute station
2. This is a non-interactive station
3. The student is provided with a scenario,

A – Combined pill
B – Jadelle
C - IUCD
D - Condoms

4. The student is to answer the questions provided

End

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MBCHB LEVEL 4 END YEAR EXAMS OCTOBER 2016

OSCE 1

GYNECOLOGY 2

NON INTERACTIVE STATION

SCENARIO

Moraa is on treatment for DVT postpartum and desires a family planning method. You have the following options A, B, C, D.

A –
B –
C -
D -

Questions

1. of the options provided which one would you recommend or not recommend for the patient and why.
2. Demonstrate how you would insert device B.

End

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MBCHB LEVEL 4 FINAL YEAR EXAMS OCTOBER 2016

OSCE 1

GYNECOLOGY 4

NON INTERACTIVE STATION

Instructions to examiner

1. This is a ten minute station
2. This is a non-interactive station
3. The student is provided with a scenario, a Hysterosalpingogram, hormonal profile and semenalysis from patients husband, an ultrasound showing PCOS/fibroid .
4. The student is to answer the questions provided

End

UNIVERSITY OF NAIROBI, COLLEGE OF HEALTH SCIENCES, SCHOOL OF MEDICINE, DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

MBCHB LEVEL 4 FINAL YEAR EXAMS OCTOBER 2016

OSCE 1

GYNECOLOGY 4

NON INTERACTIVE STATION

Instructions to student

1. This is a 10 minute station
2. This is a non-interactive station
3. You are provided with a scenario, and a number of test results
4. Answer the questions provided

End

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MBCHB LEVEL 4 END YEAR EXAMS OCTOBER 2016

OSCE 1

GYNECOLOGY 4

NON INTERACTIVE STATION

SCENARIO
Christina is a 40 year old who presents to the infertility clinic with the following results.

Questions

1. Investigation 1
    a) Name the test
    b) Interpret the finding. HSG (bilateral blocked tubes)
2. Investigation 2 – seminalysis oligozoospemia
    a. Name the test
    b. Interpret the findings.

3. Investigation 3
    a. Identify the pathology (PCOS)

    a) What is the most appropriate management method for her and why? ART

End

KENYATTA NATIONAL HOSPITAL

KNH: 206 revised

RADIOLOGICAL REQUEST / REPORT FORM

ENT NAME:	Nzuva Wanjiru Mungu			Hosp. No.	20868
/AGE 42 yrs	GENDER: F	WD / CLINIC/PVT	A16	PT. TEL. No.	
Intment:		Portable:		X-RAY No:	
..... Time.....		INVOICE No.		RECEIPT / C/ S. No.	NHIF No.
NT No.	Charges				

Clinical Summary:
Lt iliac fossa mass, ↓Pain for the last 4 days.
↑ abdomen → features of cecal and ascending colon mass.

Date of L.M.P.....

Type of Investigations Requested:

Type of Investigations	Specification	Charge
General radiography		
Computerized Tomography (CT scan)		
Magnetic Resonance Imaging(MRI scan)		
Ultrasound (U/S)		
Fluoroscopy		
Interventional Radiology		
Mammography		
Others: (Specify).....	Colonoscopy + Biopsy.	

by: Doctor's Name Dr. Muchiri ..... Signature ..... Date 24/7
Doctor's Tel. No.....

IONS:
atients to avail previous Scans / X-Ray films during the procedure.
elvic Ultra Sound and early Obstetrics patients to have full bladder by taking (4 – 6) glasses of water
inutes before the procedure .
arium Meal / Abdominal Ultra Sound Scan / CT Scan the patients should starve for 6 hours before
examination.
Preparation for other specific examinations will be advised on booking the exam
official use:

diographer Name.....Signature.....Date

UNIVERSITY OF NAIROBI
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SCHOOL OF MEDICINE
Department of Obstetrics & Gynaecology

LABORATORY REPORT FORM

PATIENTS ID: Margret Wangari **GENDER:** Female **AGE:** 24 years

VISIT DATE: 15.03.2017

SPECIMEN: HVS

INVESTIGATION: *Microscopy, Culture &Sensitivity*

PATIENT'S DOCTOR: *Dr. Kibe*

Appearance	Results	comment
Colour	Normal	-
Appearance	Normal	-

Microscopy	Results	comment
Wet Preparation	Pus -cells seen 5-10/hpf No yeast /T.V seen	-
Gram stained smear	Leucocytes No organisms seen	-

Culture	Results	comment
	Germinating yeast cells	

Technologist: ..... Date.....

Checked By: ..... Date.....

Bacteriology Section
Department of Obstetrics and Gynaecology (UoN) at Kenyatta National Hospital

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
SCHOOL OF MEDICINE DEPT. OF OBSTETRICS & GYNAECOLOGY (KNH)
P.O Box, 19676 Nairobi. Tel: 020-2726300 Ext. 43392 Direct: 020-2726360

SEMEN ANALYSIS REPORT

Name of patient_NICHOLAS OTIENO_____ _ Age_39_ Date _19/7/17_____Lab no _11/7/17_____

Name of doctor/Clinic _____Unit No _____Contact_____

Parameter value	REPORT	Ref. Reference
Duration of abstinence -	6	Days 3 - 7
Interval between ejaculations and start of analysis-	100	Minutes
Appearance -	GREYISH WHITE	Creamy white/ Greyish
Volume -	2.2	>1.5mlsx10^6/ml
Consistency -	DROPLETS	Droplets
PH -	7.5	**>7.2**
Motility (%) Grading: a. Rapid progressive b. Slow progressive c. Non progressive d. Immotile	 0% 0% 1% 99%	>40%Motility progressive + Slow progressive + Non progressive
Agglutination: Type: Severity%	NIL NIL	
Vitality (% Alive)		>58%
Concentration (sperms//ml)	2 X 10^6	>15x10^6//ml
Total sperm count -	4.4 X 10^6	>39.0x10^6/ejaculate
White blood cells (Million/ml) -	0.5 X 10^6	<1.0 x10^6/ml
Immuno bead test. Mar Test.		<50% motile spermatozoa with adherent particles
Morphology (%) I Normal II Abnormal	2% 98%	>4% Strict Criteria

Comment

ASTHENO OLIGO TERATOZOOSPERMIA

Test done by://

Name: LEONARD OCHIENG Signature_____Date_____

/

Checked by: Name _____Signature_____Date_____

NB: SEMEN ANALYSIS IS ONLY DONE ON MONDAY, TUESDAY AND THURSDAY. PATIENT SHOULD ABSTAIN FOR 3-5 DAYS

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SEMEN ANALYSIS REPORT

Name of patient_Kelvin Mwiti_ Age__32____ Date 11/08/16_Lab no_30/8/16

Name of doctor/Clinic _KNH Unit No _____Contact_0711441078_

Parameter value	REPORT	Ref. Reference
Duration of abstinence -	11	Days 3 - 7
Interval between ejaculations and start of analysis-	1	Minutes
Appearance -	Cream white	Creamy white/ Greyish
Volume -	6.0	>1.5mlsx10^6/ml
Consistency -	droplets	Droplets
PH -	7.5	>7.2
Motility (%) Grading: a. Rapid progressive b. Slow progressive c. Non progressive d. Immotile	25% 10% 10% 55%	>40%Motility progressive + Slow progressive + Non progressive
Agglutination: Type: Severity%	Mixed Mild	
Vitality (% Alive)		>58%
Concentration (sperms//ml)	01 106	>15x10^6//ml
Total sperm count -	6 106	>39.0x10^6/ejaculate
White blood cells (Million/ml) -		<1.0 x10^6/ml
mmuno bead test. Mar Test.		<50% motile spermatozoa with adherent particles
Morphology (%) I Normal II Abnormal	10% 90%	>4% Strict Criteria

Comment

Test done by:

Technologist Name ___M.Wawera_____ **Signature**_____ **Date**__15/8/16_____

Checked by:

Technologist Name _____ **Signature**_____ **Date**_____

SEMEN MORPHOLOGY

Normalities:

1. Normal-spermia

Abnormalities

- Aspermia: absence of semen
- Azoospermia: absence of sperm
- Hypospermia: low semen volume
- Hyperspermia: high semen volume
- Oligozoospermia: Very low sperm count
- Asthenozoospermia: poor sperm motility
- Teratozoospermia: sperm carry more morphological defects than usual
- Necrozoospermia: all sperm in the ejaculate are dead

Leucospermia: a high level of white blood

STATION 3:

Fetal heart rate tracing interpretation – Normal and abnormal tracings

Fetal heart rate (FHR) interpretation system

Category I

All of the following criteria must be present.

- Baseline rate: 110-160 beats per minute
- Moderate baseline FHR variability
- No late or variable decelerations
- Early decelerations may be present or absent
- Accelerations may be present or absent

Category III

Criteria for (1) or (2) should be present.
Category III tracings are predictive of abnormal fetal acid-base status at the time of observation.

(1) Absent baseline FHR variability and any of the following:
- Recurrent late decelerations
- Recurrent variable decelerations
- Bradycardia

(2) Sinusoidal pattern

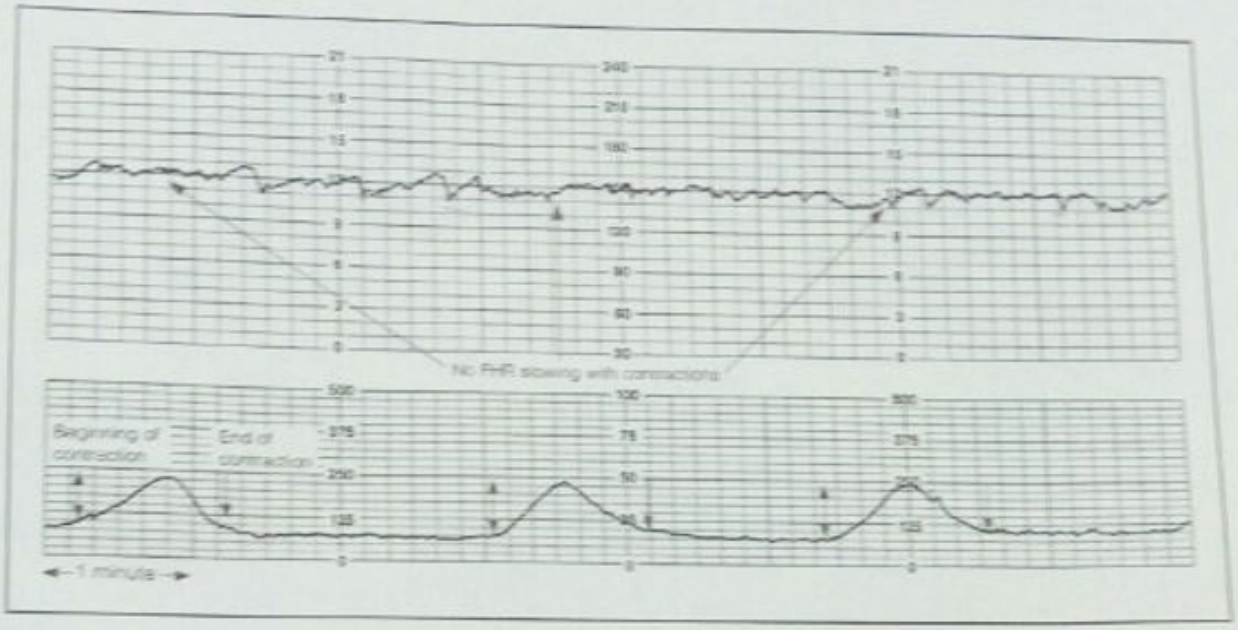
Category II

FHR tracing does not meet criteria for either category I or III and is considered indeterminate.

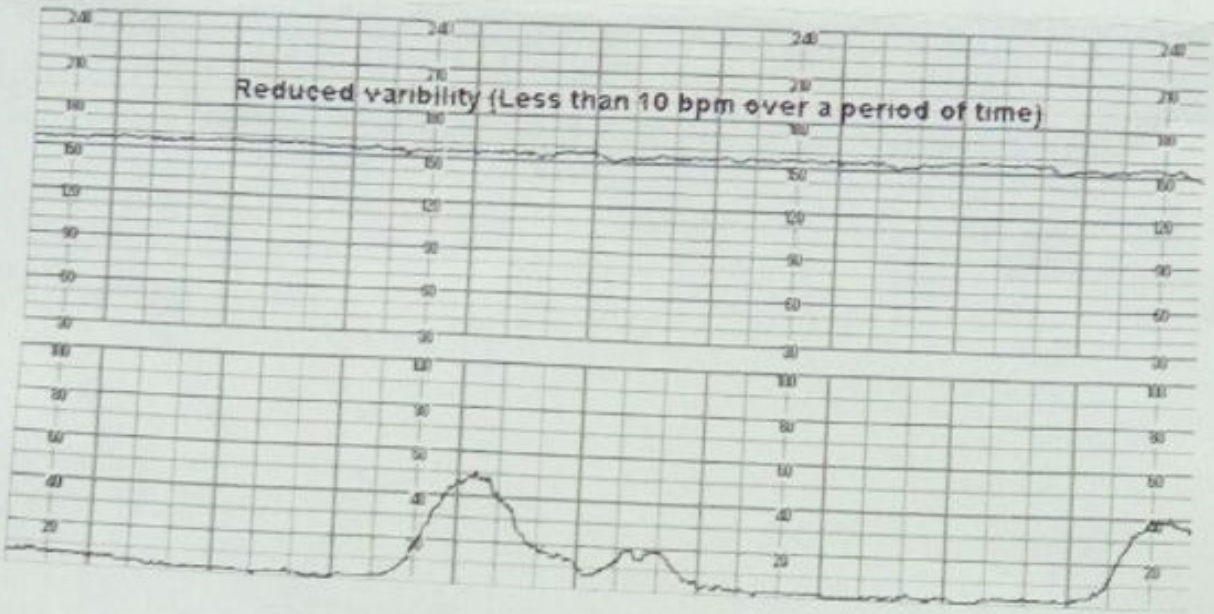
Management of II and III

- provision of supplemental oxygen,
- change in position,
- treatment of hypotension, and
- discontinuation of any uterotonic drugs being administered.

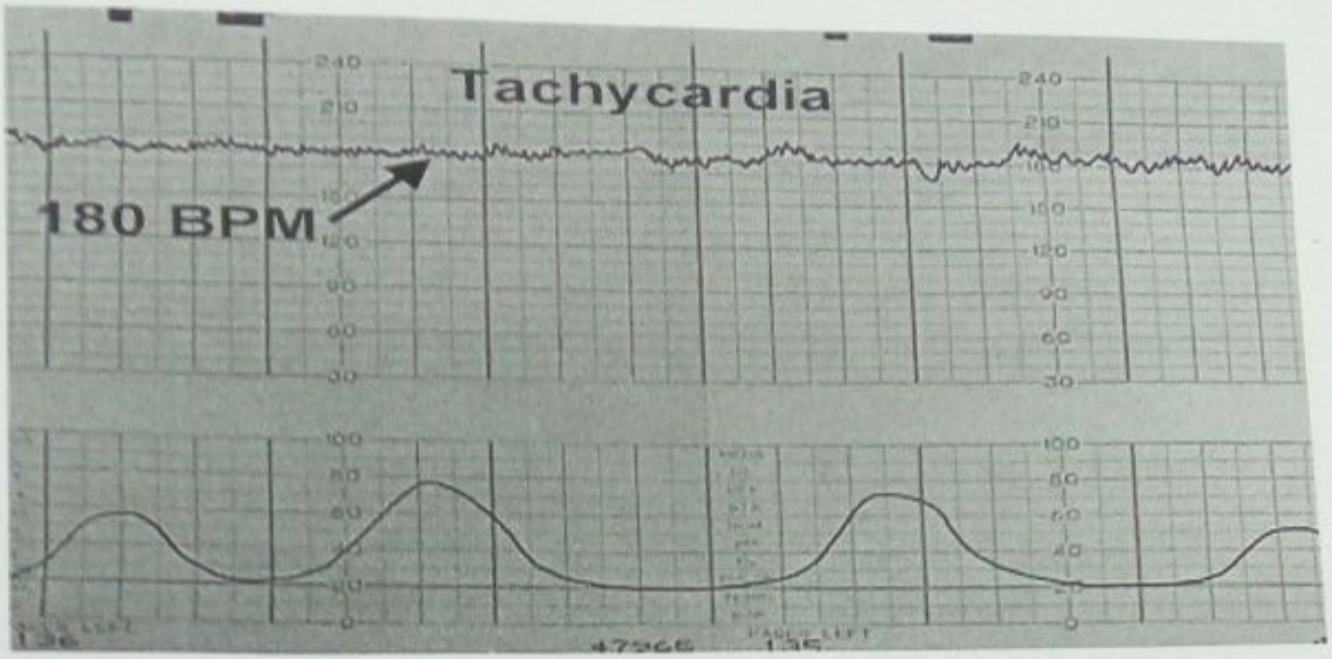
1. NORMAL CTG


No FHR slowing with contractions
Beginning of contraction
End of contraction
1 minute

2. REDUCED VARIABILITY



3. BASELINE TACHYCARDIA



Causes:

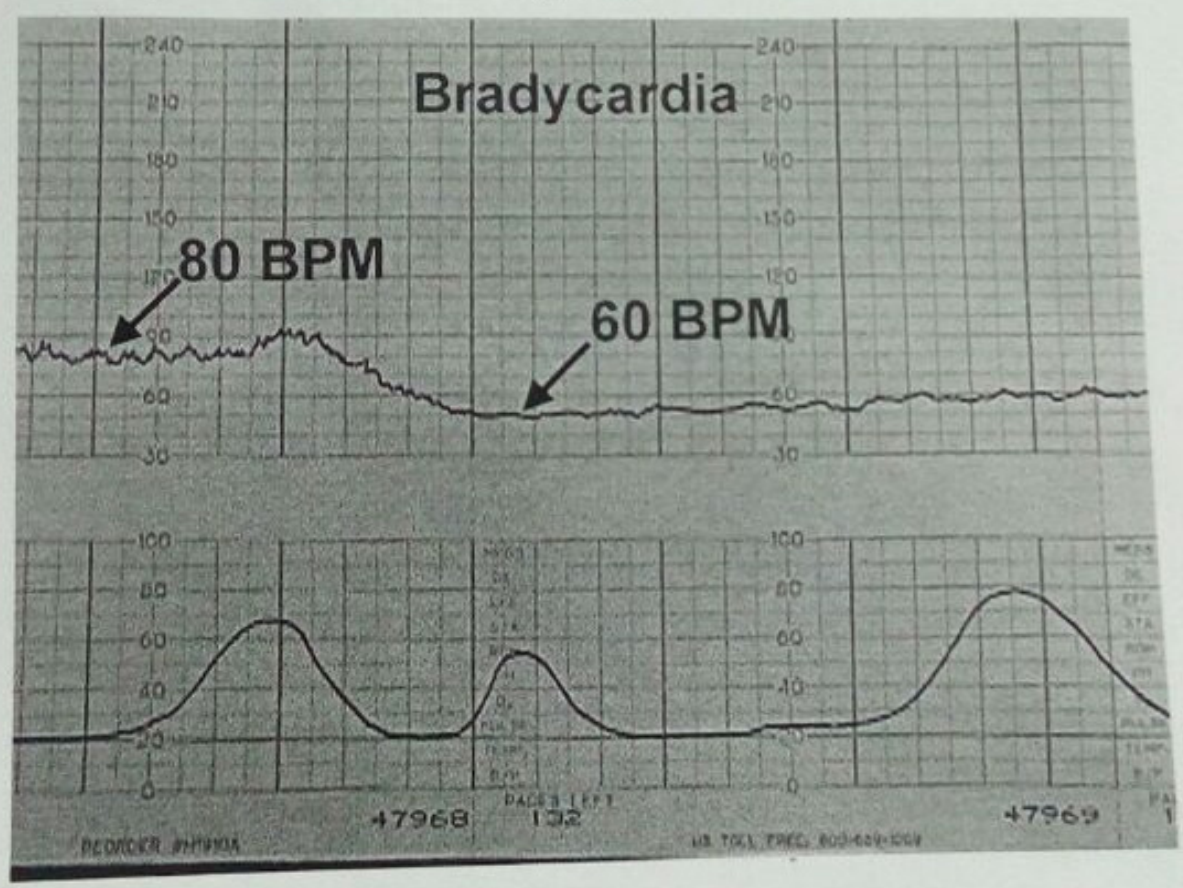
- Chronic / moderate asphyxia
- Drugs
- Prematurity
- Maternal fever
- Maternal thyrotoxicosis
- Maternal Anxiety
- Idiopathic

4. BASELINE BRADYCARDIA

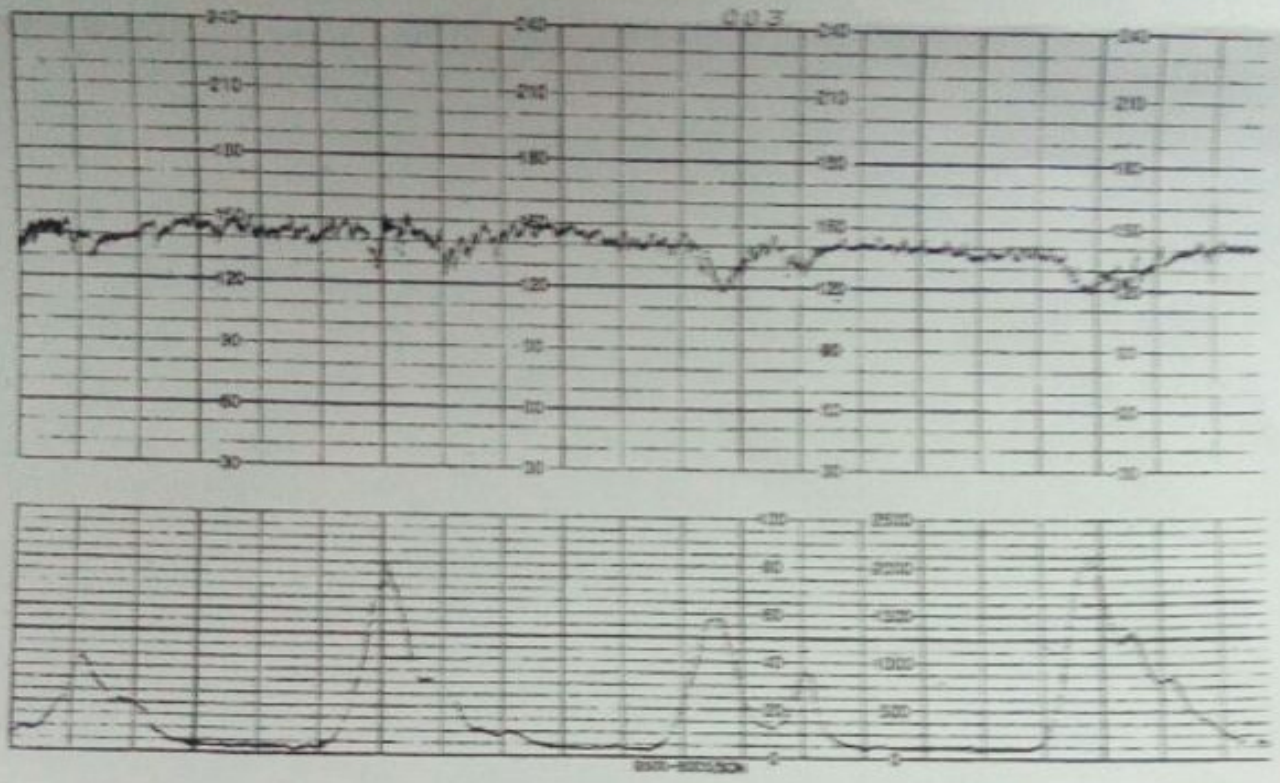
Def: less than **110 bpm** during a 10-minute period or longer

Causes

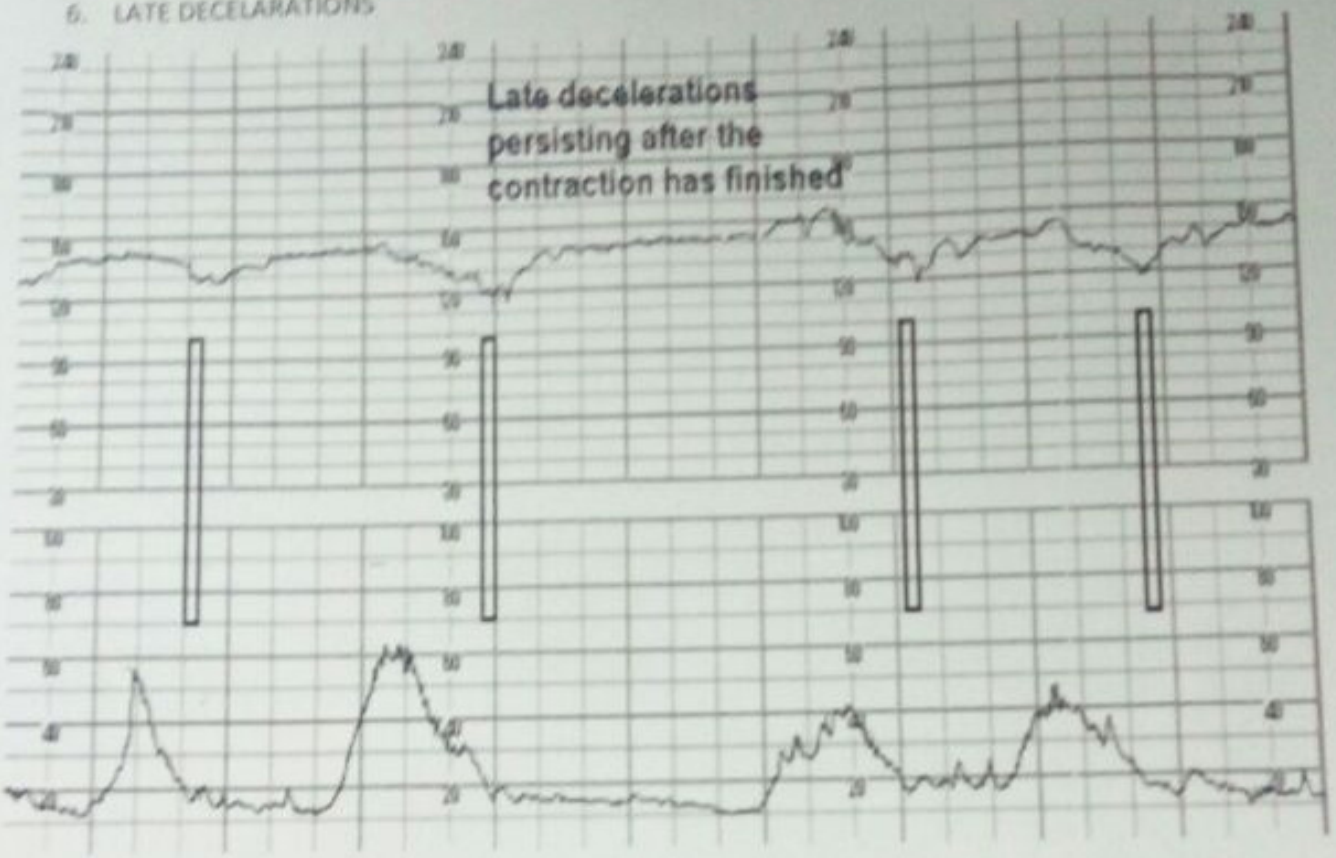
- Profound hypoxia in fetus
- Maternal hypotension
- Prolonged umbilical cord compression
- Fetal arrhythmias
- Uterine hyperstimulation
- Abruptio placentae
- Uterine rupture
- Vaginal stimulation in second stage of labor



5. EARLY DECELERATIONS



6. LATE DECELARATIONS

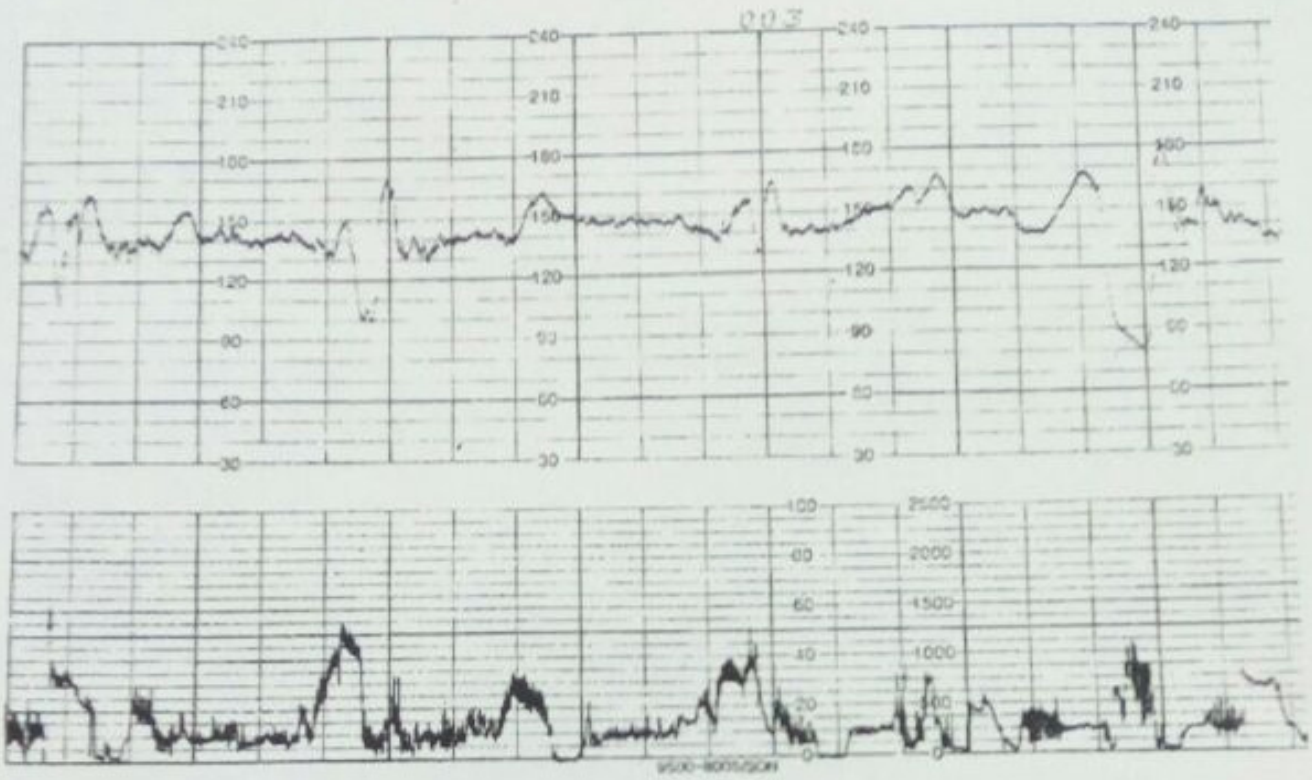


Due to acute and chronic utero-placental insufficiency

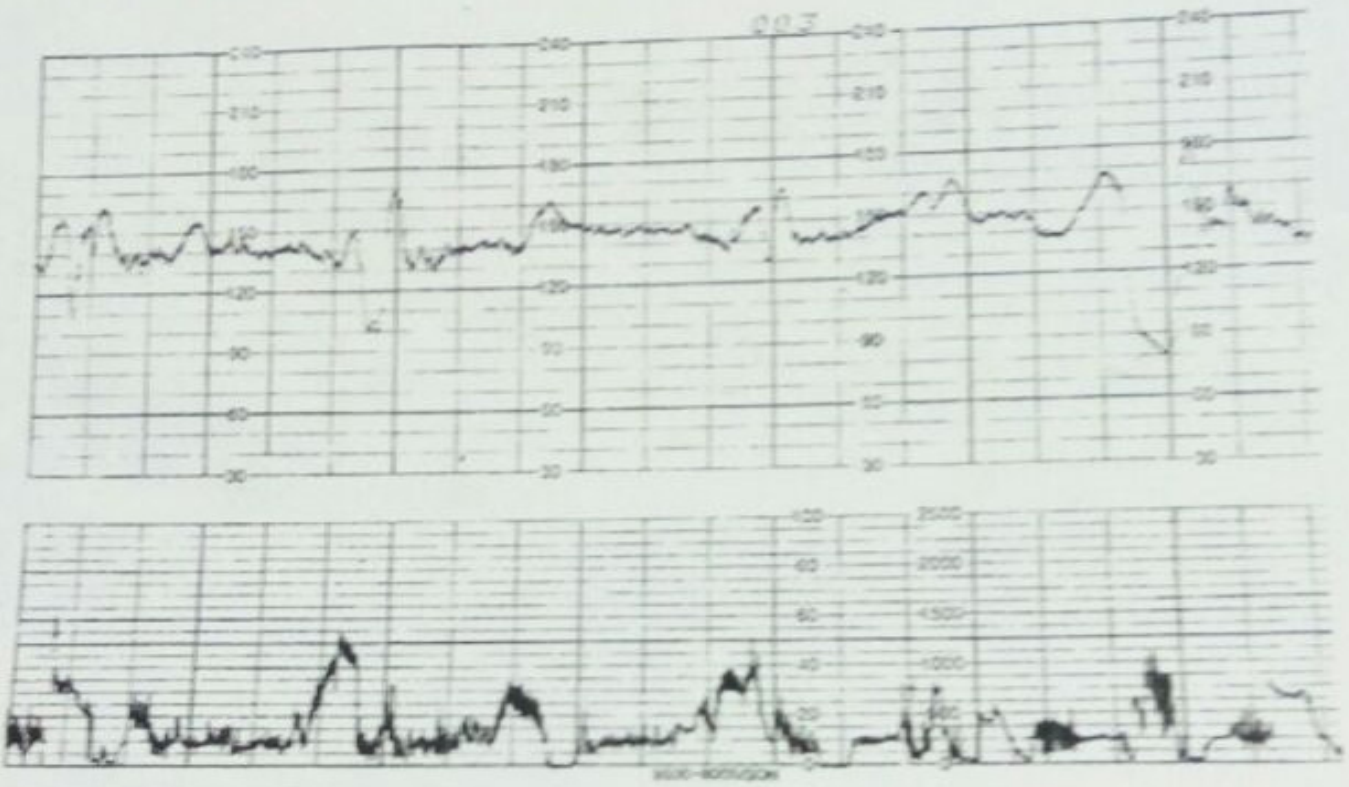
- Occurs after the peak and past the length of uterine contraction, often with slow return to the baseline
- Is precipitated by hypoxemia
- Associated with respiratory and metabolic acidosis

- Common in patients with PIH, DM, IUGR or other forms of placental insufficiency

7. VARIABLE DECELERATIONS



8. SINUSOIDAL RHYTHM



Sinusoidal pattern - distinctive smooth undulating Sine-wave baseline rate

Causes:

- Cord compression
- Hypovolemia
- Ascites
- Idiopathic (fetal thumb sucking)
- Analgesics
- Anemia
- Abruption

Management depends on clinical situation