



UNIVERSITY
OF MANITOBA

Welcome to Obstetrics at Women's Hospital

Obstetrical Cell Phone: 204-794-8490

This is intended as a guide to understand your role while on the Obstetrics service at Women's Hospital. It will also serve as a basic resource for many of the day-to-day activities that you will encounter over your rotation. If you have any questions or concerns, please let one of the Residents know. We are here to help and to make this a fun and useful experience.

The Obstetrics service includes:

- Basement (OPD): Prenatal clinics
- 2nd floor: Labour Floor (LA2=high risk) and LDRP (low-risk)
- 3rd floor (WRS3): Postpartum
- 5th floor (WRS5): Antepartum

General Service information:

- Scrubs are required in the OR, case room and delivery room, which may be found on the 2nd floor, room WT256. Ask the residents to show you if you are not sure.
- Rounds start at 0700 hours Monday-Friday in WT561 Conference Room
- Rounds start at 0800 hours on weekends/holidays (behind LDRP nursing desk)

During morning rounds, you should volunteer to take care of a few antepartum and postpartum patients for the day.

You will be assigned to cover one of the following three areas each day: Triage, LDRP/Labour Floor or wards (WRS3 and WRS5). Please ensure that your name and pager # is on the board where you have been assigned.

You will be assigned to various clinics throughout the week.

Typical Service Day

- Morning Rounds at 0700 (0800 on weekends) – sit down rounds to discuss patients
- Attend mandatory teaching rounds (Tues, Wed, Thurs)
- Noon-time rounds (WT561) – bring your lunch as the rounding time may vary
- Sign-over rounds (WT561) – typically at 1600-1700
- Please note that with the exception of morning rounds, other rounding times may vary during the day. Rounding and teaching times may change based on acute and unpredictable clinical responsibilities.

Your role on LDRP/Labour Floor:

- If you have been assigned to this area, you are expected to sign up for deliveries by writing you initials on the labour board
- Introduce yourself to the patient and to the patient's nurse
- You are expected to round on your patient regularly throughout the day (every 2-3 hours) and write a note in her chart to document her progress (see example below)
- You should assess progression of labour and the fetal heart tracing; if you have concerns with either, contact the Resident on call or the attending to discuss further management
- There are also elective c/s scheduled during the week. Medical students are generally assigned to attend some of these. If residents are interested in attending, please notify your senior administrative resident

Your role in Triage (see section below on triage visits):

- Triage is like a “mini-ER” for pregnant patients and is usually quite busy
- Patients are assessed in triage on arrival to the hospital
- You are to assess patients, perform supervised exams where necessary, and discuss your patient with the Resident or Attending
- For the sake of patient flow, please try to see these patients quickly
- If a patient is admitted, please ensure their information is written down for sign-over at rounds
- All patients must be discussed with the Attending Staff on call prior to sending the patient home or admitting to hospital.

Your role on Antepartum/Postpartum wards

- You are expected to round on your antepartum and postpartum patients throughout the day
- Antepartum patients should generally be seen before postpartum patients (unless you have an ill postpartum patient)
- If a patient is ill, please notify your Senior Resident as soon as possible.
- If there are no pressing issues with your patient, you can wait until noon or sign-out rounds to update the team
- Monday – Friday from 0800 to 1700 hours, please call the attending that the patient is admitted under (after discussion with Senior Resident) to discuss major issues or discharge. If there is no response, call the on-call attending
- After 1700 and on weekends, please call the on-call attending for the patient's primary physician
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Antepartum clinics

- All house staff will be assigned on a daily basis to clinics
- You will see patients and review them with the Attending
- If you get called for a delivery, you may leave clinic to attend
- Clinic times are as follows (and are subject to change):

Dr. Menticoglou Mon 9-12 pm; Thurs 1-4pm

Dr. Morris Tue 9-12pm; Wed 1-4pm

Dr. Yu Tue 9-12pm

Dr. Pymar Tue 1-4pm; Thurs 9-12pm

Dr. Dubyna Wed 9-12pm

Dr. Yu Wed 1-4 pm

Dr. Reynolds Fri 1-4pm

On-call responsibilities

- You are expected to follow laboring patients, sign-up for deliveries, assess Triage patients, and take calls from the wards
- The on-call clerks/interns are also expected to round on all post-op cesarean section patients the next morning *before* meeting for Rounds at 0700 hours (or 0800 hours on weekends). A list of these patients can be found on WRS3.
- If it is quiet on the labour floor/triage at night, we encourage you to take some time to rest but you should try to make an appearance every so often to check if anything needs to be done, if there are new labouring patients, etc.
- The call rooms are located on the 3rd Floor. A key is available from Kim Zeller. ***Do not lose this key!***

Mandatory weekly rounds (you must attend if post-call)

- Grand Rounds every Wednesday 0745 hours (Frederic Gaspard Theatre, Basic Sciences) except July and August
- High Risk Rounds every Thursday 0800 hours (Room WT561 Women's 5th floor) except July and August

Additional teaching sessions

- Additional informal teaching sessions typically occur at noon-time rounds

Call Groups

Manitoba Clinic

Dr. M. Bernier

Dr. M. Boroditsky

Dr. C. Corbett

Dr. H. Diamond

Dr. D. Ruddock

Dr. C. Palatnick

Dr. K. Pernarowski

Dr. Gertenstein

Dr. V. Lee

Dr. A. Logan

Dr. A. Gupta

Dr. L. Rogozinska

Dr. A. Maksymowicz

University Obstetrical Associates

Dr. D. Dubyna	Dr. M. Morris
Dr. A. Morris	Dr. I. Masoud
Dr. V. Poliquin	Dr. J. Gilbert
Dr. D. Evaniuk	Dr. J. McNaught
Dr. S. Johnston	Dr. M. Morris
Dr. Z. Al-Moumen	Dr. S. Naugler
Dr. H. Pymar	Dr. K. Yamamoto

On call for Self

Dr. S. Menticoglou	Dr. F. Lee
Dr. C. Schneider	Dr. G. McTavish
Dr. J. Arneja	Dr. R. Boroditsky

Important Phone #'s

Obs Cell Phone	794-8490
Gyne Cell Phone	794-4344
5 th Floor	787-3395
3 rd Floor	787-7777
Pharmacy	787-3035
Obs Triage	787-4201
PNAU	787-4210
Women's Admitting	787-3206
OPD Clinic	787-1781
High Risk L&D	787-3394
LDRP	787-3397
Paging	787-2071

Kim Zeller (Program Coordinator) 204-787-1988

The Basic Obstetrical Triage Visit

The intention is to perform a “focused history and physical exam” (think Emergency Department). There’s a reason why there isn’t a lot of space to write. Your goals should be:

1. To gather pertinent information based on the entrance complaint.
2. To devise a differential diagnosis, select *appropriate* investigations and decide on a management plan.
3. To present all of the above information in a concise manner to either your Senior Resident or the Attending.

This is intended as a rough how-to guide for structuring your triage note to ensure all relevant information has been included.

Start with an identifier including **Gravida, Para, Gestational Age, and Rh and GBS status**. Also **confirm dates** to wheel out the estimated date of confinement (EDC).

- use LNMP if that is all that is available
- or use EARLIEST ultrasound done

This is also a good place to **summarize any known issues in the current pregnancy or really important details** specific to the case.

HPI: This part should focus on 3 areas

1. All entrance complaints/symptoms. Common ones we see in triage are bleeding, cramping, abdominal pain, leaking fluid/discharge, and decreased fetal movement. You need to elaborate on each of these.
2. Obstetrical symptoms. This includes questions pertinent to known conditions in pregnancy
 - **Always ask** these 4 questions: Any bleeding? Any cramping? Any leaking? Any fetal movements?
 - For gestational HTN, ask about **4 specific** symptoms: Headaches, visual changes, change in edema, RUQ/epigastric pain.
 - For GDM/DM2, ask about the patient’s general sugar control.
3. General review of systems. Ask quickly about symptoms head-to-toe (headaches, SOB, CP, fever, chills, urinary/bowel symptoms, etc).

Pregnancy Hx: Ask if there have been any issues/problems in the current pregnancy or whether ultrasounds/fetal assessments have been done for any reasons.

PObsHx: Quickly ask about outcomes of other pregnancies including mode of delivery, GA at delivery, pregnancy complications, etc. This should be concise as well.

Eg. *2001 SVD at 35 weeks (induced for PIH)*
2003 CS at 39 wks for fetal distress

PMHx/PSurgHx:

Meds and Allergies:

Social Hx: if relevant

O/E: This should be a **focused** exam. For example, if there are no neurological symptoms, do not waste your time doing the CNS exam. However, if your patient is being seen for elevated BP, then reflexes and clonus should be checked. Again remember that in Obstetrics, there are 2 patients involved, the **mother and the fetus**, and we need to “examine” both.

Abdo: This will be relevant if any kind of pain/cramping is a complaint. You can perform Leopold’s maneuvers to assess for fetal lie (cephalic, breech, transverse). Symphysis fundal height (SFH) could also be measured, especially if the patient has had poor prenatal care. Remember to check for CVA tenderness, as pyelonephritis is fairly common in pregnancy.

Sterile Speculum exam: You should do this with the help of a Resident at first until you are comfortable doing the exams, as well as for any patient <37 weeks. Do this to assess for:

- any kind of bleeding
- any kind of leaking or discharge (check for pooling, cascade and ferning; take swabs if necessary)
- assess for cervical dilatation in any patient in which a vaginal exam is contraindicated (placenta previa, PPROM, membranes bulging in vagina if preterm, etc.).

General rule: Can use muco on the speculum if you just need to look. If you are contemplating checking for pooling/ferning, DO NOT USE MUCO, as it will potentially interfere with the ferning test.

PV Exam: Almost all patients with cramping need a PV exam to complete the assessment (exceptions: Placenta/vasa previa; PPROM not contracting, etc.). Again, at first this exam should be done with a Resident or a nurse until your skills improve. If the patient is <37wks, a Resident should be with you under all circumstances. The following information should be included:

__cm __% effaced __ post/mid/ant __vx/breech __soft/firm __station

Fetal Heart Tracing (FHT): Include this in the Physical Exam section, as this is our assessment of the fetus. Comment on:

- baseline heart rate (normal 120-160)
- variability (mild, moderate, severe)
- accelerations (present or absent)
- decelerations (early, late, variables or absent)
- contractions (are there any on the monitor? how often? how strong?)
- Interpretation of the tracing:
 - “reactive” or “non-reactive” if patient is not in labour
 - “normal”, “atypical” or “abnormal” if the patient is having contractions

Investigations: Only order relevant investigations. Remember, we do not order unnecessary lab tests “just because”. If the test will not change your management, then do not order it. Lab tests include general tests that most triage patients should have done and specific tests for different conditions.

Urine dipstick: Almost all patients should have this done even if there is no specific urinary complaint. Pregnant patients are prone to bacteruria which often manifests as “lower abdominal cramping”. You can also assess for dehydration in a patient with nausea/emesis (ketones) or proteinuria in a patient with high BP.

UA+/-MSU: Consider if dipstick is very positive; if you suspect renal stones (looking for RBCs, etc); if you suspect pyelo/UTI; if you want to check proteinuria

CBC: Only consider if concerns of significant bleeding, fever, etc.

PIH labs: This is “short form” for: CBC, lytes, urea, creatinine, liver enzymes, uric acid, INR/PTT, fibrinogen. Should be done for all patients with high BP or symptoms suggestive of PIH.

Liver enzymes/lipase: Consider if patient complains of RUQ/epigastric pain with normal BP (r/o cholelithiasis, cholecystitis, pancreatitis, etc.)

Type and screen/ Group and match: Consider if patient has significant bleeding or potential for bleeding (previa, PPH, very low Hgb, etc)

Others: At your discretion

Impression: Include your overall impression of the patient’s condition and include your differential diagnosis.

Plan: Devise an appropriate management plan for the patient. Be sure to discuss the case with a Resident first if you are unsure of your assessment. All patients must be discussed with the appropriate Attending Staff prior to sending the patient home or admitting to hospital.

Example:

27 yo G2P0 at 37+3 weeks gestation Rh- GBS-
Known gestational hypertension on labetalol

Reports feeling “wet” in her underwear when she woke up this morning at 8am. Some mucousy discharge associated with it. No odour. No gush of fluid experienced. No continuous leaking. No bleeding. No cramping/contractions. Good fetal movement. No fever or chills. No abdominal/back pain. No dysuria. No diarrhea. Denies headache, visual changes, RUQ pain. Small amount of swelling to ankles, worse after prolonged standing.

BP control has been good. Last FAU this week (no concerns). No other complications in the pregnancy.

PObsHx: SA in 2001

PMHx: Healthy

Meds: Labetolol 200 mg po BID; prenatal vitamins

Allergies: Penicillin (rash)

O/E: BP 137/75 HR 75 Temp 36.7

Abdo: Gravid uterus, SFH 36 cm. Cephalic presentation. Non-tender. No CVA tenderness.

Sterile Spec: No pooling, no ferning. Normal discharge seen. Cervix appears thick and closed.

PV: Closed, thick, posterior, firm, vertex, head high

FHT: Baseline 130 bpm, good variability, accels present, no decels. No contractions seen. Reactive tracing.

Labs: Urine dip: -'ve for protein, ketones, glucose

Impression: 27 yo G2P0 at 37 weeks with a Hx of well-controlled gestational HTN on labetalol presents with ?SROM. No evidence of SROM or active labour seen. Likely normal discharge as seen on speculum exam.

Plan: D/C home. Return if gush of fluid, contractions, bleeding or decreased FM. Patient to see her Ob tomorrow as planned. Patient discussed with Dr. Smith on call.

The Basic C/S Post-Operative Note

Use the following as a guide to assessing the post-op patients when you're on-call.

The assessment should be fairly brief and focused. The "SOAP" format may be useful.

Basic areas of focus:

- Pain control, type of analgesia being used
- Voiding and passing flatus/BM
- Ambulation
- Tolerating diet
- General symptoms: Chest pain, dyspnea, dizziness, weakness, calf pain, etc
- Any baby concerns (breastfeeding, etc.)

Physical exam:

- Vital signs (found in the chart under the Postpartum Care Map section)
- Abdominal exam to assess for tenderness, distension, etc. and to assess the wound (look at the incision if >24h postop)
- Respiratory exam
- Any other examination specific to additional complaints raised by the patient

Example:

27 yo POD#2 C/S for cephalopelvic disproportion

S: Well today. No concerns. Foley catheter out. Patient voiding well. Passing flatus but no BM. Ambulating well without symptoms. Pain well controlled on Tylenol #3 and Naprosen. Breastfeeding. Slight nausea last night that resolved with Gravol. No CP or SOB.

O: BP 134/73 HR 76 Temp 36.9

Resp: Clear to bases. No crackles.

Abdo: Good BS; soft; mild peri-incisional tenderness; incision dry and intact

A: Stable POD#2

(Pre-op Hgb 117 → Post-op Hgb 98)

Plan:

- Start ferrous gluconate 300 mg po TID
- Possible discharge home tomorrow?

The Basic Labouring Patient Note

All laboring patients should be rounded on **every 2-3 hours**. It is important to leave a note each time you see the patient. Your first note should include a more detailed history (typical triage history), and the following notes can be more concise. Please remember to **date and time** the notes (times are very important in obstetrics where multiple notes are written in a single day).

Important things to assess are:

- labour progression – ensure there is cervical change over time and if not, discuss with the Senior resident and/or attending about a plan to augment labour
- fetal heart tracing – interpret the tracing and review with the nurse, Senior resident and/or attending

Example:

Initial Note

G2P1 at 38 weeks gestation Rh + GBS -

Presented in spontaneous labour.

Membranes intact

PregnancyHx: – GDM – diet controlled

-blood sugars ranged 5-7

-FAU at 36 weeks:

-Biophysical profile 8/8, 50th %ile, vertex

PObsHx – SVD at 40weeks – no complications

PMHx – none

PSHx - appendectomy at age 20

Meds – prenatal vitamins

Allergies – none

O/E: AVSS (include actual values if abnormal)

Fetal heart tracing: Baseline 140, +variability, +accels, no decels

Contractions: regular q 3 min, strong

Vaginal examination: cervix 6cm, 90% effaced, station -2

Impression: Multiparous female in active labour

Plan: Monitor fetal heart tracing

Repeat PV in 2 hours to assess for progress

Subsequent Note

G2P1 at 38 weeks gestation, Rh+ GBS-

Spontaneous Labour

SROM at 5 am, clear

Doing well, comfortable with epidural.

O/E: FHT - BL 140bpm, + variability, + accelerations, no decelerations

Contractions - q 2-3min, strong

PV - 8cm, 100% effaced, station 0

Impression/ Plan: Progressing appropriately

R/A in 2 hours

The Basic Delivery Note

The delivery note needs to convey the basic events surrounding the delivery. In general terms, this should include information about the following:

- Mode of delivery? (SVD, C/S or operative vaginal delivery)
- What was delivered? (either a live/stillborn male or female)
- What do we know about the infant? (Apgars, birth weight)
- How was the placenta delivered and was it intact?
- What is the status of the perineum? (lacerations are graded from 1st to fourth degree)
- Were there any complications? (eg. shoulder dystocia, nuchal cord, PPH, etc.)
- Estimated blood loss (EBL)

Example:

Vaginal Delivery

SVD live female with Apgars 8¹, 9⁵

BW 3657g

Nuchal cord x 1 --> delivered through

Placenta delivered by gentle cord traction and intact

2nd degree laceration --> repaired with 0-Chromic

No other complications

EBL < 500cc

Who To Call.....

Sick Calls:

If you are sick – call in AM or PM *each* day you are ill

- Senior OB/Gyne Resident
(page through paging 787-2071)
- Kim Zeller 204-787-1988

OR

- Call Paging 787-2071 and ask for ‘Obstetrics Resident On Call’ to be paged

Call Switches:

- You need approval from Chief Resident
- Notify Kim Zeller (787-1988) and SAR