

Pregnancy History & Examination

Community & family medicine

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HISTORY IN OBSTETRIC

- **AN OBSTETRIC HISTORY SHOULD INCLUDE:**

- Current pregnancy details.
- Past obstetric history.
- Past gynecological history.
- Past medical and surgical history.
- Drug history and allergies.
- Family history-especially multiple pregnancy, diabetes, hypertension, chromosome or congenital malformations.
- Social history.
- History of systemic review
- Case summary

• **CURRENT PREGNANCY**

BIODATA

- Name
- Age
- Occupation
- Relationship status
- Booking status
- Gravidity (i.e. number of pregnancies including the current one).
- Parity (i.e. number of births beyond 24 weeks gestation)
- LMP
- EDD

- The **expected date of delivery (EDD)** can be calculated from the last menstrual period (LMP) using **Naegele's rule** (add 1 year and 7 days to the LMP and subtract 3 months)
- Long cycles
- Irregular periods
- Relevant use of the combined oral contraceptive pill (COCP)
- 1st trimester scan is more reliable as compare to LMP in these case



- **GRAVIDITY AND PARITY EXPLAINED**

- The terminology used is gravida x, Para a+b:
 - X is the total number of pregnancies (including this one).
 - A is the number of births beyond 24 weeks gestation.
 - B is the number of miscarriages or termination of pregnancies before 24 weeks gestation.

Example

- A woman who is pregnant for the 4th time with 1 normal delivery at term, 1 termination at 9 weeks and 1 miscarriage at 16 weeks would be gravida 4, Para 1+2.

HISTORY OF CURRENT PREGNANCY

- Ist trimester
- Second trimester
- Third trimester
- History of labor

HISTORY OF IST TRIMESTER

method of confirmation of pregnancy, LMP

General health (tiredness, malaise, and other non-specific symptoms)

Bleeding ,pain.(Ectopic pregnancy,misscariage)

Vaginal discharge

Hyperemesis

Urinary problems

Investigations(ultrasound,blood and urine test)

drug history (treatment)

vaccination

HISTORY OF SECOND & THIRD TRIMESTER

History of fetal movements

Symptoms of anemia, Miscarriage ,Ectopic pregnancy,Vaginal discharge,UTI,hyper emesis gravidarum

Symptoms of aph,pih.diabetes,preterm labor

Ask for vaccination



- Results of all antenatal blood tests-routine and specific.
- Results of anomaly and other scans (details of results can be cross checked with the notes).

- **IF SHE IS POSTNATAL:**

- Labor and delivery
- History of the postnatal period.

PAST OBSTETRIC HISTORY INCLUDES:

- Details of all previous pregnancies (including miscarriages and terminations).
- Length of gestation.
- Date and place of delivery.
- Onset of labor (including details of induction of labor).

- Mode of delivery.
- Sex and birth weight.
- Fetal and neonatal life.
- Clear details of any complications or adverse outcomes (such as shoulder dystocia, postpartum hemorrhage, or stillbirth).



- History often repeats itself, so previous antenatal, intrapartum, or postpartum complications should influence the management of this pregnancy.

- **GYNAECOLOGICAL HISTORY**

- Method of contraception before conception.
Menstrual history
- Cervical smear history.
- Coital problems

• **PAST HISTORY** (MEDICAL & SURGICAL)

Medical conditions such as hypertension, epilepsy, or diabetes.

- Details of any consultations with other physicians (neurologist or endocrinologist).
- Involvement of multidisciplinary teams.
- Details of any previous surgery.



A fetus may contract toxoplasmosis through the placental connection with its infected mother

The mother may be infected by:

Improper handling of cat litter



Handling or ingesting contaminated meat



- **DRUG AND ALLERGY HISTORY**

- Current medications
- Medications taken at any time during the pregnancy.
- Any allergies and their severity
- (anaphylaxis or a rash?).



- **FAMILY HISTORY**

- Any history of hereditary illnesses or congenital defects is important and is required to ensure adequate counseling and screening is offered.

- Familial disorders such as thrombophilia's.
- Previously affected pregnancies
- with any chromosomal or genetic disorders
- multiple gestations
- Consanguinity.



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SOCIAL HISTORY

- living status
- total family members
- earning members
- Planes for breast feeding
- Domestic violence screening

PERSONAL HISTORY

- Smoking, other narcotics.
- History of drug or alcohol abuse.
- Sleep
- Diet
- Bowel habits..

Modest Sunbathers



HISTORY OF SYSTEMIC REVIEW

- CNC
- CVS
- RESPIRATORY SYSTEM
- GIT
- GENITALIA
- URINARY SYSTEM
- LOCOMOTORY SYSTEM

EXAMINATION IN OBSTETRICS

GENERAL EXAMINATION

- Body mass index (BMI) calculated [weight (kg)/height (m)²].
Pregnancy complications are increased with a BMI < 18.5 and > 25.

VITALS (B.P, PULSE, TEMP, R.R)

- Blood pressure measured in the semi-recumbent position (45° tilt).
Use an appropriate size cuff:
too small a cuff gives a falsely high BP.



- Anemia
- Jaundice
- Cyanosis
- Dehydration
- Edema
- Clubbing
- Koilonychias
- Thyroid gland



- Breasts (exclude any lumps).
- Varicose veins and skeletal abnormalities (kyphosis or scoliosis):
 - Normal pregnancy is associated with an increase in lumbar lordosis which can lead to lower backache.

- Auscultation of the heart and lungs:
 - Flow murmurs are common in pregnancy and are not significant.
 - Cardiac murmurs may be detected for the first time in pregnancy.

ABDOMINAL EXAMINATION

- -INSPECTION.
 - Note the apparent size of the abdominal distension.
 - Note any asymmetry.
 - Fetal movements.

- **Cutaneous signs of pregnancy:**

- Linea nigra (dark pigmented line stretching from the xiphi sternum through the umbilicus to the suprapubic area).
- Striae gravidarum (recent stretch marks are purplish in color).
- Striae albicans (old stretch marks are silvery-white).
- Flattening/eversion of umbilicus (due to intra-abdominal pressure).



- **Superficial veins** (alternate paths of venous drainage due to pressure on the inferior vena cava by a gravid uterus).
- **Surgical scars** (a low pfannenstiel incision may be obscured by pubic hair, and laparoscopy scars hidden within the umbilicus).

- **ABDOMINAL EXAMINATION-**
- **PALPATION.**

- Symphysis-fundal height (SFH):
 - Palpated < 20 weeks.
 - Measured in cm > 20 weeks.
- Estimation of number of fetuses:
 - ? Multiple fetal poles.



PAWLIC GRIP



PELVIC GRIP



- **NORMAL UTERINE SIZE**

- The uterus normally becomes palpable at 12 weeks gestation.
- It reaches the level of the umbilicus at 20 weeks gestation.
- It is at the xiphi sternum at 36 weeks gestation.



- **SYMPHYSIS-FUNDAL HEIGHT**

- The SFH detects approximately 40-60% of small-for-gestational age fetuses but its predictive value in detecting large-for-dates fetuses is considerably less.
- The uterine size is objectively measured with a tape measure from the highest point of the fundus to the upper margin of the symphysis pubis.

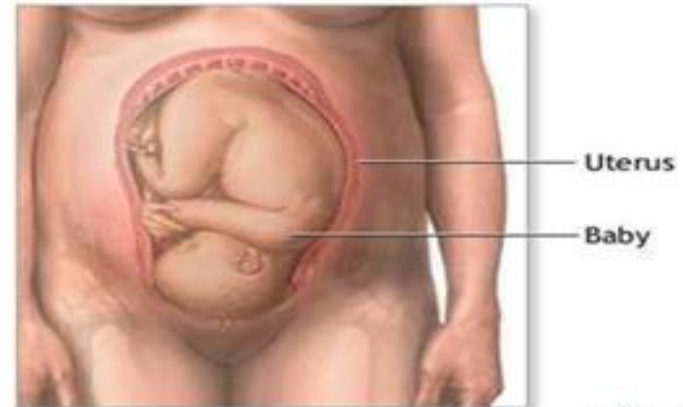
- Appropriate growth is usually estimated to be the number of weeks gestation in centimeters (at 30 weeks the SFH should be 30 cm \pm 2 cm):
- \pm 2 cm from 20 until 36 weeks gestation.
- \pm 3 cm between 36 and 40 weeks.
- \pm 4 cm at 40 weeks.

- **FETAL LIE** (relationship of longitudinal axis of fetus to that of the uterus):
 - Longitudinal-fetal head or breech palpable over pelvic inlet.
 - Oblique-the head or breech is palpable in the iliac fossa
 - Transverse-fetal poles felt in flanks

Fetus in transverse lie presentation



ADAM.



ADAM.

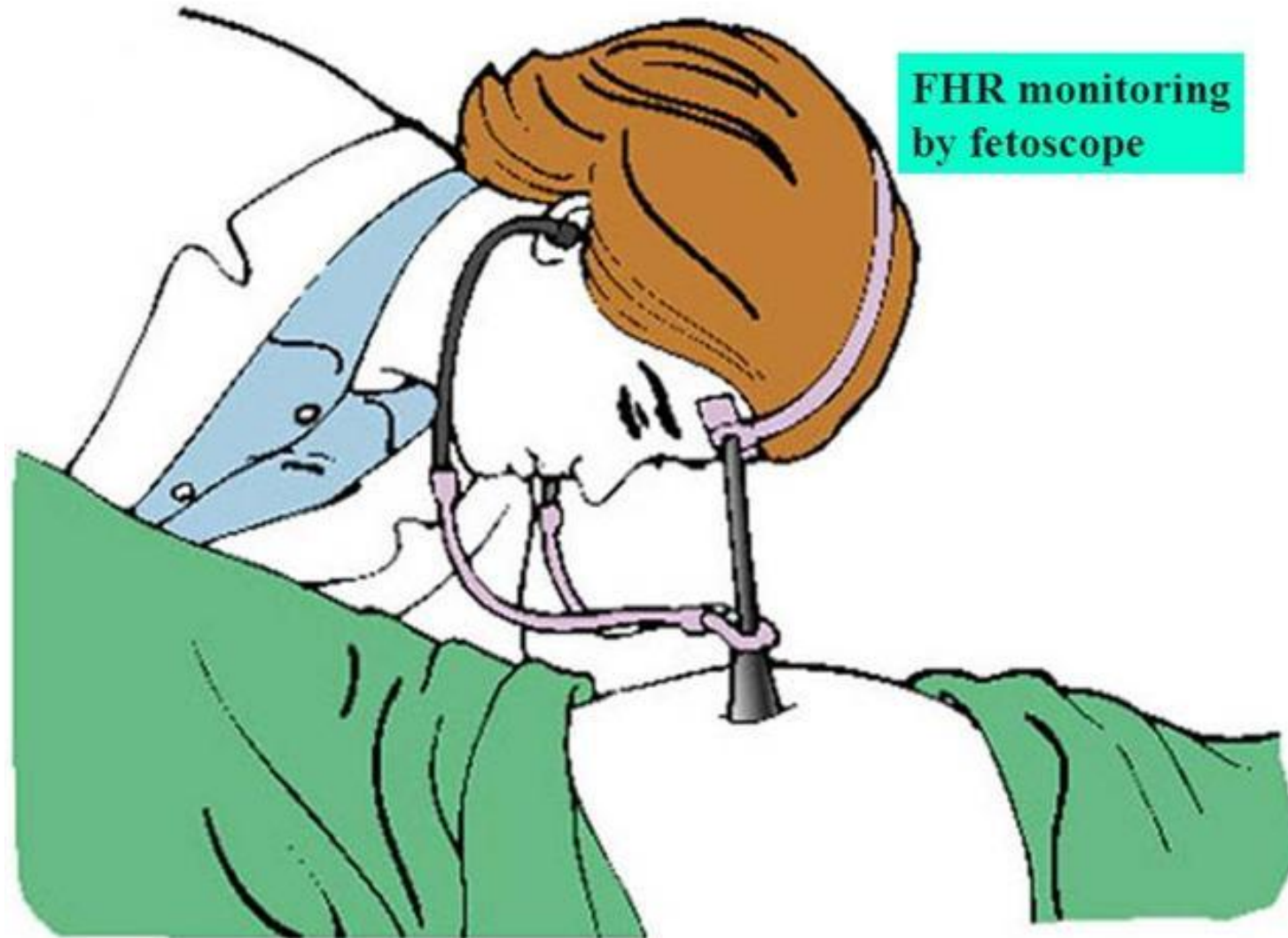
- **PRESENTATION** (part of the fetus overlying the pelvic brim):
 - Cephalic
 - Breech
 - Other (shoulder, compound)
- **AMNIOTIC FLUID VOLUME:**
 - Tense abdomen with fetal parts not easily palpated.
 - Compact abdomen with fetal parts easily palpable.

PALPATION OF UTERINE CONTRACTION



- **AUSCULTATION OF THE FETAL HEART**

- The fetal heart is best heard at the anterior shoulder of the fetus using:
 - A doppler ultrasound device (Sonicaid) from about 12 weeks gestation.
 - A fetal stethoscope (Pinard) from about 24 weeks gestation.
- In a breech presentation it is often heard at, or above, the level of the maternal umbilicus.
- The rate and the rhythm of the fetal heart should be determined over 1 minute.



Listening with a doppler



ENGAGEMENT(maximum diameter pass through pelvic inlet)

- Conventionally, engagement or the passage of the maximal diameter of the presenting part beyond the pelvic inlet, is estimated using the palm width of the five fingers of the hand. If five fingers are needed to cover the head above the pelvic brim, it is five-fifths palpable, and if no head is palpable, it is zero-fifths palpable.

- Normally, the fetus engages in an attitude of flexion in the transverse diameter of the pelvic inlet, unless the pelvis is very roomy where it may engage in any diameter.
- In nulliparous women, engagement usually occurs by 37 weeks but in multiparous women it may not occur until the onset of labour.
- Rare causes of non-engagement should always be considered and investigated with an ultrasound scan (USS) (including placenta praevia and fetal abnormality)

- **ENGAGEMENT**

- A head that is only two-fifths palpable is usually considered to be engaged (and therefore fixed in the pelvis).
- Put simply: an easily palpable head is not engaged, whereas a head more difficult to palpate is more likely to be deeply engaged.

Care must be taken, as a breech presentation can some times be mistaken for a deeply engaged head.

- **VAGINAL EXAMINATION**

- A vaginal examination (speculum or digital examination) is not part of a routine obstetric examination but may be indicated to diagnose rupture of membranes or onset of labour.