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O. M. KOSTIOUCHKINA

LABOR CASE HISTORY SCHEME

Minsk BSMU 2015

МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ
БЕЛОРУССКИЙ ГОСУДАРСТВЕННЫЙ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ
КАФЕДРА АКУШЕРСТВА И ГИНЕКОЛОГИИ

Т. А. Смирнова, Н. С. Акулич, О. М. Костюшкина

СХЕМА НАПИСАНИЯ ИСТОРИИ РОДОВ

LABOR CASE HISTORY SCHEME

Методические рекомендации

Минск БГМУ 2015

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MODEL OF THE TITLE PAGE OF LABOR CASE HISTORY

(The student should fill in all the gaps on this page)

HEALTH MINISTRY OF BELARUS
BELARUSIAN STATE MEDICAL UNIVERSITY
DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

Head of the Department of Obstetrics and Gynaecology
_____
Surname, name, patronymic
_____
(Position, scientific degree)

LABOR CASE HISTORY № _____

Patient's surname, name, patronymic: _____

Final clinical diagnosis: _____

_____

Student: _____
(Surname, name, patronymic)
Group _____
Year _____
Faculty _____

Teacher: _____
(Surname, name, patronymic)
_____
(Position, scientific degree)

Minsk 20___

GENERAL INFORMATION

1. Full name of the pregnant or parturient woman.
2. Age.
3. Date and time of admission.
4. Home address.
5. Place of work and occupation.
6. Marital status.
7. Diagnosis made at the referring institution.
8. Reasons for admission: planned preventive hospitalization; hospitalization for the examination and treatment; for the delivery.
9. Complaints on admission (if uterine contractions are present, record the time of their beginning; if the leakage of amniotic fluid is observed, note since what time).
10. Method of complete or partial sanation and cleansing (should be fully described).

GENERAL HISTORY

1. Place of birth, woman's height and weight at birth; patient mother's course of pregnancy and labor. Living conditions and the development of the expectant mother in childhood and adolescence.
2. Social conditions at the moment: diet, sleep, work and rest regime.
3. Working conditions: (nature of work, working hours) and industrial hazards (radiation, chemicals, vibration, dust, incorrect temperature regime and others).
4. Surgical interventions and diseases suffered (including rickets, childhood infections, tuberculosis, chronic, skin, venereal diseases, etc.).
5. Family history: husband's age and health, hereditary diseases registered among the relatives of both spouses (mental, endocrine disorders, cardiovascular disease, cancer and others).
6. Bad habits: smoking, alcohol or drug use.
7. Blood transfusions: reasons, complications.
8. Allergic history: intolerance to medicines, food, household chemicals.

OBSTETRIC HISTORY

1. Menstrual function: start time of the first menstrual period (menarche); establishment of the menstrual cycle (at once, for 1 year or longer period of time); duration of the menstrual cycle (normally 21–35 days); duration of menstruation (normally 3–7 days); the amount of blood lost during menstruation (normally 50–150 ml); the presence of pain syndrome and its association with menstruation (before, during or after); changes in menstrual cycle after the beginning of sexual activity, childbirth and abortions; the exact date of the first day of the last menstrual period.

2. Sexual function: the beginning of sexual activity, number of marriages, casual sexual affairs; contact bloody discharge; tenderness during sexual intercourse. Methods of contraception, its duration and effectiveness.

3. Reproductive function: the period of time from the beginning of sexual activity before the first pregnancy; the cause of its long absence. The number of pregnancies, their course and outcomes in chronological order (at what term, and the outcome of each one; occurrence, character and duration of complications during pregnancy, delivery and the postpartum period; during and after vacuum aspiration or abortion). The duration of breast-feeding, weight and height of older children at their birth, their subsequent development. The number of living children, causes of children's death.

4. Observation in the antenatal maternity clinic № _____:

a) The date of the first and last visit to the antenatal maternity clinic and pregnancy term, the total number of visits.

b) Initial body weight, height and blood pressure (at the 1st visit).

c) Examination findings provided by the antenatal maternity clinic:

- complete blood count (at the 1st visit, on the 28th, 34th weeks of pregnancy), urinalysis (at each visit);
- blood test to determine the blood group and Rh-factor;
- blood glucose (at the 1st visit and on the 22nd week of pregnancy);
- biochemical blood analysis (at the 1st visit, on the 28th, 34th weeks of pregnancy);
- serum ferritin levels (at the 1st visit and on the 30th week of pregnancy);
- blood clotting tests (at the 1st visit, on the 22nd week of pregnancy);
- D-dimers (on the 30th, 38th weeks of pregnancy);
- bacterioscopic flora study of the discharge from the urethra and cervix (at the 1st visit, on the 28th, 36th weeks of pregnancy);
- cytological study of smears from the cervical canal;
- the Wassermann test (at the 1st visit, on the 28th, 36th weeks of pregnancy), toxoplasmosis (at the 1st visit and on the 20th week of pregnancy).

d) Consultation with specialists at the 1st visit of the pregnant woman to a doctor:

- therapist (also on the 28th, 36th weeks of pregnancy);
- endocrinologist;
- ophthalmologist;
- dentist;
- otorhinolaryngologist;
- others, if indicated.

e) The presence of concomitant extragenital diseases, pregnancy complications, treatment conducted.

f) Physiological, psychological preventive preparation for the delivery, motherhood school.

g) Date of first fetus movements.

h) Date of issue of antenatal sick-leave.

i) The expected delivery date (date of labor) calculated according to:

– the 1st day of the last menstrual period;

– the 1st visit to the antenatal maternity clinic;

– the first fetus movements;

– antenatal sick-leave;

– findings of the 1st ultrasound imaging.

OBJECTIVE EXAMINATION

1. Woman's general condition. Determine: the type of constitution (normosthenic, infantile, intersexual, asthenic), body-build (female, male, virile, eunuchoid); skeletal structure and its defects, phenotypic features (presence of dysplasia and dysmorphia — micro- and retrognathia, Gothic palate, wide nasal bridge, short neck, the location of the ears, barrel-chest, hypoplastic nails, plenty of birthmarks and others); color of visible mucous membranes and skin, their condition (pigmentation, excessive greasiness, the presence of pregnancy "scarring", acne, folliculitis, scarring after undergoing surgery, etc.); the degree of development of adipose tissue and its distribution (on the hips, shoulders, breast, abdomen, thighs, etc.); features of the hair distribution (hypertrichosis, hirsutism, virilism); height, body weight and weight gain during pregnancy; body temperature.

2. Inspection of the breasts: the development, size and shape, consistency, symmetry, the presence of consolidations and tumor-like masses, the condition of the skin, areolas and nipples; the presence of discharge from the nipples, its color, consistency, character and amount.

3. Examination of the organs and systems:

a) *the condition of the cardiovascular system*: the character of pulse, blood pressure on both arms, heart sounds, its borders;

b) *the condition of the respiratory system*: respiratory rate per minute, auscultation of the lungs;

c) *the condition of the digestive system*: appetite, swallowing (difficult or not), the condition of the oral mucosa and tongue (on the examination of the mouth); palpation of the abdomen, the character of stool;

d) *the condition of abdominal rectus muscles*: presence or absence of diastasis;

e) *the condition of the urinary system*: the presence of edema, the character of urination, urine color, tapotement sign;

f) *the condition of the central nervous system*: consciousness (clear, mental confusion, delirium, coma, loss and recovery of memory); orientation in time and space;

g) *the condition of the endocrine system*: findings of the thyroid gland palpation.

OBSTETRIC EXAMINATION ON ADMISSION

The student should record:

– the date and time of examination;

– uterine contraction characteristics: frequency, duration and strength of contractions, presence of expulsive pains (if the patient was admitted with uterine contractions). Specify if the uterine contractions are missing.

The obstetric examination is conducted in the upright and supine position.

1. General obstetric examination. The following parameters should be determined:

– shape of the abdomen (ovoid (normally), spherical, in the form of cross-oval, pointed or pendulous abdomen);

– abdominal circumference (cm);

– the height of the uterus fundus (cm);

– Soloviov's index (cm);

– the shape and size of the Michaelis's rhomb;

– the size of the pelvis measured with pelvimeter (distantia spinarum, d. cristarum, d. trochanterica, conjugate externa);

– fronto-occipital fetal head size measured with pelvimeter;

– external maneuvers of obstetric examination (Leopold's maneuvers) — describe the technique and purpose of each of the 4maneuvers; findings of the examination of a ***concrete pregnant*** (the height of the uterus fundus, the part of the fetus which is in the uterus fundus; fetal lie, fetal position, vision of fetal position, fetal presentation, the station of the fetal presenting part to the pelvic inlet (above, is pressed against the inlet, with small or large segment within the inlet, in the pelvic cavity);

– signs of clinical fitness between the size of the fetus head and the mother's pelvis (signs of Vasten and Zangemeister — negative, at the same level, positive) — are described only under the following conditions: the presence of regular uterine contractions, rupture of membranes (or amniorrhexis is a term used during pregnancy to describe a rupture of the amniotic sac) and the fixation of the fetal head to the pelvis inlet;

– fetal heart rate (the place of hearing, rate, rhythm, tonality of heartbeats);

– estimated fetal weight (g) according to the formulas suggested by Bublichenko, Zhordania, Yakubova, Medvedev, Mogilev, Gerasimovich, Lukashevich et al. — formulae used must be specified together with the ongoing calculation of the expected fetal weight.

2. Investigation by means of speculum. Determine the folding of the vaginal mucosa, mucous color (cyanotic during pregnancy), the presence and character of the discharge.

Describe the abnormalities revealed (abnormal development, herpetic eruption, abnormal growth, scars, etc.).

If there is no cervix effacement, describe the shape of its vaginal part (conical innulliparous patients/cylindrical in multiparous women) and the shape of the external os (oval in nulliparous/slit-like in multiparous women). Note if the cervix effacement has occurred. Determine the character of the discharge from the cervical canal or uterine os (mucous, purulent, amniotic fluid). Describe the abnormalities revealed (previous ruptures, pseudo erosions, cervical polyps, and others).

3. Vaginal examination. Determine the condition of the vagina (free or not), the folding of its walls, the presence of malformations, tumor-like neoplasms; the condition of the cervix, its size (effaced or not, if the cervix effacement has already occurred, determine its length in cm), the presence of ruptures and their depth.

If there is no cervix effacement, describe its location (in the center, declined posteriorly, anteriorly), consistency (thick; softened, but thick in the internal os; soft), cervical dilation (closed; the external os lets a fingertip through; the cervix lets a finger through, but it is dense at the internal os; the cervix is free for one or two fingers). In multiparous patients with no cervix effacement in the latent phase of labor, assess the degree of external os dilation (in cm).

If the cervix effacement has already occurred, describe the consistency of the edges of the os (thick or thin, dense and soft, easily dilated or rigid), the degree of obstetric os dilation (in cm).

Determine the integrity of amniotic sac (intact, absent). If it is intact, then describe its condition (well poured (normally), flat, rigid when contractions paused).

Assess the station of the fetal presenting part to the planes of the pelvis, determine the location of the fontanels.

Give the characteristic of the bony pelvis: the posterior surface of the symphysis pubis, sacral hollow (smooth bones (normally), the presence of exostosis, tenderness of symphysis pubis). Determine the size of the diagonal conjugate when reaching sacropromontory.

ADDITIONAL TESTS CARRIED OUT IN HOSPITAL

1. Electrocardiography and phonocardiography (ECG and PCG) of the fetus.
2. Cardiotocography (CTG).
3. Ultrasound scan.
4. Determination of fetal biophysical profile (BPP).
5. Doppler study of blood flow in the mother-placenta-fetus system.
6. Amnioscopy.
7. Amniocentesis.
8. Cordocentesis (percutaneous umbilical cord blood sampling).
9. Colpocytologictest.
10. X-ray examination.
11. Chorionic villibiopsy.

12. Fetoscopy (direct examination of the fetus by using a thin endoscope introduced into the amniotic fluid).

13. Hormonal profile tests.

14. General clinical laboratory tests.

DIAGNOSIS MADE ON ADMISSION AND ITS SUBSTANTIATION

The diagnosis made on admission. The student should state:

– duration of gestation (in days);

– fetal lie, fetal position, vision of fetal position, fetal presentation;

– stage of labor, its number (1^{st}, 2^{nd}, etc.) according to the term of pregnancy (preterm, at term, delayed) — if the woman is in labor;

– pregnancy complications (gestosis, gestational pyelonephritis, gestational diabetes mellitus, polyhydramnios, and others), concomitant genital (cervical erosion, hysteromyoma, and others) and extragenital diseases;

– fetus conditions (development delay syndrome, large fetus, fetoplacental insufficiency, and others);

– rupture of membranes (timely, early, preterm/premature, late), if the amniotic fluid is leaking;

– labor complications (anomalies of uterine contractions, premature placental abruption and others).

Substantiation of:

– ***pregnancy*** (probable and true signs of pregnancy present at the time of examination);

– ***duration of gestation*** (in days, at the time of admission) according to:

a) the first day of the last menstruation;

b) the first visit to the antenatal maternity clinic;

c) the first fetus movements;

d) prenatal sick-leave;

e) ultrasound examination findings;

– ***position of fetus in utero*****:** on the basis of external obstetric examination, ultrasound examination;

– the presence of live or stillbirth: listening to the heartbeat; fetus movements felt by the woman and the doctor; ultrasound examination findings, CTG;

– stage of the labor (if the woman is in labor);

– obstetrical pathology;

– concomitant genital and extragenital pathology.

DIFFERENTIAL DIAGNOSIS

1. Multiple pregnancy:
– polyhydramnios;
– large fetus;
– hysteromyoma.
2. Polyhydramnios:
– multiple pregnancy;
– large fetus;
– ovarian cystoma of a large size.
3. Placental presentation (placenta previa):
– premature abruption of normally located placenta (abruptio placentae);
– rupture of the uterus (hysterorrhexis);
– cancer of the cervix.
4. Premature abruption of normally located placenta (abruptio placentae):
– placental presentation (placenta previa);
– rupture of the uterus (hysterorrhexis);
– the inferior vena cava compression syndrome;
– amniotic fluid embolism.
5. Premature rupture of membranes:
– early rupture of membranes;
– discharge of liquefied cervical mucus;
– involuntary leakage of urine.
6. Pathological preliminary period:
– primary weakness of uterine contractions;
– discoordinated uterine contractions;
– spastic colitis.
7. Primary weakness of uterine contractions:
– pathological preliminary period;
– discoordinated uterine contractions;
– clinical narrow pelvis.
8. Eclampsia:
– epilepsy;
– meningitis;
– brain tumors;
– cerebral hemorrhages;
– uremia.
9. Amniotic fluid embolism:
– premature abruption of normally located placenta (abruptio placentae);
– pulmonary embolism;
– rupture of the uterus.

10. Lohiometra:
- subinvolution of the uterus;
- postpartum endometritis;
- remnants of the placental tissue.

11. Postpartum endometritis:
- lohiometra;
- subinvolution of the uterus;
- remnants of the placental tissue.

12. Lactational mastitis:
- lactostasis;
- mastopathy;
- breast abscess;
- breast cancer.

PLAN OF MANAGING PREGNANCY OR LABOR

Pregnancy management plan (for patients admitted to the pregnancy pathology department). The student should substantiate the necessary examinations and treatment plan of a pregnant woman depending on the complications of pregnancy or extragenital diseases revealed in the patient. When administering drug therapy, state the purpose, dose, frequency and the route of administration. In the induction of labor, substantiate the technique of labor induction explaining its conditions and indications.

Labor management plan. The student should specify the way of managing the delivery (vaginal delivery or by cesarean section).

In the vaginal delivery, the plan includes procedures carried out by the doctor in each stage of labor: monitoring the status of the parturient woman, uterine contractions, fetus condition; prevention of complications in labor (bleeding, abnormal labor power, fetal hypoxia, and others). Specify concrete measures.

In case of the delivery by cesarean section specify: indications, absence of contraindications to the caesarean section, its conditions and possible technique.

Make a prognosis of labor for the mother and fetus.

Determine the permissible blood loss (0.5 % of pregnant woman's body weight).

CLINICAL COURSE OF LABOR

1. The course of the first stage of labor. Record:
- date and time of the beginning of the 1st stage of labor;
- signs of the onset of labor.

The observation journal in the 1st stage of labor is filled in every 3 hours. Specify:
- mother's complaints, her general condition;

– blood pressure on both arms, pulse rate;

– characteristic of uterine contractions (frequency, duration and the power of contractions);

– descending of the presenting fetus part (its relation to the pelvic inlet at the time of examination);

– fetus heart rate (the place of hearing, frequency, rhythm, heart rate tonality);

– preservation of amniotic fluid (intact, is leaking; if it is leaking, state its color (clear, green, yellowish-brown (old meconium), stained with blood) and consistency (liquid, moderately thick, mushy);

– clinical signs of the fitness between the size of the fetus head and the mother's pelvis (signs of Vasten and Zangemeister);

– bladder and bowel function.

It is a "must" to carry out a vaginal examination at the initial examination and after the rupture of membranes. In other cases, it depends on the indications (assessment of the labor dynamics and efficiency of uterine contractions (weak or too strong contractions, expulsive pains that began early), determination of causes of the bleeding from the birth canal, clarifying the conditions for delivery, anesthesia).

After describing the mother's vaginal status in the observation journal make the present diagnosis and complete it with the identified pathology (abnormalities of uterine contractions, fetal hypoxia and others). Include all the necessary additions to monitor the woman's and the fetus condition in the labor management plan and substantiate them. Administer and give proof of all the necessary manipulations and operations (amniotomy, caesarean section and others).

If drug therapy is administered, state the purpose, dose, frequency, route and time of drug administration.

2. The course of the second stage of labor:

– date and time of the onset of the 2^{nd} stage of labor;

– signs of the onset of the 2^{nd} stage of labor;

– biomechanism of labor in a particular mother (a detailed description of all events);

– methods of protection of the perineum (a detailed description);

– when performing an episiotomy or perineotomy — indications, method of anesthesia, technique and time of its performing;

– when performing surgical interventions (forceps, vacuum extraction, extraction of the fetus by the pelvic pole) — a description of the clinical situation, vaginal status and the substantiation of the operation necessity (specify indications, conditions, method of anesthesia), a description of the operation recording the time of its performing;

– date and time of birth of the child; the description of the newborn: full-term/preterm, with signs of postmaturity, sex, height, weight, Apgar score (after 1 and 5 minutes), head shape and location of the labor tumor, the size of

head and chest circumference, developmental peculiarities (visible malformations); resuscitation technique in the presence of asphyxia;

– describe the newborn sanation and cleansing (specify in consecutive order the primary and secondary treatment of the umbilical cord and primary cleansing of the skin).

3. The course of the third stage of labor:

– date and time of the onset of the third stage of labor;

– signs of placental separation, how the placenta was expelled (describe the technique of external receiving of the expelled placenta, if any was applied);

– description of the expelled placenta (placenta integrity, its features, sixe, special features of the structure and the attachment of the umbilical cord, its length);

– measures to prevent bleeding in the stage of placenta expulsion and the early postpartum periods;

– in case of performing surgical interventions in the 3rd stage of labor (manual removal of placenta, manual examination or curettage of uterine cavity) describe the clinical situation and substantiate the necessity of the operation (indications, conditions, method of anesthesia). Describe the operation recording the time of its performing.

4. Examination of the birth canal after the delivery: describe the condition of the birth canal and measures to restore the damaged tissues.

5. Total blood loss during the delivery.

6. Transfusion of blood components, complications.

7. Pain control during the delivery and its effect.

8. Duration of the labor: the 1st, 2nd and 3rd stages; the total duration of the labor; duration of the period from the time of rupture of membranes to the birth of the baby.

Caesarean section. If the childbirth is achieved through the caesarean section, draw up a detailed protocol of the operation. Describe the technique of laparotomy and cesarean delivery; the newborn, the newborn's sanation and cleansing (specify in consecutive order the primary and secondary treatment of the umbilical cord and primary cleansing of the baby's skin). Specify the amount of blood lost during the operation.

THE COURSE OF THE POSTPARTUM PERIOD

The first observation journal is filled in 2 hours after the delivery, the next ones — every day.

Note the puerpera's complaints and the general condition.

Take blood pressure on both arms, pulse, temperature.

Describe the condition of the breasts (soft, breast engorgement, the presence of consolidations; nipples (clean or cracked)); the character and amount of secretion (colostrum, milk; outflow (impaired or not)).

Determine the height of uterus fundus above the vagina (cm), its density and sensitivity to palpation.

Assess the character and amount of discharge from the genital tract (lohia), the condition of surgical wounds (on the anterior abdominal wall, perineum).

Note on what day the stitches were removed and how the wound is healing (primary, secondary intention).

Describe the function of the bladder and bowel.

Describe the condition of the newborn.

FINAL CLINICAL DIAGNOSIS

While composing the final diagnosis, state:

– duration of gestation (in days);

– fetal lie, fetal position, vision of fetal position, fetal presentation;

– what number the labor is (the 1st, 2nd, etc.) according to the duration of pregnancy (preterm, at term, delayed);

– complications of pregnancy revealed (gestosis, gestational pyelonephritis, gestational diabetes mellitus, polyhydramnios, and others), concomitant genital (cervical erosion, hysteromyoma, and others) and extragenital diseases;

– fetus conditions identified (development delay syndrome, large fetus, fetoplacental insufficiency, acute hypoxia (distress) and others);

– rupture of membranes (timely, early, preterm/premature, late);

– complications of labor (uterus contraction anomalies, premature placental abruption, threatening rupture of the perineum, and others); complications of the postpartum (hypotonic uterine bleeding, lohiometra, postpartum endometritis, symphysitis and others);

– birth canal in juries revealed (rupture of the cervix, perineal rupture (state the degree);

– operations performed (caesarean section, forceps, manual examination of the uterus, dissection and suturing of the perineum, closure of wounds and ruptures and others).

EXTENDED EPICRISIS

While composing the epicrisis analyze the effect of treatment, the course of the labor and postpartum period. Specify:

– pregnant woman or puerpera's surname, name and patronymic, her age and address;

– the date and time of admission, date of discharge, medical institution and department where the patient was being treated;

– the diagnosis made at the referring institution;

– final clinical diagnosis;

– information about the labor: date, duration of the labor, the total blood loss; the time of birth, newborn's weight and height, Apgar scoring;

– surgical interventions performed, blood components transfusions, complications;

– the course of the postpartum period, examinations and treatment carried out, the condition of the perineal wound or that one on the anterior abdominal wall by the day of discharge, stitches (are removed or not).

On discharge note the puerpera's and baby's condition. Specify whether they are discharged or transferred to another hospital.

Include the recommendations given to the mother on the lifestyle, diet, hygiene, breast-feeding the baby. Specify activities aimed at the physiological course of the postpartum period. Substantiate indications for an additional postnatal sick-leave, note the date of issue and its duration.

The labor case history should be signed by the student.

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