Ministry of Healthcare of the Russian Federation
Federal State Budgetary Educational Institution of Higher Education
«Northern State Medical University»
of Ministry of Healthcare of the Russian Federation

PRACTICAL SKILLS FOR EXAM IN OBSTETRICS AND GYNECOLOGY

Workbook

Arkhangelsk
2023

UDC 618

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This workbook is written for medical students studying obstetrics and gynecology in English. The notebook is compiled in accordance with the requirements of the state educational standard, contains a techniques for performing some obstetric and gynecological manipulations in step-by-step instructions in order to prepare for the practical part of the final state certification. The presented trainings can be used in practical classes or as part of selfpreparations of students.

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Министерство здравоохранения Российской Федерации
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Министерства здравоохранения Российской Федерации

ПРАКТИЧЕСКИЕ НАВЫКИ ДЛЯ ЭКЗАМЕНА ПО АКУШЕРСТВУ И ГИНЕКОЛОГИИ

Рабочая тетрадь

Архангельск
2023

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П 69

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П 69

Данная рабочая тетрадь предназначена для медицинских студентов, изучающих акушерство и гинекологию на английском языке. Тетрадь составлена в соответствии с требованиями государственного образовательного стандарта, содержит технику выполнения ряда акушерских и гинекологических манипуляций в пошаговых инструкциях с целью подготовки студентов к практической части итоговой государственной аттестации. Представленные тренинги могут быть использованы на практических занятиях или в рамках самостоятельной работы студентов.

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Contents

Introduction

1. **What was the purpose of this workbook?**
- to help 6th year students prepare for the practical part of the final exam in obstetrics and gynecology.

2. **What is included in the practical part of the exam**?
- practical skills in obstetrics and gynecology are currently represented by three stations: "late 2nd stage of labor", "3rd stage of labor" and "speculum examination". These situations are the most likely where a general practitioner may be forced to manage an obstetric-gynecological patient in the absence of a specialist, since the first two conditions are emergencies, and the latter is a common method of screening for cervical cancer in a low-risk population and may be performed without visiting gynecologist.

3. **How the exam is organized, where it takes place, what equipment is involved?**
- the practical skills exam will be held at the University Simulation Center; you must demonstrate excellent communication and practical skills according to one (!) of the three checklists you will find later in this workbook. All manipulations are designed for 5-7 minutes.
- examiners will control all your manipulations and record them in a paper document
- equipment is female half-body phantom, phantom of the fetus and placenta if needed.

4. **What is included in this workbook and how to use it?**
- this is a step-by-step approach to all three manipulations = three practical classes with demonstration session and skill practice. The information in the workbook is not given to you as a complete guide, but as a plan in which you need to fill in the gaps with the text and your practical experience. To do this, you can use our "Simulation in Obstetrics Training Course".study guide.
We recommend that you prepare for the practical class by filling in the gaps in the workbook the day before. Then go through the practice session and read the information in the workbook again and maybe add some information for yourself.

We wish you easy learning and have a fun time during practical classes. We hope you will show excellent practical skills on the final exam!

Practical class 1. Managing physiological late second labor stage

This section details how to perform a modified physical examination to screen for problems in the laboring woman. Here we should discuss the most important information for the fast but not complete (!) examination in a woman with the signs of an impending birth. More complete information you can find in our "Simulation training course in obstetrics" study guide.

What information must be identified for the woman in active labor?

Certain information is needed immediately to evaluate the following:
• *Her general physical condition*
• *Her risk status*
• *The extent of the labor*

To understand her extent of the labor you need first to distinguish *false labor* from *true labor contractions*, because in false labor the woman's body is not completely ready for the birth process and these contractions will disappear by their own.

Table Characteristics of a true and false labor

Characteristics	**False labor**	**True labor**
Uterine contractions	**Intervals**	
	Duration	
	Intensity	
Pain		

True labor *is characterized by _____, _____, and _____ uterine contractions that will _____ progressively and lead to the cervical _____ and _____.*

Pain symptoms may be _____ if the woman takes painkilling drugs, ___ true labor will _____

Signs and Symptoms of an Impending Delivery

- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____

(Fig. 1.1).

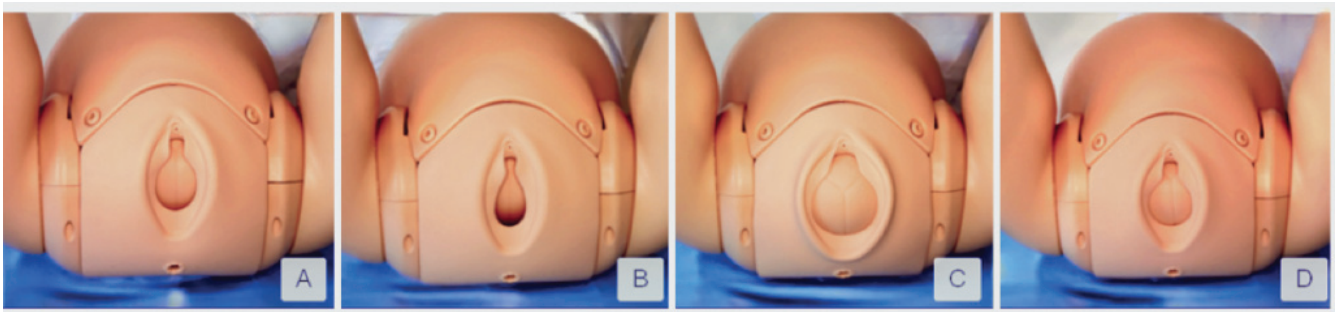


Figure 1.1. Labial separation.

A._____
B._____
C._____
D._____

- After a while, you can see a little of the baby's head coming down the vagina during contractions. The baby moves like an ocean tide: in and out, in and out, but each time closer to birth. Relaxation and bulging of the anus, with or without loss of stool, may also be seen.
- When the baby's head stretches the vaginal opening to about the size of the _____ (Figure 1.2), the head will stay at the opening – even between contractions. This is called _____. Once the head is born, the rest of the body usually slips out easily with _____.

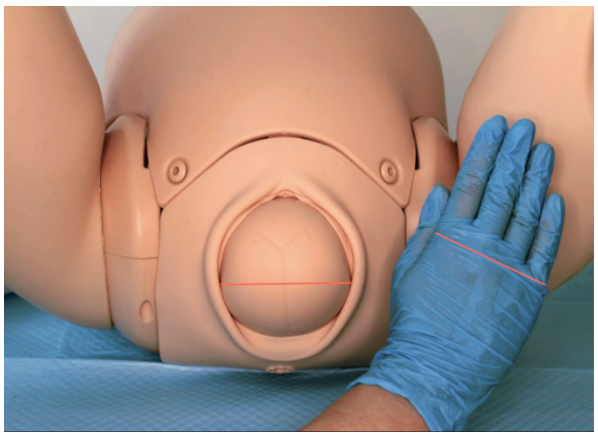


Figure 1.2. The fetal head stretches the vaginal opening

What must you do to assist with the birth for consistency?

1. **Relax and stay calm**. _____

_____

2. **Calmly call for assistance**. _____

Do not leave the room. _____

_____

3. **Position the mother comfortably** _____

_____

Lying flat can lead to the _____

_____

_____

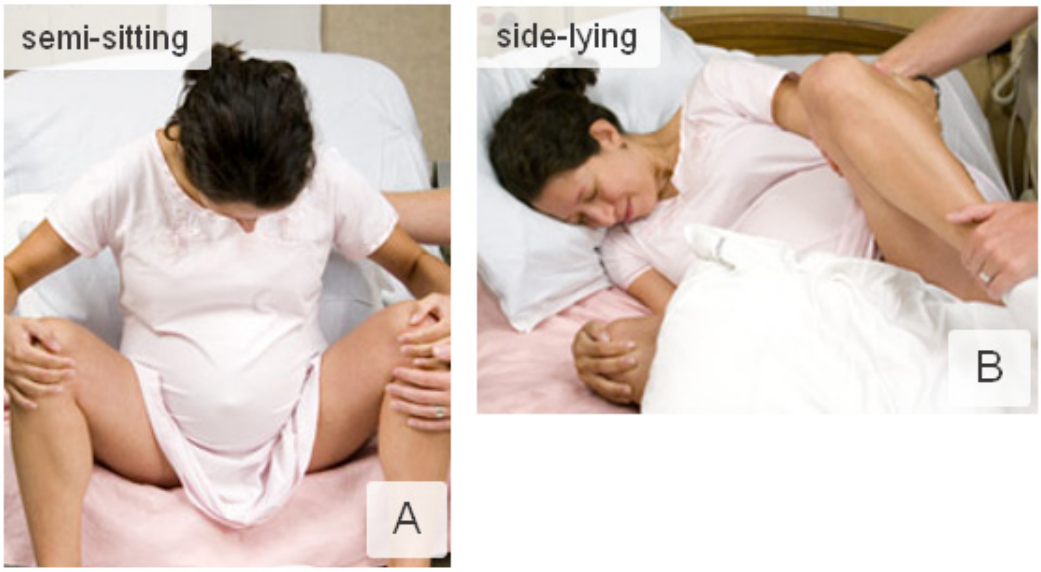


Figure 1.3. Different positions during the birth process.

A. Semi-sitting position may be the most comfortable and makes it easier for the _____ to _____.

B. Side-lying position is relaxing and helps prevent _____.

4. _____ necessary to scrub the perineum with an antiseptic, this wastes time. Do wipe away stool with sponge. Wipe excess secretions away also.

5. If chart information is not available, **obtain patient information** with a 30-second history:

- Which baby is this for you? (*nulliparous women are _____ to deliver baby fast*)
- When is your due date? (*preterm baby is usually _____and delivery may be _____, also preterm baby is at increased risk for _____ need*)
- Did you have prenatal care? (*women without history of a prenatal care are at _____ risk for possible complications*)
- Have you had any problems with the pregnancy? (*if she report about certain problem you can be better prepared to possible complications, use prophylactic measures if possible, inform about her problem when you will report to her obstetric provider*)
- Do you have any health problems? (*same – if she has any medical condition it may complicate during labor or in a postdelivery period*)

6. If possible **open the emergency birth pack** in the near of the patient. It should contain at least the following items (Fig. 1.4):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

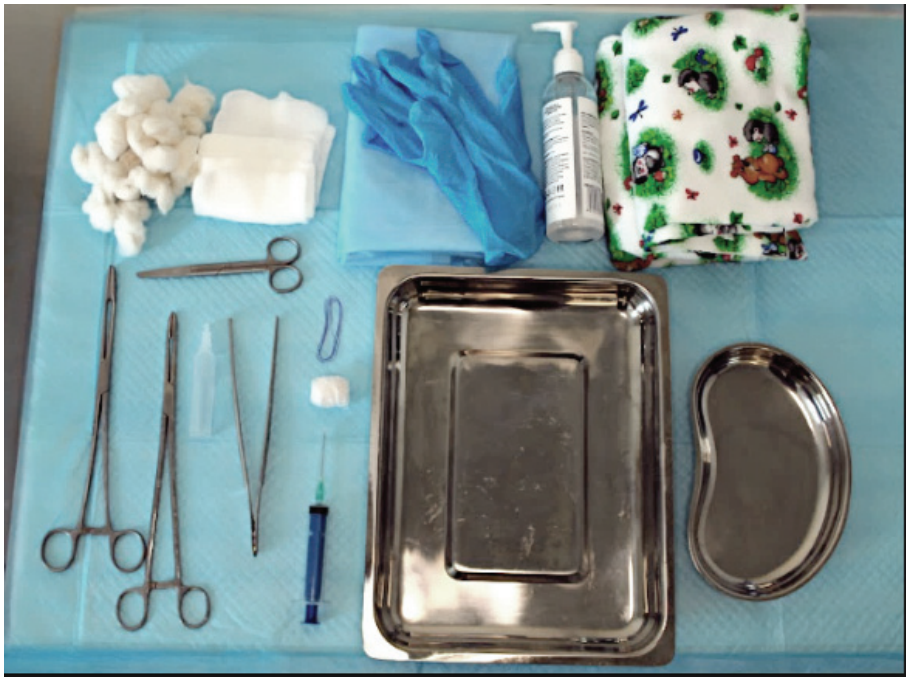


Figure 1.4. Equipment needed for attending a normal birth

8. Birth is a clean, not a sterile event. **Put on** _____, but do not waste time finding the correct size sterile if they are not readily available. If possible, provide careful handwashing, done sterile gloves, and use the sterile emergency birth pack because it will help reduce the possibility of infection.
9. Place the _____ under the woman's hips. Use a piece of cloth or gauze to cover the mother's anus; some faeces (stool) may be pushed out with the baby's head. Prepare for birth of the baby. *Do not take your eyes off the perineum*.
10. **Instruct the woman** to "feather blow" (_____) with each contraction, unless you told her to push.
    When a woman pushes, she uses abdominal muscles and increases intra-abdominal pressure. This enhances the expulsive action of the contracting uterus and potentially increasing risk for trauma of maternal tissue and the baby at the moment of fetal head is ready to fix and rotate under pubic arch. "Feather blowing" helps the woman to control the urge to push.
11. **Control of the fetal head descend** is important
    Research has shown the "hands-on" (Figure 1.5) or "hands-off" (allowing the head to birth on its own) approach to delivery of the head results in the same number of perineal lacerations. But ***never*** _____ ***on the baby's head****!*

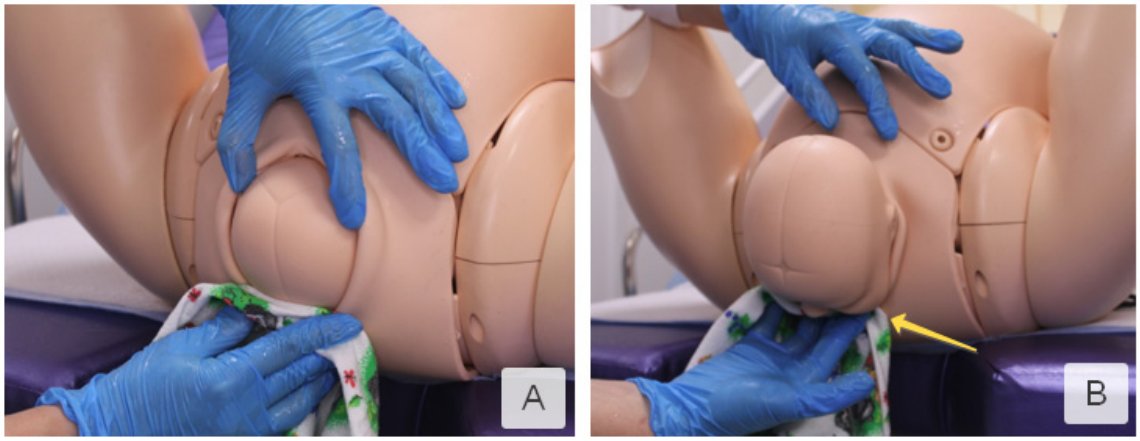


Figure 1.5. "*Hands-on*" approach to delivery of the head.
A. Maintaining _____ of the fetal head with one hand by gently pushing _____
B. Removing the perineum over the baby's face by lower hand (yellow arrow shows you baby's _____ to be manually free from perineum skin)

- Allow slow, controlled extension of the head. *Once the head has crowned*, ***ask woman to*** _____ by breathing with open mouth, now the head is born by the extension of the face, which appears at the perineum.

The moment of extension is the riskiest for perineum tears, so removing the pushing effort you make it slower and potentially less traumatic.

- With your other hand, gently ***ease the perineum over the baby's face*** (Fig 1.5.B)
- hen the head is born, and before the rest of the body comes out, you may need to help the baby breathe by ***clearing its mouth and nose***. If the baby has some mucus or water in its nose or mouth, wipe it gently with a clean cloth wrapped around your finger.

12. **Check for a** _____ by slipping one finger down the baby's neck as the head emerges

- If possible, gently slide the cord over baby's head (Figure 1.6)

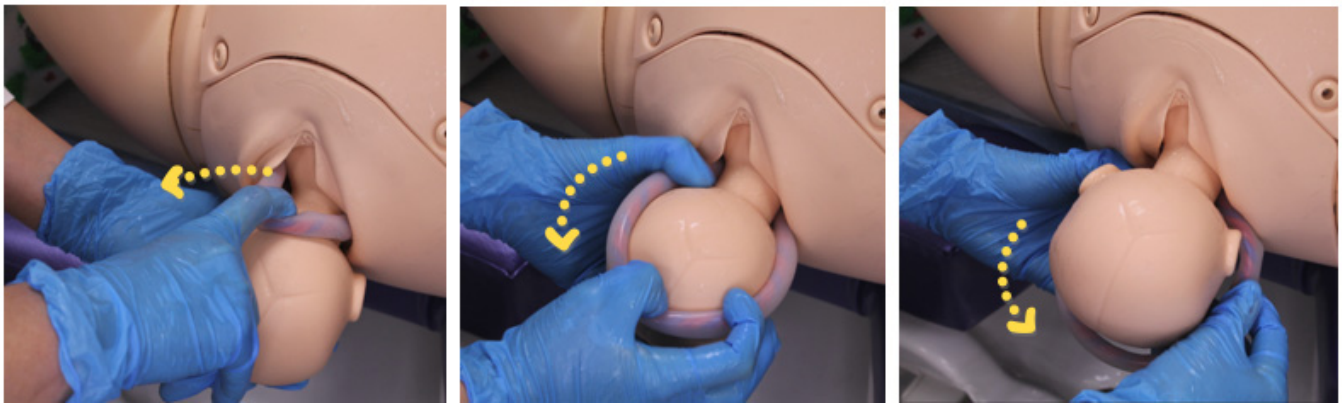


Figure 1.6. Steps of the sliding the cord over baby's head.

- If the cord is very tight, or if it is wrapped around the neck more than once, try to _____
_____
- If you cannot loosen the cord, and if the cord is preventing the baby from coming out, you may
_____

If you cut the cord before the birth of the baby, the mother must push hard and get the baby out fast. Without the cord, the baby cannot get any oxygen until he or she begins to breathe.

13. Wait for a s**pontaneous** _____ of the fetal head. It may last till _____. *Repeat your request to the mother* _____.
14. After the baby's head is born and he or she _____ *face to the mother's leg*, wait for _____. **Only after this (!) ask the mother to give a gentle push** as soon as she feels the contraction.
    *If spontaneous rotation of the fetal head does not occur within 60 sec and the fetal head retracts back against the perineum and does not attempt to externally rotate ("**turtle sign**", the shoulders are "stuck" the **shoulder dystocia** has happened).*
15. **Support delivery of the upper part of** _____ **shoulder** in a _____ fashion and then the _____ shoulder in an _____fashion Figure 1.7.

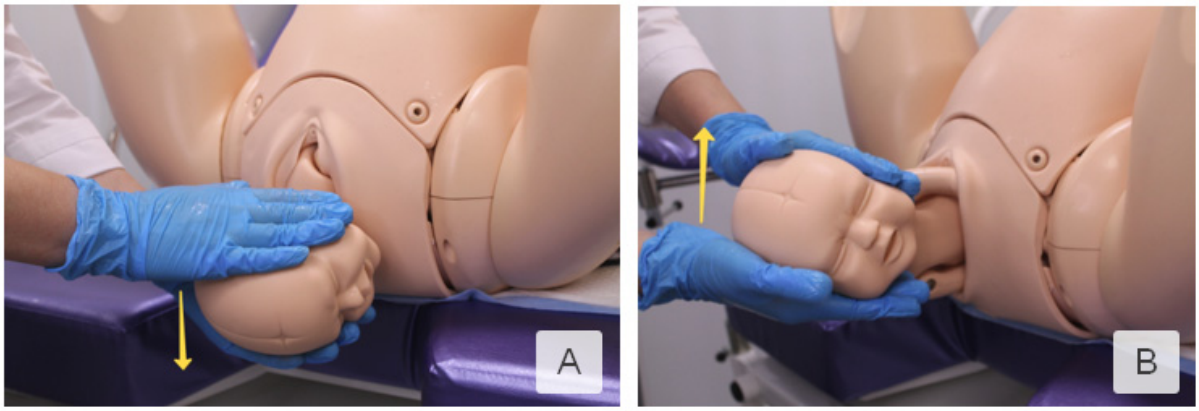


Figure 1.7. Delivery of the shoulders.

16. **Support birth of the body** by expulsion. (Figure 1.8). After the shoulders are born, the rest of the body usually slides out without any trouble. Remember that new babies are _____. Be careful not to drop the baby!

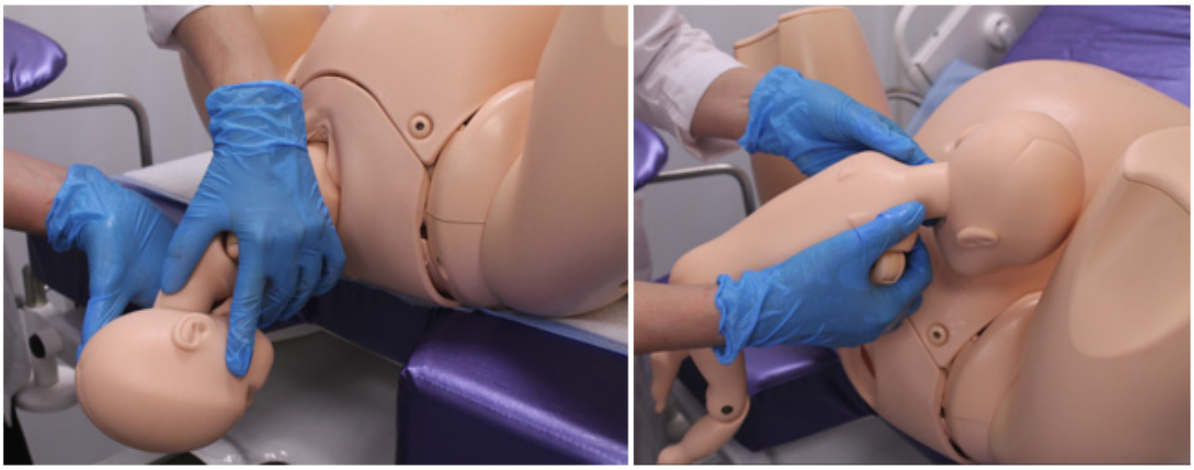


Figure 1.8. Supporting birth of the fetal body. To avoid fetal head overextension and potential spinal trauma fix its neck or just try keep him face down.

17. **Place baby** skin to skin on _____ and allow the cord to _____ (Figure 1.9).

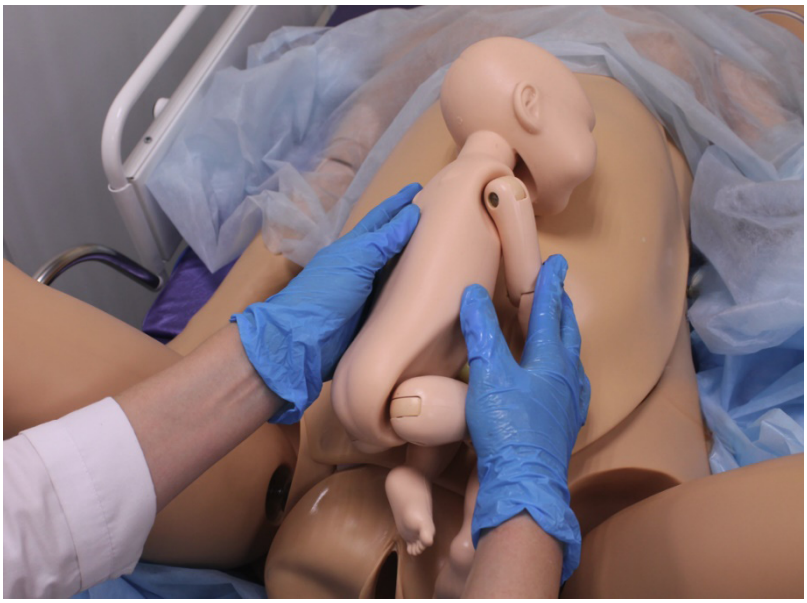


Figure 1.9. Placing baby skin to skin on mother's abdomen.

18. **! Prevent loss of body** _____ by drying the baby, then covering both mother and baby with warm blankets (Figure 1.10). This should be sufficient stimulation to assist with spontaneous respirations.

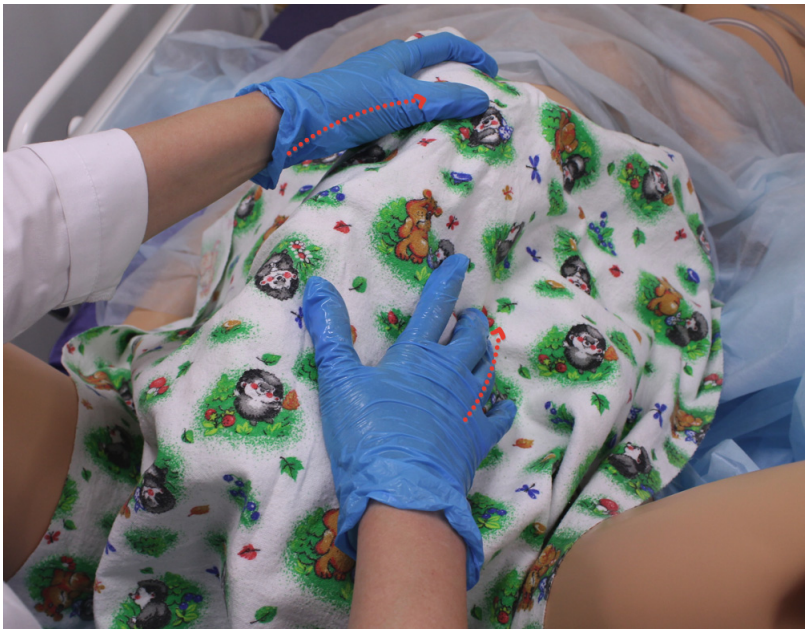


Figure 1.10. Covering baby with warm blankets and drying him is usually sufficient stimulation to assist with spontaneous respirations.

19. Allow the **umbilical cord** to stop pulsating before clamping and cutting. This will _____ to the baby. Use a sterile string or sterile clamp to tightly tie or clamp the cord about two finger widths from the baby's belly. Tie a square knot (Figure 1.11). Put another sterile string or clamp one finger from the first knot. And, if you do not have a clamp on the cord on the mother's side, add a third knot two fingers from the second knot. Putting a double knot on the cord reduces the risk of _____.

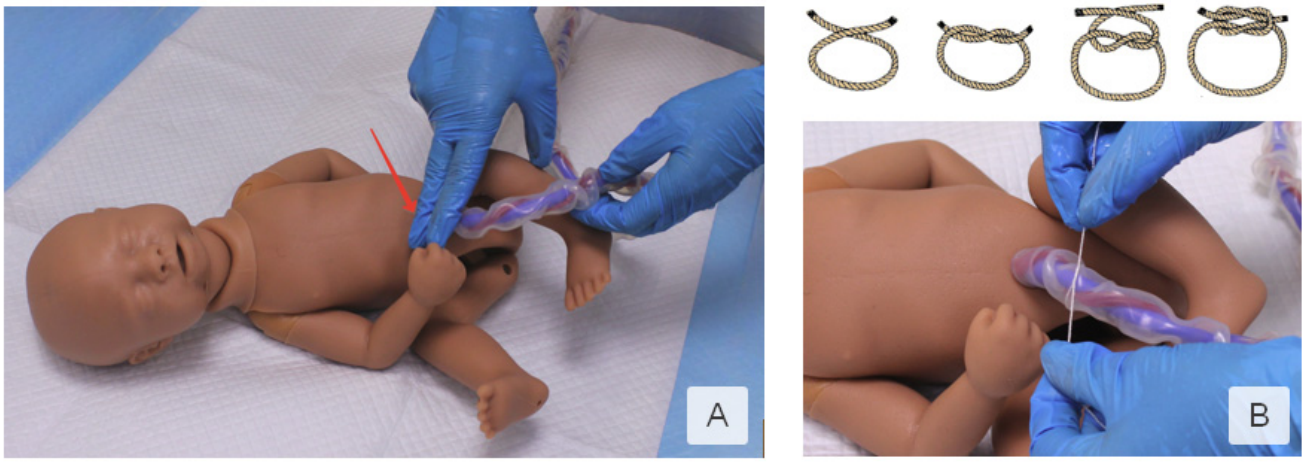


Figure 5.11. Cutting the umbilical cord. A. Two finger widths from the baby's belly. B. Tying a square knot.

20. **Cut after the second tie** (e.g. the first tie is approximately _____ cm from the baby's abdomen and the second is approximately _____ cm). Cut after the second tie with a sterile razor blade or sterile scissors.
21. **Cleaning**. Principles of cleanliness are essential in both home and health post childbirth to prevent infection to the mother and baby.
    Clean your _____, mother's _____, _____ surfaces
    Nothing unclean introduced vaginally
    The stump of the umbilical cord must be kept clean and dry to prevent infection. Wash it with soap and clean water only if it is soiled. Do not apply dressings or substances of any kind It usually falls off 4-7 days after birth, but until this happens, place the cord to prevent contamination with urine/ faeces. If the cord bleeds, re-tie it.
22. **Check the newborn**. Most babies are alert and strong when they are born. Other babies start slow, but as the first few minutes pass, they breathe and move better, get stronger, and become less blue. Immediately after delivery, clear airways and stimulate the baby while drying. To see how healthy the baby is, watch for:
    • *Breathing*:_____ .
    • *Color*: _____ .
    • *Muscle tone*: _____ .
    All of these things should be checked simultaneously within the first minute after birth. You will learn about this in detail in Neonatology classes.
23. **Warmth and bonding**. Newborn babies are at increased risk of getting extremely cold. *The mother and the baby should be kept skin-to-skin contact, covered with a clean, dry blanket.* This should be done immediately after the birth, even before you cut the cord.
    The mother's body will keep the baby warm, and the smell of the mother's milk will encourage him or her to suck. Be gentle with a new baby. The first hour is the best time for the mother and baby to be together, and they should not be separated.
    This time together will also help to start breastfeeding as early as possible.
24. **Early breastfeeding.** If everything is normal after the birth, the mother should breastfeed her baby right away. She may need some help getting started.
    ! Breastfeeding makes the ***uterus*** _____
    _____ .
    ! Breastfeeding helps the baby _____
    ! Breastfeeding comforts the baby _____ .
    ! Breastfeeding can help the mother relax and feel good about her new baby _____ .

If the baby does not seem able to breastfeed, see if it has a lot of mucus in his or her nose. To help the mucus drain, lay the baby across the mother's chest with its head lower than its body. Stroke the baby's back from the waist up to the shoulders. After draining the mucus, help the mother to put the baby to the breast again.

Practical part

During the practical class you need to show in phantoms management of an unexpected or precipitous birth according to a following check list:

Example of the task

"You arrive a scene where a young woman with term singleton pregnancy is complaining of heavy and frequent contractions, last two minutes she had urge to push. You need to manage the late second stage of labor. Comment all your manipulations"

The check list example

Date		Student's name	
Second labor stage		Task number	

N	Tasks	Ratings		
		0	**1**	**2**
1.	Introduce yourself to the patient including your name and role Confirm the patient's name Call for assistance			
2.	Assist the woman into a position of her choice, as upright as possible and ensure her comfort in this position			
3.	Explain to the patient need for obstetric examination. Seek permission and discuss findings with the woman			
4.	Ask for antiseptic and sterile gloves, clear blankets, scissors, and smth that can be used as ligatures or an emergency birth pack wash hands, put on sterile gloves			
5.	Support the woman to push as she wishes with contractions and explain the woman how to "feather blow" and how to push			
6.	After the head crowning (appearance of the parietal tubercles), ask the woman not to push (to "feather blow")			
7.	As soon as head delivered inspect for the nuchal cord, if the cord is around the neck but it is loose, slip it over the baby's head If the cord is tight, try to slip the cord over baby's shoulders (for a «Somersault» maneuver) If the tight cord prevents birth of the body, place 2 clamps on the cord approximately 2-3cm apart and cut between the clamps, quickly unwrap the cord around the neck			

8.	Repeat your request to mother not to push and allow the baby's head to rotate spontaneously, wait for shoulders to rotate into oblique (or anterior-posterior diameter)			
9.	Stand on the side of the fetal back and put one hand palm-side up below the fetal head. With next contraction and ask mother to give a gentle push Place other hand on the upper fetal head side and with downward traction on the head, deliver the anterior shoulder			
10.	As soon as anterior shoulder delivers, provide upward and outward tractions for the posterior shoulder delivery			
11.	Support the delivery of the rest of the baby's body and place the baby on the mother's chest or abdomen for the skin-to-skin contact			
12.	Note the time of birth, cover baby with the blankets			
13.	Thoroughly dry the baby and wipe the eyes. Remove the wet cloth, cover the baby's head and body with a clear blanket			
14.	Allow the cord pulsating by its own, place 2 clamps on the cord approximately 2-3cm apart and cut between the clamps			
15.	Check the newborn for breathing color and muscle tone			
16.	Encourage early breastfeeding			
17.	Wash your hands, remove gloves			
18.	Congratulate the patient, prepare for the third labor stage			
19.	Total score Rating "3" – 25-28 Rating "4" – 29-32 Rating "5" – 33-36			

_____The most common checklist items skipped by students

1. Assist the woman into a position of her choice, as upright as possible and ensure her comfort in this position
2. Stand on the side of the fetal back and put one hand palm-side up below the fetal head. With next contraction and ask mother to give a gentle push Place other hand on the upper fetal head side and with downward traction on the head, deliver the anterior shoulder
3. Note the time of birth, cover baby with the blankets

_____My items skipped from the check list

_____

_____

_____

_____

_____

_____

Practical class 2. Managing physiological third labor stage and early postdelivery

To *minimize the risks* of **postpartum hemorrhage** (PPH), a set of procedures have been developed that all birth attendants should follow, called _____ _____. Correctly applied, this protocol can reduce the risk of postpartum hemorrhage by more than 60%.
In this study session, you will learn active management procedure, this knowledge will help you to identify the complications that may arise during the third stage of labor and manage them more effectively.

The term 'active management' indicates that you are not waiting for spontaneous _____. Instead, you will use methods that will *shorten the process of uterine emptiness*, provide earlier *effective* uterine _____and minimize the *guaranteed* _____.

So, what you need to do just after the complete expulsion of the baby?
Provide management according to the following order:

1. **Check the uterus for** the presence of a _____ by palpating the uterus through the mother's abdomen. The reason for checking so carefully is because _____
   _____
2. In less than one minute after childbirth, **administer** a _____ drug. You can give the mother one of the following:
   – _____ 600 micrograms (mg), i.e., three 200 mg tablets by mouth with a drink of water.

OR (if you carry this in an icebox)
   – _____ 10 international units (IU) injected deep into the woman's thigh muscles (intramuscular injection, IM). _____
   _____

OR
   – _____ 0.4–0.5 mg injected deep into the woman's thigh muscles. Note that it is contraindicated for women with _____

When the uterus *is well contracted it will feel **very hard***. This should occur between 2-7 minutes after the administration of the drug, depending on which one is given.

3. **Observe for signs** that the **placenta is**_____:
   A. _____
   _____ ,
   B. _____
   _____ ,
   C. _____
   _____ ,

   (Figure 2.1).

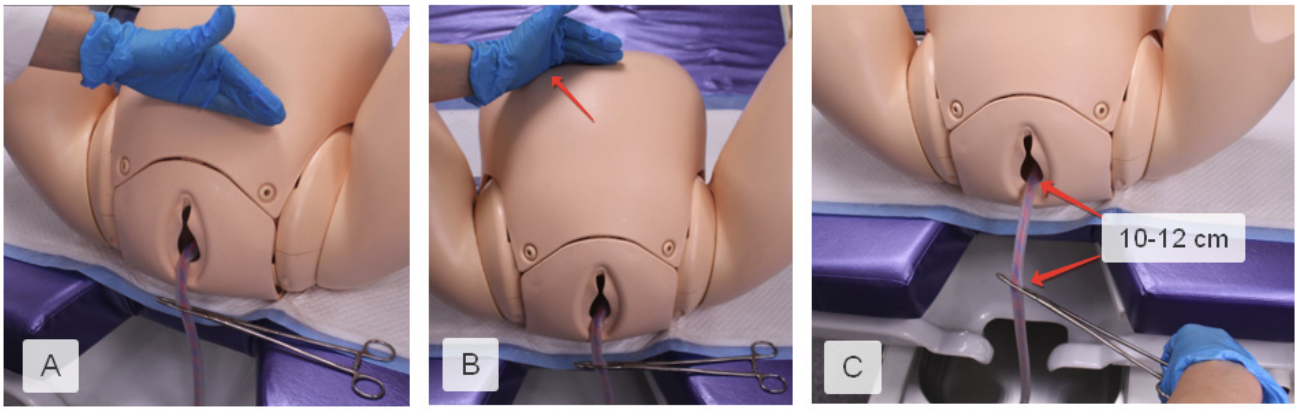


Figure 2.1. Symptoms of separation.

If all the mentioned above symptoms are _____ – placenta seems to be separated. At this moment you can ask the woman to push for the placenta delivery. In this case you continue with p. 5.

4. You also may carefully apply_____ _____ to help to expel the placenta (see Figure 2.2).

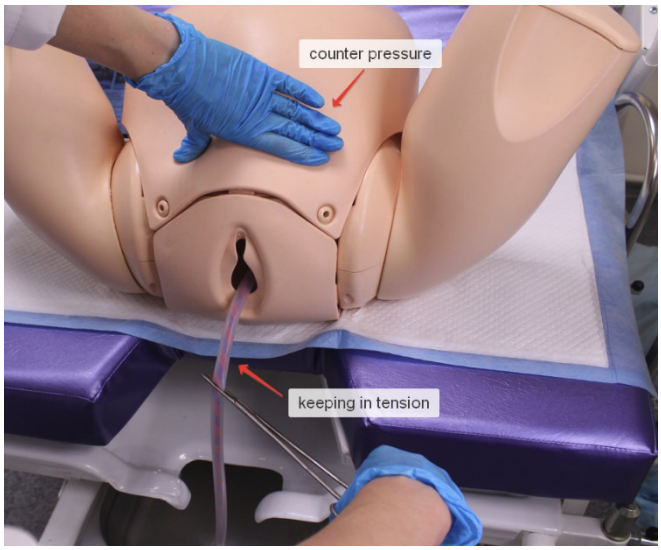


Figure 2.2. _____. The right hand is pulling the clamped umbilical cord (making traction) while the left hand is exerting counter-pressure on the lower abdomen, just above the pubic bone.

For the controlled cord traction.

1) _____ close to the perineum (once pulsation of the blood vessels stops in the cord of a healthy newborn) and hold the cord in one hand.

2) Place the other hand just above the woman's _____ and stabilize the uterus by applying _____ to the abdomen during controlled cord traction.

3) Keep slight tension on the cord and await a strong _____ (usually every 2-3 minutes).

4) With the strong uterine _____, encourage the mother to push and very gently pull downward on the cord to deliver the placenta. Continue to apply counter-pressure to the uterus. Between contractions, gently _____ and _____.

5) With the next contraction, repeat controlled cord traction with counter-pressure. If the placenta does not descend during 30-40 seconds of controlled cord traction _____ continue to _____ because of the risk of the _____.

5. As the placenta appears in the _____, hold it by _____, slowly pull to complete its delivery and gently _____ *the placenta until the membranes are* _____ *to prevent their* _____ (Fig. 2.3).

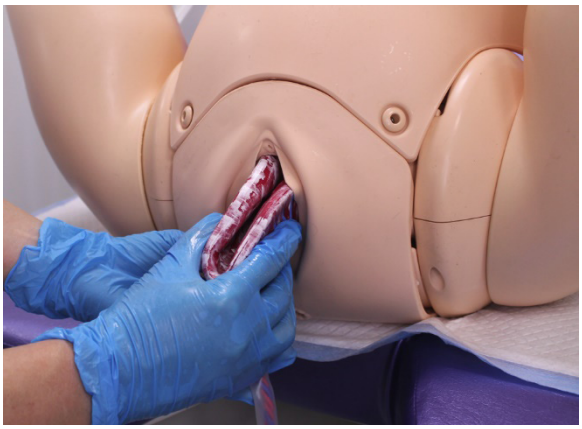


Figure 2.3. Delivery of the placenta.

Delivery of the placenta marks the end of _____.
!!!At this time the uterus should be _____, _____ *and* _____ *when you palpate the abdomen. You should be able to feel it midway between the mother's* _____ *and her* _____ _____. *There should be no bleeding from the vagina. The* _____ *should be empty.*

6. After delivery of the placenta, immediately and gently start ***massaging*** _____. This is a good way to contract it and stop the bleeding (Fig. 2.4).

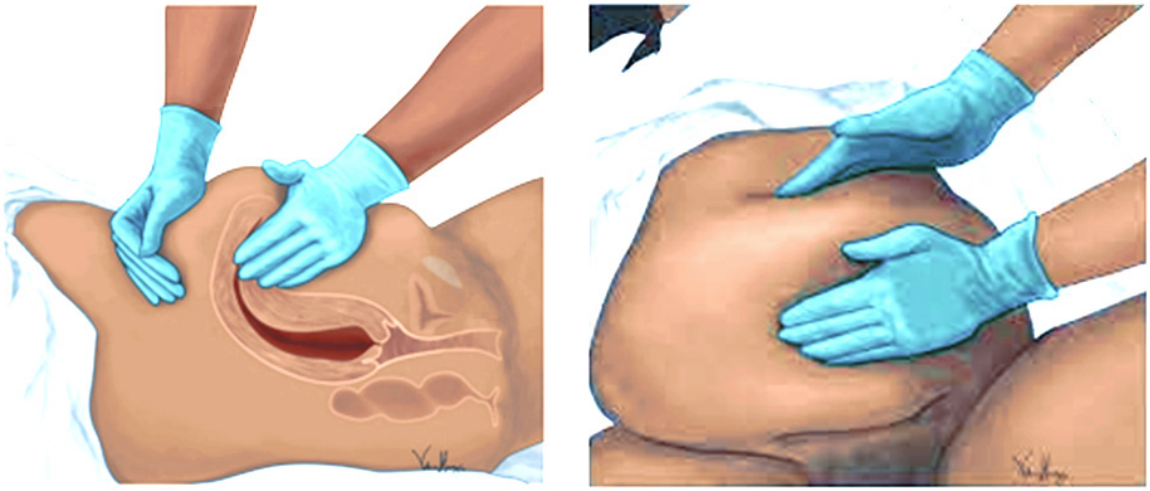


Figure 2.4. Uterine massage (rubbing the uterus).

7. **Examine the placenta** to make sure it is _____ and none of it has been retained in the uterus. If a _____ (Fig. 2.5) is missing, or there are torn _____ with _____, suspect that _____ remain in the uterus and try to refer the mother quickly.

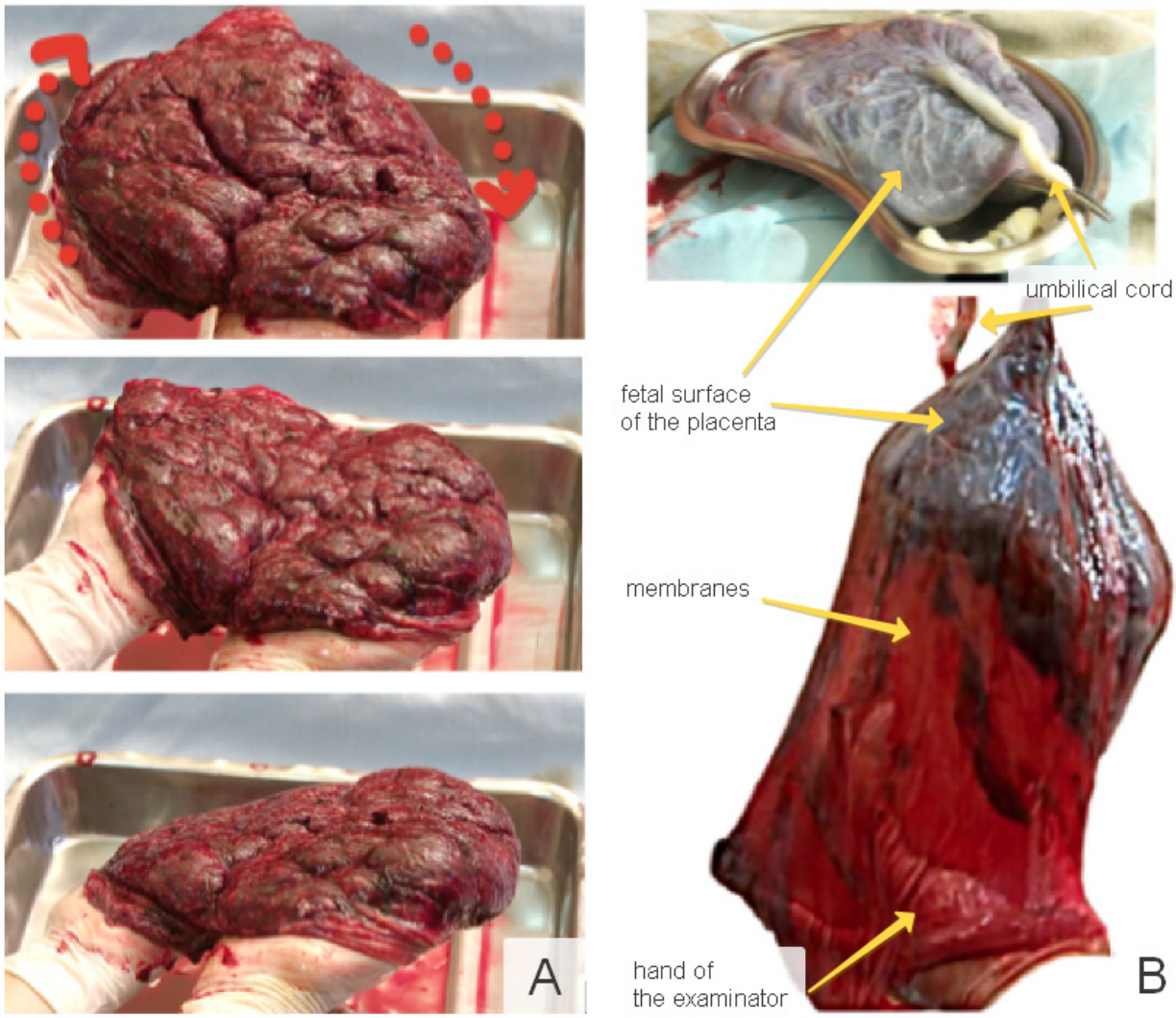


Figure 2.5. Examination of the placenta and fetal membranes A. Checking maternal surface of the placenta to see is it intact (move it for better visualization of possible defects). B. Checking membranes to see are they complete.

Checking the placenta for _____. *Hold the placenta in the palms of your hands, with the maternal side facing upward (Figure 2.5A). Make sure that all the lobules are present and fit together. Then hold the cord with one hand, allowing the placenta and membranes to hang down. Place the other hand inside the membranes, spreading the fingers out, to make sure that the membranes are complete (Fig. 2.5B). Save the placenta by placing it in a _____ and possibly _____ it for future transfer to a specialist.*

8. **Examine** the woman's _____, _____ *and* _____ for _____ and _____ by gentle separation of the labia and inspection of the lower vagina and perineum. If the membranes are torn, gently examine the upper vagina and cervix of the woman by a *sponge forceps* to remove any pieces of membrane that are present. It is dangerous for the mother if any parts of the placenta or membranes are left behind in the uterus and may lead to the _____ or infection (_____).

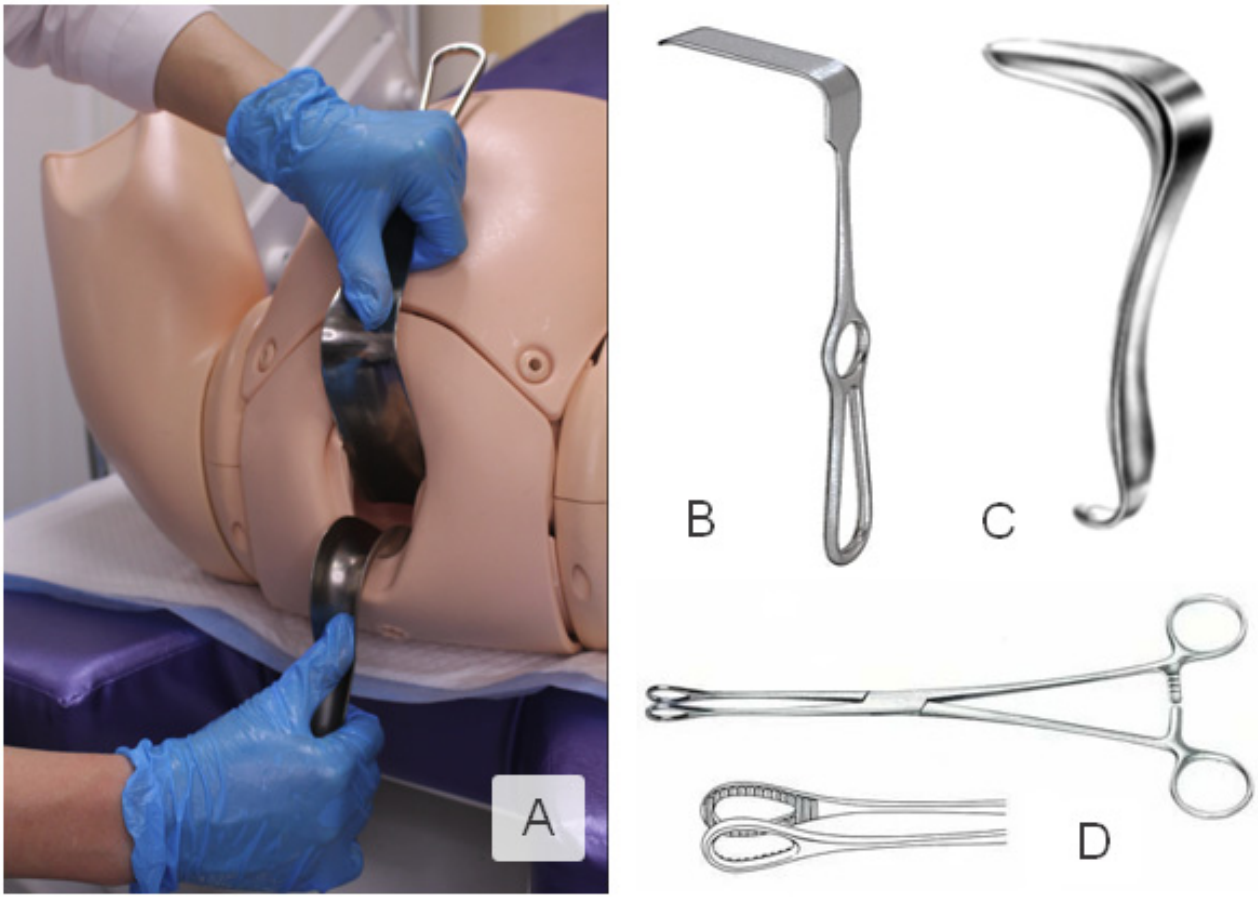


Figure 2.6. Examination of the _____with spoon-shaped vaginal specula for _____. B. Landon retractor. C. Kristeller vaginal speculum. D. Sponge forceps

9. To **complete the management of the third stage** of labor gently _____ the vulva and perineum with a weak antiseptic solution. Apply a clean pad or cloth with _____ to the area that is bleeding for about _____ minutes. If bleeding continues after this time, suturing is indicated, if this is not possible right now, refer the woman as soon as possible, keeping the pressure applied to the wound.
10. **Monitor the woman every** _____ – this means:
    1)_____ ,
    2) _____ ,
    3) _____ .
11. **Inform the woman** and her support person that the birth is about to take place.
12. **Reassure the woman** that she will be assisted and will not be left unattended.

_____Practical part

During the practical class you need to show in phantoms management of an unexpected or precipitous birth according to a following check list:

Example of the task

"You arrive a scene where a woman just delivered a live neonate without any complications. You're in the admission department of a small clinic, all other staffs are busy with patient in serious condition. You need to manage the third stage of labor. Comment all your manipulations"

The check list example

Date		Student's name		
Third labor stage			Task number	

N	Tasks	Ratings		
		0	1	2
1.	Introduce yourself to the patient including your name and role Confirm the patient's name Call for assistance			
2.	Wash hands, wears clean gloves			
3.	Ask for antiseptic, two sponge forceps, scissors, medical tray and gauze pads			
4.	Palpate the abdomen to rule out the presence of an additional baby			
5.	Clamp the cord by two sponge forceps, cut it by scissors			
6.	Check and report about positive signs of the placental separation (uterus become globular and rotated to the right, cord lengthens and not return under suprapubic pressure, ± gush of blood appears)			
7.	Ask woman to push for the placenta delivery			
8.	As the placenta is not delivered hold the clamped cord and the end of the forceps with one hand, while another place just above the woman's pubic bone and stabilize the uterus by counter-traction. Keep slight tension on the cord and await a strong uterine contraction			
9.	With the uterine contraction apply traction on the cord, continuing counter-traction to the uterus with the other hand			
10.	The appeared in vulva placenta take in two hands and gently turn it several times in a clockwise fashion until the membranes are twisted. Slowly pull to complete the delivery			
11.	Examine the placenta carefully to be sure none of it is missing inside the uterus			
12.	Examine the woman for any tears to the perineum or vagina			
13.	Estimate blood loss (medical tray)			
14.	Encourage the woman to empty her bladder (by words)			
15.	Clean mother's perineum, delivery surface			
16.	Wash your hands, remove gloves			
17.	Congratulate the patient and her family			
18.	Report the need to monitor every 15 minutes for 2 subsequent hours complains of the woman, uterine tone, blood loss volume, BP, body temperature – once (if normal)			
19.	Total score Rating "3" – 25-28 Rating "4" – 29-32 Rating "5" – 33-36			

The most common checklist items skipped by students

1. Palpate the abdomen to rule out the presence of an additional baby
2. As the placenta is not delivered hold the clamped cord and the end of the forceps with one hand, while another place just above the woman's pubic bone and stabilize the uterus **by counter-traction**. Keep slight tension on the cord and await a strong uterine contraction
3. Encourage the woman to empty her bladder (by words)

My items skipped from the check list

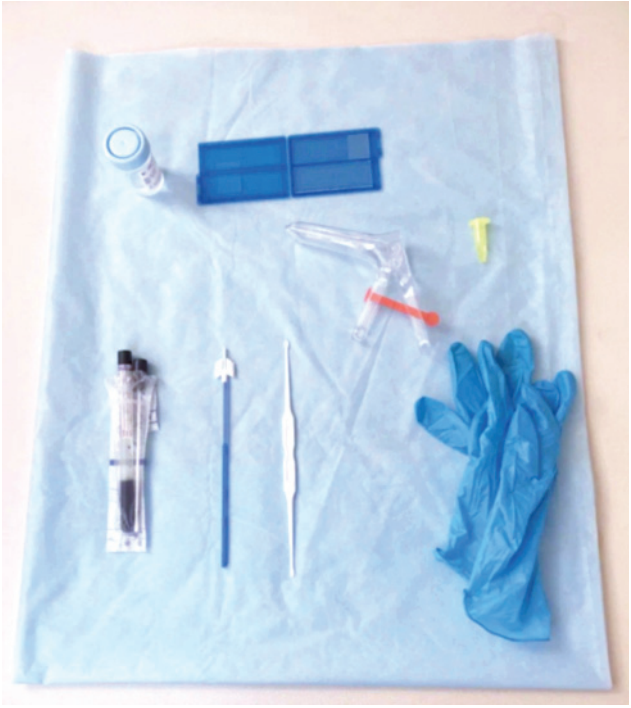
Practical class 3. Managing vaginal speculum examination

Speculum examination (other variants are “cervical screening” or “smear test”) is a common procedure to start the internal (vaginal) examination.
This procedure is frequently used in OSCE, mainly because of its importance in screening for cervical cancer. But it is also mandatory in gynecological and obstetric patients with complaints of vaginal discharge. This guide provides a step-by-step approach to performing speculum examination.

- Gather the appropriate equipment:

1._____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. Lubricant*

**Use of lubricant should be avoided when taking a cervical smear sample due to the risk of contamination. However, if lubricant is required, only a carbomer-free product that is recommended by the manufacturer of the cervical screening kit should be used*



- **Introduction**

1. Introduce yourself to the patient including your name and role. 2. Confirm the patient’s name and date of birth. 3. Provide the patient with the opportunity to pass urine before the examination. 4. Explain to the patient that they’ll need to remove their underwear and lie on the clinical examination couch, covering themselves with the sheet provided. Provide the patient with privacy to undress and check it is ok to re-enter the room before doing so. 6. Wash your hands	
6. Explain what the examination will involve using patient friendly language:	
7. Explain the need for a chaperone:	
8. Gain consent to proceed with the examination:	
9. Position the patient:	

- **Vulvar inspection**

Don a pair of _____ gloves and inspect the vulva for abnormalities:

- Ulcers: typically associated with _____.
- Abnormal vaginal discharge: _____, _____, _____.
- Scarring: may relate to _____ or lichen sclerosus (destructive scarring with associated adhesions).
- Masses: causes include _____ and _____.
- Varicosities: varicose veins are secondary to _____ or _____ _____ (e.g. pelvic malignancy).
- Female genital mutilation: total or partial removal of the clitoris and/or labia and/or narrowing of the vaginal introitus.

- **Speculum examination**

Vaginal speculum is a tool for inspecting a vaginal canal. The speculum is composed of two blades and a handle (Fig. 3.1) and has a jaw that opens up like a duck bill. Below you see multi-use metallic specula, but nowadays single use plastic specula are more common.

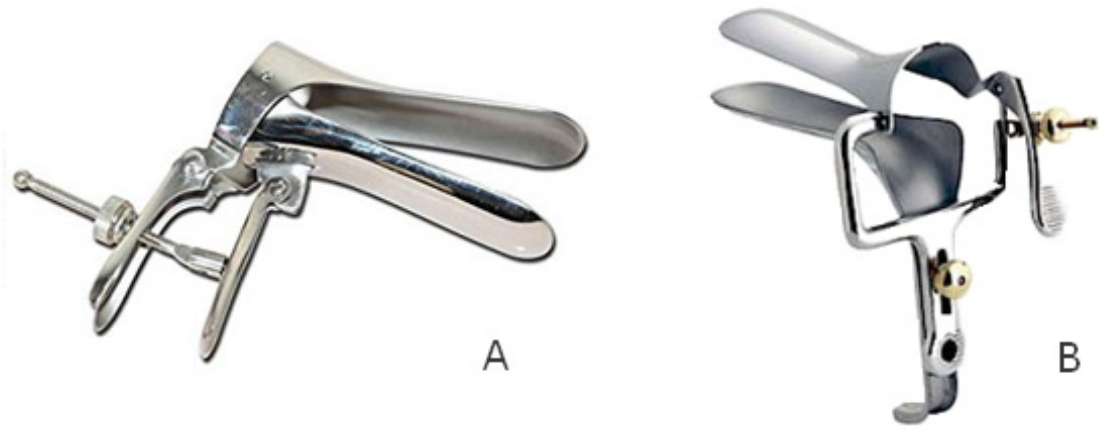


Figure 3.1. Metallic vaginal specula. A – Cusco speculum, B – Graeve speculum

The advantage of Cusco's and Grave specula is that they are _____. Therefore, an assistant's help is not needed to keep the speculum in place. By the thumb pressure on upper handle top blade hinged. The thumbscrew (lock) when is turned fixes the top blade in position (Fig. 3.2).

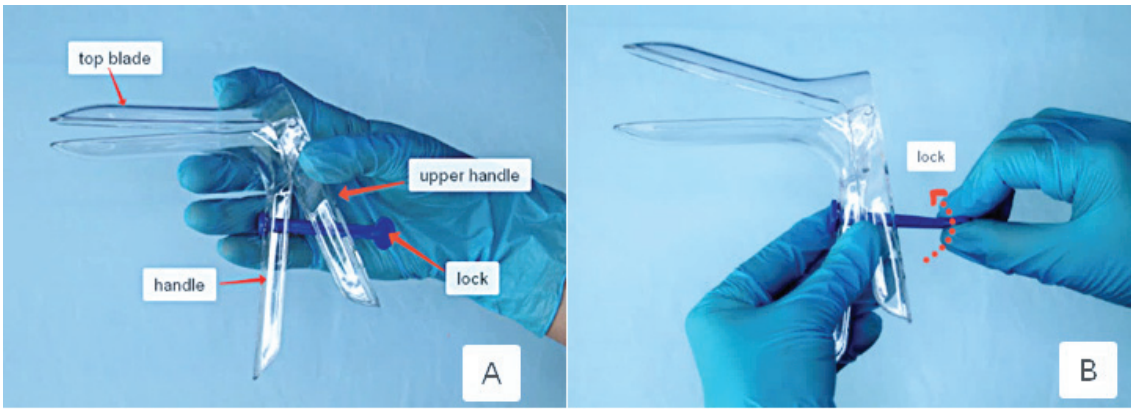


Figure 3.2 Mechanism of opening and fixation of the vaginal specula

When speculum correctly placed into vagina being opened and fixed it allows a *clear view of the* _____ (Fig. 3.3)

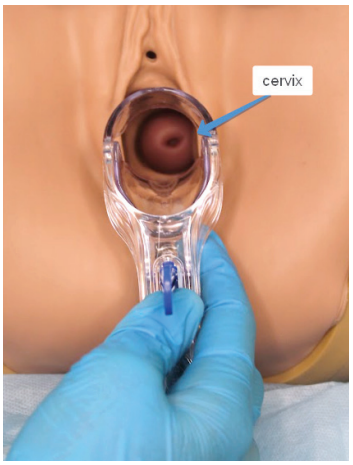


Figure 3.3 Correct placement of the vaginal speculum.

When all is prepared warn the patient you are going to _____ and ask if they're still ok for you to do so. If the patient **consents** to the continuation of the procedure, _____ *the speculum* and carry out the following steps:

1. Use your left hand (index finger and thumb) to _____ *labia* (Fig. 3.4). Gently insert the speculum sideways (blades closed, angled downwards). Once inserted, _____ the speculum back _____° so that the handle is facing upwards or downwards.

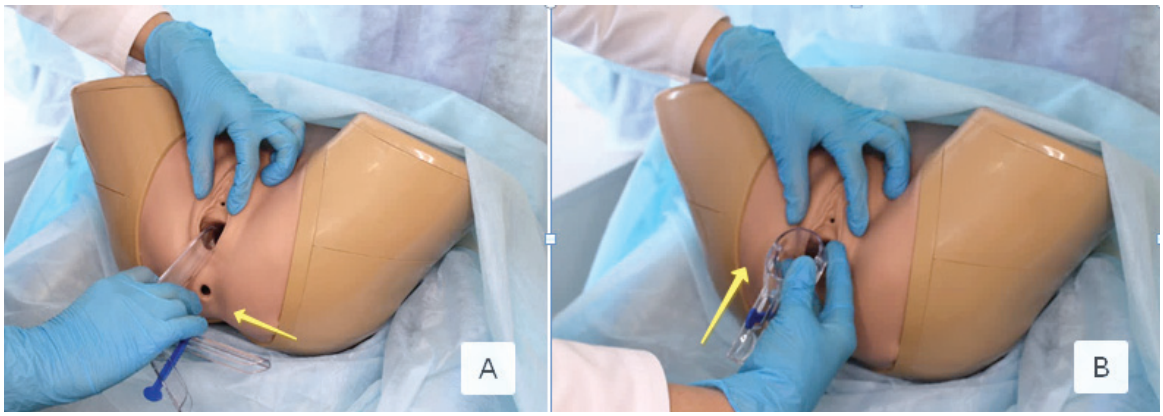


Figure 3.4 Insertion of the vaginal speculum.

2. _____the speculum blades until an optimal view of the cervix is achieved. Tighten the _____ to fix the position of the blades (Fig. 3.5).

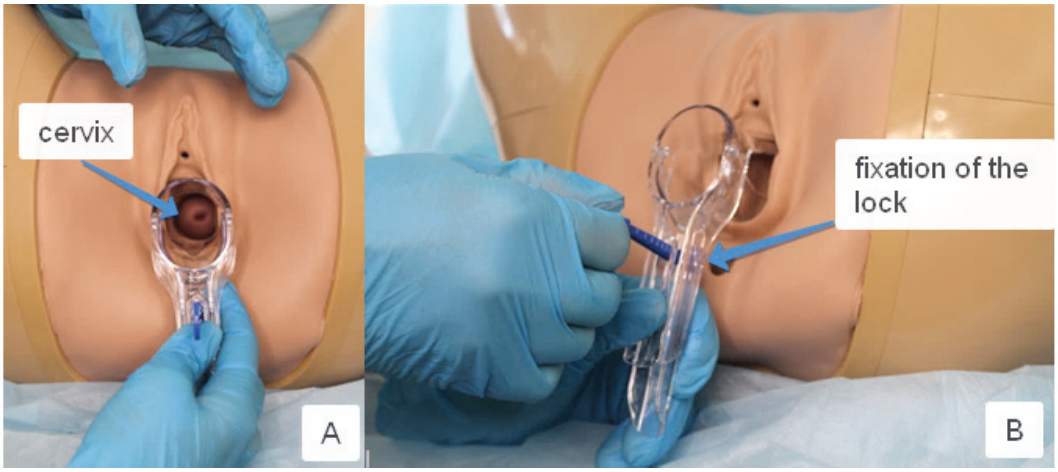


Figure 3.5 The speculum is located correct: A – cervix is visualized clearly, B – lock is closed in speculum opened position.

- **Inspect the cervix:**

Inspect for erosions around the os: most commonly associated with ectropion however early cervical cancer can have similar appearances, but typically it is associated with cervical masses.

- Ulceration: most commonly associated with _____
- Abnormal discharge: several possible causes including:

Vaginal discharges	**In gynecological patient**	**In obstetric patient**
Pus		
Blood		
Yellow-green or brown meconi-um-staned		
Liquid transparent		
Cottage cheese-like		

- **High-vaginal swab**

The high-vaginal swab is used to detect *bacterial vaginosis*, *trichomonas vaginalis*, *candida* and *Group B streptococcus*. To take a high-vaginal swab:

1. Prepare a glass slide by marking the patient ID information on it (Fig. 3.6).

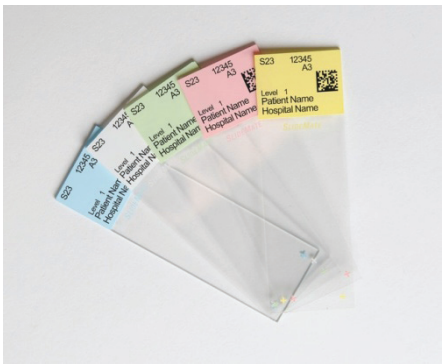


Figure 3.6. Clear glass slides with patient ID

2. Take a single-use **Volkmann spoon**. With the speculum in situ, pass the tip of the spoon through the speculum to the posterior fornix of the vagina.
3. Move the spoon for 5-10 seconds in the posterior fornix collecting any discharge present (Fig. 3.7).

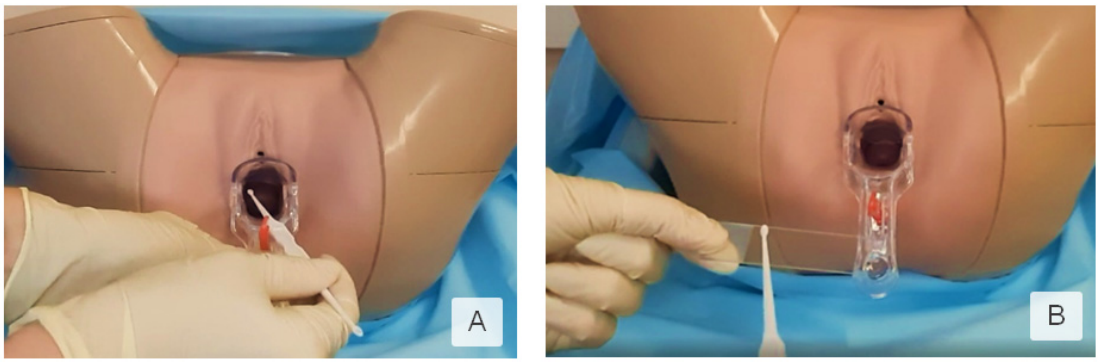


Figure 3.7. High-vaginal swab procedure. A. Collection of vaginal discharge from the posterior fornix with a spoon. B. Applying the discharges on the slide by spreading.

4. Remove the spoon and apply material by spreading as thinly as possible on 1 marked glass.

- **Cervical screening sample**

1. Insert the endocervical brush through the speculum into the endocervical canal, avoiding touching the sides of the speculum with the brush (Fig. 3.8).

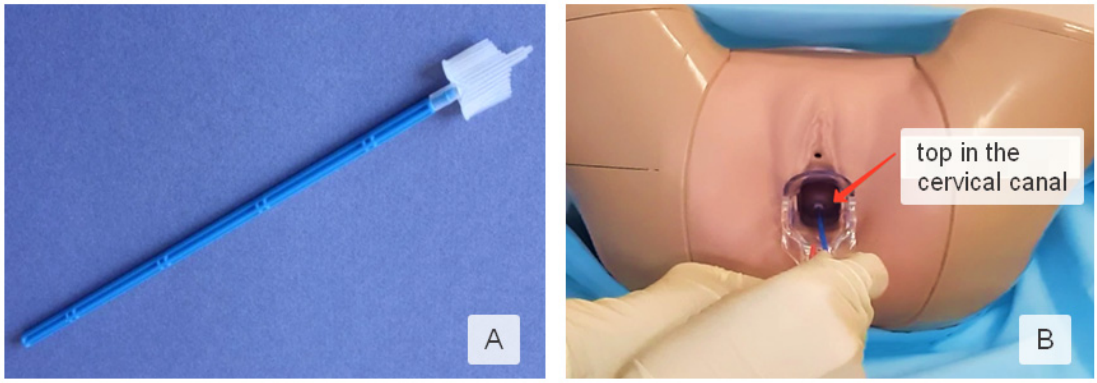


Figure 3.8. Cervical screening sample. A. Endocervical brush. B. Correct placement of the cytobrush in the cervical canal.

2. Rotate the brush in the cervical canal 5 times, 360 degrees, in a clockwise direction (Fig. 3.9).

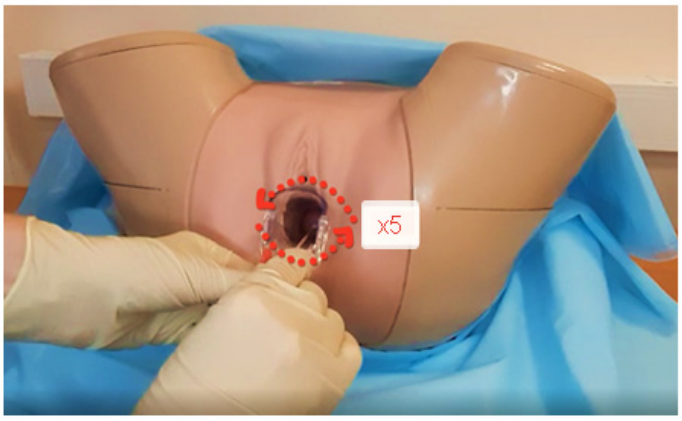


Figure 3.9. Cervical screening sample. Rotate the cytobrush in the cervical canal 5 times, 360 degrees, in a clockwise direction

3. Remove the endocervical brush, avoiding touching the speculum as you do so.
4. Transfer the sample to the liquid-based cytology container (follow local cytology guidelines for transferring the sample from the brush into the container). Methods may include: A) Sweeping the brush against the sides and the base of the container (the 'mash and bash' technique) then discarding the entire brush B) Breaking off the tip of the brush and placing this into the container (Fig. 3.10).

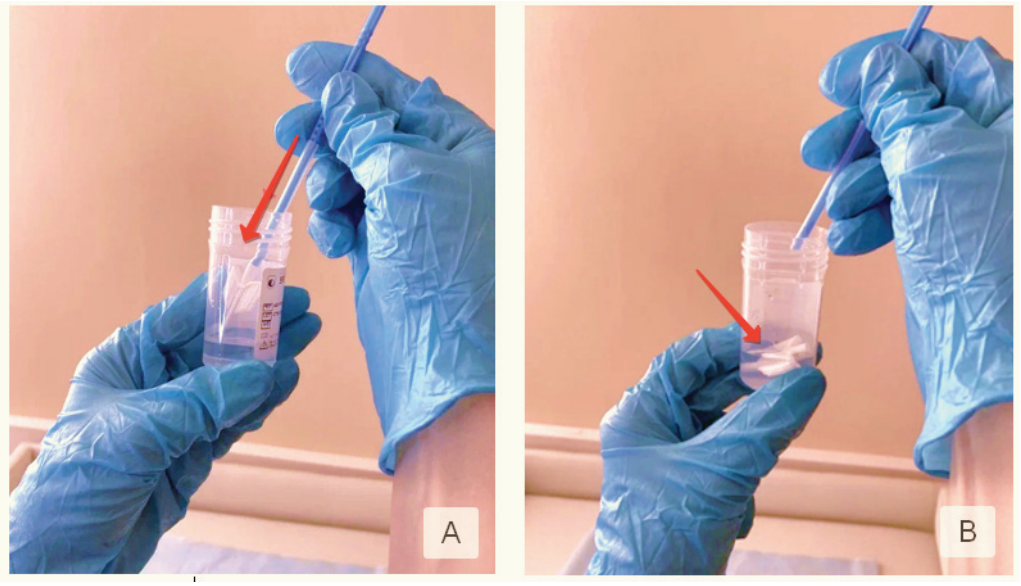


Figure 3.10. Transferring the sample into media.
A. Put the brush top in the media. B. Break and leave the tip of brush inside container.

- **To finish the procedure** you need remove the speculum. All steps need to be done in controversial order.

1. With your non-dominant hand, hold the blades of the speculum whilst you loosen the locking nut with your dominant hand. This ensures the blades do not snap shut when the locking nut is loosened. Gently remove the speculum whilst slowly closing the blades *rotating them again for 90 degrees* (for the removing it through vulva in anterior-posterior diameter) and inspecting the walls of the vagina. Dispose of the used equipment into a clinical waste bin.
2. Cover the patient with the sheet, explain that the procedure is now complete and provide the patient with privacy so they can get dressed. Provide paper towels for the patient to clean themselves.
3. Dispose of the used equipment into a clinical waste bin. Dispose gloves appropriately and wash your hands.
4. Thank the patient for their time.
5. Advise the patient that they'll be contacted with results via their preferred method (e.g. face to face or text message).

During the practical class you need to show in phantoms procedure of the speculum examination and cervical screening according to a following check list:

Example of the task

"You are GP in a small rural dispensary and today you have a 26-year-old patient. without complaints, who came for a cervical screening procedure"

The check list example

Date		Student's name		
Speculum examination			Task number	

N	Tasks	Ratings		
		0	**1**	**2**
1.	Introduce yourself to the patient including your name and role Confirm the patient's name			
2.	Explain the procedure, ask whether they have ever had a speculum performed before, ask if patient would like a chaperone present, gain informed consent for investigation			
3.	Ask patient to empty her bladder if she needs to, then to undress from the waist down, explain that he needs patient to be in the supine position on a disposable diaper (on examination couch)			
4.	Ensure equipment: single-use gloves, clear blankets, sterile warmed speculum, lubricant, single-use cytobrush, pre-labelled glass slide, pre-labelled fixative for cytological specimen			
5.	Wash your hands, put sterile gloves on			
6.	Provide inspection of the external genitalia? • pubic hair pattern • vulval skin (colour, lesions, etc.) • prolapse (no abnormalities are found)			
7.	Insert the lubricated speculum and adjust it so that the entire cervix can be seen, simultaneously describing the findings • cervical epithelium • vaginal epithelium • cervical os (ectropion, polyps, threads of IUCD, etc.) • discharge (no abnormalities are found)			
8.	Collect vaginal discharge with a Volkmann spoon from the posterior fornix vault of the vagina, spread the specimen gently on a pre-labelled glass slide along it's length			
9.	Introduce a cytobrush inside the endocervical canal and then rotate 5 times, 360 degrees, in a clockwise direction, spread the specimen into a liquid fixative solution and vigorously swirl or rotate ten times in the solution			
10.	Open the speculum lock, gently remove speculum in closed position			
11.	Take the gloves off, dispose them in the proper container, wash hands			

12.	Ask the patient to take a seat, pronounce that you will discuss • findings with the woman and the most likely diagnosis • how long it will be until patient obtains the results • that she might experience some 'light spotting' but if her loss is significant then to turn to her GP Thanks the patient			
13.	Total score Rating "3" – 16-18 Rating "4" – 19-21 Rating "5" – 22-24			

The most common checklist items skipped by students

1. Explain the procedure, ask whether they have ever had a speculum performed before, ask if patient would like a chaperone present, gain informed consent for investigation
2. Provide inspection of the perineum
3. Obtaining cytological specimen from the posterior vault instead of external os
4. Open the specula lock, gently remove it in closed position
5. Ask the patient to take a seat, pronounce that you will discuss
6. Washing hands

My items skipped from the check list

Recommended literature

1. Simulation training course in obstetrics Study guide / N.G. Istomina, M.J. Dolidze, A.N. Baranov, G.M. Burenkov / Arkhangelsk: NSMU, 2023
2. Intrapartum management modules: a perinatal education program / Betsy Babb Kennedy, Suzanne McMurtry Baird / Fifth edition. | Philadelphia : Wolters Kluwer, 2017
3. Managing complications in pregnancy and childbirth: a guide for midwives and doctors – 2nd ed. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO
4. Cunningham F, & Leveno K.J., & Dashe J.S., & Hoffman B.L., & Spong C.Y., & Casey B.M.(Eds.), (2022). Williams Obstetrics, 26e. McGraw Hill. https://obgyn.mhmedical.com/content.aspx?bookid=2977&sectionid=249396578
5. Reynolds L. Practice tips. «Somersault» maneuver for a tight umbilical cord. Can Fam Physician. 1999 Mar;45:613. PMID: 10099799; PMCID: PMC2328444.
6. Labour and Delivery Care Blended Learning Module for the Health Extension Programme https://www.open.edu/openlearncreate/mod/oucontent/view.php?id=267

Educational publication

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Workbook

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