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НАРОДОВ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ»

Кафедра акушерства и гинекологии

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OBSTETRICS AND GYNECOLOGY: CLINICAL TASKS

АКУШЕРСТВО И ГИНЕКОЛОГИЯ: КЛИНИЧЕСКИЕ ЗАДАЧИ

методические рекомендации

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Методические рекомендации написаны в соответствии с типовой учебной программой по акушерству и гинекологии для высших учебных заведений по специальности 1-79 01 01 Лечебное дело. В пособии представлены ситуационные задачи по основным разделам акушерства и гинекологии с эталонами ответов. Задачи могут быть использованы как для аудиторного контроля знаний, так и для самостоятельной работы студентов 4-6 курсов, обучающихся на английском языке по специальности 1-79 01 01 Лечебное дело.

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Perinatology

Task 1

A patient at 36 weeks of pregnancy visits the obstetrical clinic and complains of weak fetal movement during the last three days. The fundus of the uterus is slightly below the xiphoid process. The abdominal circumference is 78 cm, uterine fundus is 30 cm. The fetal heartbeat is dull, rhythmic. The head of fetus is pressed to the pelvic inlet.

Ultrasound revealed: there is one fetus in the uterus, in the head presentation without visible developmental abnormalities. The placenta is located on the right side of the uterus, has the 3rd degree of maturity. The biparietal diameter of the head is 90 mm (corresponds to 36 weeks), the abdominal circumference is 286 mm (corresponds to 33 weeks), the femur length is 65 mm (corresponds to 36 weeks). Doppler study revealed umbilical artery Doppler flow abnormalities. Cardiotocography of fetus is normal.

Diagnosis, treatment.

Task 2

A 30-year-old primiparous, 39 weeks of gestation. In the second period of labor, that lasts for 2 hours, CTG revealed persistent bradycardia 90 - 100 beats / min, and arrhythmia. Vaginal examination: the fetal head is on the pelvic floor, the sagittal suture occupies the anteroposterior diameter, the small fontannel is near the pubic symphysis.

Diagnosis. Tactics.

Task 3

A 32-year-old primiparous, was admitted to the maternity hospital at 39 weeks of gestation, with contractions that began 3 hours ago. The lie of the fetus is longitudinal, The head of the fetus is above the pelvis inlet. Fetal heart rate 134 beats / min. During the vaginal examination, when dilatation was 3 cm, rupture of amniotic membranes happens. Simultaneously with amniotic fluid escaping a loop of the umbilical cord prolapses into the vagina. The heartbeat of the fetus became arrhythmic, bradycardia up to 60 - 70 beats / min.

Diagnosis. Tactics.

Task 4

A 25-year-old primigravida was admitted to the hospital at 21week of pregnancy. In the early stages of pregnancy, PCR examination revealed virus HSV type 2 in cervical mucus; at 16 weeks of pregnancy she was treated with antibiotic macrolide group (josamycin) for ureaplasma infection.

At 21 weeks the routine ultrasound examination was performed. Ultrasound data: biparietal head diameter - 3, 90 cm (corresponds to 16 weeks),

abdominal circumference - 12 cm (corresponds to 16 weeks), femur length - 2.2 cm (corresponds to 16 weeks). Enhanced fetometry (measurement of the length of the shoulder, forearm, and chest circumference) was performed. According to the total data, the fetus corresponds to 16 weeks of pregnancy. The amniotic fluid index is 1.4 cm (normal is 10.0-17.0 cm). Umbilical artery Doppler study results: systolic-diastolic ratio is 0.

Diagnosis. Tactics.

Task 5

A 22-year-old multiparous. The dimensions of the pelvis are 27 - 28 - 30 - 18 cm, the longitudinal lie of the fetus, the head presentation. The first stage of labor lasted 12 hours, the second - 10 minutes. A child was born with an Apgar score 4; with reflex irritability.

Diagnosis. Tactics.

Task 6

A 28-year-old primiparous was admitted to the hospital at 40 weeks of pregnancy. Labor activity lasts 4 hours. The dimensions of the pelvis are normal. A soft large part of the fetus presents above the pelvis inlet. The fetal heartbeat is heard on the left at the navel, 132 beats per minute, distinct, rhythmic. Two hours after admission, colorless amniotic fluid escaped. Simultaneously with escaping of amniotic fluid a pulsating loop of the umbilical cord prolapsed into the vagina. Vaginal examination: the cervix is effaced, dilatation is 6 cm. Amniotic membranes are absent. Buttocks of the fetus presents. Bitrochanteric diameter of the fetus occupies the left oblique dimension of the pelvis, sacrum is on left anteriorly. Prolapsed cord loop is palpated.

Diagnosis? Treatment.

Task 7

A 26-year-old primiparous, 40 weeks of pregnancy. Labor activity is during 8 hours. Contractions are in 2-3 minutes for 45-50 seconds, very painful. For pain relief promedol 1% - 2.0 and atropine 0.1% - 1.0 were induced. An hour later, the second period of labor began and lasted 15 minutes. A boy was born: the tone is reduced, reflexes are depressed, breathing is rare, the skin is cyanotic, the heartbeat is 100 beats per minute.

Diagnosis. Assess the condition of the newborn by Apgar score. Tactics.

Task 8

A 25-year-old primiparous. The position of the fetus is longitudinal, the head presentation. Labor lasts 8 hours. In the second stage of labor, lasting 35 minutes, the fetal heart rate decreased up to 80-100 beats per minute. A boy was

born with a tight cord around the neck. In 1t minute after delivery, the Apgar score is 4. Diagnosis. Tactics.

Physiological pregnancy and labor

Task 1

On March 1, a 21-year-old first-pregnant woman came to the antenatal clinic to monitor pregnancy. Estimate the term of pregnancy if her last menstruation was on January 1-5.

Task 2

A 20-year-old primiparous woman was admitted to the maternity hospital with regular contractions at 38 weeks of pregnancy. Pelvis dimensions: Dist. spinarum - 25 cm, cristarum - 28 cm, trochanterica - 31 cm, conjugata externa-20 cm.

Contractions are in 4-5 minutes for 50-55 seconds. Childbirth lasts 7 hours. Fetal heart rate is 130 beats per minute. The abdominal circumference is 100 cm, the fundal height is 35 cm.

On vaginal examination: the cervix is effaced, thin, easily extensible, dilatation 6 cm. The amniotic membranes are absent, a moderate amount of clear amniotic fluid departed. The fetal head is pressed to the pelvis inlet. Sagittal suture occupies the right oblique diameter; small fontanel is on the left interiorly. The promontory is not reached. There are no exostoses in the pelvis.

Diagnosis.

Task 3

A 35-year-old multiparous. Delivery is on time. Pelvis dimensions: Dist. spinarum - 25 cm, cristarum - 28 cm, trochanterica - 31 cm, conjugata externa-20 cm. Regular contractions last 7 hours, rupture of amniotic membranes happened an hour ago. Contractions for 55-60 seconds, in 2-3 minutes. The lie of the fetus is longitudinal. Fetal heart rate is 140 beats in a minute.

Vaginal examination: complete dilatation. The amniotic membranes are absent. The head of the fetus occupies the whole pubic symphysis and 2/3 of the sacral fovea. Sagittal suture occupies the right oblique diameter. Small fontanel is on the left interiorly.

Make the diagnosis, determine the station of the head (degree of descent) according to vaginal examination.

Contracted pelvis. Cephalopelvic disproportion (Anatomically and clinically narrow pelvis)

Task 1

19-year-old primigravida was admitted to the maternity hospital with regular contractions in 5-6 minutes. The term of pregnancy is 40 weeks. The dimensions of the pelvis: 24 - 26 - 29 - 18 cm. The abdominal circumference - 90 cm, the fundal height - 37 cm. The fetal head is pressed to the pelvis inlet.

Vaginal examination: the cervix is effaced, dilatation 3 cm, the amniotic membranes are intact, be in tension during the contractions. Sagittal suture occupies the left oblique diameter of the pelvis, small fontanel is on the interiorly right. Diagonal conjugate - 11 cm.

Diagnosis. Tactics.

Task 2

Multiparous, labor in term. The abdominal circumference - 90 cm, the fundal height - 34 cm. The diameters of the pelvis: 26 - 28 - 30 - 18 cm. The head presentation. The fetal heart sound is 140 beats per minute.

Vaginal examination: the cervix is not detected, the amniotic membranes are absent, the station of the head of the fetus is a large segment ("just engaged") at pelvis inlet, sagittal suture occupies the transverse diameter of the pelvis, small fontanel is on the left, caput succedaneum is absent. The diagonal conjugate is 11 cm. The discharge is clear fluid.

Diagnosis. Tactics.

Task 3

A 35-year-old multiparous. Pregnancy 39 weeks. The first delivery was 10 years ago, the child died on the 3^{d} day. The second delivery 8 years ago ended craniotomy. The dimensions of the pelvis: 27 - 28 - 31 - 17 cm. The abdominal circumference - 110 cm, the station of fetal head is above the pelvis inlet ("on the brim").

Vaginal examination: the cervix is effaced, dilatation 3 cm. The amniotic membranes are intact, tense. The fetal head is above the pelvis inlet. Sutures and fontanels of the fetal scull are not detected. Diagonal conjugate 10 cm.

Diagnosis. Tactics.

Injuries to the birth canal

Task 1

A 28-year-old patient entered the maternity hospital with a full-term fetus that was born in an ambulance. The duration of labor is 2 hours. After the birth of the baby, bleeding began in a bright stream. Placenta is squeezed by the midwife according to the Credit- Lazarevich technique. Bleeding continues as a bright stream. Pulse 100 beats per minute with weak filling. The skin and visible mucous membranes are pale. BP 90/50 mm Hg. The uterus is well contracted, it is dense.

Diagnosis. Tactics.

Task 2

A pregnant woman at 36 weeks gestation was admitted to the maternity hospital. The previous pregnancy 4 years ago ended with a cesarean section due

to severe uterine inertia which was refractory to medicine treatment. In the morning after lifting the weight, she felt pain in the epigastric region, nausea.

The general condition is satisfactory. Heart rate 100 beats per minute, BP 110/60 mm Hg. On the anterior abdominal wall there is a postoperative scar 13 cm long, healed by secondary tension. In the middle third, the scar is stellate, intimately connected with the underlying tissues, painful on palpation. There is no labor activity. The uterus is tense, its contours are clear, in the area of the scar − painful. Fetal heart sound is distinct, rhythmic, 156 beats per minute. There is no discharge from the genital tract.

Diagnosis. Tactics.

Task 3

A 38-year-old pregnant woman was taken to a maternity hospital in a severe condition. It's her 5th pregnancy and 3^{d} delivery. Two pregnancies ended by spontaneous abortions. Two deliveries lasted a long time, the weigh of children was 3500g and 3800 g. Postpartum period was uneventful.

The labor lasts for more than 14 hours, rupture of amniotic membranes happened after onset of regular contractions. Contractions were very strong, but the fetal head remained movable above pelvis inlet ("floating" above the brim). The diameters of the pelvis are normal. The abdominal circumference -105cm, the fundal height-40 cm.

Two hours ago, pushes appeared. After several pushes the patient suddenly felt a strong sharp pain in the right side of the abdomen, dizziness, cold sweat. Her temperature was 35.6°C, pulse was 120 beats per minute, her BP - 90/60 mm Hg. The paleness of the skin and visible mucous membranes was identified. The abdomen was swollen and painful on palpation. The fetal heart sound was not audible. From the genital tract scanty bloody discharge occurred.

Diagnosis. Tactics.

Task 4

A 21-year-old woman in labor was admitted to the hospital with intense contractions. Regular contractions started 12 hours ago. Rupture of amniotic membranes had happened 2 hours before admission to the hospital.

Her body temperature was 36.5°C. Her pulse was 80 beats per minute with satisfactory filling. Her BP was 110/60 mm Hg. Woman's height 158 cm, her weight 60 kg, bony skeleton with pronounced signs of rachitic. The diameters of the pelvis: 27 – 28 – 31 − 17,5 cm. The abdominal circumference is 94 cm, the fundal height -34 cm. The fetal head was pressed to the pelvis inlet ("on the brim"). Fetal heart sound was audible right below woman's navel; it was distinct, rhythmic and 132 beats per minute.

Vaginal examination: complete dilatation of the cervix. Amniotic membranes are absent. The fetal head is pressed to the pelvis inlet ("on the

brim”). The sagittal suture does not strictly correspond with the available transverse diameter of the inlet, it is deflected anteriorly toward the symphysis pubis . Small fontanel is on the right. The diagonal conjugate is 10.5 cm.

Diagnosis. Tactics.

Multiple pregnancy

Task 1

A 35-year-old primiparous, 39 weeks of pregnancy has dichorionic diamniotic twins. The first stage of labor, dilatation of the cervix is 4 cm. The lie of the first fetus is longitudinal, the buttocks presents to the pelvic inlet; the lie of the second fetus is transverse, the head is on the right. The heartbeats are distinct, 140-146 beats per minute.

The dimensions of the pelvis: 23-26-28-17 cm. The diagonal conjugate is 10.5 cm. The Soloviev index is 14.5 cm.

Diagnosis. Tactics.

Miscarriage

Task 1

A 23-year-old primigravida was admitted to the hospital with complaints of pulling pains in the lower abdomen and back.

Anamnesis: menstruation starts at the age of 16, becomes regular in a year. The cycle is 30 days, menstruation lasts for 3-4days, it’s painful, blood loss is moderate.

The last menstruation was 8 weeks ago. On specula examination: the cervix has conical shape, mucosa is cyanotic, a round external os closed. On vaginal examination: the cervical canal is closed, the body of the uterus corresponds to a 7-8-week pregnancy, and the tone of the uterus is increased. Appendages on both sides are without masses or tenderness.

Diagnosis? Treatment.

Task 2

A pregnant woman visited the clinic for women with complaints of cramping pain in the lower abdomen, small bloody discharge from the vagina. The term of pregnancy is 12 weeks. This pregnancy is the 2nd. The first one ended in premature labor at 36 weeks.

Vaginal examination: the cervix has tubular shape; external os is slit-shaped and closed. The uterine body is enlarged up to 12 weeks of pregnancy, the tone of the uterus is increased. Both adnexa are without masses or tenderness. There's blood on the glove.

Diagnosis?

Task 3

A 28-year-old pregnant woman visited a clinic for women with complaints of aching pain in the lower abdomen and lower back. The term of gestation is 17-18 weeks. In the anamnesis there are one labor and three artificial abortions.

Vaginal examination: the cervix is 2.5 cm long, the cervical canal admits one finger till the internal os, the uterine body is enlarged according to the term of pregnancy, vaginal discharge is mucous, in moderate amount.

What is the most likely diagnosis? Tactics.

Preterm labor

Task 1

A 28-year-old pregnant woman with a 32-week gestation was admitted to the maternity hospital complaining of cramping pains in the lower abdomen in 8-9 minutes. On examination, the uterus corresponds to the term of pregnancy, its tone is increased, the lie of the fetus is longitudinal, the head is pressed to the pelvis inlet, the fetal heartbeat sound is distinct, rhythmic, 146 beats/min.

On vaginal examination: the cervix is effaced, thin, dilatation is 2 cm. The amniotic membranes are intact. The head is pressed to the pelvis inlet, the bones of the skull are not firm, the sagittal suture and the fontanels are wide. The promontory is not reached.

Diagnosis? Tactics.

Postmaturity

Task 1

A 30-year-old primiparous woman was admitted to the hospital at 42 weeks and 4 days of pregnancy (298 days). On external examination the tone of the uterus is normal, the lie of the fetus is longitudinal, the fetal head is pressed to the pelvis inlet. Fetal heartbeat is quiet, rhythmic, 110 beats per minute. The estimated weight of the fetus is 4200 g, the pelvis is normal. CTG and ultrasound reveales signs of fetal intrauterine hypoxia (fetal biophysical profile-4 points, Impaired uteroplacental blood flow of the 3d degree, low amniotic fluid index). On amnioscopy, the amount of amniotic fluid is reduced, and the water is green.

On vaginal examination: the cervix is 3 cm long, dense, deviated posteriorly, the cervical canal admits one finger, the amniotic membranes are intact. The head is pressed to the pelvis inlet, the bones of the skull are hard, the sagittal suture occupies the left oblique diameter, is closed.

Diagnosis? Tactics?

Breech presentation

Task 1

A woman in labor is taken to the hospital by an ambulance. This pregnancy is the third, full-term. The first pregnancy ended with a normal delivery, the second - with a miscarriage.

Contractions are regular. The fetal lie is longitudinal, the presenting part is buttocks. On vaginal examination the rupture of amniotic membranes happened, after which there was a decrease in the fetal heartbeat up to 100 beats per minute.

There is complete dilatation of the cervix, amniotic membranes are absent, a pulsating loop of umbilical cord is felt in the vagina. The buttocks of the fetus are pressed to the pelvic inlet.

Diagnosis. Tactics.

Task 2

A 25-year-old multigravidawas admitted to the hospital at 38 weeks of pregnancy. The diameters of the pelvis are 25-28-32-21 cm. The height of the uterus fundus is 35 cm, the circumference of the abdomen - 98 cm. The pelvic pole is a presenting part. The fetal heartbeat is distinct, 140 beats per minute.

A vaginal examination was performed: the cervix is 1.5 cm long, soft, middle-positioned, the cervical canal admits two fingers, the amniotic membranes are intact and the fetal foots are above the pelvis inlet. The promontory is not reached.

Diagnosis? Choose the delivery method.

Malpositions and malpresentations of the fetus. Facial presentation

Task 1

A 35-year-old multiparous was admitted to a maternity unit at 40 weeks gestation with regular contractions. The size of the pelvis is normal. An estimated weight of the fetus is 3500 g. The head is pressed to the pelvis inlet. The fetal heartbeat is 136 beats / min, distinct. Contractions in 3-4 minutes for 50-55 seconds, moderate strength.

Vaginal examination: the cervix is effaced, cervix dilatation is 7-8 cm, membranes are ruptured. The head is pressed to the pelvis inlet, the eye sockets, nose, mouth, and chin are palpated. Facial line occupies the left oblique diameter; the chin of the fetus is on the left posteriorly. The promontory is not reached.

Diagnosis? Tactics.

Pregnancy in women with a uterine scar

Task 1

A 29-year-oldwoman in labor is admitted with regular labor activity, which began 4 hours ago. The term of pregnancy is 38 weeks. This pregnancy is the 3rd. The first delivery 5 years ago completed with a caesarean section due to severe uterine inertia which was refractory to medicine treatment. The child

weighing 3600 gr is alive. The second pregnancy completed with an artificial abortion.

On obstetric examination. The fetal lie is longitudinal. The head is pressed to the pelvis inlet. The fetal heartbeat sound is distinct, rhythmic 140 beats/ min. On vaginal examination, the cervical dilatation is 4 cm.

With subsequent monitoring of the woman in labor for 4 hours, labor activity is weak, contractions in 6-7 minutes, last 20-25 seconds. On vaginal examination the cervix dilatation is 5 cm.

Diagnosis. Tactics.

Task 2

A pregnant woman was delivered to the maternity hospital at 36 weeks of gestation. The previous pregnancy 4 years ago completed with a cesarean section due to severe uterine inertia which was refractory to medicine treatment. Today in the morning after lifting the weight epigastric pain and nausea appeared.

The general condition is satisfactory. The heart rate is 90 beats per minute, BP-110/60 mm Hg. There is a postoperative scar 13 cm long on the anterior abdominal wall healed by second intention. In the middle third, the scar is star-shaped, intimately connected with the underlying tissues, painful on palpation. There is no labor activity. The uterus is tense, its contours are clear, palpation of the areas near scar is painful. The fetal heartbeat is distinct, rhythmic, 156 beats per minute. There is no discharge from the vagina.

Diagnosis. Tactics.

Physiology and pathology of the postpartum period

Task 1

A 29-year-old multiparous. The 10 th day after delivery. In labor took place prolonged rupture of amniotic membranes of 14 hours. On the 8th day after delivery the patient complained of fever up to 38.6 °C, chills, acute pain in the left shin.

On the 10th day after delivery, edema of the left leg was diagnosed; difference in circumference between the affected and the normal leg is 4 cm.

The affected leg is swollen, painful, white and cold, pain in calf muscles presents. Pulse rate is 104 beats per minute. The uterine fundus lies at the level of thesymphysis pubis. Vaginal discharge is serous, odorless.

Diagnosis. Tactics.

Task 2

A patient is transferred to the maternity hospital on the 4th day after delivery. Labor was complicated by prolonged rupture of amniotic membranes. Labor was completed by obstetric forceps. She complaints of lower abdominal

pain, weakness, malaise, rising temperature up to 38.1 °C. Pulse is 100 beats per minute, with satisfactory filling and tension. Blood pressure 120/80 mm Hg.

Vaginal examination: The uterine fundus lies about 10 cm above the symphysis pubis. On palpation uterus is painful, consistency is soft. Discharge from the vagina is dark- bloody, bad odor. Complete blood test: white blood cells-10x109 g/l, ESR-45 mm/h, hemoglobin - 60 g/l; Microscopic examination of vaginal discharge: leucocytes - 40-60 in the field of view, flora: bacilli, cocci.

Diagnosis. Tactics

Task 3

A 25-year-old primiparous. On the 6th day after the labor, pain in the left breast occurs, body temperature-38.5 C.

Objectively: in the upper outer quadrant of the left breast presents a hard tender area5x6 cm. The overlying skin is red and hot.

The fundus of the uterus lies at the level of the symphysis pubis. Lochial discharge is moderate, serous, odorless.

Diagnosis. Tactics.

Task 4

A 30-year-old primiparous, the labor was prolonged (duration of delivery 24 hours). In labor occurred preterm rupture of amniotic membranes, primary and secondary uterus inertia.

On the 6th day after delivery, the temperature is 38° C, chills. Pulse 98 to 100 beats per minute, rhythmic, satisfactory properties. On both lower extremities present varicose veins. In the area of the left shin soreness along the veins, skin hyperemia, no edema.

Complete blood test: white blood cells-13x109 /l, ESR-60 mm / h, leucocyte formula without pathology.

Diagnosis. Tactics.

Task 5

A 33-year-old patient M. complaints of abundant and foul-smelling vaginal discharge and fever up to 38.6 C on the 4th day after delivery.

The patient suffers from chronic pyelonephritis for 2 years. This pregnancy is the sixth: the first one ended with labor on time, the four subsequent – with artificial abortions, two of which were followed by acute endometritis. This pregnancy was without complications.

The total labor time was 19 hours and 20 minutes.

Objectively: the skin is moist, the mucous membranes are pale. In the lungs breathing is vesicular. Heart rate 92 beats per minute. The heart sound is distinct, rhythmic. Blood pressure 110/70 mm Hg on both hands.

On palpation the abdomen is soft, painful in the lower parts. The liver and spleen are not palpable. Symptom of lumbar pounding in the kidney area on the

right is weakly positive. The uterus fundus lies about 15 cm above the symphysis pubis, on palpation, uterus is tender and soft. Lochial discharge became bloody, abundant and foul-smelling.

On vaginal examination: the cervix is not closed, the cervical canal admits 2 fingers easily. The uterus is soft, enlarged accordingly to 14-15 weeks of pregnancy. Appendages on both sides are not defined, their area is painless on palpation. The vaginal fornices are without flattening, masses or tenderness. Lochial discharge becomes abundant and foul-smelling.

Diagnosis. Tactics.

Task 6

A 26-year-old patient, the fourth day of the puerperal period.

From the anamnesis: this labor is second, at term. In labor happened injury to perineum of the II degree, repaired by stitches. The first two days after the labor passed without complications. By the end of the 3rd day the patient had the temperature risen up to 37,3 C, a headache, burning and pain at the area of the stitches on the perineum and vagina.

Objectively: blood pressure 120/80 mm Hg, pulse 78 beats per minute, satisfactory properties. Internal organs are without pathology.

The breast is soft, the nipples are non-affected. The abdomen is soft, painless on palpation. The fundus of uterus lies about 12 cm above the symphysis pubis , the uterus is dense, painless. Lochia is moderate and bloody. Stitches on the perineum wound are covered with a purulent plaque, the tissues around the wound are red and swollen, painful on palpation.

Diagnosis. Tactics.

Task 7

On the 5th day after giving birth a 27-year-old patient felt a chill, there was a rise of temperature up to 39^0 C, the general condition worsened.

From anamnesis: delivery is 2nd, at term, complicated by prolonged rupture of amniotic membranes (24 hours), secondary uterine inertia, intrauterine fetal hypoxia, high station of the presenting part. Delivered by cesarean section, the child was extracted in the posterior view. From the 4th day of the postoperative period, the general condition of the patient started deteriorating progressively. Now she complains of general weakness, chills, lower abdominal pain, rising of temperature upto $39{,}0^0$ C.

Objectively: pulse is 96 beats per minute, rhythmic, with satisfactory filling and tension. Internal organs are without pathology.

The abdomen is soft. The fundus of uterus lies about 13 cm above the symphysis pubis, on palpation uterus is tender and soft.

On vaginal examination-the cervix has tubular shape, the cervical canal admits one finger easily. The uterus is enlarged according to 14 weeks of pregnancy, rounded shape, painful on palpation. There is an indurate tender

mass which extends from the left uterus to the lateral pelvic wall and to which the uterus is firmly fixed. The uterus is pushed to the contra lateral side.

Right appendages are enlarged, painless. Foul-smelling vaginal discharge presents.

During bacteriological examination, Staphylococcus was detected.

Diagnosis. Tactics

Task 8

A 28-year-old patient K. was admitted to the hospital two days ago after the labor. Labor was the first, at term, complicated with pre-labor prolonged rupture of membranes of 20 hours, clinically narrow pelvis, symptoms of threatening rupture of the uterus. An emergency caesarean section was performed.

The postpartum period was normal for 2 days. By the end of the second day, the condition began to progressively deteriorate, vomiting appeared, severe abdominal pain, gas retention. There was no defecation.

Objectively: the skin is pale, with a grayish color. The tongue is dry and covered with grayish plaque. Body temperature is 38,50C. Pulse is 120 beats per minute, blood pressure - 110/70 mm Hg. The abdomen is swollen, painful on palpation, Shchetkin's - Blumberg symptom is positive. On percussion - blunting percussion sound in the lower side of the abdomen.

Data from additional examination methods: leucocytosis-17, 5x109/l,

ESR-55 mm / hour, leucocyte formula shift to the left.

Diagnosis. Tactics.

Early gestosis. Rare (atypical) types of gestosis of the 2nd half of pregnancy

Task 1

A 22-year-old pregnant woman, gestational age of 7-8 weeks, was admitted to the gynecological department with complaints of decreased appetite, nausea, vomiting 3-5 times a day, more often after eating. Body weight decreased by 1 kg.

On admission to the hospital the general condition is satisfactory. The body temperature is normal. The skin and visible mucous membranes are of normal color. Pulse 90 beats / min, rhythmic, with satisfactory filling and tension. BP 120/70 mm Hg. Blood and urine tests have no pathological changes.

Diagnosis. Tactics.

Task 2

A 25-year-oldfirst pregnant A. visited the antenatal clinic at gestational age of 5-6 weeks with complaints of lack of appetite, nausea, vomiting 6 to 10 times a day, regardless of food intake, body weight loss is 1.2 kg during 1 week.

General condition is of moderate severity. Increased excitability is noted. The skin and visible mucous membranes are of normal color, dry.

Body temperature is low-grade. Pulse is 100 beats/min, rhythmic, with satisfactory filling and tension. BP 100/60 mm.Hg. Daily diuresis 850 ml.

Diagnosis. Tactics.

Task 3

A 21-year-oldpregnant T. was delivered to the gynecological department by an ambulance. Pregnancy is 8 weeks. Complaints of weakness, nausea throughout the day; vomiting occurs more than 15 times a day. Food is not assimilated. Body weight decreased by 8.5 kg.

The patient's condition is serious. She is exhausted, breath has smell of acetone.

The temperature is low-grade, the skin is icteric, dry. Pulse is 110 per minute, with poor filling and tension. BP 90/60 mm Hg. Heart sounds are muffled. The tongue is coated with a white coating, dry. The abdomen is soft, painless. Diuresis is reduced to 400 ml per day.

In the biochemical blood test: blood urea nitrogen, urea, bilirubin are increased, albumin, cholesterol, potassium and chloride decreased. In the urinalysis proteinuria and cylindruria revealed, reaction to acetone is sharply positive.

Diagnosis. Tactics.

Task 4

A 25-year-old pregnant I. at 33-34 weeks of pregnancy, visited the antenatal clinic with complaints of edema on the legs. This pregnancy is her first. History of present illness – chronic pyelonephritis was diagnosed by nephrologist. The pregnancy’s weight gain was 14 kg, during last week – 1.0 kg.

General condition is satisfactory. Skin and visible mucous membranes are of normal color. Pulse is 64 beats per minute, with satisfactory filling and tension. BP 120/80 and 115/80 mmHg. The uterine tone is normal. The lie of the fetus is longitudinal, with the head presentation. The fetal heart beats are distinct, rhythmic,140 beats per minute. The lower extremities are swollen.

Complete blood test and urinalysis are without pathology.

Diagnosis. Tactics.

Task 5

A 27-year-old patient S., gestational age 30 weeks, was admitted to the hospital with complaints of decreased appetite, nausea, and marked itching of the skin. General condition is satisfactory. The skin and visible mucous membranes are of icteric color. The respiratory rate is 18 breaths per minute. Ps is 80 beats / min, rhythmic, with satisfactory filling and tension. BP 120/80 mm Hg. The tongue is wet, clean. The uterine tone is normal. The lie of the fetus is longitudinal, with the head presentation. The fetal heart sounds are

distinct, rhythmic, 136 per minute. There are no dischages from the genital tract.

The patient was examined clinically and laboratory. In the complete blood test presents leukocytosis, neutrophilia, accelerated ESR; in a biochemical blood test - increase of serum bilirubin, cholesterole, a 2-fold increase of ALT and AS and alkaline phosphatase level. Coagulogram reveals hypocoagulation.

Diagnosis? Differential diagnosis? Obstetric tactics?

Task 6

A 25-year-old woman, K, term of pregnancy is 33 weeks, was admitted to hospital with complaints of lack of appetite, weakness, nausea, vomiting of the color of "coffee grounds", pain and a feeling of heaviness in the epigastric region, itching of the skin.

The general condition is serious. The skin and visible mucous membranes are of icteric color, with traces of scratching. Respiratory rate is 20 per minute. Pulse 120 beats / min, satisfactory filling and voltage. BP 150/100 mm Hg. The uterus tone is normal. The lie of the fetus is longitudinal, the head is movable above the pelvis inlet. The fetal heartbeat is distinct, rhythmic, 136 per minute. Discharge from the genital tract is not visible. Edema of the lower extremities and the anterior abdominal wall. Diuresis – 400 ml per day.

Laboratory examination revealed: leukocytosis, elevated ESR, hyperbilirubinemia – 100 mmol/l, hypoproteinemia – 50 g/l, hypofibrinogenemia – 1.8 g/l, thrombocyte level is 150x109/l, a slight increase in transaminases, alkaline phosphatase, an increase in prothrombin time and APPT, a sharp decrease antithrombin III.

Diagnosis? Screening and treatment plan?

Task 7

A 24-year-old pregnant P., was admitted to maternity hospital at term of pregnancy of 37-38 weeks complaints of edema, elevated blood pressure.

In anamnesis: chronic pyelonephritis. Present pregnancy is the second, the first was in 2005 and completed with an artificial abortion. At 33-34 weeks of gestation this pregnancy was complicated with moderate preeclampsia and IUGR first degree.

General examination: BP is 150/100mm Hg., 155/90 mm Hg; edema on the legs and anterior abdominal wall presents. The uterine tone is normal. The height of the uterus fundus is 32 cm, the circumference of the abdomen 109 cm. Pelvis diameters are 26-28-30-20. The fetal heartbeat is distinct, 140 beats per minute.

In urinanalysis: protein 1.6 g/l, leucocytes – 2-3 in field of vision, hyaline cylinders – 1-2. In the biochemical analysis total protein level is 59 g/l, urea – 4.7 mmol/L.

On vaginal examination: the cervix is 1.0 cm long, soft, middle-positioned, the cervical canal admits two fingers. The amniotic membranes are intact. The fetus's head is pressed to the pelvis inlet. The promontory isnot reached.

Considering the term of pregnancy, long-term preeclampsia, the mature cervix an amniotomy was done. The labor was conducted with the participation of an anesthesiologist which provided pain relief and co-worked in the treatment of preeclampsia. Newborn weighing 2150 g, length 43 cm, Apgar score 8/8 points was born. The total duration of delivery – 6 hours 50 min.

Because of preeclampsia, the woman was transferred to the intensive care unit. BP 130/90, 130/80 mm Hg, pulse – 72/min, proteinuria (urine taken by catheter) – 1.2 g/L.

Despite complex therapy of gestosis during 14 hours after delivery, the patient complained of discomfort and epigastric pain. It was registered: blood pressure 160/115, 170/120 mm Hg, decrease plts from 233 to $122 \cdot 10^9$/l; ALT increased from 34.8 to 404 u/l and AST from 37.4 to 231 u/l; LDH – 1648 u/l; total bilirubin – 42,0 μm, straight – 2.1 μm, indirect – 39.9 μm; proteinuria – 2,3 g/l, total protein – 55 g/l, the urine is of dark cherry color. Ultrasonography revealed that the liver is only slightly larger (+1 cm), capsular contour is smooth, parenchymal echogenicity is medium-grained, with moderate diffuse changes, the weakening of the ultrasonic signal in the deeper portions.

Hypertensive conditions during pregnancy

Task 1

Primiparous with moderate preeclampsia at 38 weeks of pregnancy. In the second stage of labor with the beginning of pushing, blood pressure increased to 180/110 mm Hg. There is no headache. Vision is clear. The fetal heartbeat is distinct, rhythmic, 140 beats per minute.

Vaginal examination: the fetal head is located in the narrow part of the pelvic cavity (midpelvis), the amniotic membranes are absent.

Diagnosis. Tactics.

Task 2

A22-year-old primigravida was taken to the maternity hospital by an ambulance at term of pregnancy 39-40 weeks with complaints of pain in the back of the head, forehead, epigastric region, visual disturbances.

During pregnancy visited the clinic for women irregularly. On the last visit at 38 weeks an increase in blood pressure up to 135/95 - 140/95 mm Hg, swelling of the legs (shins) were marked. She refused hospitalization. Today the woman On examination there is massive edema of the face, limbs, of the anterior abdominal wall and the lumbar region. BP 140/95 - 155/90 mm Hg, pulse 88 beats per minute, satisfactory properties. Internal organs are without pathology. The uterine tone is normal. The height of the uterus - 35 cm, the

abdominal circumference -101 cm. The dimensions of the pelvis: 26-29-31-21 cm.

In the general analysis of urine - protein 1.0 g/l.

Diagnosis. Tactics.

Task 3

A 24-year-old primiparous M, came to the maternity hospital with complaints of headache, poor health, cramping pain in the lower abdomen at the 36-37 weeks of pregnanacy.

From the history notes somatoform dysfunction of vegetative nervous system of mixed type, overweight (height-164 cm, weight before pregnancy-85 kg). From 32 weeks of pregnancy she notes an increase in weight up to 1.0 kg per week, swelling of the lower extremities, from 34 weeks - increasing in blood pressure up to 140/90 mm Hg. Offered hospitalization refused, outpatient treatment didn't use.

On examination: inhibited, breathing through the nose is difficult. Ps 98 beats per minute. BP-180/110 and 175/100 mm Hg. Contractions are normal strength and duration. The amniotic membranes are intact. The height of the uterus fundus - 31 cm, the abdominal circumference -92 cm. Lie of the fetus is longitudinal, the head is pressed to the pelvis inlet. Fetal heartbeat is distinct, rhythmic, 136 beats per minute. There is edema of the lower extremities, anterior abdominal wall and face. There is protein 1.0 g/l in the general analysis of urine.

Vaginal examination was performed during which appeared motor anxiety, small fibrillar twitching of the face and arm muscles, which passed into tonic cramps. After an attack of convulsions that lasted 1.5 minutes, consciousness was restored.

Inhalation general anesthesia (sevoflurane) was used. Vaginal examination: cervix is effaced, dilatation is 3 cm, amniotic membranes are intact, the head of fetus is pressed to the pelvis inlet (engaged).

Diagnosis. Tactics.

Task 4

A primiparous patient, 38-39 weeks gestation, was admitted to the maternity hospital with labor activity, which began 6 hours ago. Rupture of amniotic membranes happened on the onset of labor.

From the anamnesis: from 36 weeks of pregnancy, she marks an increase in body weight up to 1.0 kg per week, edema of the lower extremities, increase BP up to 140/90 mm Hg. The proposed hospitalization refused, treatment in outpatient clinic didn't take.

Now she has complaints of headache, pain in the epigastric region, blurring before eyes. On the examination, edema of the face and lower extremities is noted. Temperature-37.00 C, pulse-94 beats per minute, rhythmic

and intense. BP – 185/110 mm Hg, 190/100 mm Hg. In general urine analysis: protein 2.0 g/l.

Soon after the admission the pushing began for 60-65 seconds in 2-3 minutes. The lie of the fetus is longitudinal, the head of the fetus is in the pelvic cavity. Fetal heartbeat on the left, below the navel, 134 beats per minute, rhythmic.

Vaginal examination: dilatation is complete, the amniotic membranes are absent, the fetal head is in a narrow part of pelvic cavity (midpelvis), sagittal suture occupies the right oblique diameter, small fontanelle is on left and anterior.

While performing the vaginal examination, a seizure occurred, accompanied by loss of consciousness.

Diagnosis. Tactics.

Task 5

A primiparous woman, 37 weeks of pregnancy, was admitted to the maternity hospital. She is unconscious. On the road there were convulsions. The skin has cyanotic color. Blood stained foam comes out of the mouth. BP is 200/100, 190/95 mm Hg. The fetal heartbeat 140 beats per minute, distinct, rhythmic.

Vaginal examination: the cervix is effaced; dilatation is 5 cm. Amniotic membranes are intact. The head of the fetus is engaged, the small segment of the head passes the pelvic inlet. Sagittal suture occupies the right oblique diameter; small fontanelle is on left and anterior. The promontory is not reached.

In the urine analysis - protein 1.5 g/l.

Diagnosis. Therapy.

Task 6

A 30-year-old pregnant woman was taken to the maternity hospital by ambulance due to seizure, with a darkened consciousness. Pregnancy term is 38 weeks. She suffers from hypertension. The day before, she had a headache, nausea, vomiting. Legs are swollen.

Diagnosis. Tactics.

Rh-immunization

Task 1

A 32-year-old pregnant woman with Rh- sensitization (antibody titer 1: 128) has 1 birth and 2 induced abortions in anamnesis. During present pregnancy, diagnostic cordocentesis was performed at 33-34 weeks. Condition of the fetus was assessed. It has Rh-positive blood group, hemoglobin 53 g/l, hematocrit - 21 %, which was an indication for intrauterine transfusion of washed red blood cells.

At 36 weeks gestation a live premature baby boy was born weighing 2650 g, 47 cm long. The Apgar score is 7 points. Skin is pale, and the face is yellow. The liver is enlarged. Hemoglobin - 169 g/l, cord blood bilirubin - 71.4 mmol/l .

Diagnosis. Tactics.

Task 2

A 28-year-old patient at 24 weeks of pregnancy for the first time Rh-antibodies were detected in the titer 1:16. In history there are two artificial termination of pregnancy at 8 and 12 weeks of pregnancy .

This pregnancy is the third. Blood test for the presence of antibody titer, conducted in dynamics, showed growth of the titer up to 1:64 at 37 weeks of pregnancy. According to ultrasound data, there is a thickening of the placenta, polyhydramnios, increase in the size of the fetal liver and spleen. On examination amniotic fluid at 35 weeks of pregnancy the optical density of bilirubin was 0.237 units (zone 2 on the Lily scale).

At 37 weeks of pregnancy, she gave birth. The newborn is rated on the Apgar score 7-8 points. There is pallor of the skin, jaundice of the sclera and mucous membranes.

The analysis of cord blood revealed: indirect bilirubin - 92.2 mmol/l, hemoglobin 120 g/l, direct Coombs reaction is positive, blood type - A (II), Rh-positive.

Diagnosis. Tactics

Obstetric Bleeding

Task 1

1. A 26-year-old multiparous with the second pregnancy, 40 weeks. The first pregnancy ended with an abortion. An hour after the fetus birth, the placenta delivered. Immediately severe bleeding began. On examination of the placenta a missing part is detected.

Diagnosis. Tactics.

Task 2

A 26-year-old woman has the third delivery at 39 weeks. The baby is alive, full-term. In 30 minutes after the birth, severe bleeding began. Blood loss is 500 ml. Placenta separation signs have been examined - the placenta is separated. Diagnosis. Tactics.

Task 3

A 28-year-old multiparous woman at 40 weeks pregnant gave birth to a live full-term newborn. After 20 minutes, the bleeding started (blood loss is about 500 ml). The woman turned pale, her pulse is 90 beats per minute. BP 100/60mm Hg. The fundus of the uterus is 2 transverse fingers above the navel. Placenta separation signs are absent.

Diagnosis. Tactics.

Task 4

A 34-year-old multiparous. Pregnancy 37 weeks. The diameters of the pelvis are normal. The delivery starts in term and lasts for 6 hours. Contractions are of moderate strength in 7-9 minutes. Suddenly severe bleeding starts. Fetal heart sound is 128 beats per minute, rhythmic, left below the navel.

Vaginal examination: the cervix is shortened, admits two fingers. The amniotic membranes are intact and the edge of the placenta is palpated on the left side. Fetal head is above the pelvis inlet, ballotable ("floating' above the brim), the promontory is not reached.

Diagnosis. Tactics.

Task 5

A 35-year-old multiparous has 39 weeks of pregnancy. The diameters of the pelvis: 26 - 28 - 30 - 20 cm. Labor is in term. Contractions are weak, the lie of the fetus is longitudinal, the head is above the pelvis inlet. Fetal heart sound is distinct. In 3 hours after onset the contractions, severe bleeding occurs.

On vaginal examination: the cervix dilatation is 4 cm, the internal os is covered by the placenta.

Diagnosis. Tactics.

Task 6

A 25 year-old multiparous has 38 weeks of pregnancy. The circumference of the abdomen is 110 cm. Amniotic fluid escaped, 2 liters. In 3 hours after rupture of amniotic membranes, a live full-term fetus weighing 3500 g was born.

In 30 minutes, placenta delivered and was examined for its completeness - it is intact (without a missing part). Profuse bleeding with clots starts from the vagina.

Diagnosis. Tactics.

Task 7

A 32 year-old multiparous woman has full-term pregnancy. The first pregnancy ended with a normal birth. The second pregnancy was terminated with a medical abortion, which was complicated with an inflammatory process of the uterus and appendages.

The diameters of the pelvis are normal. The lie of the fetus is longitudinal. Fetal head is movable above the pelvis inlet. The heartbeat of the fetus is distinct, rhythmic 128 beats per minute. The contractions started 3 hours ago. An hour after the onset of the contractions, bleeding from the vagina started.

Vaginal examination: dilatation of the cervix is 6 cm. The spongy tissue covers the internal os not entirely – on the left anterioly it is possible to palpate the fetal membranes. Profuse bleeding.

Diagnosis. Tactics.

Task 8

A 32 year-old multiparous was admitted to the maternity hospital at 40 weeks of pregnancy with good labor activity. In anamnesis is one normal labor and 2 artificial abortions. After the 2nd abortion, there was repeated curettage of the uterus.

Labor activity continued 6 hours. A live full-term baby girl weighing 3400 g was born. Blood loss is 250 ml, bleeding continues. There are no signs of the placenta separation.

Diagnosis. Tactics.

Task 9

A pregnant woman was admitted to the hospital with bloody discharge from the vagina. Ultrasound examination revealed: the fetus corresponds to 35 weeks of pregnancy, the placenta is located on the anterior wall of the uterus. An echo-negative zone of 4.0 x 1.0 cm is detected between the basal surface of the placenta and the uterine wall.

Fetal heartbeat is arrhythmic, about 100 beats/min.

Diagnosis. Tactics.

Task 10

A 28-year-old primiparous. Pregnancy 40 weeks. Was admitted to the maternity hospital. Delivery takes 24 hours. The woman doesn't feel fetal movement. Rupture of amniotic membranes happened 20 hours before entering the maternity hospital. Body temperature - 38.5◦C.

Diameters of the pelvis: 25 -28 -31 - 20 cm. The abdominal circumference – 105 cm. The small segment of the fetal head is pressed to the pelvis inlet. The symptom of Genkel-Vasten is positive. The fetal heart sound is not audible.

Vaginal examination: complete cervix dilatation. The anterior edge of the cervix is swollen. The amniotic membranes absent, the fetal head station is on the pelvis inlet ("on the brim"). The fontanels are not determined due to a large caput succedaneum. The promontory is not reached. Smelling discharge.

Diagnosis. Tactics.

Somatic Diseases in Pregnant Women

Task 1

A 25-year-old multigravida S., 8 weeks of gestation, was admitted to the hospital with complaints of shortness of breath on a little physical exertion. Consulted by a cardiologist, diagnose: Chronic rheumatic heart disease. Mitral stenosis. Heart failure H_{IIA}.

On auscultation of the heart, cardiologist and heart surgeon heard a soft protodiastolic murmur in the 2d, 3rd or 4th intercostal space at the left sternal

border. With repeated auscultation of the heart, the following features of heart sounds were revealed: it intensifies on exhalation and physical exertion; with the maneuver of Valsalva, after 6-8 contractions of the heart, it reaches the previous intensity.

Diagnosis. Tactics.

Task 2

A 29-year-old parturient woman, pregnancy term 40 weeks, was admitted to the hospital in the second labor stage. During pregnancy, congenital heart disease was diagnosed. Complains of shortness of breath, pulse 98 beats per minute, arrhythmic. The lie of the fetus is longitudinal, the fetal heartbeat is 160 per minute.

Vaginal examination: the head of the fetus is determined near the pelvic floor; sagittal suture occupies the right oblique diameter.

Diagnosis? Tactics?

Task 3

A woman at 24 weeks' gestation begins to develop anemia rapidly. In the complete blood count: erythrocytes – 3.3 x 10^{12} / l, hemoglobin – 88 g/l, anisocytosis, poikilocytosis, microcytosis, reticulocytes - 0.2%.

Diagnosis. Tactics.

Task 4

A 29-year-old pregnant M. at a gestational age of 34 weeks, complains of blurred vision, dizziness, dry skin, brittle nails, hair loss. Examination revealed pallor of the skin and mucous membranes. The pulse is 100 beats per minute, rhythmic. On auscultation of the heart, the Ist tone at the apex is weakened, systolic murmur is audible over all points of the heart. There is vesicular breathing in lungs. The liver and spleen are not enlarged.

In the complete blood count: hemoglobin – 93 g/l, erythrocytes – 2,7x 10^{12}/l, colour index – 1.3, leucocytes – 3.8 x 10^{9}/l: eosinophils – 1%, stab neutrophils – 1%, segmented neutrophils – 56%, lymphocytes - 32%, monocytes – 10%, anisocytosis, poikilocytosis, macrocytosis, thrombocytopenia. Serum iron - 15.2 micromole / l.

Diagnosis. Tactics.

Task 5.

A 29-year-old pregnant woman with complaints of weakness and increased fatigue was referred to a physician for a consultation. Her medical history includes one term birth without complications a year ago.

Her skin was pale and her pulse rate was 82 beats per minute. BP 120/80 mm Hg. The uterus was enlarged to 24 weeks of gestation, in normal tone. The

fetal heartbeat is distinct, rhythmic, 136 beats per minute. There was no discharge from the genital tract.

Peripheral blood count: hemoglobin 92 g/l, erythrocytes. – 3,3x 10^{12}/l, color index 0.8, reticulocytes 1%.

Diagnosis. Tactics.

Task 6

A 28-year-old pregnant woman complains of pain on the right side of the lower abdomen, nausea, single episode of vomiting. Pregnancy 24 weeks. Is sick for 5- 6 hours. Pain began in the epigastric region, and then shifted to the lower right abdomen. Temperature 37.5 ^{0}C.

General condition is satisfactory. The skin has the usual color. Pulse 94 beats per minute, blood pressure 110/70 mm Hg. The tongue is dry, covered with white plaque and "fetor oris" is present. The abdomen is not swollen, soft, and painful on palpation in the right iliac region. Symptoms of peritoneal irritation are weakly positive on the right. Uterus has normal tone, fundus height corresponds to 24weeks of pregnancy.

In the complete blood count : hemoglobin level - 115 g / l, leucocytes – $10x10^9$ / l, stab neutrophils - 13%, segmented neutrophils - 65%, ESR - 20 mm / hour.

Diagnosis. Tactics.

Task 7

A 28-year-old pregnant woman K., 28 gestational weeks was admitted to the hospital with complaints of pain in the right lumbar region and lower abdomen, painful urination, fever up to 38.2^0 C.

In the anamnesis: this pregnancy is the first, the first trimester was complicated by acute cystitis, nonspecific vaginitis.

Examination: satisfactory condition, temperature 38.2^{0}C. The abdomen is painless on palpation, there are no peritoneal symptoms. The uterus is enlarged up to 28 weeks, the tone is increased. Symptom of striking lower back in the area of the projection of the kidneys is positive on the right. On transvaginal ultrasound examination, the cervix is shortened to 25 mm, the internal os is closed.

Complete blood count: leucocytes - $14x10^9$/ l, hemoglobin - 110 g / l, leucocytes - $3.44x10^{12}$ / l. Urinalysis: specific gravity - 1020, protein - 1 g / l, leucocytes - 50 - 60 in the field of view, leucocytes are absent, a lot of bacteria are detected.

Diagnosis. Tactics.

Task 8

A 25-year-old pregnant S., 8 weeks of pregnancy, admitted to the hospital. Complaints of frequent low-grade fever, muscle pain, progressive general

weakness, and decreased ability to work, periodic heartbeats and sharp headaches.

Sick for 2 months, the condition worsens. During this time, she was only once examined; myocarditis, neurosis, vegetovascular dystonia were diagnosed, the recommended treatment had no effect.

On examination, patient is asthenized, the skin is pale, without a rash.

Enlarged and dense cervical, axillary and inguinal lymph nodes size + 1.5 cm, slightly sensitive are palpated Pulse 104 beats per minute, rhythmic. BP - 100/70 mm Hg. Heart sounds are rhythmic, muffled, systolic murmur over the apex. The enlarged liver is palpated. Palpation of the muscles is moderately painful.

Laboratory test revealed toxoplasma.

Diagnosis. Tactics.

Task 9

A 17-year-old pregnant woman (gestational age 19 weeks), student, lives in a dormitory. Was admitted to the hospital on the 2nd day of illness with complaints of skin rashes, slight malaise. The disease began acutely with rash on the body and rise the temperature up to 38.0 ° C.

Examination: body temperature – 37.3°C, slight general weakness. Conjunctivitis, mucous discharge from the nose. Rash was finely spotted on unchanged skin. Mild hyperemia of the oropharynx. Painful posterior cervical and occipital lymph nodes were palpable. Pulse - 80 beats per minute, BP - 100/70 mmHg. There are no pathology in the lungs and abdominal organs.

Blood test reveals leukopenia, lymphocytosis, 10% of plasma cells, ESR is not increased.

Diagnosis. Tactics.

Task 10

A multiparous woman, full-term pregnancy, was admitted to the maternity hospital with regular contractions that started 4 hours before. The abdominal circumference – 100 cm, fundus uteri – 35 cm. Size of the pelvis: 25-28-32-21 cm. The lie of the fetus is longitudinal, the head is pressed to the pelvis inlet. The fetal heartbeat is distinct, rhythmic, 152 beats per minute.

On visual examination of the labia and inner thighs – massive areas of weeping, confluent, bright pink rashes on the labia. Vaginal examination: the cervix is effaced, soft, dilation is 5 cm. The amniotic membranes are intact. Fetal head is pressed to the pelvis inlet.

In blood tests for TORCH – IgM and IgG are positive for herpes simplex virus type II.

Diagnosis. Tactics.

Task 11

A woman at 32 weeks of pregnancy with overweight visited an antenatal clinic. She has no complaints. BP 120/70-125/80. There is no edema, the uterine tone is normal, the fundus height is 3-6 cm higher than the umbilicus, the lie of the fetus is longitudinal, the fetal head is above the pelvis inlet, ballottable. The fetal heartbeat is muffled, rhythmic, 142 beats / min.

The fasting plasma glucose level is 5.6 mmol/L. In a previous analysis, the glucose level was 5.3 mmol /l.

Diagnosis. Management.

Pediatric gynecology

Task 1

A 7 year old patient T. was born from healthy parents, heredity is not burdened. Until the age of three, she grew and developed normally. At the age of 3, she got sick with tuberculous meningoencephalitis, for which she was treated for 4 years in a specialized hospital. At the age of 6, the girl had secondary sexual characters (first the mammary glands began to increase, then there were hair on the pubis and in the armpits), from 6 years 7 months, there were irregular scanty bloody discharge from the genital tract. Objectively, the girl looks older than her age (9-10 years). Her stature is 134 cm, weight 31 kg. There are some consequences of meningoencephalitis: right side hemiparesis, motor aphasia, mental retardation. The child is excited, says a lot, incoherently, there is a pronounced general motor excitability. The degree of sexual maturity: Ma2P1Ax1. On rectoabdominal examination, a noticeably enlarged uterus is defined, the appendages are not palpated. The external genitalia are infantile. Laboratory, clinical, radiological and endocrinological investigations did not reveal any pathological data.

Diagnosis.Treatment.

Task 2

Patient L., 4 years 10 months, was admitted to the clinic for the phenomena of premature puberty. History data: birth weight was 2000g, parents are healthy, heredity is not burdened. At the age of six months, she suffered from pneumonia. Until this age, she developed normally. From the age of 3 years and 6 months, mammary glands began to develop, and scant pubic hair appeared. At 4 years and 6 months, menstrual-like bleeding appeared which was repeated periodically. Objectively: physical development corresponds to approximately 8 years of age (height 121 cm, weight 21.8 kg). Mental development corresponds to the actual age of the child. Examination of organs and systems did not reveal any pathology.

Diagnosis.Treatment.

Task 3

A 16-year-old patient K. came to the gynecologist with complaints of the absence of menstruations. She was born of healthy parents, weight at birth was 3600, 0, length 52 cm. Grew and developed normally. At the age of 10 the growth of mammary glands began, at the age of 11 pubic hair appeared, a little later - the armpits hair. On general examination: height 167 cm, weight 58 kg. Her somatotype is normosthenic. The body fat distribution correspondes to the female type. The sexual formula is Ma3P3Ax3Me0. On gynecological examination: the external genitalia are developed correctly. The labia majora cover the labia minora and clitoris. The external urethral meatus and the openings of the Bartholin's (greater vestibular glands) ducts look intact. The hymen is intact, its opening 0.6 cm in diameter. The attempt to probe the vagina is negative – the probe enters the vagina by 1 cm. On rectoabdominal examination, the impression is that the vagina tube, cervix and uterus are absent, a thin cord is palpated at the place of their location; in the area of both adnexa, the formations corresponding to the consistency and shape of the ovaries are palpated. Ultrasound examination of pelvic organs - the uterus is absent; both ovaries are visualized. Genetic testing - karyotype 46 XX.

Diagnosis.Treatment.

Task 4

A 5-year-old patient K. complaints of a severe itching in the perineal area. The girl's mother notes that the child has become restless, sleeps poorly, and often touches the external genitalia with her hands. General examination: the girl is overweight, height 117 cm, weight 31 kg. The skin is dry. Secondary sexual characteristics are absent. On examining the external genitalia, pronounced hyperemia of the vulva, edematous, and traces of scratching were revealed. Laboratory tests (smear and cultural) detected Staphylococcus aureus. Fasting blood sugar level – 8.7 mmol/l.

Diagnosis. Treatment.

Task 5

A 8 year old patient P. According to the mother, 3 months ago the girl had bloody discharge from the vagina for 3 days, then the mammary glands started to grow. The General condition of the child is satisfactory, asthenic body type, low nutrition. The mammary glands are enlarged (MA2). Pubic and the armpits hairs are absent. The abdomen is slightly enlarged in lower parts, where palpation defines a dense painless and mobile mass.

On gynecological examination: the external genitalia correspond to age, and there is a juiciness of vulva, unusual for age. Mucous discharge from the vagina presents. Rectoabdominal examination determines the movable, painless, lumpy mass, the impression that it comes from the right ovary; the body of the

uterus is a little more than normal, the left ovary can not be palpated. The pelvic ultrasound confirms the presence of a tumor originating from the right ovary.

Diagnosis.Treatment.

Task 6

A 13.5-year-old girl complains of periodic lower abdomen pain. for 5 months. Secondary sex characteristics are developed normally. Sexual formula Ma2P2Ax2Me0. Palpation of the abdomen reveals an uniform globular mass in the hypogastrium, the upper pole of which is 2 fingers higher than the pubic symphysis. Vulval inspection reveals the bulging hymen, bluish-purple in color. Rectal examination confirms the tight elastic mass.

The presumptive diagnosis. Management.

Task 7

A six-year-old girl who does not attend kindergarten is referred by a district pediatrician to a pediatric gynecologist with complaints of abundant white vaginal discharge, itching in the perineum. Vulval inspection reveals: hyperemia of the skin and mucous membranes, traces of scratching, abundant discharge from the vagina, hyperemia of the skin around the anus. The material was taken for bacterioscopical and bacteriological examination. Escherichia coli were identified. The treatment was prescribed, which did not lead to success.

Presumptive diagnosis. Mistakes made during examination. Further tactics of the doctor.

Infections of the pelvic organs

Task 1

A mother with a 4-year-old girl, who has itching and redness in the area of the external genitalia, purulent discharge from the genital tract. These symptoms occur recurrently throughout the year. Perineal hygiene is adequate. The child is observed by an allergist in connection with atopic dermatitis (skin rashes on the elbow folds and face).

Diagnosis.Tactics.

Task 2

A 25-year-old patient R. was admitted to the gynecological department with complaints of pain in the area of external genitalia, pain and discomfort while walking, fever. The pain started four days ago, after hypercooling. Last menstruation 3 weeks ago.

On examination, there is an unilateral tender swelling 4x3 cm in size of the posterior half of the labium major. The overlying skin appears red, edematous, hot to the touch, and there is a fluctuation on palpation.

On specular and bimanual examination no pathology was revealed.

Diagnosis.Tactics.

Task 3

A 37-year-old patient was admitted to the gynecological department with complaints of pain in the lower abdomen with irradiation to the sacrum and lower back, an increase in body temperature up to 38-39°C, thirst, dryness of the mouth. Ill for 2 weeks. Last menstruation was 8 days ago. For 9 years, uses the IUD for contraception.

Objectively: the skin is pale, with feverish blush. The heart rate is 100-110 beats/min, with satisfactory properties. Blood pressure 120/80 mm Hg. The abdomen is symmetrical in shape, participates in the act of breathing, and is soft when palpated, slightly painful in the lower parts. Symptoms of irritation of peritoneum are absent.

On speculum examination: mucopurulent discharge escaping out through the cervical os covering the threads of the IUD are visible.

On a bimanual examination: The uterine body is in anteversio-anteflexio position, painful on palpation, pushed to the right side. The uterus is firmly fixed to a left-side indurate tender mass, which extends to the lateral pelvic wall. The mass is hard in density. Right appendages are without masses or tenderness.

In the complete blood test: leucocytes -15x109, left shift reveals, hemoglobin - 98 g/l.

Diagnosis. Treatment plan.

Task 4

A 32-year-old patient M. was admitted to the gynecological department with complaints of sharp pain in the lower abdomen, a feeling of heat, chills, weakness.

Objectively: the general condition of moderate severity, pulse 112 beats/min, rhythmic, with satisfactory filling and tension. Body temperature is 38.8^{o}C. The tongue is dry, covered with a white coating. The abdomen is moderately swollen; does not move with respiration. There is generalized deep tenderness on abdomen. There is lower abdominal guarding and signs of irritation of the peritoneum.

Vaginal examination: cervical motion is tender; bilateral tubo-ovarian mass are determined with clear boundaries, bilateral tubo-ovarian mass are determined with clear boundaries, firmly fixed to the uterus, stationary, sharply painful on palpation. Discharge is purulent in moderate quantity. Laparotomy was performed and revealed muddy effusion in abdominal cavity, hyperemia of the parietal and visceral peritoneum, uterus and ovaries of normal size and appearance. The fallopian tubes are pyosalpinx with closed ampullary parts fixed to the posterior surface of the uterus.

Diagnosis. Definitive surgery.

Task 5

A 30-year-old patient N. was admitted to the gynecological department with complaints of severe pain in the lower abdomen, increased body temperature, chills, nausea and weakness. She is not married. Two weeks ago, there was an accidental sexual intercourse. Fell ill acutely: the body temperature increased up to 39.5° C, low abdominal pain, chills, and nausea occurred.

Objectively: General condition is of moderate severity. The pulse is 120 beats/min, rhythmic, with satisfactory properties. BP 120/80 mmHg. Body temperature 39.3° C. The shape of the abdomen is correct, the abdominal wall moves with respiration, palpation is sharply painful in the lower parts, where abdominal guarding and signs of irritation of the peritoneum present.

Speculum examination reveals purulent discharge escaping out through the cervical os. On bimanual examination: The cervix is tender on movements, the vaginal fornices are deep. The uterus and adnexa cannot be palpated due to abdominal guarding and soreness of the anterior abdominal wall.

Diagnosis, management plan.

Task 6

A 24-year-old patient L. complains of heavy vaginal discharge with an unpleasant strong fish-like odor sometimes. Gynecological examination: external genitalia and vaginal mucosa without signs of inflammation. Vaginal discharge is abundant, grayish-white. The pelvic organs are normal.

Bacterioscopy of the vaginal secretions reveals "clue cells".

Diagnosis, treatment.

Task 7

A 22-year-old patient V. was admitted to the gynecological department with complaints of aching pain in the lower abdomen which radiate to the lower back, an increase in body temperature to 37.8^{0}C, white yellow-green color. Considers herself sick for a week.

Objectively: the general condition is satisfactory. The abdomen is soft, moderately painful on palpation in the lower regions. There were no signs of peritoneal irritation, and Pasternatsky's symptom was negative on both sides. Urination is normal.

On speculum examination: there is swelling and redness around the external cervical os, purulent white discharge from the cervical canal.

Bimanual examination: the movement of the cervix is painful, the uterine body is of normal size, dense consistency, mobile, painless. Both appendages are enlarged, painful on palpation. The vaginal fornices are deep and painless. Gram-negative intracellular diplococci (“coffee-bean-shaped”) are detected in the smear from the cervical canal.

Make a diagnosis. Schedule a treatment.

Task 8

A 22-year-old patient R. came to the doctor of clinic for women with complaints of sudden profuse and offensive vaginal discharge irritation and itching within and around the introitus, a feeling of heaviness in the vagina.

She is ill for a week. Two weeks ago she had an accidental sexual intercourse.

On speculum examination: The vaginal walls become red and inflamed with multiple punctuate hemorrhagic spots. When wiping the walls of the vagina with a gauze swab, the latter is colored with a pink -bloody. In the posterior vaginal fornix – accumulation of thin, greenish-yellow and frothy offensive discharge. No pathology was revealed on the bimanual examination.

Diagnosis, management, treatment.

Task 9

A 22-year-old patient V. visited the clinic for women with complaints of intense vulvovaginal pruritus, itching, white “cottage cheese type” discharge from the vagina. Considers herself ill for 5 days.

On speculum examination: the mucous membrane of the vagina and cervix is sharply hyperemic, edematous. The discharge is thick, curdy white and in flakes, adherent to the vaginal wall, but easily removable with a gauze swab. Vaginal examination did not detect any pathology.

Make a diagnosis and prescribe treatment.

Task 10

A 23-year-old patient D. complains of pain, burning in the area vulvae, pain when urinating, fever up to 37.7°C, irritation and itching within and around the introitus.

On gynecological examination: vesicles with transparent contents were found on the skin and mucosa of the external genitalia, size from 2 mm to 5 mm, hyperemia around. There is swelling over the labia minora and majora. Vaginal mucosa is without pathology. The cervical mucosa is hyperemicin the area of the external os. The pelvic organs are without pathology.

Make a preliminary diagnosis. Make a plan of examination and treatment.

Menstrual function and its disorders

Task 1

A 22 year-old patient M. was admitted to the hospital with complaints of moderate bleeding from the vagina during10 days that appeared 2 days after the end of menstruation.

Make a plan for examination.

Task 2

A 23-year-old patient N. visited the clinic for women with complaints of the absence of menstruation for a year. What history data is necessary for making a diagnosis? What are the presumptive diagnoses?

Make a plan of examination of the patient to clarify the diagnosis.

Task 3

A 24-year-old patient M. visited the gynecologist complaining of irregular menstruation - 4-5 times a year. The last menses was 2 months ago. A progesterone test was carried out, after which menstruation began. What conclusion can be drawn from the results of this test?

Diagnosis? Examination plan?

Task 4

A 14-year-old patient M. was admitted to the gynecological Department with complaints of weakness, dizziness, and profuse bleeding from the vagina during 6 days. Menstruations are from the age of 13, irregular (after 6-8 weeks), abundant, with clots, 8-10 days, painless. On examination: the skin is pale. Heart rate 94 beats per minute, rhythmic, with satisfying filling and tension. AD 100/70 mm Hg.

Gynecological status: external genitalia are developed normally, female-pattern hair growth, hymen is intact. Discharge from the vagina is bloody, abundant. On rectoabdominal examination, pathology was not found. In the blood test, hemoglobin level is 90 g/l.

Diagnosis. Tactics.

Task 5

A 28-year-old patient L. admitted to the emergency gynecological department with complaints of prolonged vaginal bleeding after delaying the menstruation for 3 months. Test for chorionic gonadotropin is negative. Speculum and bimanual examination revealed no pathological changes. Hysteroscopy followed by uterine curettage was performed. The result of histological examination of the endometrial sample: endometrium of the late phase of proliferation.

Diagnosis. Tactics.

Task 6

A 34-year-old patient M. was admitted to the gynecological department with complaints of heavy blood discharge from the vagina.

Menstruation from 13 years, in 28 days, 4-5 days, moderate, painless.

She had two births, which passed without complications. She denies gynecological diseases. The last menstruation started 3 weeks ago and has not ended until now.

On speculum examination: the vaginal and cervical mucosa is clean. The discharge is bloody and abundant.

On bimanual examination: no pathology was found.

Diagnosis. Treatment plan.

Task 7

A 43-year-old patient C. after a 2-month absence of menstruation complains of a profuse bloody discharge from the vagina for 10 days. During the last 2 years the menstrual cycle was irregular: the interval between menstruations was 2-3 months. Gynecological illnesses are denied.

On speculum examination: the vaginal and cervical mucosa is clean.

The discharge is bloody and abundant. No pathology was found on the bimanual study.

Diagnosis. Treatment plan

Task 8

A 19-year-old patient A. complained of the absence of menstruation for 1,5 years. From anamnesis: menstruations started at the age of 13, became regular in the 6 month, up to 17 years were regular, in 28 days, lasted for 4-5 days, was moderately painful, not abundant.

At the age of 17, she began to limit herself in food, because of she considered her weight excessive. In a year she lost 10 kg, and menstruation has stopped.

The state of health remained satisfactory. She eats very little, explaining this by aversion to food. Periodically she admitted laxatives. Does not have a sexual activity.

Objectively: stature is 164 cm, weight 43 kg. The skin is pale, flaking on the elbows. The mammary glands are flabby. Blood pressure 90/60 mm Hg. Body temperature – 36.2 ^{o}C.

On gynecological examination: the external genitalia is hypotrophy, the vulva mucosa is pale and dry. On rectoabdominal examination, the uterus is small, dense, mobile, painless, appendages on both sides are not defined, their area is painless.

According to ultrasound data, the uterus body is 30x30x21 mm in size, the endometrium is not visualized, M-echo is linear.

The volume of the right ovary is 3.8 cm^3, left ovary – 3.2 cm^3.

The follicles are poorly expressed.

Diagnosis. Treatment plan.

Neuroendocrine gynecological syndromes

Task 1

A 50-year-old patient K. visited the obstetrician-gynecologist with complaints of "hot flushes" up to 12 times a day, sweating, palpitations, headache, dizziness, hypertension, irritability, insomnia, unmotivated fears. Notes that the last year the menstrual cycle was irregular, sometimes in 2-3 months, meager, painless. She denies gynecological diseases.

On speculum examination: the vaginal and cervical mucosa looks clean, thinned, dry. On bimanual vaginal examination; no pathology.

Preliminary diagnosis. Examination and treatment plan.

Task 2

A 38-year-old patient A. visited a doctor in the clinic for women with complaints of dryness and itching in the vagina, pain during sexual intercourse. She considers herself sick for 3 years, after laparotomy, hysterectomy with bilateral removal of the uterus appendages for diffuse peritonitis, metroendometritis, bilateral purulent tubo-ovarian mass. During the postoperative period antibacterial, detoxification, desensitizing and general strengthening therapy was performed. The sutures healed by primary intention, she was discharged after 15 days. Two weeks after the surgery, 'hot-flushes' appeared and had being continued for 8 months, then stopped. She did not receive any treatment.

On speculum examination: the vaginal mucosa is thinned, with a translucent vascular network, the discharge is light, poor.

On bimanual vaginal examination: the vagina of the woman who gave birth. The cervix, uterine body, and appendages are missing, and the parametria have not been changed.

Diagnosis, treatment plan.

Task 3

A 27-year-old patient P. complains of irritability, weakness, tearfulness, breast swelling, and puffiness of the face, shins, weight gain, and itchy skin. The severity of complaints increases while menstruation is approaching, after its onset, these complaints disappear. She reports a chronic bilateral adnexitis In her history. On speculum and bimanual vaginal examination, no pathological changes were detected.

Diagnosis, treatment.

Task 4

A 16- year- old female patient O. complaints of rare, scanty menstruation. During the examination, the attention is drawn to the patient's short stature, wide shoulders, narrow pelvis, short limbs, hypertrophied body muscles,

underdeveloped mammary glands, male-pattern hair growth. Menstruation from the age of 15, in 38-49 days, scanty, painless.

During gynecological examination: external genitalia are developed according to the female type, there is an increased clitoris, hypoplasia of the labia majora and minora.

In rectoabdominal examination: the uterus is slightly less than normal, dense, mobile, painless, appendages on both sides are not defined, their area is painless.

Diagnosis, examination and treatment plan.

Task 5

A 23-year-old patient Yu., complains of absence of menstruation for 7 months, infertility.

Menses started from 13 years, irregular, with delay of 2-3 months, meagre, painless. Since the age of 13, she has been noticing hair growth on the back of her thighs, shins, and above her lip. Married for 3 years, contraception not been used, pregnancy does not occur.

On examination: hypertrichosis of the skin; pigmentation and hyperkeratosis in axillary, inguinal areas, under the mammary glands; obesity with visceral stored fat tissue.

On bimanual examination: the uterus body is in anteversio-flexio, normal size, dense, mobile, painless. Enlarged on both sides, dense, painless ovaries are palpated.

Diagnosis. Survey plan.

Task 6

A 24-year-old patient R. complains of rare, scanty menstruation. Menstruation from the age of 17, irregular, after 45-60 days, 2-3 days, scanty, painless. Married for 3 years. Had one pregnancy, which was spontaneously interrupted at an early date.

On examination: athletic type of physique, mammary glands are hypoplastic, conical in shape, there is excessive hair growth on the on the extremities, inner thighs, perineum, lower abdomen; on the face, back and chest-acne vulgaris.

On gynecological examination: the external genitals are developed correctly, the clitoris is slightly enlarged. On vaginal examination: the vagina is narrow, the cervix is subconical in shape, and the external os is closed. The body of the uterus is slightly less than normal, dense, mobile, painless. The ovaries are enlarged in size; the right one is slightly larger than the left, dense, painless.

Ultrasound findings: uterine hypoplasia, both ovaries enlarged slightly asymmetrically, with cysts 5-7 mm in diameter, their capsule not thickened.

Clinical examination of the hormone status reveals low estrogen level.

Hormone assay: 17-OH-progesterone and DHEA increased, LH/FSH ratio-1.5:1, dexamethasone test is positive.

Diagnosis, treatment.

Task 7

A 17-year-old patient M. visited the gynecologist for the first time complaining on the absence of menstruation. On objective examination, the attention is drawn to: short stature (135 cm), short neck with low hair line, and webbing of the neck, low-set ears, cubitus valgus, broad shield chest, and deformity of the metatarsal bones.

On gynecological examination: underdevelopment of the mammary glands, hair in the armpits and pubis is sparse, the external genitals are formed according to the female type, labia majora and labia minora are hypoplastic.

On rectoabdominal examination, the small uterus is palpated, the appendages are not defined.

Diagnosis. Survey plan.

Task 8

A 37– year-old patient S. complained of the absence of menstruation for 1.5 years, hot-flushes.

From anamnesis: menstruation onset at 14 years, established at 16 years, 3-5 days, in 28 days, moderate, painless. Sexually active from the age of 18.

She became pregnant 2 years after the beginning of sexual life. During pregnancy, presented threatened abortion, childbirth was without complications. Menstruations return back in 8 months after the labor. Since the age of 34, menstruations became irregular, in 45-50 days and meagre. At the age of 36, menstruation stopped, and hot flashes, insomnia, irritability appeared. She denies gynecological diseases. There was no pathology of the internal organs.

On speculum examination: the vaginal mucosa was dry. Cervix was cylindrical in shape, mucous was clean. The discharge was colorless and poor. On bimanual examination: the uterus body was in anteversio-flexio, slightly smaller than normal, firm, painless, mobile. Appendages on both sides were not defined; their area was painless on palpation.

Diagnosis. Examination and treatment plan.

Diagnosis. Preterm Ovarian failure

Family planning. Contraception

Task 1

A 18-year-old patient K. visited the family planning office of the clinic for women for contraception counseling. She has been sexually active since the age of 16, irregularly, unmarried, no pregnancies.

Assign a method of contraception.

Task 2

A 42-year-old patient I. has been suffering from hypertension for 5 years, and has an obese of the first degree. She is married, has regular sexual activity. In the history 2 births, 2 induced abortions present.

Assign a method of birth control.

Task 3

A 24-year-old woman visited a doctor of a clinic for women. During sexual intercourse a day ago, the condom broke. The last menstruation was 2 weeks ago. Assign a method of contraception

Task 4

A 19-year- old young woman has regular sexual activity in marriage. During the next 2 years she is not planning to get pregnant because of her university studies. What methods of contraception can be recommended to the patient?

Task 5

A 20-years-old woman is not married, has frequent sexual activity with several sexual partners. What methods of contraception can be recommended to the patient?

Task 6

A 32- year- old patient N. has regular sexual activity in marriage. In the history present 2 normal births, 2 induced abortions. After the second induced abortion 2 years ago, she suffered from right-sided adnexitis. For 2 last years, there was no exacerbation of the inflammatory process. She's not planning any more pregnancies. What methods of contraception can be recommended to the patient?

Task 7

A 24-year-old woman came to the family planning office complaining of heavy and prolonged menstruation during two menstrual cycles after the insertion of the IUD. Make an examination and treatment plans.

Task 8

A 25-year-old patient V. came to the doctor of the clinic for women with complaints of the absence of pregnancy for 4 years. Sexual activity since the age of 20, there were no pregnancies. She denies gynecological diseases. Objectively: asthenic habitus, low nutrition. Internal organs are without pathology. On bimanual examination: the uterus body is rejected posteriorly, of normal size and shape, painless, restricted mobility. Both adnexa are without masses, but tender on palpation. The vaginal fornices are deep, without

tenderness, thickening or a definite mass, palpation of the sacro-uterine ligaments is painful. Discharge from the vagina is light whites, mucous. The presumptive diagnosis. Examination and treatment plan.

Task 9

A 30-year-old patient P. came to the doctor of the clinic for women for a certificate of health. No complaints. Menstruation started from the age of 12, established immediately, 4-5 days, in 28 days, moderate, painless, during the last 2 years last 7 days. She has been sexually active since the age of 20 in marriage. She suffered from an inflammatory disease of the uterus appendages, that happened after an induced abortion at the age of 25. She was treated inpatient and outpatient. Internal organs and laboratory tests are without pathology. On bimanual vaginal examination: the vagina is intact. The cervix is subconic in shape, the external os is closed. The uterine body is in anteversio-anteflexio position, it is dense, painless, restricted mobility, the size is normal. Both adnexa are without masses or tenderness, but there is tissue thickening in the area of their. On the examination for STD, chlamydia infection and a large number of white blood cells were detected. Diagnosis. Management tactics.

Emergency conditions in gynecology

Task 1

A 26-year-old patient K. was admitted to the gynecological department on October 15 with complaints of spotting bleeding from the vagina since October 10, recurrent pain in the right iliac region, dizziness. The last menstruation was on September 6. The specular examination revealed light cyanosis of the cervix, dark blood spotting from the cervical canal. On digital vaginal examination, the uterus is slightly enlarged, softened, and painful when shifted anteriorly. The left appendages are not changed. Enlarged and painful appendages are palpated to the right and posterior of the uterus. Palpation of the vaginal fornix is moderately painful.. Diagnosis. Tactics.

Task 2

A 25-year-old patient M. came to the gynecological department with complaints of pain in the lower abdomen for 2 weeks and prolonged dark spotting from the vagina. Last menstruation was 8 weeks ago. She thought she was pregnant, was interested in staying pregnant.

On admission, the general condition is satisfactory. Pulse 76 b/min, rhythmic, with satisfactory filling and tension. BP is 120/80 mm HG. The abdomen is painful on palpation in the lower parts. There are no symptoms of peritoneal irritation.

On specular examination: the vaginal and cervical mucosa is cyanotic. The discharge is dark-bloody, spotting. On bimanual vaginal examination: the normal vagina of a woman who did not give birth. Cervix is conical in shape,

the external os is closed. The body of the uterus corresponds to 5-6 weeks of pregnancy, somewhat softened, painless. The right appendages has adhesions, clearly not palpable, their area is painless. On the left and behind the uterus, an irregular, painful mass is palpated; size 12x10 cm. Palpation of the posterior fornix is sharply painful.

Diagnosis. Tactics.

Task 3

A 28-year-old patient D. visited the gynecological department with complaints of sharp pain in the lower abdomen, which appeared suddenly. A brief unconsciousness occurred. Last menstruation was 2 weeks ago.

Objectively: the general condition is moderate severity. The skin and visible mucous membranes are pale. Pulse 120 beats / min, rhythmic, satisfactory properties. Blood pressure 90/50 mm hg. Palpation of the anterior abdominal wall is somewhat tense, Shchetkin's symptom is weakly positive.

On bimanual examination: palpation of the uterus and appendages is difficult due to sharp pain and tension of the anterior abdominal muscles. Palpation of the posterior fornix is painful.

Diagnosis. Tactics.

Task 4

A 42-year-old patient G. came to the doctor of the clinic for women with complains of pain in the lower abdomen, increase in body temperature up to 38°C for 2 days. She did not visit the gynecologist for 5 years.

Objectively: the abdominal bloating is absent, abdomen evenly involved in breathing, on palpation is painful. There are no symptoms of peritoneal irritation. On bimanual examination: the body of the uterus corresponds to 10 weeks of pregnancy, is dense, with the uneven surface, on the anterior surface of the uterus a subserous fibroid 5x4 cm is palpated, painful, soft consistency. Both adnexa are without masses or tenderness. Discharge is scanty light whites without a smell.

Diagnosis. Therapy.

Task 5

A 30-year-old patient R. was admitted to the gynecological department with complaints of sharp pain in the lower abdomen, nausea, vomiting, which appeared yesterday suddenly. She has been suffering from chronic inflammation of the uterus appendages for 2 years.

Objectively: body temperature is 37.3 ^{o}C. Pulse 120 beats / min, rhythmic, with satisfactory properties. Blood pressure 110/70 mm hg. The tongue is dry, coated white coating. The abdomen takes a limited part in the act of breathing. The tension of the muscles of the anterior abdominal wall is determined, more on the right. On the right is a positive symptom of Shchetkin.

Bimanual vaginal examination: normal-sized uterine body, dense, deflected to the left due to the mass located in the right area. Right appendages are palpated as rounded shape mass with smooth surface, elastic consistency, size 10x14 cm. The mass is sharply painful when attempting to shift. The left appendages are not defined, their area is painless.

Diagnosis. Tactics.

Task 6

A 22-year-old patient M. was taken to the gynecological department by ambulance with complaints of acute pain in the lower abdomen, weakness, dizziness. The pain occurred suddenly after physical exercises. At home, unconsciousness occurred. Last menstruation was 6 weeks ago. She uses contraception - IUD.

Objectively: the skin is pale, cold sweat. Pulse 100 beats/min, BP 90/50 mm Hg. Symptoms of peritoneal irritation are positive. On percussion in the lateral parts of the abdomen the sound is dull.

On specular examination: the vaginal and cervical mucosa is cyanotic, clean. The discharge – minor dark spotting.

Bimanual vaginal examination: when the cervix is displaced, there is a sharp soreness. The body of the uterus corresponds to 6 weeks of pregnancy, several soft consistency, and mobile. In the area of the right appendages, a mass presents with a soft consistency without clear contours. Left appendages are not defined, their area is painless. The posterior fornix of the vagina is protruding, sharply painful when palpated.

Diagnosis. Tactics.

Endometriosis

Task 1

A 36-year-old woman N. came to a doctor with complaints of periodic bloody discharge from the vagina, which appears 2-3 days prior to menstruation. She considers herself sick for about 6 months.

In gynecological history she reports about the cervical ectopy, which was diatermokoagulated.

On specula examination: the vaginal mucosa is normal. A blue-purple spot 1x1. 5 cm is visualized on the vaginal part of the cervix, "at 7 o'clock", the focus is easy to bleed when you touch it. The discharge is light and mucous. On bimanual examination any pathology is detected.

Presumptive diagnosis. Examination and treatment plan.

Task 2

A 20-year-old patient N. was taken for emergency diagnostic laparoscopy for suspected ectopic pregnancy.

On laparoscopy examination the following were revealed: the uterus, left appendages, and the right fallopian tube are not changed. The right ovary is present as a mass covered with a white-bluish membrane, through which the dark-brown ("chocolate») content is visualized. The mass forms tight adhesions with the back surface of the uterus, rectum, uterine tube and bowel.

Diagnosis. Surgery options. The treatment after surgery.

Task 3

A 36-year-old patient T. reports that during the past 2 years her menses have become very heavy, prolonged and painful, accompanied with feeling of heaviness and " burning" in the pelvic cavity. Uterotonics do not help. Endometrial pipelle biopsy was carried out, histological examination results - mucosal glands in the phase secretion.

On bimanual examination: The uterine body is in anteversio-anteflexio position, enlarged to 7 weeks of pregnancy, has spherical shape with a smooth surface, is dense, mobile, tender on palpation. Both adnexa are without masses or tenderness. Discharge is scanty light whites without a smell.

In the blood test hemoglobin is 90 g/l, red blood cells-2, 5x1012/l, white blood cells-6, 5x109/l, ERS-5 mm/h.

Diagnosis. Examination and treatment plan.

Cancer-predisposing and premalignant lesions of the female genitalia

Task 1

A 65-year-old patient V. visited a clinic for women with complaints of pruritus that is more than soreness, burning in the area of the external genitalia. sleeplessness and dysuria. Last time visited gynecologist six years ago.

On inspection of the external genitalia, whitish plaques are visible on the vulva. The skin is thin and looks white. Scratching results in subepithelial hemorrhages (ecchymosis) presens. There is a narrowing of the vaginal introitus.

The internal genitalia are without pathology.

Make a preliminary diagnosis, plan of examination and treatment.

Task 2

A 23 year old patient P. visited a clinic for women with complain of white discharge and contact spotting from the vagina which appeared 3 months ago. Menstruations started at the age of 13, became regular in some month, last for 4 days, are painless, moderate, in 28 days. Sexual life since 21 years, pregnancies and any gynecological diseases are absent.

On specula examination: the cervix is subconic in shape. The surface of the mucosa 2cm around the external os is bright red, grainy, covered with pus-like mucous discharge, easily bleeding when touched.

Make a preliminary diagnosis, plan of examination and treatment.

Task 3

A 28-year-old patient K. visited a clinic for women for routine examination.

On specula examination: on the posterior lip of the cervix a white patch with a shiny, waxy surface and a clear margin is visualized.

On bimanual examination any pathology is detected.

Preliminary diagnosis, examination and treatment plan.

Task 4

A 38 year old patient K. presents for a routine check-up. No complaints.

On specula examination: the cervix is cylindrical in shape. There is a bright red area extending beyond the external os in the ectocervix at the anterior lip. The lesion is smooth. The discharge is light and mucous. On bimanual examination any pathology is detected.

Preliminary diagnosis, examination and treatment plan.

Task 5

A 38 year old patient K. presents for a routine check-up. No complaints.

On specula examination: the cervix is cylindrical in shape. Speculum examination reveals a rounded mass measuring 1x0.5 cm arises from the cervical canal. The discharge is light and mucous. On bimanual examination any pathology is detected.

Preliminary diagnosis, examination and treatment plan.

Task 6

A 46-year-old patient V. was admitted to the gynecological department with complaints of heavy bloody discharge from the vagina. The bleeding started 15 days before after 2 months of absence of menstruation. During last 2 years the interval between menstruations was 2-3 months. She denies any gynecological diseases.

On the day of admission, diagnostic curettage of the uterus and the cervical canal have been carried out: the length of the uterus on the probe was 8 cm, the walls were smooth, without deformation. The obtained tissue samples were examined histologically: simple endometrial hyperplasia without atypia was detected. Make a diagnosis and prescribe treatment for this patient

Task 7

A 55-year-old patient M. visited the clinic for women with complaints of the low abdominal pain, the appearance of bloody discharge through 3 years after the cessation of menstruation.

What special and additional methods of examination should be performed in this patient to clarify the diagnosis? What are the presumptive diagnoses?

Perinatology

Task 1

Diagnosis: Pregnancy 36 weeks. Pregnancy related edema (Gestational edema). Placental insufficiency, disorder of fetoplacental blood flow, 1b degree. Fetal growth retardation, the 1 degree, asymmetric type.

Tactics: Treatment of gestosis (Pregnancy related edema), improvement of placental blood flow. The repeated ultrasound (fetometry and Doppler examination) after 2 weeks. With an improvement in placental blood flow and an increase in the abdominal circumference, pregnancy is continued.

Task 2

Diagnosis: Pregnancy 39 weeks. Term labor, second period. Anterior view of occipital presentation. Fetal distress.

Tactics: The application of outlet obstetric forceps.

Task 3

Diagnosis: Pregnancy 39 weeks. Labor at term. First period. Early rupture of the membranes. Cord prolapse. Fetal distress (Acute fetal hypoxia).

Tactics: Urgent delivery by caesarean section.

Task 4

Diagnosis: Pregnancy 21 weeks. Ureaplasmosis, genital herpes. Primary decompensated placental insufficiency. Oligohydramnios. Intrauterine growth restriction the 3^d Stage, symmetrical type.

Tactics: termination of pregnancy for medical reasons.

Task 5

Diagnosis: Labor at term. Rachitic flat pelvis I degree. Precipitous second stage of labor . Moderate asphyxia of the newborn. Traumatic brain injury to the newborn?

Tactics. Place under a radiant heater, dry the baby. A pulse oximeter placed on the right hand. Te baby is put flat, head in midline with slight extension position. Immediate suction of the oropharynx and nasopharynx is done. Stimulus to back and sole (gentle rubbing). Oxygen (100%) is administered by bag and mask .: Continuous Positive Airway Pressure may be given if necessary. Support should be continued until respirations are spontaneous, color improves and the heart rate is > 100 bpm.

Task 6

Diagnosis: Pregnancy 40 weeks, Labor at term, 1st period, breech presentation, 1st position, anterior view. Prolapse of the umbilical cord.

Tactics. Cesarean section. With prolapse of the umbilical cord, the risk of acute fetal hypoxia is high.

Task 7

Diagnosis: Moderate asphyxia of the newborn (5 points), drug-induced depression of the newborn.

Tactics. Clearing the airways from mucus, maintaining breathing (Ambu bag).

Task 8

Diagnosis. Severe asphyxia of the newborn.

Tactics. Removing mucus from the airways, intubation and resuscitation measures, monitoring the condition.

Physiological pregnancy and labor

Task 1

Diagnosis: The gestation age is 8 weeks and 3 days.

Tactics. The gestational age is calculated from the first day of the last menstrual period.

Task 2

First stage of normal labor. Longitudinal lie, cephalic presentation of fetus. Anterior view, first position (left).

Labor management. To monitor carefully the progress of labor, maternal and fetal conditions so as todetect any complication early.

Task 3

Diagnosis. Second stage of normal labor. Longitudinal lie, cephalic presentation of fetus. Anterior view, first position (left).

Labor management. The station of the head – achieves the midpelvis (the narrow plane of pelvis cavity), “0”.

Contracted pelvis. Cephalopelvic disproportion (Anatomically and clinically narrow pelvis)

Task 1

Diagnosis. Full term pregnancy. Normal labor, first stage. Anterior view, second position (right).

Generally contracted pelvis.

Tactics. Vaginal delivery. During labor, perform a functional assessment of the pelvis (diagnosis of cephalopelvic disproportion).

Task 2

Diagnosis: II period of term labor. Simple flat pelvis (Platypelloid).

Tactics. To deliver through vagina, taking into account the average fetal weight, the degree of contracted pelvis, correct mechanism of labor, and normal labor activity. Considering contracted pelvis, to perform functional assessment of the pelvis during labor.

Task 3

Diagnosis: Pregnancy 39 weeks. Labor III, at term. The first stage of labor. Rachitic flat pelvis II degree. The large fetus. Bad obstetric history.

Tactics. Cesarean delivery.

Injuries to the birth canal

Task 1

Diagnosis: Pregnancy 40 weeks (280) days. Childbirth I, at term, rapid, roadway. Early postpartum period. Bleeding. Hemorrhagic shock, stage II. Rupture of cervix?

Tactics. Speculum examination of the cervix and vagina. Suturing of the cervical tear. Simultaneously - central and peripheral vein catheterization, bladder catheterization, antishock measures (blood volume restoration, hemotransfusion, etc.).

Task 2

Diagnosis: 36 weeks' pregnancy (252 days). Bad obstetric history (uterine scar following cesarean section). Scar failure (secondary healing of the scar). Spontaneous uterine scar rupture (Scar dehiscence).

Tactics. Emergency laparotomy. Cesarean section. Assessment of the scar, if the margins are clean, repair is done after excision of the fibrous tissue at the margins. Sterilization should be discussed.

Task 3

Diagnosis: Pregnancy at 39-40 weeks. Labor III, at term. Second stage of labor. Large fetus. Completed rupture of the uterus. Intrauterine fetal death. Hemorrhagic shock II stage. Bad obstetric history.

Tactics. Catheterization of the central and peripheral veins, catheterization of the urinary bladder, intubation, anti-shock measures (the restoration of the circulatory blood volume, hemotransfusion, etc.), anesthesia, laparotomy, hysterectomy.

Task 4

Diagnosis: Pregnancy 39-40 weeks. Labor III, at term. II stage of labor. Rachitic flat pelvis II degree. Posterior asynclitism. Clinically narrow pelvis. Tactics. Delivery by cesarean section.

Multiple pregnancy

Task 1

Diagnosis: Pregnancy 39 weeks Labor I, at term. I period of labor. Twins. Breech presentation of the first fetus. Transverse lie of the second fetus. Generally contracted pelvis II degree. Primiparous woman at 35 years of age.

Tactics. Taking into account the pelvic presentation of the first fetus and the transverse lie of the second fetus in a 35-year-old primiparous woman with an anatomically narrow pelvis, the second degree, cesarean delivery is preferred.

Miscarriage

Task 1

Diagnosis: Pregnancy 7-8 weeks. Threatened spontaneous abortion. Bad (eventfull) obstetric and gynecological anamnesis.

Tactics: Hospitalization and therapy for continuation of pregnancy: antispasmodics (spasmolytic), vitamins, sedative therapy.

Task 2

Diagnosis: Pregnancy 12 weeks. Started (Threatened) abortion.

Tactics: Hospitalization, examination to determine the cause, urgent ultrasound to determine the degree of detachment of the gestational sac and the presence of fetal heartbeats, treatment to prolong the pregnancy (if the fetus is alive), taking into account the presumed cause of abortion.

Task 3

Diagnosis: Pregnancy of 17-18 weeks, imminence (threatened) late abortion, Cervical incompetence

Tactics: hospitalization in order to treat the threat of miscarriage, correction cervical incompetence with the obstetrics pessary or a circular suture on the cervix.

Preterm labor

Task 1

Diagnosis: Pregnancy of 32 weeks. Beginning preterm labor.

Tactics: Stop contractions by intravenous drip administration of selective beta2-adrenomimetic hexoprenaline (ginipral), start prevention of fetal respiratory distress syndrome with dexamethasone.

Postmaturity

Task 1

Diagnosis: Pregnancy 42 week 4 days. Post-term pregnancy. Placental insufficiency, chronic fetal hypoxia, the stage of decompensation. Large fetus. Immature cervix.

Tactics: Urgent delivery by caesarean section.

Breech presentation

Task 1

Diagnosis: Pregnancy 39-40 weeks. Labor at term, the third. II period of childbirth. Breech presentation. Cord prolapsed. Acute fetal hypoxia. Bad obstetric history.

Tactics: Urgent delivery by caesarean section.

Task 2

Diagnosis: Pregnancy 38 weeks. Foo Task 4t presentation of the fetus.

Tactics: Cesarean delivery is planned based on the foot presentation of the fetus.

Malpositions and malpresentations of the fetus. Facial presentation

Task 1

Diagnosis: Pregnancy is 40 weeks, Term labor II, 1st period. Facial presentation, second position, anterior view.

Tactics: With an anterior view of the facial presentation of the fetus, birth through the natural birth canal is impossible. Delivery by caesarean section is indicated.

Pregnancy in women with a uterine scar

Task 1

Diagnosis: Pregnancy 38 weeks. Labor II at term, 1st period. Uterine inertia. Bad obstetric history (scar on the uterus after cesarean section).

Tactics: Considering the uterine scar, it is recommended that the woman should be delivered by cesarean section. Treatment of uterine inertia with uterotonics is contraindicated in the presence of a uterine scar.

Task 2

Diagnosis: Pregnancy 36 weeks (252 days). Bad medical history (scar on the uterus after cesarean section). The threat of uterine rupture along the scar.

Tactics: Emergency delivery by cesarean section, before the operation ftorotanovy anaesthesia for the prevention of uterine rupture.

Physiology and pathology of the postpartum period

Task 1

Diagnosis: Postpartum period at the 10th day. Postpartum tromboflebitis of the left tibia deep veins.

Tactics: Rest, bandaging of both shins with a tight elastic bandage or compression knitwear; daily measurement of the circumference of both shins; antibacterial therapy; low-molecular-weight heparins.

Task 2

Diagnosis: Postpartum period, the 4th day. Postpartum metroendometritis.

Tactics: Adequate fluid and calorie are maintained by intravenous infusion. Anemia is corrected by blood transfusion followed with oral iron. Antibiotics: Ideal antibiotic regimen should depend on the culture and sensitivity report.
Before the report, broad-spectrum antibiotics plus Metronidazole should be started. Surgical evacuation of the retained uterine products should be done after antibiotic coverage for 24 hours to avoid the risk of sepsis and uterine perforation.

A sonography of the pelvic organs should be taken. Pulse, respiration, temperature, lochial discharge, and fluid intake and output are recorded.

Task 3

Diagnosis: Postpartum period on the 6th day. Left-sided serous mastitis.

Tactics: Antibacterial, desensitizing, detoxification therapy, vitamins. Breast has to be emptied at frequent intervals. A tight fitting bra has to put on. Warm compressions at regular intervals and gentle breast massage a day. Ultra high frequency therapy.

Task 4

Diagnosis: Postpartum period on the 6th day. Postpartum thrombophlebitis of the superficial veins of the left tibia.

Tactics: Rest, bandaging both shins with a tight-elastic bandage or compression knitwear. Daily measurement of the circumference of both shins. Antibacterial therapy. Low-molecular-weight heparins under the control of a coagulogram.

Task 5

Diagnosis: The postpartum period on the 4th day. Acute postpartum endometritis. Exacerbation of chronic pyelonephritis.

Tactics: Antibacterial, infusion, anti-inflammatory therapy. Surgical evacuation of the retained uterine products should be done after ultrasonography of the pelvic organs. Pulse, respiration, temperature, lochial discharge, and fluid intake and output are recorded.

Task 6

Diagnosis: The postpartum period 4th day. Postpartum ulcer of the perineum.

Tactics: Antibacterial therapy taking into account the antibiotic resistance bacteria. Local treatment: removal of stitches, wound cleaning with antiseptic solutions, 10% sodium chloride solution or proteolytic enzymes, then

stimulation of the healing process, physiotherapy. Once the infection is controlled secondary suture may be given.

Task 7

Diagnosis: Postpartum period - 7th day. Acute postpartum endometritis, left-sided adnexitis.

Tactics: Antibacterial, infusion, anti-inflammatory therapy. Surgical evacuation of the retained uterine products should be done after ultrasonography of the pelvic organs. Pulse, respiration, temperature, lochial discharge, and fluid intake and output are recorded.

Task 8

Diagnosis: Postpartum period, 3d days. Postpartum general peritonitis.

Tactics: Urgent surgical intervention – laparotomy, hysterectomy with fallopian tubes, drainage of the abdominal cavity, intubation of the intestine followed by peritoneal dialysis. Antibacterial, infusion, detoxification therapy. Correction of acid-base status, immunity and cardiovascular activity.

Early gestosis. Rare (atypical) types of gestosis of the second half of pregnancy

Task 1

Diagnosis: Pregnancy 7-8 weeks. Vomiting of pregnant women of mild severity.

Tactics: Examination (Complete blood test, biochemical blood analysis (total protein and fractions, liver enzymes, electrolytes), acid-base state, coagulogram, general urine analysis, urine analysis for acetone, Rehberg test, urine analysis for Nechiporenko. Daily diuresis measurement, pulse monitoring, electrocardiogram and blood pressure ultrasound of the abdominal cavity are shown. Treatment: sedative therapy; balanced, fractional nutrition, liquid intake of 1-1. 5 liters per day, folic acid.

Task 2

Diagnosis: Pregnancy 5-6 weeks. Moderate vomiting of pregnant women.

Tactics: Examination (Complete blood test, biochemical blood analysis (total protein and fractions, liver enzymes, electrolytes), acid-base state, coagulogram, general urine analysis, urine analysis for acetone, Rehberg test, urine analysis for Nechiporenko. Daily diuresis measurement, pulse monitoring, electrocardiogram and blood pressure ultrasound of the abdominal cavity are shown. Hospitalization in a hospital. Treatment: sedative therapy, balanced, fractional nutrition, infusion therapy up to 1.5-2 liters per day, desensitizing therapy, regulation of tissue metabolism, vitamin therapy, antiemetic drugs, physiotherapy.

Task 3

Diagnosis: Pregnancy 5-6 weeks. Severe vomiting of pregnant women.

Tactics: Examination (Complete blood test, biochemical blood analysis (total protein and fractions, liver enzymes, electrolytes), acid-base state, coagulogram, general urine analysis, urine analysis for acetone, Rehberg test, urine analysis for Nechiporenko. Daily diuresis measurement, pulse monitoring, electrocardiogram and blood pressure ultrasound of the abdominal cavity are shown. Treatment: sedative therapy, balanced, fractional nutrition, infusion therapy up to 1.5-2 liters per day, desensitizing therapy, regulation of tissue metabolism, vitamin therapy, antiemetics, physiotherapy. In the absence of the effect of the therapy, the decision on the termination of pregnancy.

Task 4

Diagnosis: Pregnancy 33-34 weeks. Related to pregnancy edema. Chronic pyelonephritis in remission.

Tactics: It is necessary to hospitalize a pregnant woman in a hospital for a complex clinical and laboratory examination: a complete blood test, platelets, hematocrit, a general urine test, a biochemical blood test (bilirubin, urea, protein and its fractions, sugar, ALT, AST, electrolytes), a coagulogram, a Zimnitsky urine test, a Nechiporenko urine test, a Rehberg test, determination of daily diuresis, dynamics of body weight gain, ECG, consultations of related specialists (therapist, optometrist), ultrasound of the abdominal cavity, fetal ultrasound with fetal dopplerometry, fetal CTG. For the purpose of treatment, we will prescribe a therapeutic and protective regime (tincture of valerian, motherwort, etc.), therapeutic nutrition, antioxidants (kanefron, folic acid, ascorbic acid, etc.), disaggregants (curantil), drugs that improve utero-placental blood circulation (actovegin, instenon, etc.).

Task 5

Diagnosis: Pregnancy 30 weeks. Cholestatic hepatosis (Intrahepatic cholestasis)

Differential diagnosis should be carried out between viral hepatitis, obstructive jaundice - cholelithiasis, Drug induced or Hemolytic jaundice.

Management. Exclude all medicines (except mandatory ones). Ttreatment: hepatic diet, enterosorbents, hepatoprotectors.

If the clinical symptoms increase, if the fetus deteriorates, or if there is a combined obstetric pathology, an early termination of pregnancy is performed.

Task 6

Diagnosis: Pregnancy 33 weeks. Acute fatty liver

The examination includes: blood pressure, heart rate, pulse oximetry, ECG; complete blood count (platelets, hematocrit) and urine; biochemical analysis of blood (bilirubin, cholesterol, transaminases ALAT and ASAT, total

protein and its fractions, alkaline phosphatase, urea, creatinine, potassium, sodium, chlorine); coagulogram; ultrasound of the abdominal cavity; fibrogastroscopy according to indications; detection of viral markers of hepatitis; EEG; hourly diuresis; fetal monitoring; consultations of an infectious diseases specialist-hepatologist, therapist, neurologist, surgeon, anesthesiologist-resuscitator.

Task 7

Diagnosis: The post-partum period (1st day). Severe preeclampsia. Chronic pyelonephritis, remission. HELLP – syndrome.

Tactics: Complex therapy with the participation of resuscitator, hematologist, neurologist, ophthalmologist: plasmapheresis, transfusion of fresh frozen plasma, red blood cells, colloidal and crystalloid solutions, according to indications – platelets; glucocorticoids, hypotensive therapy, hepatoprotectors, antibiotics, protease inhibitors, if indicated, artificial lung ventilation.

Hypertensive conditions during pregnancy

Task 1

Diagnosis: Pregnancy 38 weeks. Term labor, II period. Severe preeclampsia.

Tactics: Due to the increasing severity of preeclampsia, intravenous general anesthesia to stop pushing activity, obstetric forceps should be used. Intensive therapy continues in the postpartum period (anticonvulsant, antihypertensive, infusion therapy).

Task 2

Diagnosis: Pregnancy 39-40 weeks. Severe preeclampsia. Fetal growth retardation.

Tactics: Hospitalization in the intensive care unit, stabilization the condition of the patient (antihypertensive therapy, diazepam, anti-convulsive therapy with magnesium sulfate, rational infusion therapy), monitoring the patient's and fetal condition, delivery after stabilizing the patient's condition during 6-24 h.

Task 3

Diagnosis: Pregnancy 36-37 weeks. Preterm Labor I, I period. Eclampsia. Fetal growth retardation.

Tactics: Using inhalation anesthesia, perform catheterization of the peripheral vein, bladder, anticonvulsant therapy, antihypertensive and infusion therapy. After stabilization of the patient's condition emergency delivery by caesarean section, continuation of intensive care in the postpartum period.

Task 4

Diagnosis: Pregnancy 38-39 weeks. Term Labor I, II period. Eclampsia.

Tactics: General anesthesia (intravenous), diazepam, emergency delivery by applying obstetric forceps, continuation of intensive care in the postpartum period.

Task 5

Diagnosis: Pregnancy of 37 weeks. Term Labor I, I period. Eclampsia. Eclamptic coma.

Tactics: Oxygen inhalation, the inhalation anesthesia, catheterization of the peripheral vein and bladder, anticonvulsant therapy, antihypertensive and infusion therapy, emergency delivery by caesarean section, continuation of intensive care in the postpartum period.

Task 6

Diagnosis: Pregnancy 38 weeks. Chronic arterial hypertension. Eclampsia (the period of resolution of seizures).

Tactics: Oxygen inhalation, the inhalation anesthesia for catheterization of the peripheral vein, bladder; anticonvulsant, antihypertensive, infusion therapy, emergency delivery by caesarean section, continuation of intensive care in the postpartum period.

Rh-immunization

Task 1

Diagnosis: Hemolytic disease of the newborn, jaundice.

Tactics: Transfer to the intensive care unit, detoxification therapy (glucose, crystalloids), monitoring of hourly bilirubin gain, phototherapy.

Task 2

Diagnosis: Hemolytic disease of the newborn, jaundice.

Tactics: Transfer to the intensive care unit. Monitoring of hourly bilirubin gain. Detoxification therapy (glucose, crystalloids), monitoring of hourly bilirubin gain, phototherapy. If the condition worsens - exchange blood transfusion.

Obstetric Bleeding

Task 1

Diagnosis: Pregnancy 40 weeks (280) days. Labor I, at term. Early postpartum period. Retention of the placenta pieces. Bleeding.

Tactics: Manual examination of the uterus; removal of parts of the placenta; volume replacement.

Task 2

Diagnosis: Pregnancy 39 weeks (273) day. Labor III, at term, III period Retained placenta. Bleeding.

Tactics: Methods of the placenta expulsion (Abuladze, Genter, or Lazarevich-Credit' methods); volume replacement.

Task 3

Diagnosis: Pregnancy 40 weeks (280) days. Labor II, at term. III period. Partial adherence of the placenta. Bleeding. Hemorrhagic shock I degree.

Tactics: Intravenous anesthesia; manual separation and removal of the placenta; volume replacement.

Task 4

Diagnosis: Pregnancy of 37 weeks. Labor I, at term. I period. Marginal placenta previa. Bleeding.

Tactics: Amniotomy. If the bleeding doesn't stop – caesarean section.

Task 5

Diagnosis: Pregnancy 39 weeks (273). Labor II, at term. I period. Central placenta previa. Bleeding.

Tactics: Caesarean section.

Task 6

Diagnosis: Pregnancy 38 weeks (266) days. Labor II, at term. Polyhydramnios. Early postpartum period. Hypotonic bleeding..

Tactics: Empty the bladder; external massage of the uterus; uterotonic agents, manual examination of the uterus; Volume replacement.

Task 7

Diagnosis: Pregnancy 40 weeks. Labor II, at term. I period. Lateral placenta previa. Bleeding.

Tactics: Amniotomy. If the bleeding doesn't stop – caesarean section.

Task 8

Diagnosis: Pregnancy of 40 weeks (280) days. Labor II, at term. III period. Partial adherence of the placenta. Bleeding.

Tactics: Intravenous general anesthesia; manual separation and removal of the placenta; blood volume replacement.

Task 9

Diagnosis: Pregnancy 35 weeks (245 days). Placenta abruption. Bleeding. Acute hypoxia of the fetus.

Tactics: Emergency caesarean section.

Task 10

Diagnosis: Pregnancy 40 weeks (280) days. Labor I, at term, prolonged. Early rupture of amniotic membranes. Prolonged rupture of membranes. Chorionamnionitis in labor. Large fetus. Stillbirth.

Tactics: Antibiotic therapy. Intravenous anesthesia; embryotomy (craniotomy).

Somatic Diseases in Pregnant Women

Task 1

Diagnosis: Pregnancy at 8 weeks. Chronic rheumatic heart disease. Mitral stenosis. Aortic valve insufficiency. Heart failure H IIA.

Tactics: Termination of pregnancy for medical reasons.

Task 2

Diagnosis. Labor at term, 2nd stage of labor. Head presentation, fetal head in the pelvic cavity. Heart failur Tactics. Cavity (low) Forceps

Task 3

Diagnosis. Pregnancy 24 weeks. Iron-deficiency anemia of moderate degree {severity).

Management: Examination of serum ferritin, serum iron and total iron binding capacity to confirm the diagnosis. Anemia treatment for 1.5-2 months - loading dose Fe 150 mg/day, thereafter a maintenance dose of Fe 40-60 mg daily is to be continued for at least 3-6 months, and rational diet. Diet rich in iron - liver (*preference is given to beef, because the iron content in this product is maximum*), meat, egg, green vegetables, green peas, figs, beans, whole wheat, onion, pomegranate fruit, green apples, buckwheat and oat porridge.

Task 4

Answer. Pregnancy at 34 weeks. Megaloblastic (vitamin B12- folate deficiency) anemia.

To confirm the diagnosis – MCV (is more than 100 $\mu 3$). MCH (more than 33 pg), MCHC (normal), serum folate and vitamin B12 (Cyanocobalamin) levels, bone marrow puncture. Treatment: administration of folic acid 1-4 mg orally daily along with iron and nutritious diet. The main sources of folic acid are green leafy vegetables, cauliflower, spinach, liver, kidney. Excessive cooking destroys much of the folate in food

Task 5

Answer: Diagnosis: Pregnancy II, 24 weeks. Mild degree of iron deficiency anemia.

Tactic: Examination of serum ferritin, serum iron, and total iron binding capacity to confirm the diagnosis.

Outpatient treatment in an antenatal clinic with iron medications for 3-6 months. Supplementary iron therapy with Daily administration of 100-120 mg elemental iron for 1.5-2 months, after - 40-60 mg/day up to 3-6 months.

A realistic balanced diet rich in proteins, iron and vitamins.

Task 6

Diagnosis: Pregnancy 24 weeks. (24 weeks pregnant.) Acute appendicitis.

Tactics: Appendectomy. Prophylactic therapy to maintain pregnancy

Task 7

Diagnosis: Pregnancy at 28 weeks. Acute gestational pyelonephritis. Threatening preterm labor.

Tactics: Inpatient treatment: antibacterial, infusion, antispasmodic therapy.

Task 8

Diagnosis: Pregnancy 8 weeks. Acute toxoplasmosis.

Tactics: Termination of pregnancy for medical reasons. Treatment of toxoplasmosis.

Task 9

Diagnosis: Pregnancy 19 weeks. Rubella.

Tactics: Termination of pregnancy for medical reasons.

Task 10

Diagnosis: Pregnancy 39-40 weeks. Labor I at term, first stage. Recurrent genital herpes infection (acute).

Tactics: Cesarean delivery, antiviral therapy.

Task 11

Diagnosis: Gestational diabetes

Management: Lifestyle changes: Medical Nutrition Therapy and physical exercise. The woman should walk/ aerobic exercise for 30 min a day (150 minutes per week). Self-monitoring of blood glucose regularly should be emphasized.

Pediatric gynecology

Task 1

Diagnosis: True precocious puberty of cerebral origin. Treatment is therapy for the primary disease, in the absence of effect – progestogens.

Task 2

Diagnosis: True precocious puberty (constitutional form). Follow-up with a gynaecologist, endocrinologist and neurologist. Treatment: Psychotherapy, vitamin therapy.

Task 3

Diagnosis. Mayer-RokitanskyKüster-Hauser syndrome (Complete agenesis of the vagina associated with absence of uterus).

Treatment is vaginal reconstruction (vaginoplasty). Treatment options are: (1) Nonsurgical, (2) Surgical

Task 4

Diagnosis: Secondary nonspecific vulvovaginitis with a background of diabetes mellitus. Treatment of the underlying disease, local treatment: sitting baths with decoction of chamomile, sage; perineal hygiene.

Task 5

Diagnosis: Hormone-producing tumor of the right ovary. False precocious puberty. Treatment is removal of the tumor.

Task 6

The presumptive diagnosis. Imperforate hymen. hematocolpos hematometra

Management. Cruciate incision of the hymen and drainage of blood

Task 7

Presumptive diagnosis. Vulvovaginitis.

Mistakes made during examination: No test for Threadworm infestation.

Further tactic. Bacteriological examination of the discharge, gram stain. Smear from the anal area for detection of pin or threadworm. Stool examination may reveal the threadworm.

Infections of the pelvic organs

Task 1

Diagnosis. Atopic vulvovaginitis.

Treatment: removing the cause of allergies, desensitizing general and local therapy.

Task 2

Diagnosis: Bartolin's gland abscess.

Management plan: surgical treatment (excision of the abscess, drainage); bacteriological and bacterioscopic examination of the contents of the abscess; antibacterial therapy.

Task 3

Diagnosis. Endometritis due to intrauterine contraceptive device. Left parametritis.

Treatment: removal of the intrauterine contraceptive device, conservative anti-inflammatory therapy.

Task 4

Diagnosis: Bilateral pyosalpinx with perforations, adhesions in the pelvis, peritonitis.

Definitive surgery is the separation of adhesions, bilateral salpingectomy, drainage of the abdominal cavity.

Task 5

Diagnosis: Acute bilateral salpingoophoritis, pelvioperitonitis (gonorrheic etiology?).

Management plan: secretions from the urethra, Bartholin's gland, and endocervix are collected for Gram stain and culture. Detection of all others STD should be done. Antibiotics sensitivity test is also to be performed.

Analgesic, antibiotics are to be prescribed even before the microbiological report is available. For gonorrheic infection cephalosporins of the III-IV generation used. For the mixt-infection combination of antibiotics should be prescribed. Dehydration and acidosis are to be corrected by intravenous fluid. Intravenous antibiotic therapy is recommended for at least 48 hours. In the absence of the effect of the complex therapy for 24-48 hours, surgical treatment is indicated (removal of the purulent focus, drainage of the abdominal cavity). To treat adequately the male sexual partner simultaneously.

Follow up: Cultures should be made 7 days and at monthly intervals following menses after the therapy Treatment is performed by a dermatologist-venereologist in a specialized department.

Task 6

Diagnosis. Bacterial vaginosis.

Treatment: Local antimicrobial therapy (metronidazole, ornidazole, clindamycin, etc.). At the second step – lactic acid to reduce pH and Vaginal suppositories containing Lactobacillus acidophilus to promote colonization with normal vaginal flora.

Women should be advised to refrain from sexual activity or use condoms consistently and correctly during the treatment regimen.

Task 7

Diagnosis: Exacerbation of chronic inflammation of the uterine appendages due to gonorrhea infection, gonococcal endocervicitis.

Bacteriological examination for gonorrhea and detection of all others STD should be done. Antibiotics sensitivity test is also to be performed.

Schedule a treatment.The patient is transferred to a specialized department, the treatment is carried out by a venereologist.

The specific treatment for gonorrhea is used (cephalosporins). It should be borne in mind that the patient with gonorrhea must be suspected of having trichomoniasis, syphilis or chlamydial infection. As such, treatment should cover all the four. Topical treatment can be applied - antiseptic and and antimicrobial agents.

Follow up. Repeat smears and cultures from the discharge are to be done after 7 days following the full course of treatment. The tests are to be repeated following each menstrual period until it becomes negative for three consecutive reports. To treat adequately the male sexual partner simultaneously.

In nulliparious patient rehabilitation may be needed: physiotherapy procedures, dissolve therapy, phytotherapy.

Task 8

Diagnosis. Trichomonas vaginitis.

Treatment principles: anti-trichomonas medication orally and locally to both partners at the same time, avoiding sexual activity and alcohol until the end of treatment, monitoring treatment results one week after the end of the course and after menstruation.

Task 9

Diagnosis. Candida vaginitis.

Treatment: Corrections of the predisposing factors should be done, if possible. Local fungicidal drugs commonly used are of the polyene orazole group. Nystatin, clotrimazole, miconazoleeconazole are used in the form of either vaginal cream or pessary. One pessary is to be introduced high in the vagina at bedtime for consecutive 2 weeks.

Task 10

Preliminary diagnosis: Acute vulvitis, endocervicitis of herpetic etiology. Examination plan: PCR and ELISA diagnosis of vesicular contents, cervical canal scrapings. Treatment plan: Antiviral therapy, immunotherapy (interleukins - Interferon альфа-2b suppositories).

Menstrual function and its disorders

Task 1

The plan. Medical history, general examination, examination of organs and systems, special gynaecological examination, pregnancy test, complete blood test, general urine test, coagulogram, gonorrhoea smear, oncocytology smear, pelvic ultrasound, pipelle biopsy and hysteroscopy if indicated.

Task 2

Anamnestic data needed: whether or not she had menstruation before, previous illnesses, reproductive function (childbirth, abortions), weight loss, stressful situation.

Examination plan: general examination, examination of the vagina and cervix on speculum;

Bimanual vaginal examination, functional diagnostics tests (Evaluation of peripheral or endorgan changes), ultrasonography of the pelvic organs, hormone profile (FSH, LH, prolactin, testosterone, cortisol, estrogens, progesterone, fT4, TTH), specialist consultations (ophthalmologist (examination of the fundus and visual fields), endocrinologist). When indicated: Computed tomography of the adrenal glands (to exclude adrenal tumor); Magnetic resonance imaging of the hypothalamic-pituitary region (to exclude a pituitary tumor).

Task 3

Conclusion. The patient has anovulatory menstrual cycles.

Task 4

Diagnosis: Juvenile uterine bleeding. Anemia. Management: Hormonal hemostasis with COC, treatment of anaemia, prevention of recurrent bleeding - regulation of menstrual cycle.

Task 5

Diagnosis: Dysfunctional (anovulatory) uterine bleeding in reproductive age. Tactics : hormonal correction of menstrual function (COC or gestagens in the second phase of the menstrual cycle) and restoration of reproductive function.

Task 6

Diagnosis: Abnormal uterine bleeding in reproductive age. Ultrasonography. If uterine cavity is not empty – uterine curettage for hemostasis, with hysteroscopy and histological examination of the biopsy specimen. Treatment is "To stop bleeding and regulate the cycle": hormonal correction of menstrual function (COC, gestagens in the second phase of the menstrual cycle) if dysfunctional uterine bleeding is confirmed.

Task 7

Diagnosis: Dysfunctional uterine bleeding of late reproductive age.

Treatment plan. To stop bleeding: Uterine curettage and hysteroscopy with biopsy (to exclude histological abnormalities).

To regulate the cycle.

Task 8

Diagnosis: Amenorrhea due to anorexia nervosa. Treatment: normalization of body weight, psychotherapy, vitamin therapy, if menstruation does not return after weight normalization - cyclic hormonal therapy for 3-6 months.

Neuroendocrine gynecological syndromes

Task 1

Diagnosis: Climacteric syndrome of moderate severity. Examination plan: ultrasonography of the pelvic organs, examination to exclude any contraindications to hormone replacement therapy

Treatment:

Nonhormonal treatment: Lifestyle modification (physical activity, reducing high coffee intake, cessation of smoking and alcohol. There should be adequate calcium and vitamin D intake (300 m of milk). Nutritious diet—balanced with calcium and protein.

Phytoestrogen therapy .

Menopausal replacement therapy in the absence of contraindications to hormones.

Task 2

Diagnosis: Artificial menopause (Postcastration syndrome). Treatment - hormone replacement therapy in combination with physiotherapy

Task 3

Diagnosis: Premenstrual syndrome (Premenstrual Tension Syndrome), swelling form.

Treatment: psychotherapy, diet, vitamin therapy, physiotherapy, prostaglandin inhibitors, hormonal therapy.

Task 4

Diagnosis: Congenital adrenal hypoplasia (Adrenogenital syndrome), pubertal form. Examination: blood tests for 17-OHP (17-hydroxiprogesterone), testosterone, dexamethasone testing; ultrasonography of the pelvic organs; adrenal computed tomography. Treatment: glucocorticoid replacement therapy.

Task 5

Diagnosis: Polycystic ovary syndrome. Primary infertility. Metabolic Syndrome? Examination: hormonal test (FSH, LH, estrogens, progesterone, testosterone, Dehydroepiandrosterone-Sulfate, 17-hydroxiprogesterone), ultrasonography of the pelvic organs. Testing for metabolic syndrome (waistline, blood pressure, HDL cholesterol level, triglyceride level and fasting blood sugar).

Treatment: weight loss. Correction of insulin resistance. Stimulation of ovulation according to indications after normalizing body weight.

Task 6

Diagnosis. (Non-classical) Congenital Adrenal Hyperplasia.

Treatment: glucocorticoid hormones, for the treatment of hypertrichosis - COC with an antiandrogenic effect, if indicated - stimulation of ovulation.

Task 7

Diagnosis. Turner's (Shereshevsky-Turner's) syndrome

Special investigations. Karyotype and Sex chromatin study. Serum gonadotropins. Laparoscopy if indicated. Ultrasonography of the pelvic organs ("Streak" gonads).

Task 8

Examination plan: ultrasonography of the pelvic organs, hormonal profile (FSH is very high, E2 is low, twice repeated). To exclude general diseases. Treatment plan: hormone replacement therapy until the age of natural menopause.

Family planning. Contraception.

Task 1

Barrier methods of contraception and spermicides.

Task 2

Voluntary surgical sterilization.

Task 3

Intrauterine devices

Task 4

Hormonal contraception, IUD insertion.

Task 5

Barrier methods, specially condom, diaphragm with spermicides.

Task 6

IUD, hormonal contraception, voluntary surgical sterilization.

Task 7

Special gynecological examination, ultrasonography of the pelvic organs, complete blood test. If anemia is severe remove the IUD; in the absence of anemia, prescribe haemostatic drugs.

Task 8

Diagnosis: Primary infertility. Suspected external genital endometriosis (retrocervical, Sacro-urerine). Examination: husband's spermogram, smears for STD, ovulation assessment, hormonal test, laparoscopy if no treatment effect within 6-12 months. Treatment: hormonal therapy with agonist of RH-LH or gestagens or combined estrogen-gestagens drugs, immunotherapy, antiprostaglandin and sedatives.

Task 9

Diagnosis: Secondary infertility (tubal-peritoneal factor). Chronic endometritis, bilateral adnexitis, periadnexitis of chlamydial etiology. Tactics: anti-inflammatory treatment for both spouses. In the future, decide on laparoscopy in order to separate pelvic adhesions, clarify the condition of the fallopian tubes and perform the necessary interventions on the fallopian tubes.

Emergency conditions in gynecology

Task 1

Diagnosis: Disturbed right-sided tubal pregnancy terminated with a tubal abortion. Tactics: sonography, puncture of the posterior vaginal fornix, laparoscopy if the diagnosis is confirmed, removal of the right fallopian tube.

Task 2

Diagnosis: Disturbed tubal pregnancy followed with intraligamentary hematoma formation.

Tactics: Laparotomy (Laparoscopy), salpingectomy.

Task 3

Diagnosis: Ovarian apoplexy, intra-abdominal haemorrhage, grade I haemorrhagic shock. Tactics: Ultrasonography, puncture of the posterior vaginal fornix. Laparotomy, resection and suturing of the ovary.

Task 4

Diagnosis: Uterine myoma, Subserous fibroid, Necrosis of the fibroid. Therapy: urgent hospitalization, laparotomy, extirpation of the uterus with fallopian tubes.

Task 5

Diagnosis. Torsion of the pedicle of the ovarian tumor.

Tactics: Urgent surgical treatment - laparotomy, salpingo-oophorectomy.

Task 6

Diagnosis: Tubal pregnancy on the right side, rupture of the fallopian tube. Intra-abdominal bleeding. Hemorrhagic shock stage I. Tactics: Laparotomy, removal of the right fallopian tube.

Endometriosis

Task 1

Diagnosis: Endometriosis of the cervix.

Tactics: colposcopy before menses, Targeted cervical biopsy followed by histological examination. Treatment of endometriosis.

Task 2

Diagnosis. Endometrioid cyst of the right ovary (Ovarian endometrioma).

Treatment: Laparoscopic cystectomy, separation of adhesions. Treatment to prevent recurrence in the post-operative period.

Task 3

Diagnosis. Adenomyosis, menorrhagia. Secondary anemia of mild severity.

Tactics: Ultrasound before and after menstruation, hysteroscopy and metrosalpingography if indicated

Treatment: hormone therapy (progestins, gonadotropin releasing hormone agonists, estrogen-progestogenic drugs), immunotherapy, sedatives.

Cancer-predisposing and premalignant lesions of the female genitalia

Task 1

Diagnosis. Lichen sclerosis. Leukoplakia of the vulva

Examination plan: digital vaginal and rectovaginal examination. PAP text. Colposcopy followed by a targeted vulva biopsy – if it indicated.

Treatment. General lifestyle advice: Patients should avoid the use of deodorants, spermicides, depilatory creams and perfumes (allergic or irritant dermatitis).™ A non-irritant soap should be used in the area and dried carefully without much rubbing™ The patient should use either cotton underwear or nothing at all.™ Histopathological diagnosis has to be made by biopsy prior to institution of any therapy. Ultrapotent topical steroids clobetasol is very effective. Local application has to be continued nightly daily for 1 month followed by alternate night for the second month and thereafter twice weekly. Usually, there is improvement following topical use of clobetasol for a period of 3 months. Failure of improvement needs exclusion of coexisting fungal infection, use of irritant cream or carcinoma. Lesions resistant to corticosteroids need treatment with tacrolimus and pimicrolimus. There are

immunosuppressants and calcineurin inhibitors, anti-inflammatory agent for local use. Surgery and CO2 laser vaporization may be needed to release adhesion for the treatment of urinary retention or narrow vaginal introitus. Use of cryotherapy or laser ablation is rarely needed. Release of labial or preputial adhesions may be needed.

Task 2

Diagnosis. Cervicitis. Cervical ectopy.

Plan of examination and treatment.

First step. Examination and treatment of cervicitis: secretions from the urethra and endocervix are collected for Gram stain and culture, STD (chlamidia). Local anti-inflammatory treatment (Interleukins (interferon), antiseptics and antimicrobials antiviral agents) is conducted.

Second step – after cure of cervicitis: PAP smear test, colposcopy.

Task 3

Diagnosis. Leukoplakia of the cervix.

Examination: Pap smear test, Herpes simplex virus, Human papilloma virus, STD testing**.** Colposcopy followed by a targeted biopsy of the cervix and cervical curettage. Local anti-inflammatory treatment (Interleukins (interferon), antiseptics and antimicrobials antiviral agents). In the case of a benign process diathermocoagulation or cryosurgery or laser vaporization may be used.

Task 4

Diagnosis. Cervical ectopy?

Plan of examination and treatment. Secretions from the urethra and endocervix are collected for Gram stain and culture, STD (Chlamydia especially). Local anti-inflammatory treatment if endocervicitis is revealed. PAP smear (cytological examination), colposcopy, cervical biopsy if indicated.

Persistent ectopy with troublesome discharge should be treated surgically by thermal cauterization thermal cauterization or cryosurgery or best by laser vaporization.

Task 5

Diagnosis. Cervical Polyp.

Management: a smear from urethra and cervical canal for bacterioscopical examination, PAP test, ultrasound of the pelvic organs. Polypectomy accompanied by cervical curettage and endometrial aspiration biopsy. Histologic examination of the removed polyp and curetted material.

Ultrasound control after 3 months.

Task 6

Diagnosis: Simple endometrial hyperplasia without atypia.

Treatment. Taking into account the age and results of the endometrial biopsy, the patient should be prescribed gestagens from the 5th to the 25 th day of the menstrual cycle for 6 months or gonadotropin-releasing hormone agonists.

Task 7

General examination, Specific examination methods – speculum examination, smear for oncocytology, bimanual vaginal examination. Ultrasonography of the pelvic organs. Endometrial sampling (Hysteroscopy and biopsy. Colposcopy according to indications.

The presumptive diagnosis: Hormone producing (feminizing) tumor of the ovary; cervical cancer; endometrial cancer.

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