

**Case 1**

A 17 year old primigravida is referred to the antenatal clinic by the community midwife who feels that the uterine size has not increased sufficiently in the last three weeks.

On examination of the abdomen the symphysis-fundal height measures 27cm. She has an ultrasound scan and the results are shown.

1. What is the diagnosis?

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2. What other investigations might be appropriate (think about *both* your patients!)?

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3. Outline your initial plan of management

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4. When it comes to delivery, how might it be achieved and why?

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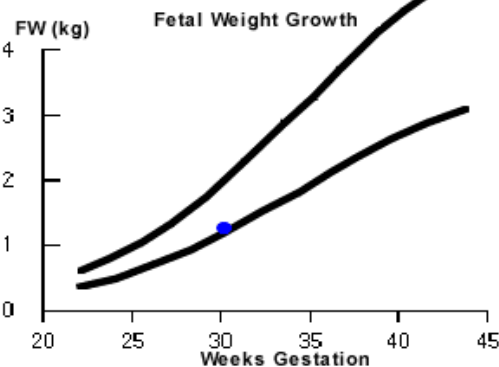
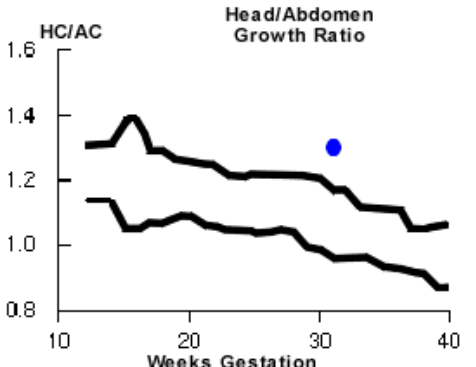
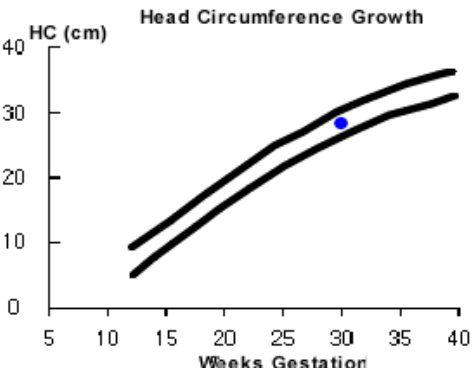
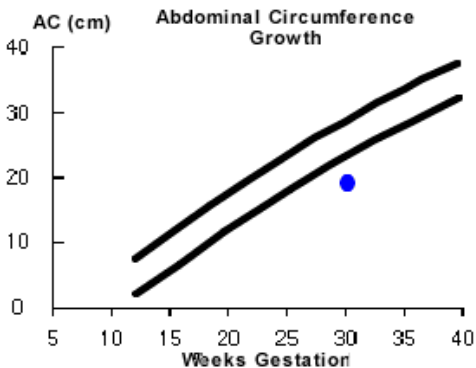
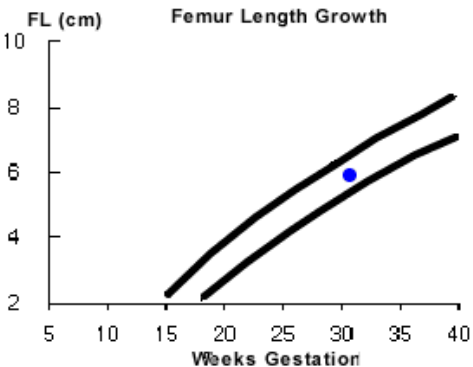
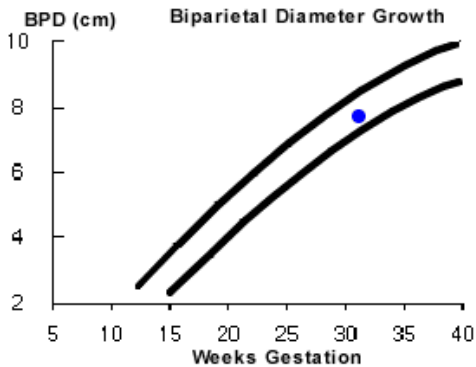
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5. If you saw her in the booking clinic in her next pregnancy, how would you manage her this time around?

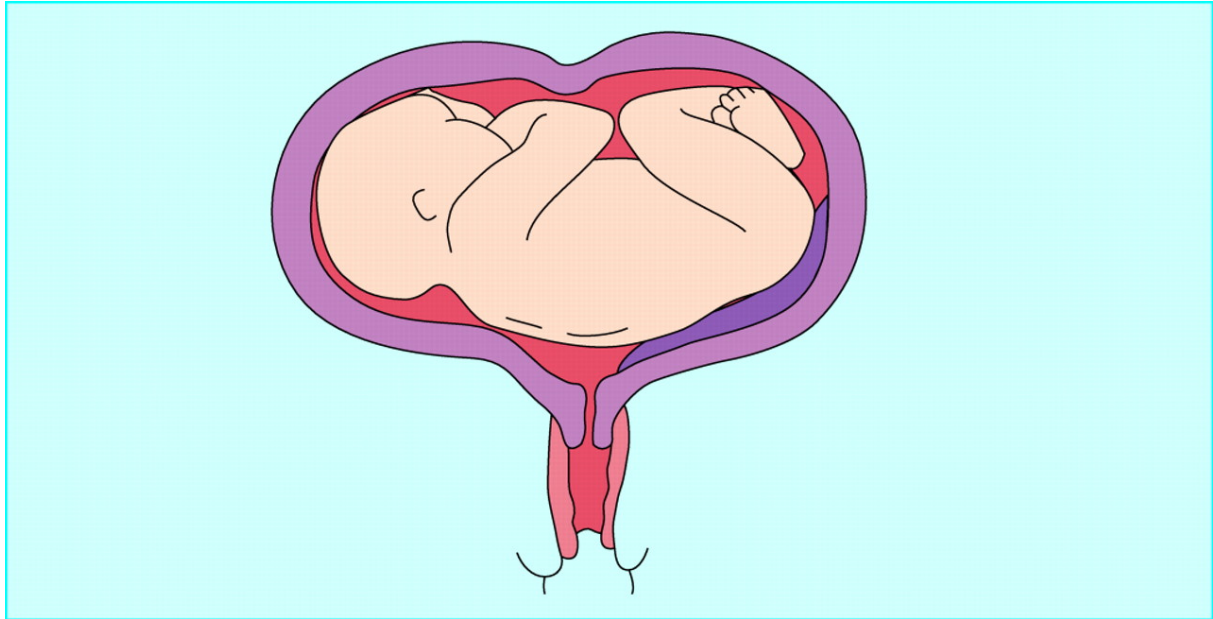
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Case 1 (cont'd)



**Case 2**



A 38 year old African woman in her fourth pregnancy presents at 39 weeks gestation with ruptured membranes and no contractions. There has been a small amount of fresh red vaginal bleeding. The majority of her pregnancy was spent abroad and she has received little antenatal care. Her previous pregnancies and deliveries were all normal. Above is a schematic drawing of the findings on abdominal palpation and ultrasound scan.

1. What is the diagnosis?

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2. How and when is it normally diagnosed in the UK?

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3. What can make this condition more likely to occur?

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4. You are the admitting obstetrician – how do you manage her from here (not including history/examination)

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5. Describe complications which might occur as a result of the condition.

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**Case 3**

The next page shows a partogram of a primigravida who attends in spontaneous labour.

1. From the partogram, what factors do you see which make her higher risk than normal?

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2. The first stage appears to be going slowly. What is the commonest cause of this delay? What has been done to help speed up labour progress?

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3. What factors must the obstetrician consider before prescribing intravenous oxytocin?

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4. What is the most common side effect of oxytocin? How is it treated?

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5. If a caesarean section is performed during labour:

- a. What structures are divided to reach the baby?
- b. Which complications must you inform the woman about when obtaining written consent?

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**Case 4**

See the case study overleaf and answer the following questions:

- 1. What do the following terms mean?
  - a. Position
  - b. Effacement
  - c. Moulding

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- 2. At what time would you have anticipated delivery based on initial labour progress?

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- 3. What is the diagnosis (describe the current problem summarised in a sentence)?

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- 4. What is the plan of management for the safe delivery of this woman's baby? What findings if any make you think she might not achieve a vaginal delivery?

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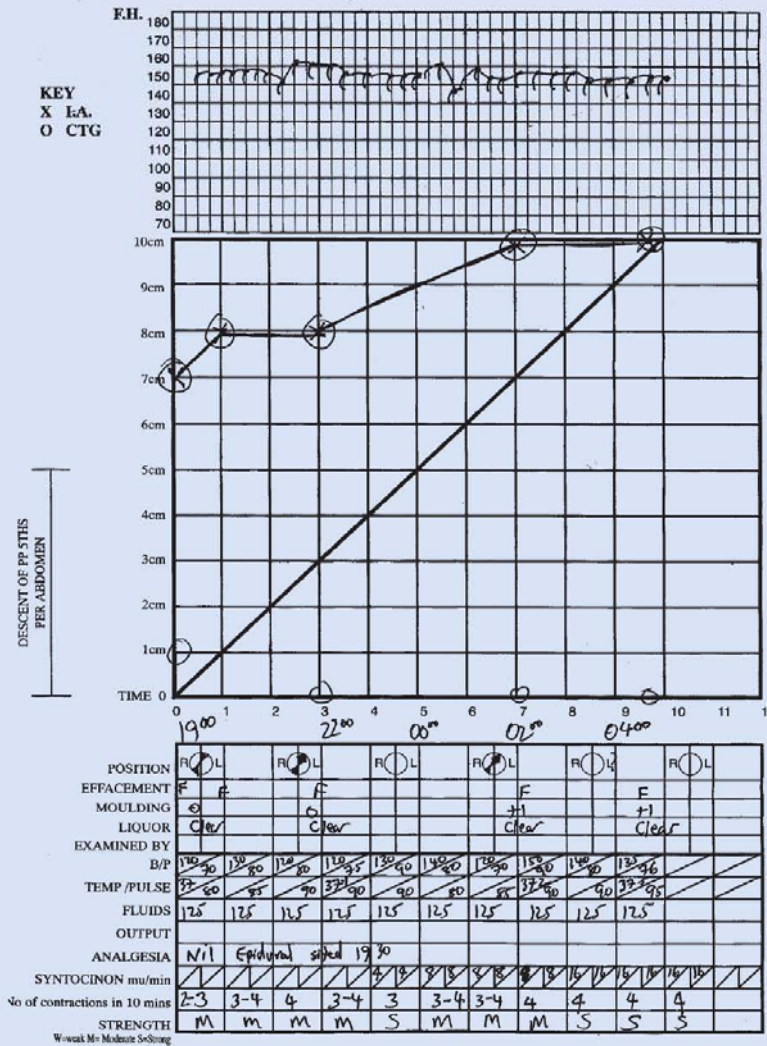
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### Case study

You are called to the delivery suite to see a 32-year-old primigravida who had an uncomplicated pregnancy and has been fully dilated for 2.5 hours and pushing for one hour. The presenting part is not visible at the introitus. Her partogram is as follows:



On examination, she is a healthy woman of normal stature, the baby appears to be of moderate to large size and the fetal head is not palpable on abdominal assessment. The CTG is reassuring and the contractions are regular 4 in 10 minutes. On vaginal examination, the head is at station 0 to +1cm below the ischial spines, there is a moderate caput, grade 2 moulding and the position is a deflexed right occiput-posterior (ROP).