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Course Webpage

The website for OBST 7500 is a 2.4 Moodle site. To access the website:

1. Go to https://ay14.moodle.umn.edu/my/
2. Login using your x.500.
3. Search ‘Course overview’ for OBST 7500

If you do not see the course on the Moodle site please contact the course coordinator at egger016@umn.edu to ensure that you are on the course roster. You may also contact Moodle help site moodle@umn.edu.

Changes to this site are underway. The Medical School will be switching to LCMS+ for the AY 2014-15. Our Moodle site will stay current until the switch is made. Students will be notified at that time.
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SECTION I. INTRODUCTION

Department Vision

Define the standard of care for all women, today and tomorrow.

Program Mission Statement

The Department of Obstetrics, Gynecology, and Women’s Health strives to optimize women’s health care by preparing medical students to provide compassionate, appropriate, and effective care for women throughout their careers.
SECTION II. CLERKSHIP SITE CONTACTS

Duluth
Site Director (St. Luke’s): Melissa Miller, M.D.
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  Site Coordinator: Paula Guisfredi
  Phone: 218-726-7034
  Email: pguisfre@d.umn.edu

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Site Director: Virginia Lupo, M.D.
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  Site Coordinator: Leslie Booker
  Phone: 612-873-2750  Fax: 612-904-4274
  Email: Leslie.Booker@hcmed.org

Methodist Hospital
Site Director: David Brown, M.D.
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  Site Coordinator: Cherie Kammerer
  Phone: 952-993-5135
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Regions Hospital
Site Director: Abby Mello, M.D.
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  Site Coordinator: JoEllyn Pilarski
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Site Director: David Kroska, M.D.
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University of Minnesota Medical Center - Fairview
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   Site Coordinator: Deborah Egger-Smith
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   Email: egger016@umn.edu

St. John’s Hospital
Site Director: Megan McEllistrem-Ramirez, M.D.
Pager: 651-339-4356

Unity Hospital
Site Director: Nick Hamel, M.D.
Pager: 612-539-6866

John Haugen and Associates - Edina
Site Directors: Hope Frisch Kalin, M.D.
                   Andrea Flom, M.D.
Email: hopefrisch@yahoo.com
       andreaflom@aol.com

Maple Grove, Park Nicollet Clinic and Maple Grove Hospital
Site Director: Christine Goudge, M.D.
Email: csgoudge@yahoo.com
### SECTION III. CURRICULUM AND EVALUATION

**Medical School Objectives**

Graduates of the University of Minnesota Medical School should be able to:

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>ACGME ESSENTIAL COMPETENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate mastery of key concepts and principles in the basic sciences and clinical disciplines that are the basis of current and future medical practice.</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>2. Demonstrate mastery of key concepts and principles of other sciences and humanities that apply to current and future medical practice, including epidemiology, biostatistics, healthcare delivery and finance, ethics, human behavior, nutrition, preventive medicine, and the cultural contexts of medical care.</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>3. Competently gather and present in oral and written form relevant patient information through the performance of a complete history and physical examination.</td>
<td>Patient Care; Interpersonal and Communication Skills</td>
</tr>
<tr>
<td>4. Competently establish a doctor-patient relationship that facilitates patients’ abilities to effectively contribute to the decision making and management of their own health maintenance and disease treatment.</td>
<td>Patient Care; Interpersonal and Communication Skills</td>
</tr>
<tr>
<td>5. Competently diagnose and manage common medical problems in patients.</td>
<td>Medical Knowledge; Patient Care</td>
</tr>
<tr>
<td>6. Assist in the diagnosis and management of uncommon medical problems; and, through knowing the limits of her/his own knowledge, adequately determine the need for referral.</td>
<td>Medical Knowledge; Patient Care; Practice-Based Learning and Improvement</td>
</tr>
</tbody>
</table>
7. Begin to individualize care through integration of knowledge from the basic sciences, clinical disciplines, evidence-based medicine, and population-based medicine with specific information about the patient and patient’s life situation.

8. Demonstrate competence practicing in ambulatory and hospital settings, effectively working with other health professionals in a team approach toward integrative care.

9. Demonstrate basic understanding of health systems and how physicians can work effectively in health care organizations, including:
   - Use of electronic communication and database management for patient care.
   - Quality assessment and improvement.
   - Cost-effectiveness of health interventions.
   - Assessment of patient satisfaction.
   - Identification and alleviation of medical errors.

10. Competently evaluate and manage medical information.

11. Uphold and demonstrate in action/practice basic precepts of the medical profession: altruism, respect, compassion, honesty, integrity and confidentiality.

12. Exhibit the beginning of a pattern of continuous learning and self-care through self-directed learning and systematic reflection on their experiences.

13. Demonstrate a basic understanding of the healthcare needs of society and a commitment to contribute to society both in the medical field and in the broader contexts of society needs.
Clerkship Objectives

The objectives for this clerkship were developed by the Association of Professors in Gynecology and Obstetrics. They are used by clerkships across the country and represent the consensus of national leaders in obstetrics and gynecology education. Thoroughly covering these objectives will leave you well-prepared for your final exams.

An abbreviated outline is listed here. You **MUST** review the detailed outline with specific objectives, which you will find on the Moodle site.

Unit One: Approach to the Patient
1) History
2) Examination
3) Pap Smear and Cultures
4) Diagnosis and Management Plan
5) Personal Interaction and Communication Skills
6) Legal and Ethics Issues in Obstetrics and Gynecology
7) Preventive Care and Health Maintenance

Unit Two: Obstetrics
Section A: Normal Obstetrics
8) Maternal-Fetal Physiology
9) Preconception Care
10) Antepartum Care
11) Intrapartum Care
12) Immediate Care of the Newborn
13) Postpartum Care
14) Lactation

Section B: Abnormal Obstetrics
15) Ectopic Pregnancy
16) Spontaneous Abortion
17) Medical and Surgical Conditions in Pregnancy
18) Preeclampsia-Eclampsia Syndrome
19) Isoimmunization
20) Multifetal Gestation
21) Fetal Death
22) Abnormal Labor
23) Third-Trimester Bleeding
24) Preterm Labor
25) Preterm Rupture of Membranes
26) Intrapartum Fetal Surveillance
27) Postpartum Hemorrhage
28) Postpartum Infection
29) Anxiety and Depression
30) Postterm Pregnancy
31) Fetal Growth Abnormalities

Section C: Procedures
32) Obstetric Procedures

Unit Three: Gynecology
Section A: General Gynecology
33) Contraception and Sterilization
34) Abortion
35) Vulvar and Vaginal Disease
36) Sexually Transmitted Infections and Urinary Tract Infections
37) Pelvic Relaxation and Urinary Incontinence
38) Endometriosis
39) Chronic Pelvic Pain

Section B: Breasts
40) Disorders of the Breast

Section C: Procedures
41) Gynecological Procedures

Unit Four: Reproductive Endocrinology, Infertility, and Related Topics
42) Puberty
43) Amenorrhea
44) Hirsutism and Virilization
45) Normal and Abnormal Uterine Bleeding
46) Dysmenorrhea
47) Menopause
48) Infertility
49) Premenstrual Syndrome and Premenstrual Dysphoric Disorder

Unit Five: Neoplasia
50) Gestational Trophoblastic Neoplasia
51) Vulvar Neoplasms
52) Cervical Disease and Neoplasia
53) Uterine Leiomyomas
54) Endometrial Carcinoma
55) Ovarian Neoplasms

Unit Six: Human Sexuality
56) Sexuality and modes of Sexual Expression

Unit Seven: Violence Against Women
57) Sexual Assault
58) Domestic Violence
Clerkship Requirements

Didactic Lectures
On the first day of your rotation, you must attend a series of live lectures. You must sign in to this event in order to receive credit. An unexcused absence from day 1 orientation will result in a 3-point deduction from your total points for the period.
There are additional lectures, recorded by faculty members in the department, available on the Moodle site. These lectures may be reviewed at the convenience of each student, but all lectures MUST be reviewed.

Grand Rounds
Students will be required to attend one Grand Rounds during the clerkship. You must sign in to Day One Lectures and Grand Rounds. If you do not sign in, you will not receive credit, no exceptions. Failure to attend Grand Rounds will result in a 3 point deduction from your total points for the period.

Grand Rounds are held at the Brennan Center on the UMMC-Fairview Riverside Campus. The Brennan Center is located on the main floor of the East Hospital Building. The schedule for 2014-2015 Grand Rounds is listed below. The schedule will also be announced at Day One Lectures, and you will receive an e-mail reminder with the topic of discussion, parking information and directions.

<table>
<thead>
<tr>
<th>Period</th>
<th>Mandatory Grand Rounds Date</th>
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<tbody>
<tr>
<td>Period 1</td>
<td>June 17, 2014</td>
</tr>
<tr>
<td>Period 2</td>
<td>August 19, 2014</td>
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<tr>
<td>Period 3</td>
<td>No Grand Rounds due to Peri Op Services</td>
</tr>
<tr>
<td>Period 4</td>
<td>October 21, 2014</td>
</tr>
<tr>
<td>Period 5</td>
<td>December 16, 2014</td>
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<tr>
<td>Period 6</td>
<td>January 20, 2015</td>
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<tr>
<td>Period 7</td>
<td>March 17, 2015</td>
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<tr>
<td>Period 8</td>
<td>April 21, 2015</td>
</tr>
</tbody>
</table>
Clinical Responsibilities
The Department of Obstetrics, Gynecology and Women’s Health places medical students at 11 different hospital sites. The number of patients seen, the types of problems encountered, and the number of gynecological and obstetrical procedures done will vary by site and by time of year. Even though the types of experiences you and your classmates have will vary, each site is operating under the same set of goals and objectives set forth by our department.

Tracking Clinic Procedures
While in clinic, you must track your experiences using E*Value software module called PxDx. Instructions are listed on the Moodle site. The department faculty has determined that the procedures listed on PxDx are necessary for all students to experience in order to meet the objectives of the course. Tracking procedures helps direct students and preceptors to learning opportunities, and it also informs the Clerkship Director if sites are not meeting our clerkship objectives.

Tracking your procedures will not count towards your final grade, but it should be used to direct your learning. Call nights are often an excellent time to experience some of the procedure requirements.

Mid-Rotation Evaluation
At the mid-point of the rotation, you will be required to meet with your clinical preceptor and/or resident in order to discuss your performance and complete a mid-rotation evaluation form (available on the Moodle site). Before this meeting, you should rate your own performance. You should be ready to discuss procedures or clinical patients with your preceptor, so that your preceptor can help expose you to the procedures you have not yet seen. The mid-rotation evaluation is not an indicator of your final grade. It is a tool designed to show you your current strengths and weaknesses and give you a chance to improve in the rest of the rotation. It will be your responsibility to make sure your preceptor evaluates you mid-rotation using this form! You must return the mid-rotation evaluation form to the Medical Student Coordinator by the given deadline.
Problem-Based Learning
All students enrolled in the clerkship will attend problem-based learning sessions. These PBL sessions are facilitated by a faculty member, and they are designed to improve your communication and problem-solving skills, as well as clinical medicine knowledge.

You will work through ten cases during your clerkship. You will be given copies of the cases in advance so you may prepare for discussion.

Sessions are generally held weekly, although faculty members may adapt the schedule at their discretion. PBL schedules will be distributed on the second day of the rotation at your site orientation.

NBME Shelf Exam
On the last day of the rotation, in the afternoon, students will take the National Board of Medical Examiners' Subject Examination in Obstetrics and Gynecology.

Medical students are expected to take the examination for required clerkships on the designated date. A medical student who is not able to take the shelf examination for a required clerkship on the designated date, due to an unforeseen emergency (e.g. illness or extraordinary circumstances), must request permission from the clerkship director to take the shelf examination when it is next scheduled. All effort should be made to take the exam on the next available date. The examination is obtained from the National Board of Medical Examiners and can only be taken on regularly scheduled dates. Students will receive a grade of "incomplete" until the results of the make-up test are known and a new grade is assigned.

All students must pass the NBME Subject Exam in Obstetrics and Gynecology (the "shelf exam") to pass the course. You must earn a score of 60 or better to pass the exam. If you fail the exam once you will have an opportunity to retake the exam. A second failure will result in failure of the clerkship. (Please note: Students who fail the exam with a score below 60,
but pass the clerkship, will re-take the exam as stated above. Students who fail the exam, and receive a cumulative score prior to extra credit of below 65.9 for the clerkship course, will repeat the clerkship.)

Optional clinical training
If you are interested in doing optional pregnancy termination training, please let the Medical Student Coordinator know as soon as possible (preferably before the rotation begins). We will arrange for you to spend one to two days of the rotation working at Whole Woman’s Health Clinic in downtown Minneapolis. Space is limited and we cannot guarantee availability for this training.

Extra Credit Reflective Writing Paper
Students will have the opportunity to earn 1-3 extra credit points by writing essay of reflective writing. The subject matter of the paper must address an ethical or professionalism incident that was encountered during the OB/GYN Women’s Health rotation. The paper will be evaluated by three faculty.

Topics should be reflective of students’ response to interactions with patients, faculty, residents, fellows, students and/or a personal reaction to situations that occurred during this rotation. Grading criteria are technical and clarity, insight and humanism. Other criteria: 1-2 pages, double spaced, Times New Roman, 12 pt. Please be sure your name is on the paper. Papers must be emailed to the course coordinator by the date of the final exam.

Evaluation & Grading
Clinical Evaluation Score (51%)
Your clinical performance is evaluated with the standard Medical School Clinic Evaluation. Your evaluator can evaluate you on fifteen items, each using a four-point scale. A raw clinic ratio is determined by dividing the total number of points earned by the maximum possible points the student could have received. (A question skipped by the evaluator does not affect the raw clinic ratio.)
The raw ratio is translated into a final clinical evaluation score using a normalized scale. The normalized scale was determined so that a “2” on the evaluation corresponds to a 70%, a “3” corresponds to roughly 87%, and a “4” translates to 100%. The clinic score is worth a maximum of 51 points towards the final score.

Example: If an evaluator responds to 14 of the 15 items on the evaluation, the student can earn a maximum of 56 points (4*14). If the student receives 48 of the 56 maximum points, his/her raw clinic score is 48/56 = 0.857. That raw score translates to a 93.3% on the normalized scale, so the student will receive .933 * 51 = 47.58.

**NBME Shelf Exam- 41%**
Your shelf exam is worth 41 maximum points on your final grade. Your points are calculated by multiplying your raw exam score by 0.41.

**Problem-Based Learning (PBL) (8%)**
Based on your performance in PBL, you earn between 0 and 8 points. The points are determined by the PBL instructor’s review and evaluation.

**Day 1 Orientation and Grand Rounds Attendance**
If you do not attend Day 1 Orientation and/or Grand Rounds as required, you will lose 3 points for orientation and 3 points for Grand Rounds from your final score.

**Final Grades**
Your final score is determined by adding your shelf exam points, clinic points, and PBL points (three points are subtracted for missing grand rounds, two points deducted for missing day 1 orientation). Extra Credit is added after a passing grade is determined. Student cannot pass the course based on extra credit, but can increase an already passing score. Students receive an H for
honors, E for excellent, S for satisfactory, or N for failing based on the following grading scale:

Scores greater than or equal to 90.0    Honors
Scores between 82.0 and 89.99    Excellent
Scores between 65.9 and 81.99    Satisfactory
Scores less than 65.9    Fail

We respect the integrity and thoughtfulness of our site directors in determining the final grade for students. Grades are final!

Minimum Passing Requirements for OB 7500:
The course director, in conjunction with the site director, reverses the right to determine a non-passing score for any student who:

- Fails in clinical performance with a score less than 35.70 (70%)
- Receives a "Below expectations" in professionalism on any evaluation
- Failure of the NBME Shelf exam twice
- Lack of attendance (unexcused or excessive absence of 2 weeks or more) during the clerkship
- Fails to make-up work if absent more than 0.5 days/week (required courses only) within 90 days or have an approved make-up plan within 30 days.

The Obstetrics and Gynecology clerkship requires students to score at least 65.9 points (prior to extra credit) as a total score to pass the clerkship. In addition, students must pass the shelf exam (score 60 or higher) to pass the course.
SECTION IV. GENERAL POLICIES AND PROCEDURES

Checking Your Email

The clerkship coordinator communicates with students solely via email. You are responsible for abiding by the University’s email policy:

A University-assigned student email account shall be the University’s official means of communication with all students on the Twin Cities campus. Students are responsible for all information sent to them via their University assigned email account. If a student chooses to forward their University email account, he or she is responsible for all information, including attachments, sent to any other email account.

Attendance

No student shall miss more than 3 full weekdays of the OBST 7500 rotation. Time off must be requested in advance. Follow the instructions emailed to you by the clerkship coordinator before the course to request time off. Absences in excess of the maximum will be addressed on a case-by-case basis by the Clerkship Director. Site coordinators will notify the Clerkship Director of any absences in excess of the 3-day maximum. Make up time for absences in excess of 3 days will be at the discretion of the site director with approval from the clerkship director. Time must be made up no more than 90 days after the end of the rotation, or students must have an approved make-up plan in place within 30 days. If the time is not made up within the 90 days or no plan is in place to complete the course work required, a failure will be given for the course and you will need to re-take the entire clerkship.

Students may also request weekend days off, but all will be expected to take a fair share of Friday and weekend night call (at least two Friday or weekend nights during the rotation).
If illness or emergency prevents you from performing your duties, you must notify the Medical Student Coordinator (612-626-4939) and your site coordinator or preceptor. Failure to notify these individuals will result in a 'below expectation' score on professionalism and a possible failure in the course.

Students are required to attend the lectures on the first day of the course and one Grand Rounds during the rotation. **Missing these events will result in a grade deduction.**

**Medical Student Professionalism Code**

The Department of Obstetrics, Gynecology, and Women’s Health expects that students will abide by the following professionalism code, developed at the University of Minnesota Medical School:

“As medical students in lecture, small group, an administrator's office, clinic, or the hospital, whether patients are in the room or not, we are professionals and will strive to act as such. We recognize that the behavior and attitudes of the individual medical students reflect back on our classmates, our school, and our profession.

Professionalism should be integral to the relationship between students and physicians, among students, and among physicians. Students often model their professional behavior and attitudes on what they see in resident and faculty behavior. We will do our best to nurture an environment of mutual respect.

We will endeavor to uphold the following tenets of professionalism:
- Be on time.
- Prepare for class, small groups, clinic, and rounds.
• Treat all patients, faculty, staff, classmates, medical specialties, and health care team members with respect and consideration, without regard to gender, age, race, religion, ethnicity, class or sexual orientation.
• Dress appropriately, including wearing a clean white coat and/or appropriate identification during all anticipated patient contact.
• Respect that faculty have devoted their time to teaching medical students in lectures, small groups, clinics, and hospitals.
• Commit to lifelong learning.
• Assist others.
• Protect patient confidentiality.
• Fulfill responsibilities assigned to us with careful consideration of consequences to both patients and colleagues.
• Consult with those more knowledgeable when necessary.
• Adhere to the highest standard of integrity and honesty in all professional relationships, including those with pharmaceutical and industry representatives.
• Show respect in all oral, written, and e-mail communications, including patient presentations, course evaluations and test question challenge forms.

In conclusion, we embrace the professional virtues of honesty, compassion, integrity, fidelity, and dependability.”

Professionalism and Women’s Health

The University of Minnesota Medical School expects that you will demonstrate professionalism in all of your clinical rotations. You are expected to uphold the basic values of the medical profession: altruism, respect, compassion, honesty, integrity, and confidentiality. Because of the intimate nature of breast and pelvic examinations, your clerkship in women’s health requires the utmost professional conduct.

It is essential that you comply graciously with your patient’s wishes. Most patients will gladly accept your involvement in their care, but it is always a
patient’s choice. You must have a chaperone present when performing breast and pelvic examinations. Also, before beginning the rotation, you must review the Policy on Performing Pelvic Exams on Anesthetized Patients, available on the Moodle course site.

As a reminder, the following are required objectives, related to professionalism, of the obstetrics and gynecology clerkship:

1. Establish rapport with patients.

2. Demonstrate interpersonal and communication skills that build trust by addressing contextual factors (e.g. culture, ethnicity, language/literacy, socioeconomic class, spirituality/religion, age, sexual orientation, disability).

3. Interact with the patient to gain her confidence and cooperation, and assure her comfort and modesty.

4. Work cooperatively with patients, their social supports and other members of the health care team.

5. Assess your own strengths and weaknesses with regard to personal interactions.

**Dress Code Policy**

Medical students are expected to be neat, clean, and orderly at all times during the performance of training program activities. Jewelry, clothes, hairstyle and fragrances should be appropriate for the performance of duties in the hospital or clinic.

The student’s identification badge is to be worn whenever the student is involved in clinical or administrative duties.
Medical students are expected to dress according to generally accepted professional standards appropriate for their training program. Each training program may set more specific guidelines for dress code standards in its program. Where safety is a factor, students should use common sense in choosing clothing and shoes for training activities. Scrub suits are appropriate for designated areas, e.g. Operating Room, Labor & Delivery. In all other areas, a white coat must be worn over the scrub suit. Scrubs may not be worn into the hospital from home.
Duty Hours Policy

Medical students will follow the ACGME duty hours policy that applies to all residents at the University.

Duty hours are defined as all clinical and academic activities related to the education program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Students must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

A 10 hour time period for rest and personal activities must be provided between all daily duty periods, and after in-house call.

In-house call must occur no more frequently than every third night, averaged over a four-week period. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Students may remain on duty for up to 4 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, conduct outpatient continuity clinics, and maintain continuity of medical and surgical care.
Legal Considerations

Unfortunately, the practice of obstetrics and gynecology is a high-risk business from a litigation standpoint. A few common-sense rules will help keep you out of legal trouble:

1. **Check out all patients** to a midwife, nurse practitioner, resident or faculty and get all notes co-signed immediately.
2. **Never do a pelvic examination on a patient alone.** This is the proper method, not only for your protection but also for patient comfort during such an exam. In labor and delivery, make sure a nurse, midwife, or physician is present whenever you perform a vaginal examination.
3. **Never** do a vaginal delivery unsupervised! About 85% of all practicing obstetricians have been sued for bad outcomes associated with pregnancy. A certified nurse midwife or a physician should be present and supervising you during all obstetric procedures. If you write a delivery note and that supervising individual has disappeared, **take the time to find them to sign that note.** If the delivery has an untoward outcome, this may be the only evidence you have as to who was, in fact, supervising you. Don’t assume that you or the supervising person will remember, because charges are often brought years after the delivery occurs.
4. **When in doubt, check it out!** There is a supervisor in every area where you will be functioning and your level of autonomy is increased based upon the supervisor’s evaluation of your ability to accept responsibility. If you feel uncomfortable, **demand that they check you.** If you are not sure, **demand that they check you.** If you think something is wrong, **demand that they check you.** In addition to patient care, you are here to learn, and it is our responsibility to make sure that you learn correctly.
Protocol for Exposure to Blood Borne Pathogens During Educational Experiences

1. Perform basic first aid immediately as instructed in the student orientations prior to rotations.
   - Clean the wound, skin or mucous membrane immediately with soap and running water. Allow blood to flow freely from the wound. Do not attempt to squeeze or "milk" blood from the wound.
   - If exposure is to the eyes, flush eyes with water or normal saline solution for several minutes.

2. All students on an educational rotation in the State of Minnesota will contact the Boynton Health Service (BHS) 24-Hour Triage Nurse immediately at calling (612) 625-7900 and notify his/her preceptor at the site. The student will identify him/herself as having a blood-borne pathogen exposure.
   - The BHS Triage Nurse will take the student through a rapid assessment about risk status and direct the student where to seek treatment.
   - Students will be expected to contact BHS immediately because of the need for rapid assessment about prophylactic medications, rapid prescribing of medications, if indicated, and the limited capacity of a student to assess his/her own injury.
   - With assistance of the BHS 24-Hour Triage Nurse and the student's preceptor or other designated person, the student will attempt to secure pertinent information about the source patient information for discussion during the risk assessment.

3. Standard employee procedures of institution where exposure occurs will be used for initial assessment of the source patient. (Permission form, what blood assays to draw, etc.) The standard procedures typically include the following information:
   - When: Approximate time of exposure
   - Where: Location of exposure (e.g., hospital, office, clinic, etc.)
• What: Source of the exposure (e.g., blood, contaminated instrument, etc.)
• How and How Long: Skin, mucous membrane, percutaneous; and how long (e.g., seconds/minutes/hours), exposure time
• Type of device
• Status of the patient: negative, positive, unknown HIV/Hepatitis B/Hepatitis C status
  o Whether or not patient is at risk for HIV, Hepatitis B or Hepatitis C infection
  o Multiple blood transfusions (1978-1985)
  o IV Drug User
  o Multiple sexual partners, homosexual activity
  o Known HIV positive/and/or have symptoms of AIDS
  o Significant blood or body fluid exposure

4. If the student is assessed at high risk for HIV infection following rapid assessment, the student should seek prophylactic medication treatment immediately. HIV post-exposure prophylactic medication should ideally be instituted, (i.e., first dose swallowed), within two hours. During the evaluation, the BHS Triage Nurse will assist students in selecting the most appropriate location for initial treatment.

5. All students (high risk and low risk) with an exposure should complete a follow-up assessment at Boynton Health Services within 72 hours of exposure. This appointment can be scheduled during the initial assessment with the BHS Triage Nurse (612) 625-7900. The costs of prophylactic medications and follow-up treatment will be covered at Boynton Health Services by student fees. Off-campus treatment will be the student's personal responsibility or covered by the student's insurance coverage.

6. All students will complete a Boynton Health Service Reportable Educational Exposure Form and Occupational Exposure Forum and mail or carry these completed forms to the BHS for their scheduled follow-up appointment. These forms will be available from the BHS Triage Nurse. Students must know that blood-borne pathogen exposure and the possible
subsequent treatment are treated as an OSHA incident, requiring documentation in a separate restricted access medical record. Confidentiality is assured.

7. In accordance with the Needlestick Safety Law, the exposed student will receive prevention discussions, counseling and follow-up on the exposure.
SECTION VI. RESOURCES

Sample Admission to Labor and Delivery Note

CC: Onset of ctx, SROM, vaginal bleeding, decreased fetal movement, abdominal trauma, etc.

HPI: _yo G__P____ @ __wks __days by (certain/uncertain) LMP of ___ (consistent with/not consistent with) ultrasound at __ wks gestation who presents with ___. Discuss here: fetal movement/contractions/loss of fluid (time)/vaginal bleeding/vaginal discharge.

ROS: Headache, GI issues, Respiratory issues

Prenatal Care (PNC): Clinic, Gestational age at first visit, Total number of visits, Weight gain, BP prior to 20 weeks, Pregnancy complicated by ___

Labs: Including Blood type, Hgb, Plts, Rubella, RPR, HIV, GCT, GTT, GC/Chlam, Urine cx, GBS, Pap, Quad screen

Ultrasounds: Date of ultrasound, gestation at ultrasound, EDC, placental location, presentation, anatomy, etc.

Past history:

Obstetrics: List each pregnancy-abortion (NSVD, wt 4000 grams, complicated by gestational diabetes and shoulder dystocia)

Gynecology: Paps, STD history

PMH and PSH:

Medications: PNV, FeSO4

Allergies: No Known Drug Allergies (NKDA)

Social history: Ask about Tobacco/EtOH/Drugs, social support

Physical exam (focused):

Vital signs, General
CV, Resp - (Many pregnant women have a murmur)
Abd - Gravid, fundus non-tender (NT), fundal height (FH) 38cm

Leopold maneuvers:
Fetus is vertex (VTX), estimated fetal weight (EFW) 3300 gm
Sterile speculum examination if indicated to rule out rupture of membranes (ROM)
Sterile vaginal exam (SVE) = 4cm/80%/VTX/ –1 station per M.D./RN
Fetal heat monitor – Baseline 140’s, accelerations present, (absent/minimal/moderatemarked) variability, no decelerations
Tocometer – Contractions q 4-5 min
Ext – +1 edema bilaterally, non-tender

**Pertinent Admission Labs:**

**Assessment:** 26yo G3P1 at ___ wks, in labor with fetal heart rate tracing (FHRT) reactive

**Plan:** Admit to L&D
- NPO except ice chips
- Continuous electronic fetal monitoring
- Labs: CBC, T&S, RPR
- Anticipate NSVD
- GBS status ____, antibiotic
- Plan for pain control

**Your name and date/time**

**Sample Delivery Note**

1. IUP at ___ wks ___ days, delivered by (Normal, Vacuum, Forceps, etc.)
2. Labor- spontaneous/induced/augmented (max Pitocin rate)
3. ROM - on date/time, spontaneous vs. assisted, color, for ___ hours
4. GBS status- antibiotic date started, time started for ___ doses
5. Anesthesia- epidural, pudendal, ITN, local
6. Episiotomy
7. Infant- delivered on date/time, viable M/F infant, weight, position, Apgars, nuchal cords, suctioning, and presence of NICU nurses
8. Placenta- spontaneous/manual, time, intact or not, # of vessels, Pitocin
9. Lacerations- cervical, perirethral, perineal (degree and repair)
10. Complications
11. EBL
12. Duration of labor: first stage, second stage, third stage, and total
13. Postpartum condition
14. In attendance: staff, residents, med students

**Your name and date/time**
Sample Labor Progress Note

S: Patient complains of ___. Currently has ___ for pain control.

O: Vital signs
Fetal heat monitor (External/Internal) – Baseline 140’s, accelerations present, (absent/minimal/moderate/marked) variability, no decelerations
Tocometer (External/IUPC)– Contractions q 4-5 min
Cervical Exam- 5cm dilated/80% effaced/0 station, vertex
Membranes- Intact/Ruptured

A: IUP at ___ wks gestation, currently in active labor
P: Include plans for monitoring, medications, pain options, GBS status
Your name and date/time

Sample Preeclampsia Note (Labor or Postpartum)

**Never write/type “Mag” always use “Magnesium” instead.**

S: Headache/visual changes/abd pain/nausea/shortness of breath/chest pain

O: Vital signs including I & Os for last 4, 8 and 24 hours
Lungs- Evaluate for pulmonary edema
Abd- Evaluate for RUQ pain
Ext- Reflexes, edema
Fetal heat monitor and Tocometer (External/Internal)
Cervical Exam and Membrane status
Labs- Include recent CBC, LFTs, BUN, Creatinine, Magnesium level

A: IUP at ___ wks gestation, currently on magnesium for seizure prophylaxis due to mild/severe pre-eclampsia
P: 1. Magnesium at ___ mg/hour. Level is/is not therapeutic. Patient has/does not have signs or symptoms of magnesium toxicity.
2. Blood pressure is ____, requiring antihypertensive medication
3. Urine output is ______
4. Include plans for monitoring, medications, pain options, GBS status

Your name and date/time
Sample Operation Note

Pre-op Diagnosis: Symptomatic uterine fibroids or Pregnancy at ___ wks, failure to progress
Post-op Diagnosis: Same
Procedure: TAH/BSO, Cesarean Section
Surgeon (Attending):
Residents:
Anesthesia: General endotracheal (GET), Spinal, LMA, IV sedation
Complications: None
EBL: 300 cc
Urine Output: 200 cc, clear at the end of procedure
Fluids: 2,500 cc crystalloid (include blood or blood products here)
Findings: Exam under anesthesia (EUA) and operative findings OR Viable M/F infant in cephalic/breech presentation weighing ___ grams, Apgars of ___. Cord gases ____. Infant to newborn nursery/NICU.
Specimen: Cervix/uterus
Drains: If placed
Disposition: Recovery room, Surgical ICU, etc

Your name and date/time
Sample Postpartum Notes (SOAP format)

**Subjective:** Ask every patient about the 5 B’s:
- Breast or bottle feeding – Breastfeeding/planning to? How is it going?
- Birth Control plans – Consider breastfeeding status
- Bleeding (lochia) – Clots? How many pads?
- Baby – Healthy? Do you plan circumcision for baby boy?
- Bottom – Having any complaints related to urination/defecation?
- Baby blues (depression) – Ask about signs or symptoms of depression.
- Pain – cramps/perineal pain/leg pain? Does medication control it?

**Objective:**
- Vital signs and note tachycardia, elevated or low BP, temperature
- Focused physical exam including
  - Heart
  - Lungs
  - Extremities: Edema? Cords? Tender?
  - Breasts/Perineum: evaluate with help of resident if specific complaints regarding breasts/perineum
- Postpartum labs: Hemoglobin, Blood type, Rubella status

**Assessment/Plan:** PPD # S/P NSVD or Vacuum or Forceps (with 4th-degree laceration, with pre-eclampsia s/p Magnesium Sulfate)
- General assessment – Afebrile, doing well, tolerating diet
- Contraception plans (must discuss before patient goes home)
- Rubella vaccine prior to discharge?
- Breastfeeding? Does she need lactation consultant?
- Rhogam, if Rh-negative and infant Rh-positive
- Discharge and follow-up plan
- Patients usually go home if uncomplicated 24-48 hours postpartum
- Follow-up appointment scheduled in 2-6 weeks postpartum

**Your name and date/time**
Sample C/S Postpartum Note

Day #1 (Post-op day POD#1)

Subjective: Ask every patient about the 5 B’s, also:
• Pain – relieved with medication?
• Nausea/vomiting
• Passing flatus (rare this early post-op)

Objective:
• Vital signs and note tachycardia, elevated or low BP, temperature
• Input and output
• Focused physical exam including
  o Heart and Lungs
  o Abd: Soft? Location of the uterine fundus – below umbilicus? Firm? Tender?
  o Incision: Clean and dry, intact? Staples or not?
  o Extremities: Edema? Cords? Tender?
  o Breasts/Perineum: evaluate with help of resident if specific complaints regarding breasts/perineum
• Postpartum labs: Hemoglobin, Blood type, Rubella status

Assessment/Plan: POD #1 status post (S/P) C/S or repeat C/S
• Afebrile, tolerating pain, oral intake, adequate urine output (>30cc/hr)
• Routine post-op care
  o Discontinue Foley
  o Discontinue PCA or IV pain medications and convert to PO pain Meds when tolerating PO
  o Ambulate TID
  o Advance diet as tolerated
  o Discontinue IV when tolerating PO
• Check Hgb or CBC on POD #1
• Anticipate discharge on POD #3 or 4

Your name and date/time
Sample Postoperative Cesarean Section Orders

Sample C/S Orders

Admit to: Recovery Room, then postpartum floor
Diagnosis: Status post (s/p) C/S for arrest of descent
Condition: Stable
Vitals: Routine, q shift
Allergies: None
Activity: Ambulate with assistance this PM, then up ad lib
Nursing: Strict input and output (I&O), Foley to catheter drainage, call M.D. for Temp > 38.0, pulse > 110, B P < 90/60 or > 140/90, encourage breastfeeding, pad count, dressing checks, and Ted hose until ambulating
Diet: Regular as tolerated; some hospitals only allow ice chips or clear liquids
IV: Lactated ringers (LR) or D5LR at 125 cc/hr, with 20 units of Pitocin x 1-2 liters
Labs: CBC in AM
Medications:
  • Morphine sulfate PCA (patient controlled analgesia) per protocol (1 mg per dose with 10 minute lockout, not to exceed 20 mg/4 hours)- only if no Duramorph in Spinal anesthetic
  • Percocet 1-2 tabs PO q 4-6 hours prn pain, when tolerating PO well
  • Zofran/Compazine prn nausea
  • Ibuprofen 800 mg PO q 8 hours prn pain, when tolerating PO well
  • Prophylactic antibiotics if indicated
  • Thromboprophylaxis for high-risk patients
  • Rhogam, if Rh-negative

Your name and date/time
Women’s Health History Outline

I. General considerations
   A. Establish relationships
   B. Style pointers
      • Use nonjudgmental tone
      • Maintain eye contact
      • Use open-ended questions
      • Minimize interruptions
      • Use directed questions to clarify specific points
   C. Provide opportunity to ask and answer questions without the patient’s family/friends present
   D. Patient encounters are patient education opportunities
   E. Written and oral summaries of patient histories should follow standard medical H&P formats

II. Non-verbal observations
   A. Race
   B. Cultural background
   C. Emotional tone
      • Facial expression
      • Posture
   D. Note patient interactions with family/friends present at the interview, when applicable

III. Chief complaint, in patient’s own words, if possible

IV. History of the present illness, including pertinent positives and negatives

V. Menstrual history
   A. Age of menarche
   B. Age at menopause, where applicable
   C. Past and current menopausal symptoms
D. Past and current use of hormone replacement therapy
E. Post-menopausal bleeding
F. Current cycle characteristics
   • First day of the last menstrual period (also in HPI)
   • Frequency of current flow – usually 21-40 days
   • Duration of flow – average 4-7 days
   • Amount estimate
     o Clots present
     o Pad or tampon count – usually unreliable measure of blood
     o Average <80 cc
   • Associated symptoms, i.e.
     o Cramping
     o Mood changes/depression
     o Diarrhea/constipation
     o Headache
     o Swelling
     o Bloating
   • Impact of current birth control method on menstrual flow and symptoms, where applicable (i.e. OCP’s, IUD)
   • Patient’s current management of associated symptoms (i.e. NS Aid’s, anti-depressants, diuretics, exercise, dietary modifications)

VI. Obstetric history
   A. Gravity = total number of pregnancies, including current
   B. Parity = short-hand numeric summary of pregnancy outcomes
      • Term deliveries (37-42+ weeks)
      • Pre-term deliveries (variable definitions, i.e. 20 – 36 weeks)
      • Elective and spontaneous abortions, ectopics, molar gestations
      • Living children (may exceed total number of deliveries, due to multiple gestations)
      • Make separate note of circumstances influencing the number of living children patients report, such as surrogate parenthood, giving children up for adoption, deaths of children unrelated to their births, adopting children, etc.
C. Term and pre-term deliveries
   • Date
   • Duration of gestation
   • Type of delivery
     o Vaginal
     o Breech
     o Forceps/vacuum
     o Cesarean, including indication
   • Sex of baby
   • Fetal/neonatal complications for the baby, including current condition
   • Maternal complications, including post-partum
D. Abortions/ectopic/molar pregnancies
   • Elective terminations
     o Estimated gestational age
     o Associated medical conditions (i.e. maternal disease, fetal chromosomal abnormalities)
     o Method (medical, surgical, labor induction)
     o Complications
   • Spontaneous abortions
     o Estimated gestational age
     o Methods of diagnosis (i.e. symptoms, US, serial HCG’s)
     o Need for uterine instrumentation (D&C)
     o Complications
     o Results of evaluation for recurrent SAB’s
   • Ectopic pregnancies
     o Location of pregnancy
     o Treatment modalities (medical/surgical)
   • Molar pregnancies – include treatment history

VII. Gynecologic history
A. Pap smear history
   • Date and results of most recent
   • Prior abnormal results, including evaluation, treatment and follow-up
B. Gynecologic infections
   • Sexually transmitted infections, including
   • Assessment of past and current risk factors, including HIV
   • Results of routine screening tests
   • Other, i.e. bacterial vaginosis, candida
C. Contraceptive history – include dates, methods, complications and reasons for changes
D. Sexual history
   • Satisfaction with current sexual function/relationships
   • Orientation
   • Whether or not orgasmic
   • Dyspareunia
   • Current/past abuse or assault
E. Infertility history
   • Evaluation
   • Treatment
   • Outcomes
F. Urinary and fecal incontinence
G. Summarize gynecologic surgical procedures
   • Date
   • Indication and final diagnosis
   • Complications
   • Examples include
     o Office biopsies
     o Dilation and curettage
     o Laparoscopy
     o Hysterectomy
     o Pelvic reconstruction

VIII. Past medical history
A. Past and present medical diagnoses
B. Impact on personal reproductive health issues, i.e.
   • Menstrual cycles
   • Fertility
   • Childbearing decisions
• Choice of specific contraceptive methods
• HRT

C. Compliance with age-appropriate preventive health recommendations
• Screening tests, i.e. cholesterol, mammography
• Vaccination

IX. Past non-gynecologic surgical history
A. Intra-abdominal surgical procedures
• Date
• Indication and final pathologic diagnosis
• Complications
• Examples include
  o Appendectomy
  o Cholecystectomy
  o Hernia repair
B. Non-abdominal surgical procedures
• Date
• Indication and final pathologic diagnosis
• Complications, especially bleeding and anesthesia related
• Examples include
  o Breast biopsy, surgery
  o Thyroidectomy

X. Medications
A. Consider teratogenic potential
B. Consider interactions with contraceptive medications

XI. Allergies, including reactions

XII. Family history
A. Report serious illnesses and causes of death for first degree family members
B. A scertain disease patterns among family members
C. Inquire about diseases pertinent to the patient’s ethnic background
D. Mendelian disorders, i.e. hemophilia, Duchenne’s muscular dystrophy
E. Multifactorial disorders, i.e. congenital anomalies, diabetes, hypertension

XIII. Social history
   A. Smoking history
   B. Alcohol intake
   C. History of illicit drug use
   D. Occupation
   E. Diet
   F. Exercise
   G. Hobbies
   H. Recent travel
   I. Current social support system
   J. Problematic relationships: abuse/violence

XIV. Review of systems

Adapted from Association of Professors of Gynecology and Obstetrics Medical Student Educational Objectives, 7th edition, copyright 1997.
Sample Gynecologic History and Physical

Introduction: Name, age, gravidity, parity and presenting problem

HPI:

Past Medical History/Past Surgical History:

Past Gynecologic History:

• Menses – menarche, cycle duration, length, heaviness, intermenstrual bleeding, dysmenorrhea, and menopause (if relevant).
• Abnormal Pap smears, including time of last Pap
• Sexually transmitted infections
• Sexual history
• Postmenopausal women. Ask about hypoestrogenic symptoms, such as hot flashes or night sweats, vaginal dryness, and about current and past use of hormone/estrogen replacement therapy.
• Mammogram

Past OB History: Date of delivery, gestational age, type of delivery, sex, birthweight and any complications

Family History:

Allergies:

Medications:

Social History:

Physical Exam: Complete

Review of Systems:

Plan:

1. Pap smear
2. Endometrial biopsy obtained
3. Medications, etc.
Two Sample Gyn Clinic SOAP Notes

Example 1:

S. 22 y/o G2P2 here for annual exam. Regular menses q 28 days with no intermenstrual bleeding. IUD for contraception since birth of last child 2 years ago. No problems with method. Minimal dysmenorrhea. Mutually monogamous relationship x 6 years. No hx of abnormal Paps. + BSE, jogs twice a week, no smoking, no abuse, + seat belts.

O. Breasts: No masses, adenopathy, skin changes
   Abd: No masses, soft, NT
   Pelvic:
   Ext genitalia: Normal
   Vagina: pink, moist, well rugated
   Cervix: multiparous, no lesions
   Bimanual: uterus small, anteverted, NT, no adnexal masses or tenderness

A. Normal exam

P. Pap, RTC 1 year

* * * *
Example 2:

S. 33 y/o G3P1 with LMP 1 week ago here for follow up of chronic left sided pelvic pain. Patient first seen 6 months ago with complaints of pain x 2 years. She describes pain as dull and aching, intermittent, with no relationship to eating but increased before and during menses. Pain has gotten worse over the last 6 months and requires her to miss work 2-3 days per month. No relief with NSAIDs. Patient has history of chlamydia 5 years ago for which she was treated. No history of PID. Three partners within the past year: no condom use. No GI symptoms: regular BMs, no constipation, diarrhea, nausea or vomiting. Past history of ectopic x 2 with removal of part of the left and right tubes. Also had ruptured appendectomy at age 20. On birth control pills for contraception.

O. Abdomen: 1+ LLQ tenderness, no peritoneal signs
   Pelvic: Ext genitalia: Normal
   Vagina: no discharge
   Cervix: no lesions
   Biman: uterus small, retroverted, NT, 3+ left adnexal tenderness,
   no right adnexal tenderness, no masses palpated

A. Pelvic pain unresponsive to medical management; rule out endometriosis vs adhesive disease vs chronic PID vs other

P. Schedule diagnostic laparoscopy
Admission Orders

These vary a little from case to case, but the following are fairly general (format is ADC VAN DISMAL):

- **Admit:** To the specific service or team
- **Diagnosis:** List the diagnosis and the names of any associated surgeries or procedures
- **Condition:** Such as Stable vs Fair vs Guarded
- **Vitals:** Frequency
- **Activity:** Ambulation, showering
- **Nursing:** Foley catheter management parameters
  - Prophylaxis for deep venous thrombosis
  - Incentive spirometry protocols
- **Call orders** Vital sign parameters for notifying the team
  - Urine output parameters
- **Diet:** Oral intake management
- **IVF:** Rates are typically set at 125 cc per hour
- **Special:** Drain management
  - Oxygen management
- **Meds:** Pain medications
  - Prophylactic orders, such as for sleep or nausea
  - The patients' regular medications
- **Allergies:**
- **Labs:** Typically includes hemoglobin/hematocrit
Commonly Used Abbreviations

AB abortion
MAB missed abortion
SAB spontaneous abortion
TAB therapeutic abortion
EAB elective abortion
ACOG American College of Obstetricians and Gynecologists
AFP Alpha Fetoprotein
MSAFP maternal serum alpha-fetoprotein
AGUS atypical glandular cells of unknown significance
AMA advanced maternal age
AFI amniotic fluid index
APGO Association of Professors of Gynecology & Obstetrics
AROM artificial rupture of membranes
ASCUS atypical squamous cells of unknown significance
BBOW bulging bag of water
BBT basal body temperature
BMD bone mineral density
BPD biparietal diameter
BPP biophysical profile
BSO bilateral salpingo-oophorectomy
BTBV beat-to-beat variability
BTL bilateral tubal ligation
CIN cervical intraepithelial neoplasia
CPD cephalopelvic disproportion
CRL crown rump length
CST contraction stress test
CT chlamydia trachomatis
CVS chorionic villi sampling
D & C dilatation & curettage
D & E dilatation & evacuation
DIC disseminating intravascular coagulopathy
DI/DI dichorionic/diamniotic twins
EDC/EDD estimated date of confinement/estimated date of delivery
EFM  electronic fetal monitoring
EFW  estimated fetal weight
EGA  estimated gestational age
EMB  endometrial biopsy
ERT  estrogen replacement therapy
ETOP elective termination of pregnancy
FAVD forceps assisted vaginal delivery
FHR/FHT fetal heart rate/fetal heart tracing or tone
FL   femur length
FLM  fetal lung maturity
FM   fetal movement
FSE  fetal scalp electrode
FSH  follicle stimulating hormone
FTP  failure to progress
GBS/GBBS group B beta streptococcus
GC   gonorrhea
GDM  gestational diabetes mellitus
GIFT gamete intra-fallopian tube transfer
GnRH gonadotropin releasing hormone
G_P_ gravida, para (TPAL - term, preterm, abortions, living children)
GTD  gestational trophoblastic disease
HCG  human chorionic gonadotropin
BHCG beta human chorionic gonadotropin (usually serum)
UHCG urinary human chorionic gonadotropin
HELLP hemolysis, elevated liver enzymes, low platelets
HGSIL high-grade squamous intraepithelial lesion
HPL  human placental lactogen
HPV  human papilloma virus
HRT  hormone replacement therapy
HSG  hysterosalpingogram
HSV  herpes simplex virus
I & D incision & drainage
ICSI intracytoplasmic sperm injection
IUD  intrauterine device
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUFD</td>
<td>intrauterine fetal death</td>
</tr>
<tr>
<td>IUGR</td>
<td>intrauterine growth retardation</td>
</tr>
<tr>
<td>IU1</td>
<td>intrauterine insemination</td>
</tr>
<tr>
<td>IUP</td>
<td>intrauterine pregnancy</td>
</tr>
<tr>
<td>IUPC</td>
<td>intrauterine pregnancy pressure catheter</td>
</tr>
<tr>
<td>IVF</td>
<td>in vitro fertilization</td>
</tr>
<tr>
<td>LCP</td>
<td>long, closed, posterior</td>
</tr>
<tr>
<td>LEEP/LOOP</td>
<td>loop electrical excision procedure</td>
</tr>
<tr>
<td>LGA</td>
<td>large for gestational age</td>
</tr>
<tr>
<td>LGSIL</td>
<td>low grade squamous intraepithelial lesion</td>
</tr>
<tr>
<td>LH</td>
<td>luteinizing hormone</td>
</tr>
<tr>
<td>LMP/LNMP</td>
<td>last menstrual period/last normal menstrual period</td>
</tr>
<tr>
<td>LOA/LOT/LOP</td>
<td>left occiput anterior/left occiput transverse/left occiput posterior</td>
</tr>
<tr>
<td>LTC</td>
<td>long, thick, closed</td>
</tr>
<tr>
<td>LTCS/LVCS</td>
<td>low transverse C-section/low vertical C-section</td>
</tr>
<tr>
<td>MFM</td>
<td>maternal fetal medicine</td>
</tr>
<tr>
<td>MVU</td>
<td>Montevideo units</td>
</tr>
<tr>
<td>NST</td>
<td>non-stress test</td>
</tr>
<tr>
<td>NSVD</td>
<td>normal spontaneous vaginal delivery</td>
</tr>
<tr>
<td>NT</td>
<td>nuchal translucency</td>
</tr>
<tr>
<td>NTD</td>
<td>neural tube defect</td>
</tr>
<tr>
<td>OCP</td>
<td>oral contraceptive pills</td>
</tr>
<tr>
<td>OT</td>
<td>occiput transverse</td>
</tr>
<tr>
<td>PCO/PCOD</td>
<td>polycystic ovarian disease</td>
</tr>
<tr>
<td>PCT</td>
<td>pelvic inflammatory disease</td>
</tr>
<tr>
<td>PIH</td>
<td>pregnancy induced hypertension</td>
</tr>
<tr>
<td>PMB</td>
<td>postmenopausal bleeding</td>
</tr>
<tr>
<td>POC</td>
<td>products of conception</td>
</tr>
<tr>
<td>POD/PPD</td>
<td>post-operative day/postpartum day</td>
</tr>
<tr>
<td>PPH</td>
<td>postpartum hemorrhage</td>
</tr>
<tr>
<td>PPROM</td>
<td>preterm premature rupture of membranes</td>
</tr>
<tr>
<td>PROM</td>
<td>premature rupture of membranes</td>
</tr>
<tr>
<td>PTL</td>
<td>preterm labor</td>
</tr>
<tr>
<td>PUBS</td>
<td>percutaneous umbilical blood sampling</td>
</tr>
</tbody>
</table>
PUPPPSS pruritic urticarial papules and plaques of pregnancy
ROA/ROT/ROP right occiput anterior/right occiput transverse/right occiput posterior
ROM rupture of membranes
SBE self breast exam
SGA small for gestational age
SROM spontaneous rupture of membranes
SSE sterile speculum exam
STD/STI sexually transmitted disease/sexually transmitted infection
SVE sterile vaginal exam
TAH total abdominal hysterectomy
TOA tubo-ovarian abscess
TOL trial of labor
TRIPLE TEST MSAFP/HCG/Estriol
TVH total vaginal hysterectomy
US ultrasound
VAVD vacuum-assisted vaginal delivery
VB vaginal bleeding
VBAC vaginal birth after C-section
VAIN vaginal intraepithelial neoplasia
VIN vulvar intraepithelial neoplasia
Glossary

Abortion:

(a) **Elective (Induced)**: The intended termination of a pregnancy by medical or surgical intervention.

(b) **Spontaneous (Accidental)**: The spontaneous termination of a pregnancy before the 20th week, with the fetus weighing less than 500 grams.

(c) **Complete**: The complete emptying of the uterus of the products of conception.

(d) **Incomplete**: All products of conception have failed to be extruded from the uterus.

(e) **Inevitable**: Evidence of impending abortion by bleeding, cramping, rupture of membranes, and/or open cervix.

(f) **Missed**: Failure of dead products of conception to be extruded from the uterus, 6 weeks after fetal loss.

(g) **Recurrent**: Three or more spontaneous abortions.

(h) **Septic**: An infection complicating an abortion.

(i) **Threatened**: The presence of vaginal bleeding and/or uterine cramping with a closed cervix in pregnancy.

(j) **Tubal**: The extrusion of the tubal pregnancy through the fimbriated end of the fallopian tube.

**Abruptio placentae**: The premature separation of a normally implanted placenta.
**Acromegaly**: A progressive enlargement of peripheral parts of the body, head, hands, extremities due to excessive production of growth hormone.

**Adenomyosis**: The presence of growth of endometrial tissue in the muscle of the uterus.

**Adnexa**: The appendages of the uterus, tubes, ovaries, and associated ligaments.

**Adrenarche**: Development of pubic and axillary hair at the time of puberty.

**Amenorrhea**: The absence of menses, primary or secondary.

**Aminocentesis**: The withdrawal of amniotic fluid, usually through the abdomen for diagnostic or therapeutic reasons.

**Amniotic fluid**: The liquid surrounding the fetus confined by the amnion.

**Anorexia nervosa**: A mental disorder marked by a reduction in food intake and leading to excessive weight loss and amenorrhea.

**Anovulatory bleeding**: Intermittent uterine bleeding not associated with ovulation or any uterine pathology.

**Antepartum**: Prior to labor and delivery.

**Apgar score**: A physical assessment of the newborn at 1-minute and 5-minute periods.

**Arrhenoblastoma**: An androgen-producing tumor of the ovary associated with virilization, rare.
**Ascites:** An accumulation of serous fluid in the peritoneal cavity.

**Atony, uterine:** the loss of normal uterine muscle tone post partum, resulting in excessive uterine bleeding.

**Autonomy, medicine:** The right of a patient to determine what health care she will accept.

**Barr bodies:** The number of Barr bodies is one less than the number of x chromosomes in that cell.

**Bartholin cyst:** A cystic enlargement of the Bartholin gland usually due to an obstruction of its duct.

**Bartholin glands:** These are a pair of non-palpable glands located at 4 and 8 o’clock in the vaginal opening.

**Basal body temperature:** Body temperature reading when at rest. May be useful in determining ovulation.

**Benign cystic teratoma:** (dermoid cyst) a germ cell tumor of the ovary consisting of all three germ layers.

**Biophysical profile:** A physical assessment of a fetus when evaluating ultrasound findings, breathing movements, fetal tone, amniotic fluid volume, and electronic fetal heart monitoring.

**Biphasic temperature curve:** A 0.3 to 1° F change in basal body temperature from follicular to luteal phase indicating ovulation.

**Breakthrough bleeding:** Endometrial bleeding from a non-organic cause during the use of oral contraceptives from a non-organic cause.

**Breech:** Refers to the abnormal presentation in pregnancy and labor.
**Cancer staging:** Evaluation of the extent of cancer by clinical or surgical measures.

**Carcinoma in situ:** A tumor of epithelial cells confined to the area above the basement membrane.

**Cesarean delivery:** A delivery of a fetus by way of the abdominal route.

**Chloasma:** Brownish discoloration of the face seen in pregnancy and often with oral contraceptives (mask of pregnancy).

**Chorioamnionitis:** Inflammation of the chorion and amniotic membranes.

**Chorionic villus sampling:** Sampling of the chorionic villi for cytogenic evaluation of the fetus by way of transcervical or transabdominal route.

**Climateric:** A period in the life of a female during the transition from reproductive to a non-reproductive state associated often with physical and psychological change.

**Clomiphene:** A synthetic non-steroidal compound used to stimulate ovulation by its antiestrogenic effect of the hypothalamus.

**Coitus interruptus:** Intentional withdrawal of the penis from the vagina before ejaculation.

**Colporrhaphy:** (Anterior) repair of the anterior wall of the vagina. (Posterior) repair of the posterior wall of the vagina.

**Colposcopy:** Examination of the vagina and cervix by instrumentation that employs low magnification.
**Condyloma acuminatum**: Benign papillomas of the vulva and vagina thought to be due to HPV.

**Cone biopsy**: A conical excision (biopsy of) the cervix for the purpose of histological evaluation.

**Contraception**: Any method that prevents conception (hormonal, etc.)

**Corpus luteum**: Yellow body of the ovary that follows rupture of an ovarian follicle.

**Cryptomenorrhea**: Obscurred uterine bleeding due to imperforate hymen.

**Cul-de-sac**: A pouch in the peritoneal cavity located between the rectum and the uterus.

**Culdocentesis**: Aspiration of the cul-de-sac of intraperitoneal fluid by way of the posterior vaginal fornix.

**Culdoscopy**: Visual evaluation of the internal genitalia by introducing an instrument though the posterior vaginal fornix.

**Curettage**: A scraping of the uterine cavity for diagnostic or therapeutic reasons.

**Cushing syndrome**: A complex symptom produced by hypersecretion of the adrenal cortex.

**Cystocele**: A hernia of the anterior vaginal wall produced by weakness in the pubocervical fascia resulting in relaxation of bladder support.

**Cystogram**: A radiogram of the bladder produced by injecting a contrast medium.
Cystometry: Measuring the pressure, volume control, and function of the urinary bladder.

Cystoscopy: Visualization of interior of bladder by cystoscope.

Decidua: Changes in the endometrium attributable to the hormonal effects of progesterone.

Dilation: Opening of the cervix by physiological means.

D immunoglobulin [RhO(D) immunoglobin]: An immunoprotein used to prevent sensitization.

Disseminated intravascular coagulation (DIC): A type of coagulopathy often seen in pregnancy where fetal death, sepsis, hemorrhage, or amniotic fluid embolus is present.

Double set-up: Preparation in the OR that enables a surgeon to proceed with either the abdominal or vaginal delivery.

Dysmenorrhea: Menstruation associated with cramps.

Dyspareunia: Discomfort in the vagina associated with intercourse.

Dystocia: Difficult or abnormal labor.

Dysuria: Painful urination.

Eclampsia: A seizure associated with pre-eclampsia.

Ectropion: Columnar epithelium that extends from the endocervix to the ectocervix.
**Effacement**: A thinning of the cervix that occurs prior to or during labor.

**Embryo**: A description of the conceptus from blastocyst to the end of the 8th week of gestation.

**Endometrial biopsy**: A sampling of endometrial tissue for diagnosis.

**Endometriosis**: Endometrial implants found outside of the uterine cavity that respond to the hormonal effects of estrogen and progesterone.

**Endoscopy**: The instrumental evaluation of any hollow viscus or space.

**Enterocele**: A herniation of the small bowel in the posterior cul-de-sac between the vagina and the rectum.

**Episiotomy**: An incision made in the perineum at the time of parturition to facilitate delivery.

**Erectile Dysfunction**: Inability to achieve or maintain an erection.

**Estrogen therapy**: The exogenous replacement of estrogen in the menopausal patient.

**Estrogen, unopposed**: The use of estrogen only in menopausal patients without the addition of progesterone.

**Exenteration, pelvic**: A virtual pelvic clean out of internal genitalia including the bladder and rectum as a treatment of an extensive pelvic tumor.

**Fern (ferning)**: A fern-like pattern of dried cervical mucous indicating ovulation. A similar pattern seen with dried amniotic fluid in detecting ruptured membranes.
**Fibrocystic changes (breast):** Multiple cysts in the breast tissue that respond to hormonal changes, common.

**Foreplay:** The pre-coital activity that partners employ to arouse sexual desire.

**Functional ovarian cyst:** A cyst arising from a graafian follicle or corpus luteum, benign.

**Functioning ovarian tumor:** An ovarian neoplasm that is hormone producing.

**Fundal dominance:** Uterine contractions found to be stronger in the fundus than in the lower uterine segment.

**Galactorrhea:** The breast produces milk in the absence of a pregnancy.

**Gender (sex) role:** An individual’s concept of their feeling of the behavior and activity appropriate to the male or female sex.

**Gonadal agenesis:** Congenital absence of the ovarian tissue.

**Gonadal dysgenesis:** Defective development of the gonads (congenital).

**Gonadotropin:**

(a) **Human chorionic (hCG):** A glycoprotein hormone similar to the lutenizing hormone (LH) that is produced by syncytiotrophoblast.

(b) **Human menopausal (hMG):** A product consisting primarily of FSH and some LH from the urine of post-menopausal women.

**Granulosa cell tumor:** An estrogen stimulating ovarian tumor.
**Gravida**: A pregnant women.

**Gravidity**: The total number of pregnancies a woman has had including the present one.

**Hemoperitoneum**: The presence of blood in the peritoneum.

**Hermaphrodite**:

(a) **True, rare**: Dual gonadal development ovotestis or separate ovary and the testis.

(b) **Pseudo, female**: Masculinization of the fetus in the uterus presenting ambiguous genitalia (enlarged clitoris).

(c) **Pseudo, male**: normal secondary sexual characteristics at puberty but no menses and testicular tissue is found.

**Hilus cell tumor**: An uncommon ovarian tumor that is associated with virilization.

**Hirsutism**: The presence of increasing hair growth of male type distribution in the female due to excess male hormone.

**Hormone therapy (HRT)**: Replacement of estrogen and progestin therapy at menopause.

**Hot flashes**: A common symptom in menopausal women due to a vasomotor disturbance presumed to be due to estrogen deficiency. Hot sensations predominate in the head and upper thorax.
**Hydatiform mole**: A pathological condition of pregnancy characterized by cystic degeneration of chorionic villi. The fetus may or may not be present. (A complete or incomplete mole.)

**Polyhydramnios**: An excessive amount of amniotic fluid (hydramnios), usually more than 2 liters.

**Hyperplasia, endometrial**: An abnormal proliferation of the endometrial lining with varying degrees of glandular and stromal tissue. Types: Cystic & adenomatous.

**Hyperthecosis**: A proliferation of the cortical stroma of the ovary, post menopausal.

**Hypoestrogenism**: A condition produced by failing ovarian function and manifested in estrogen-dependent tissues.

**Hypofibrinogenemia**: A deficiency in circulating fibrinogen which might associate with disseminated intravascular coagulation (DIC).

**Hypogonadism**: A subnormal production of hormones by the gonads.

**Hysterectomy**:

(a) **Abdominal**: Removal of the uterus through the abdominal wall.

(b) **Subtotal**: Removal of the uterine corpus while retaining the cervix.

(c) **Total**: Removal of the entire uterus and cervix (not the ovary or tubes).

(d) **Vaginal**: Removal of the uterus through the vagina.

*Laparoscopically-assisted vaginal hysterectomy (LAVH): detachment of the ovarian vessels and portions of the broad ligament*
through a laparoscope. The remainder of the hysterectomy is done vaginally.

(e) **Radical**: Removal of the uterus, parametria, cervix and upper vagina.

**Hysterosalpingography**: The evaluation of the uterine cavity and tubes by inserting radiopaque dye, through the cervix and viewing the results with fluoroscopy.

**Hysteroscopy**: Endoscopic viewing of the uterine cavity.

**Hysterotomy**: A surgical incision in the wall of the uterus.

**Imperforate hymen**: A hymenal membrane that does not have any opening for menstruation.

**Incoordinate uterine activity**: The absence of a synchronous contraction pattern of the uterus which results in an ineffective labor.

**Infertility**: Inability to achieve pregnancy in the absence of contraception. Over 12 months.

**Intervillous space**: A compartment in the placenta where maternal blood bathes the chorionic villi allowing maternal fetal exchange.

**Intraductal papilloma**: Papilloma found in the milk duct often causing bleeding from the nipple and is usually benign.

**Intrauterine device (IUD)**: A mechanical device inserted into the uterine cavity to prevent pregnancy.

**Intrauterine growth retardation (IUGR)**: Failure of the fetus to attain normal or expected uterine growth.
**Intromission**: The process of penile insertion into the vagina.

**Karyotype**: The photographic reproduction of a chromosomal pattern of a cell in metaphase arranged according to a specific classification.

**Labor**: The expulsion of the fetus from the uterus.

(a) **Induced**: Initiated artificially.

(b) **Stimulated**: Labor stimulated with the use of pitocin.

(c) **Augmented**: Addition of pitocin after natural onset of labor.

**Laparoscopy**: Exploration of the abdominal cavity by endoscopy with/without the aid of pneumoperitoneum.

**Leiomyoma**: A smooth muscle cell tumor of the uterus (fibroid), usually benign.

**Leiomyosarcoma**: A malignant tumor of the smooth muscle cells.

**Leukoplakia**: A superficial whitish lesion of the vulva with some malignant potential.

**Levator muscle**: A muscular layer that forms the pelvic floor and consists of the iliococcygeus, pubococcygeus, and puborectalis muscles.

**Libido**: An individual’s sexual drive or urge.

**Ligament**:

(a) **Cardinal**: A dense supportive connective tissue that attaches to the lateral aspect of the cervix to the sides of the pelvis. The primary support of the uterus.
(b) **Uterosacral**: A ligamentous attachment from the posterior cervix to the sacrum. The ligament contains autonomic nerves and circles the rectum posteriorly.

**Ligation, tubal**: Any mechanical or surgical interruption of the fallopian tube for the purpose of sterilization.

**LMP**: Last menstrual period.

**LNMP**: Last normal menstrual period.

**Mastitis**: An inflammatory condition of the breast tissue.

**Masturbation**: Manipulation of the genitalia to produce orgasm.

**Maturation index**: A method of comparing the proper ratio of parabasal cells to intermediate and superficial vaginal epithelial cells.

**Maturity**: A description of a fetus weighing 2500 grams or more.

**Membranes, premature rupture of (PROM)**: The rupture of the amniotic sac prior to the onset of labor.

**Menarche**: The beginning of menstruation.

**Menopause**: The cessation of menses due to natural ovarian failure, usually age 48 to 52.

**Menorrhagia**: When excessive menstruation is prolonged.

**Metaplasia**: A reversible change when one adult cell type is replaced by another. The most common type of metaplasia is when columnar cells are replaced by squamous cells.

**Metrorrhagia**: Intermenstrual uterine bleeding.
**Midpelvis**: An imaginary plane in the midpelvis defined by three points: the ischial spines and the inferior border of the pubis.

**Mortality**:

(a) **Fetal**: Death of conceptus from two months to birth.

(b) **Maternal**: Death of any woman from any cause while she is pregnant or within 90 days of termination of her pregnancy.

(c) **Neonatal**: The death of an infant in the first 28 days of life.

(d) **Perinatal**: The death of a fetus or infant between 20 weeks of gestation and 28 days after birth.

**Mosaicism**: The presence of different chromosomal constitutions in an individual’s cells.

**Mucus, cervical**: Secretions from the uterine-cervical glands that are influenced quality and quantity wise by estrogen and progesterone. Estrogen is clear with spinnbarkeit associated with ovulation.

**Neonatal**: The first 28 days of life.

**Non-stress test (NST)**: The well-being of the fetus measured by electronic fetal monitoring, not in labor.

**Oligomenorrhea**: Infrequent menstruation.

**Orgasm**: This represents the climax of sexual excitement.

**Osteoporosis**: A condition that is characterized by decrease in bone mass with decreased density and enlargement of bone spaces producing porosity and fragility.
Ovulation, induction of: The use of artificial means to produce ovulation.

Oxytocin: A hormone produced by the posterior lobe of the pituitary gland that has an effect on the smooth muscle tissue of the uterus and on the mammary glands.

Papanicolaou smear (Pap smear): An evaluation of exfoliated cells from the cervix, endometrial cavity, or vagina for the detection of cancer or the evaluation of a patient’s hormonal status.

Parity: The number of pregnancies in which the fetus has reached viability.

Pelvic floor: The muscles and fascia of the pelvis that support the pelvic organs.

Pelvic inflammatory disease (PID): An inflammation of the internal female genitalia most often associated with venery.

Pelvic inlet: The upper boundary of the true pelvis; posteriorly the alae of the sacrum laterally by the linea terminalis and anteriorly by the symphysis pubis.

Perinatal: A combination of the fetal and neonatal periods (i.e. 20 weeks of gestation and 28 days after birth).

Perineorrhaphy: A vaginoplastic repair of the perineum.

Perineum: The pelvic floor and associated structures such as the vagina, urethra, rectum, and pelvic muscles.

Pessary: A device introduced into the vagina to support the uterus and/or bladder.
**Placenta previa**: A condition in pregnancy where the placenta is located in the lower portion of the uterus and may cause antepartum bleeding.

**PMP**: Previous menstrual period.

**Pneumoperitoneum**: The introduction of air or CO₂ into the peritoneal cavity.

**Polycystic ovary syndrome (disease) PCOD**: A condition of multiple follicular cysts of the ovary associated with oligomenorrhea and infertility and oligoovulation.

**Polymenorrhea**: Frequent episodes of menstruation.

**Position**: A designated point on the presenting part of a fetus as it relates to the anteroposterior or transverse portion of the maternal pelvis.

**Post-menopausal bleeding**: Any bloody discharge from the uterus, cervix, or vagina that occurs one year after menopause.

**Post-term pregnancy**: A pregnancy that exceeds 42 weeks gestation.

**Preeclampsia**: An occasional disorder in pregnancy associated with hypertension, edema, and proteinuria.

**Pregnancy, ectopic**: A pregnancy located outside of the uterine cavity, most often tubal.

**Prematurity**: A condition in which the fetus weighs 1000 to 2499 grams.

**Premenstrual syndrome (PMS)**: A disturbing assortment of symptoms experienced in the progestational phase of the menstrual cycle.
**Presentation:** A description in which the long axis of the fetus is related to the long axis of the mother (i.e. longitudinal, transverse).

**Presenting part:** The specific part of the fetus that is palpated by vaginal exam.

**Primigravida:** First time pregnancy.

**Prolapse:**

(a) **Cord:** A situation when the umbilical cord drops below the presenting part and is either occult or obvious.

(b) **Uterine:** A condition in which the uterus descends in various degrees because of relaxed ligamental support. Most commonly seen in parous women.

**Pseudocyesis:** False pregnancy. Symptoms suggest pregnancy but no conception has occurred.

**Puberty:** A period in the life of a young woman where secondary sex characteristics appear on the way to full maturity.

(a) **Delayed:** Lack of changes by age 14.

(b) **Precocious:** Secondary sex characteristics before 7.5 years.

**Puerperium:** The immediate period after parturition which lasts six to eight weeks.

**Quickening:** The first perception, on the part of the patient, of fetal movement during pregnancy.
**Rectocele**: A protrusion of the rectum as seen on the posterior vaginal wall.

**Reflux, tubal**: The retrograde discharge of menses or fluid from the endometrium into the peritoneal cavity by way of the fallopian tubes.

**Resection, tubal**: The removal of a portion of the fallopian tube by surgical means. It is usually for the purpose of permanent contraception.

**Rhythm**: A method of conception control where couples abstain from coitus during ovulation time.

**Rubella (German measles)**: One of the many exanthemata of viral origin but one that may be associated with fetal malformations if contracted during pregnancy.

**Salpingectomy**: Removal of a fallopian tube.

**Salpingo-oophorectomy**: Removal of a tube and an ovary.

**Schiller test**: A test of the cervix designed to locate suspicious lesions. A solution of iodine is added, and the white areas that do not stain are biopsied.

**Secondary sexual characteristics**: Sexual characteristics and physical changes in the pubescent female due to hormonal responses.

**Semen analysis**: An evaluation of semen in which several characteristics of spermatozoa are analyzed.

**Sexuality**: The psychological and physiological expression of one's sexual behavior.

**Sims-Huhner test**: A study of cervical mucus within two hours of coitus to evaluate the number, normality, and motility of spermatozoa.
**Skene glands**: Vestibular glands that open into the urethra.

**Sonography (ultrasonography, ultrasound)**: A diagnostic aid in which high frequency sound waves are employed to detect normal and abnormal findings in the abdomen and the pelvis.

**Spinnbarkeit**: The thin, stretching of cervical mucus demonstrated during the ovulatory phase.

**Station**: Using the ischial spines. The relationship of the presenting part to this landmark +2 means 2 cm below the spine, -2 means 2 cm above the spine, etc.

**Sterility**: The ability to procreate.

**Stress incontinence**: The unintentional loss of urine with increased intra-abdominal pressure as a result of weakness in bladder support.

**Striae gravidarum**: Stretch marks on the anterior abdominal wall as a result of an enlarging abdomen during pregnancy.

**Supine hypotensive syndrome**: A fall in the blood pressure in a reclining pregnant woman due to the obstruction of the venous return by the compressed uterus.

**Teratogen**: A foreign agent that produces a physical defect in a developing embryo.

**Testicular feminization**: A syndrome of androgen insensitivity noted by primary amenorrhea, a female phenotype, testes in the place of ovaries, the absence of a uterus, and a male genotype.

**Thecoma**: A functioning theca cell tumor of an ovary.
**Thelarche:** The initiation of breast development.

**Trimester:** A three-month period during a nine-month pregnancy. Certain events are associated with various trimesters.

**Trophoblast:** The epithelial layer of the chorion covering the placental villi.

**Tubercles, Montgomery:** Sebaceous glands in the areola portion of the breast which enlarge during pregnancy and lactation.

**Urethrocele:** A prolapse of the posterior urethra as seen on the anterior vaginal wall.

**Vasectomy:** An interruption of the vas deferens by surgical means for the purpose of sterilization.

**VBAC:** Vaginal birth after cesarean section.

**Viability:** The ability of a fetus to live outside the uterus. It must weigh at least 500 grams. (Though this definition changes with advancements in medicine).

**Virilization:** Masculinizing traits in the female (i.e. hirsutism, body build, etc.).

**Withdrawal bleeding:** Uterine bleeding that occurs when hormonal support of the endometrium is withdrawn.