UniSHAMS

POSTING LOG BOOK

YEAR 5

OBSTETRICS & GYNAECOLOGY

Name:

Student No.:

Mobile Number:

Session/Semester:

Group:

Posting date

Begin: **End:**

LOG BOOK YEAR 5
MAJOR POSTING
Obstetrics & Gynaecology

Lecturer in charge:

Clinician(s) in charge:

Dear Medical Students,

This booklet is intended as a guide for augmenting and recording the practical experience that you should strive to gain during your posting. The cliché that "the patient should be your textbook" is very true and only regular contact with patients will enable you to truly assimilate and make your own the knowledge obtained from books and lectures.

Students learn differently; but reading about, discussing and seeing patients with different clinical problems reinforces and consolidates your knowledge base. Seek out opportunities whenever possible to practice your history taking, physical examination and technical skills. More importantly, you should learn to prioritize patient problems and report on your patients in a clear, organized fashion, whether orally or in writing. You should also learn to utilise the clinical data obtained from the history and examination of the patient to build up a differential diagnosis and management plan. Link your reading to the patient problems you encounter in the wards, outpatients, etc.

Specific professional behaviours are expected of medical students during their clinical attachment. Empathy, sensitivity and compliance with the patient's wishes are essential. Asking patients if you can observe or participate in their care is common courtesy. Most patients gladly accept students as part of their health care team, but it must be remembered that this is always the patient's choice.

It is imperative that the student ensures that his/her attendance is signed for by the most senior member of the clinical team present during that session. Attendance to all clinical sessions – particularly outpatients and theatre – is mandatory, and forms an integral part of the assessment.

The Outpatients and the Specialist Clinic is the ideal place for the student to learn the skills of abdominal and to observe pelvic examination.

The students should strive to follow-up and observe the labour progress of as many patients as possible during the clinical posting.

The student should use the operating theatre sessions to gain an overall view and understanding of the basic principles of the common operating procedures in order that he/she will be capable to explain the overall concept of the procedure to their future patients.

During the fifth-year posting the student should strive to clerk fully at least two obstetric or two gynaecological patient. These cases should be written up fully. At least one obstetric case should be accompanied by a labour progress summary outlined on a Partogram.

Core Clinical Skills and Competences:

A series of core skills and competencies have to be attained throughout your posting. These are outlined in the table below,

Knowledge Criteria	Clinical Competency	Professional Skills & Atti-
Be able to take Obstetrics and Gynaecology history.	Be able to take & analyse an obstetric and gynaecological history in a succinct and logical manner.	Be able to show empathy and develop rapport with patients. Be able to appreciate the psychological and social impact of disease on patients and their relatives.
Be able to elicit Physical signs.	Be able to: a. Perform abdominal palpation of a pregnant and non-pregnant abdomen; b. Observe pelvic examination including inspection, speculum and bi-manual; c. Assist in a cervical smear/	Respect to patients' dignity and confidentiality. Develop communication skills.
Develop communication skills.	Develop listening and interviewing skills.	Develop and understanding of effective communication; be this verbal and non- verbal.
Be able to assess maternal & foetal well-being and compromise.	Be able to manage routine antenatal care and be able to identify high risk situations. Be familiar with the role of U/S in fetal well-being assessment.	Be familiar with the use of appropriate protocols and guidelines.
Be familiar with the mechanisms of normal and abnormal labour and delivery.	Be familiar with a normal Vaginal Delivery. Be able to interpret at CTG.	Develop a realistic recognition of own competence level.
Develop Counselling Skills - especially in relation to: a. contraception choice; b. pre-conceptional health; c. menopausal health; d. postnatal care; e. choice of surgery; f. postoperative care.	Be able to give clear information and feedback, and share information with patients.	Be familiar in the selection of operative procedure with due regard to degree of urgency, likely pathology and anticipated prognosis. Recognition that decision making is a collaborative process between doctor and patient.

COMPETENCE LEVEL DESCRIPTORS

Clinical Skills Levels Descriptors:

Level	Descriptors
1	Able to describe the task
2	Able to apply the principles or theory of the specific task. May have seen the task being perform.
3	Have experience performing the task or perform under supervision.
4	Able to relate the theory and principles and indications of the specific task. Able to perform the task.

Student are required to acquire the following skills and demonstrate the same to their lecturer/Hospital specialist/consultant at the prescribed level and obtain a signature of knowing/performing the skill.

a) OUTPATIENTS CASES NOTED

No.	DATE	INTERESTING CASES SEEN (note at least two cases per session attended)	LEVEL TO ACHIEVE	ATTENDANCE CONFIRMED BY SPECIALIST
1.			4	
2.			4	
3.			4	
4.			4	

b) OPERATIONS OBSERVED

No.	Patient's Name	RN	Date	Diagnosis	Type of Surgery	Level to Achieve	Surgeon's Signature
1.						2	
2.						2	
3.						2	
4.						2	

c) WARD ROUND

INTERESTING CASES SEEN
(note at least two cases per session attended)

No.	Patient's Name	RN	Date	Diagnosis	Level to Achieve	Supervisor's Name	Sign
1.						4	
2.						4	
3.						4	
4.						4	

d) BEDSIDE TEACHING

No.	Patient's Name	RN	Date	Diagnosis	Level to Achieve	Supervisor's Name	Sign
1.	**CASE 1 GYNAE**				4		
2.	**CASE 2 GYNAE**				4		
3.	**CASE 1 OBSTET-RICS**				4		
4.	**CASE 2 OBSTET-RICS**				4		

CASE 1 GYNAE – (LEVEL 4)

IDENTIFICATION DATA
Patient's name Age Race
Address Last normal menstrual period
Date of admission Date of clerking

Pn. _____
Age ? yrs, Malay lady, Para ? , married for ? years / Last Child birth ? yrs
LMP : ? days flow, ? menorrhagia, ? dysmenorrhea (D?-D?)

HOPI
Main complaint – describe symptoms
describe severity of symptom
progression of symptoms

? Significant - ve – other related systems (eg. ? PCB, ? IMB, urinary tract, gastro-intestinal tract etc.)
? Significant +ve – eg. Warfarin therapy, h/o fall
? Constitutional symptoms - ? LOW, ? LOA, ? fever

Past Gynae History
Menstrual History : Menarche ? yr, menses 5 days normal flow with regular 28 days cycles, no menorrhagia, no dysmenorrhea, no PCB, no IMB, no STD. ? last PAP smear done on _____ was told normal. On ? contraception ? durations
Patient has no previous gynaecological problem and no previous gynaecological operation done before

Past Obstetric History (POH)
Deliveries - ? complications

Past Medical History
Patient has no DM, Hyptx, Asthma and no Heart disease.

Past Surgical History
Patient has no previous surgical problem and no previous surgical operation done before

Family History
Father ? yrs old. Mother ? yrs old. No Hyptx, DM, Asthma and Heart disease.
Patient 3rd of 5 siblings. All her siblings has no Hyptx, DM, Asthma and Heart disease.
No history of malignancy in the family.

Drug / Allergy History
Presently, patient is on T. Haematinic 1/1 od.
She has no history of allergy to drugs or sea-food.

Personal / Social History
Married for ? years
Occupation : patient and husband
Income : patient and husband
Education level : patient and husband
Bad habits (smoking, drink alcohol, drud abuse) : patient and husband
Environment live-in : House ? type, ? electricity/clean tap water supply/flushed toilet system
Distance from nearest Health Clinic/Hospital ? km
Support : Patient has good support from her mother, if needed.

Diet history : if indicated.

Systemic Reviews
Respiratory system
– ? Shortness of breath, ? wheezing, ? early morning coughs

Cardio vascular system
– ? palpitations, ? Orthopnea, ? PND

Abdominal / genito-urinary system
- ? Abdominal pain, ? vomiting, ? diarrhea, ? constipation, ? urinary frequency, ? dysuria, ? hesistancy, ? urgency

Central nervous system
- ? Headache, ? blurring of vision, ? fits, ? muscle weakness

Musculo-skeletal system
– ? Bone pains, ? joint pains, ? back pains, ? muscle pains

Endocrine system
– ? tremors, ? heat or cold intolerance, ? polydipsia / polyuria

Clinical Examination
General examination
Patient is comfortable, lying supine on bed, slight prop-up 30' and supported with 1 pillow.
She is not in pain or in any distress.
Her Bp was ? mmHg, PR was ? bpm, regular rhythm, normal volume. Patient is not dypsnic with RR of ? breath per min. She is afebrile with temperature of 37'C. Patient is normal built with wt of ? kg.
There is branula attachment over dorsum of her right hand, attached to a Dextrose Saline drip infusion.
There is no clubbing and no peripheral cyanosis. The capillary refill time was < 2 seconds.
She is not pale and no jaundice.
Her hydration status was good. Her oral hygine was good. There is no central cyanosis and no dentures.
There is no goitre and her JVP was not raised. Supra-clavicular and cervical lymph-nodes are not palpable.
There is no ankle edema blateral

Other systems examination
Respiratory system
The air-entry was equal bilateral. Lungs were clear bilateral. There was no crepitations and no rhonchi.

Cardio-vascular system
1st and 2nd heart sound was heard and normal. There was no murmurs.

Breasts examination
The breasts were symmetrical bilateral. The nipples were everted and not deviated. There was no nipple discharge. No mass palpable bilaterally.

Specific system examination
Abdomen examination
The abdomen appear fullness over the supra-pubic region. The abdomen moves symmetrical with respiration. The umbilicus is centrally placed and flat. There is no dilated veins, no pulsatile mass seen. There is no surgical scar seen and cough impulse was negative.
The abdomen was soft and non-tender.
There was a mass palpable over the supra-pubic region, correspond to 14 weeks uterus, centrally placed, firm in consistency, non-tender, smooth surface, well-defined margin, measuring 14cm x 12cm, mobile side-ways but not up-and-down. I could not get below the mass.

Liver and spleen were not palpable. Both kidneys were not ballotable.
Shifting dullness was negative.
Bowel sound was heard and normal. There was no bruit heard over the abdominal mass.
I would like to complete my examination with speculumn examination and vaginal examination.

PROVISIONAL DIAGNOSIS :

1.
2.

Differential Diagnosis : (if any)
1.
2.

Investigations
- Blood
- Urine
- Others
  - HVS C&S
  - PAP smear ---> PAP smear result
  - Pipelle endometrial sampling --> HPE report
- Imaging
  - Ultrasound pelvic/abdominal Scan,
  - CXR,
  - CTTAP / MRI

Your management plan for this patient (immediate and subsequent management)

Management and progress of patient in wad

Follow-ups

Discussion

Conclusion / Learning points

References:

References:

Discharge summary

Referral letter (for continue management)

Mock prescription slip (for patient on discharge)

Professional component – reflection of case

Communication issues:

Spiritual issues:

Ethical issues:

Professional judgement:

Critical appraisals (what have you learn from this case)

CASE 1 OBSTETRICS - (LEVEL 4)

IDENTIFICATION DATA

Patient's name Age Race
Address Gravidity Parity
Last normal menstrual period Expected date of delivery
Periods of gestation
Date of admission Date of clerking

Pn. _____
Age ____ yr, Malay lady, Gravida ___ + Para____ at ___ POA
LMP: _____, EDD: _____ - (Sure of date, early UPT done at 6 weeks +ve, early scan dating done at 10 weeks POA equals to date).

HOPI
Main complaint – describe symptoms
describe severity of symptom
progression of symptom

? any Abdominal pain, ? LL, ? Fetal movements good
? any Significant - ve – other related systems (eg. urinary tract, gastro-intestinal tract etc.)
? any Significant +ve – eg. h/o abdominal massage, h/o fall or trauma to abdomen.

Antenatal History

This is a planned and wanted pregnancy.
Scan done at booking ? POG
Her first booking was at ? POA - ? booking BP, ? Wt/BMI, ? Ur test done alb/sugar, ? VDRL/HIV screen, ? Hb
Total number of AN follow-ups, on each f/ups ? BP, ?urine alb/sugar, ? fundal height, ? FM, ? weight gain ? any excessive early pregnancy symptoms, quickening felt ? POA, im ATT give at ? POA.
Patient has another ? scans done at ? POA, ? findings, latest scan done at ? POA findings was ?
Serial Hb done at ? POA, ? findings, her latest Hb at ? POA was ?
? admission at ? POA, ? diagnosis, ? treatment given, ? duration stay in wad
On her last Antenatal follow-up at ? POA on day of present admission, she was noted to have ? problem and referred for further management of her problem.

Past Obstetric History (POH)
Previous deliveries - ? complications
On ? Contraception after deliveries, ? duration
Past Gynae History
Menarche ? yr, menses 5 days normal flow with regular 28 days cycles, no menorrhagia, no dysmenorrhea, no PCB, no IMB, no STD. ? last PAP smear done on _____ was told normal.
Patient has no previous gynaecological problem and no previous gynaecological operation done before

Past Medical History
Patient has no DM, Hyptx, Asthma and no Heart disease.

Past Surgical History
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Family History
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Patient 3rd of 5 siblings. All her siblings has no Hyptx, DM, Asthma and Heart disease.

Drug / Allergy History
Presently, patient is on T. Haematinic 1/1 od.
She has no history of allergy to drugs or sea-food.

Personal / Social History
Married for ? years
Occupation : patient and husband
Income : patient and husband
Education level : patient and husband
Bad habits (smoking, drink alcohol, drud abuse) : patient and husband
Environment live-in : House ? type, ? electricity/clean tap water supply/flushed toilet system
Distance from nearest Health Clinic/Hospital ? km
Wishes : to have ? children
Support : Patient has good support from her mother, if needed.
Diet history : if indicated.

Systemic Reviews
Respiratory system
– ? Shortness of breath, ? wheezing, ? early morning coughs

Cardio vascular system
– ? palpitations, ? Orthopnea, ? PND

Abdominal / genito-urinary system
- ? Abdominal pain, ? vomiting, ? diarrhea, ? constipation, ? urinary frequency, ? dysuria, ? hesistancy, ?

urgency

Central nervous system
- ? Headache, ? blurring of vision, ? fits, ? muscle weakness

Musculo-skeletal system
– ? Bone pains, ? joint pains, ? back pains, ? muscle pains

Endocrine system
– ? tremors, ? heat or cold intolerance, ? polydipsia / polyuria

Clinical Examination
General examination
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She is not in pain or in any distress.
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There is branula attachment over dorsum of her right hand, attached to a Dextrose Saline drip infusion.
There is no clubbing and no peripheral cyanosis. The capillary refill time was < 2 seconds.
She is not pale and no jaundice.
Her hydration status was good. Her oral hygine was good. There is no central cyanosis and no dentures.
There is no goitre and her JVP was not raised.
There is no ankle edema blateral

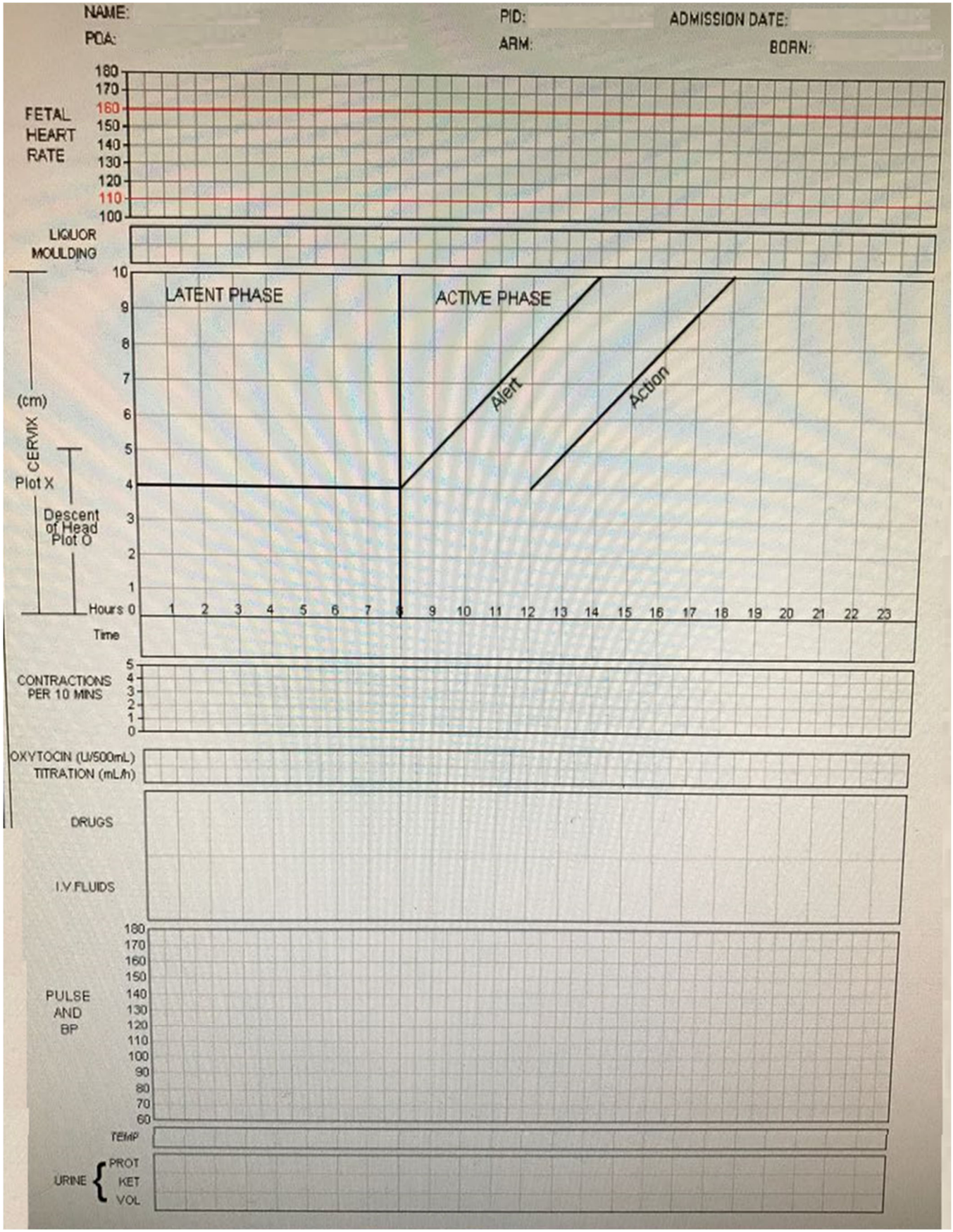
Other systems examination
Respiratory system
The air-entry was equal bilateral. Lungs were clear bilateral. There is no crepitations and no rhonchi.

Cardio-vascular system
1st and 2nd heart sound was heard and normal. There was no murmurs.

Breasts examination
The breasts were symmetrical bilateral. The nipples were everted and not deviated. There was no nipple discharge. No mass palpable bilaterally.

Specific system examination
Abdomen examination
The abdomen is distended with a gravid uterus, as evidence by linea nigra and striae gravidarum. The abdomen moves symmetrical with respiration. The umbilicus is centrally placed and flat. There is no dilated veins, no pulsatile mass and no fetal movement seen. There is no surgical scar seen and cough impulse was negative.
The abdomen was soft and non-tender. The uterus was soft and non-tender. No contractions felt.
The uterus is 36 weeks with symphysio-fundal height measuring 36 cm, and correspond to dates. There is a singleton fetus, in longitudinal lie with cephalic presentation, the head is not engaged and 4/5 palpable. The fetal back is on the maternal left. Liquor is clinically adequate. The estimated fetal weight was 2.8 kg. The fetal heart rate was 145 bpm and regular.

I would like to complete my examination with a vaginal examination (speculumn examination and vaginal examination - in PPROM, PROM).



Age ____ yr, Gravida ___ + Para____ at ___ POA

1.
2.
3.

Investigations
- Blood
- Urine
- Others: eg. HVS C&S, ECG
- CTG
- Abdominal ultrasound Scan

Your management plan for this patient (immediate and subsequent management)

Management and progress of patient in wad

Follow-ups

Discussion

Conclusion

References:

Discharge summary

Referral letter (for continue management)

Mock prescription slip (for patient on discharge)

Professional component – reflection of case
- Communication issues:
- Spiritual issues:
- Ethical issues:
- Professional judgement:

Critical appraisals (what have you learn from this case)

e) Deliveries

In each blank you should write:
a. The name of the patient
b. Date of the admission or attendance
c. Diagnosis
d. Case sheet No.

	DATE	NORMAL DELIVERY OBSERVED	LEVEL TO ACHIEVE	ATTENDANCE TO BE CON-FIRMED BY MEDICAL OFFICER
1.			3	
2.			3	
3.			3	
4.			3	
5.		**EPISIOTOMY SUTURING**	3	
6.		**EPISIOTOMY SUTURING**	3	
7.		**EPISIOTOMY SUTURING**	3	
8.		**EPISIOTOMY SUTURING**	3	

	DATE	CAESAREAN DELIVERY OB-SERVED	INDICATIONS	LEVEL TO ACHIEVE	ATTENDANCE TO BE CONFIRMED BY SURGEON
1.				2	
2.				2	
3.				2	
4.				2	

	DATE	OTHER ABNORMAL DELIVERY OBSERVED	INDICATIONS	LEVEL TO ACHIEVE	ATTENDANCE TO BE CONFIRMED BY SURGEON
1.		**FORCEPS DELIVERY**		2	
2.		**FORCEPS DELIVERY**		2	
3.		**VACUUM DELIVERY**		2	
4.		**VACUUM DELIVERY**		2	

f) RECORDS OF PROCEDURES
(note at least two cases per session attended should be observed)

f) BASIC SKILLS

SKILLS	SESSION 1	SESSION 2	SESSION 3	SESSION 4	LEVEL TO ACHIEVE	SIGNATURE CONFIRMED BY MEDICAL OFFICER
P.V examination Bimanual examination					3	
Cusco speculum examination					3	
Insertion of I.V canula					4	
Taking blood sample					4	
Urethral Catheterization					4	

f) OBSTETRICS
(note at least two cases per session attended should be observed)

SKILLS	SESSION 1	SESSION 2	SESSION 3	SESSION 4	LEVEL TO ACHIEVE	SIGNATURE CONFIRMED BY MEDICAL OFFICER
Antenatal care (B.P, weight, height, obstetric abdominal examination)					3	
Postnatal examination					3	
CTG Interpretation					3	
2nd Trimester U/S Scan					2	
Doppler U/S Studies					2	

f) Gynaecology

(note at least two cases per session attended should be observed)

SKILLS	SESSION 1	SESSION 2	SESSION 3	SESSION 4	LEVEL TO ACHIEVE	SIGNATURE CONFIRMED BY MEDICAL OFFICER
Contraception					2	
High Vaginal Swab					2	
D & C (endometrial bi-opsy)					2	
PAP Smear					2	
Colposcopy					2	

g) ADDITIONAL OBSERVED PROCEDURES - OBSTETRIC

SKILLS	SESSION 1	SESSION 2	SESSION 3	LEVEL TO ACHIEVE	SIGNATURE CONFIRMED BY MEDICAL OFFICER
Induction of labour				2	
Augmentation of labour				2	
Amniotomy				2	
External cephalic version (ECV)				2	
Delivery of placenta (CCT)				3	
Manual removal of placenta				2	
Magnesium sulphate preparation				2	
Neonatal Resuscitation				1	
Neonatal Assessment				1	

g) ADDITIONAL OBSERVED PROCEDURES - GYNAECOLOGY (OPERATIVE)

SKILLS	SESSION 1	SESSION 2	SESSION 3	LEVEL TO ACHIEVE	SIGNATURE CONFIRMED BY MEDICAL OFFICER
Dilatation and curettage				2	
Hysteroscopy				2	
Laparoscopic procedures - Cystectomy - Tubal patency test - Salpingectomy				2	
Hysterectomy - Vaginal - Transabdominal - Laparoscopic				2	
Myomectomy - Transabdominal - Laparoscopic				2	
Preoperative preparation - Preoperative counselling and assessment - Informed consent				2	
Baby Friendly Hospital Initiative (BFHI) and counselling for breast-feeding.				2	

h) SEMINARS

NO.	DATE	TITLE / SUMMARY	LEARNING POINTS	LEVEL TO ACHIEVE	ASSESSMENT	LECTURER'S SIGNATURE
1.				4		
2.				4		
3.				4		
4.				4		

N.B.

Slides must be attached.

i) TASK-BASED LEARNING (TBL) - (one case) (LEVEL 4)

✍ **Case presentation:**

✍ **Differential Diagnosis:**

✍ **Diagnosis:**

✍ **Investigations:**

✍ **Treatment:**

LOG BOOK ASSESSMENT

	Type	Poor <40%	Satisfactory 40-75%	Excellent >75%
A	**OUTPATIENTS CASES NOTED**	0	1	2
B	**OPERATIONS OBSERVED**	0	1	2
C	**WARD ROUND**	0	1	2
D	**BEDSIDE TEACHING**	0	1	2
E	**DELIVERIES (OBSERVED)**	0	1	2
F	**RECORD OF PROCEDURES (OBSERVED)**	0	1	2
G	**ADDITIONAL PROCEDURES (OBSERVED)**	0	1	2
H	**SEMINARS (4)**	0	1	2
I	**TASK-BASED LEARNING (TBL)**	0	1	2

Total : **Percentage:** **%** **Assessment component:**

Assessor's Signature:

Name/Signature:

Date: