**FEDERAL STATE BUDGET EDUCATIONAL
HIGHER EDUCATION INSTITUTION
"ROSTOV STATE MEDICAL UNIVERSITY"
MINISTRY OF HEALTH OF THE RUSSIAN FEDERATION**

FACULTY OF TREATMENT AND PREVENTION

Evaluation materials on practice

"Practice of obstetrics and gynecology"

(appendix to the work program of the discipline)

Specialty 05/31/01 General Medicine

2023

1. List of competencies formed by practice

General professional (OPK), professional (PC)

Code and name of professional competence
OPK-4. Able to use medical devices provided for in the procedure for providing medical care, as well as conduct examinations of the patient in order to establish a diagnosis.
PC-3 Prescribing treatment and monitoring its effectiveness and safety

2. Types of assessment materials in accordance with the competencies being developed

Name competencies	Types of assessment materials	number of tasks **for 1 competency**
OPK-4, PK-3	Practical skills.	30 with sample answers

OPK-4

1. Measuring the abdominal circumference of a pregnant woman.

Standard of skill: abdominal circumference is measured with a centimeter tape: in front - at the level of the navel, in the back - the middle of the lumbar region.

2. Determination of the height of the uterine fundus.

Standard of skill: this is the distance from the upper edge of the symphysis pubis to the fundus of the uterus, measured with a centimeter tape.

3. Measurement of distantia spinarum.

Skill standard: measured with a pelvis in the supine position. The doctor stands facing and to the right. The branches of the tazometer are picked up in such a way that the thumbs and forefingers hold the buttons, and the scale with divisions is facing upward. Using the index fingers, probe the most distant points of the anterosuperior spines, press the buttons of the pelvis meter to them and determine the size using the pelvis meter scale.

4. Measurement of distantia cristarum.

Skill standard: measured with a pelvis in the supine position. The doctor stands facing and to the right. The branches of the tazometer are picked up in such a way that the thumbs and forefingers hold the buttons, and the scale with divisions is facing upward. Using your index fingers, you probe the most distant points of the iliac crests, press the buttons of the pelvis meter to them and determine the size using the pelvis meter scale.

5. Measurement of distantia trochanterica.

Skill standard: measured with a pelvis in the supine position. The doctor gets up

face and right. The branches of the tazometer are picked up in such a way that the thumbs and forefingers hold the buttons, and the scale with divisions is facing upward. Using your index fingers, you probe the most distant points of the greater trochanters of the femurs, press the buttons of the pelvis meter to them and determine the size using the pelvis meter scale.

6. Measurement of conjugate externa.

Standard of skill: the woman is placed on her side, with her back to the doctor, the underlying leg is bent at the hip and knee joints, and the overlying leg is straightened. The button of one branch of the pelvis is installed in the middle of the upper outer edge of the symphysis, the button of the other branch is pressed against the suprasacral fossa (between the spinous processes of the 5th lumbar and 1st sacral spines).

7. Measurement of conjugate diagonalis.

Standard of skill: The index and middle fingers are inserted into the posterior fornix of the vagina and with the end of the middle finger they try to reach the most protruding point of the promontory; the base of the index finger is pressed against the lower edge of the symphysis and this place is marked. After removing the hand, measure the distance between the top of the middle finger and the mark on the hand.

8. Carrying out the first appointment of external obstetric examination. Standard of skill: the palmar surfaces of both hands are positioned on the uterus so that they tightly cover its fundus (the gestational age is determined by the level of the uterine fundus). The large part of the fetus (the head, which is standing or the buttocks) is determined in the bottom.

9. Conducting a second external obstetric examination. Standard of skill: The doctor’s hands are on the side walls of the uterus to determine where the back and small parts of the fetus are. Palpation occurs alternately with the hands. The position of the fetus (longitudinal, transverse) and the position of the fetal back in the longitudinal position and the fetal head in the transverse position are determined.

10. Conducting the third appointment of external obstetric examination. Standard of skill: the thumb and middle finger of the right hand cover the presenting part and determine the presenting part, its position and relation to the entrance to the pelvis. For a comparative assessment of two large parts of the fetus and to clarify the presentation, the doctor conducts an examination with both hands simultaneously, grasping the head and pelvic end of the fetus, located above the symphysis and near the fundus of the uterus.

11. Carrying out the fourth appointment of external obstetric examination. Standard of skill: the doctor stands on the right and faces the patient’s legs and places his hands in the lower part of the uterus, fingers facing the entrance to the pelvis. The fingers slowly penetrate between the presenting part of the fetus and the entrance to the small pelvis on both sides, while simultaneously palpating the presenting part.

12. Conducting an internal vaginal examination.

Standard of skill: the index and middle fingers are inserted into the vagina, examining the hands. Determine the condition of the vagina and pelvic floor muscles.

The condition of the cervix, the condition of the amniotic sac, and the presenting part are assessed. Identification points of the presenting part are determined. The condition and relief of the bony pelvis, diagonal to the conjugate, are determined.

13. Auscultation of fetal heart sounds in pregnant women.

Standard of skill: auscultation is performed with a stethoscope, starting from the second half of pregnancy. With a stethoscope, the heartbeat is heard at a point that depends on the position and presentation of the fetus. With cephalic presentation, the heartbeat is heard below and to the side of the navel. In the first position - on the left, in the second position - on the right, in the rear view - laterally. With breech presentation, the heartbeat is heard above the navel. When the fetus is in a transverse position, the heartbeat is heard below the navel.

14. Determination during vaginal examination of the movable head above the entrance to the pelvis (in case of occipital presentation).

Standard of skill: during vaginal examination, the pelvic cavity is free, the head is high. You can feel the nameless line, promontory and womb. The head is movable. Arrow-shaped seam in transverse size. Large and small fontanel at the same level

15. During vaginal examination, identification of the head pressed against the entrance to the pelvis (in occipital presentation).

Standard of skill: during vaginal examination, the pelvic cavity is free, the head is high. You can feel the innominate line, the promontory and the inner surface of the pubis. The head is motionless. Arrow-shaped seam in transverse or oblique dimensions.

16. During vaginal examination, identification of the head, a small segment at the entrance to the pelvis (with occipital presentation).

Standard of skill: the sacral cavity is free, you can approach the promontory with bent fingers, the inner surface of the pubic symphysis is free. The head is motionless. Arrow-shaped seam in transverse or oblique dimensions.

17. During vaginal examination, identification of the head, a large segment at the entrance to the pelvis (with occipital presentation).

Standard of skill: the upper third of the sacral cavity and the inner surface of the pubic symphysis are occupied by the head. The head is motionless. The ischial spines can be easily palpated. The head is bent, the small fontanel is located below the large fontanel. Arrow-shaped seam in transverse or oblique dimensions.

18. During vaginal examination, identification of the head in the wide part of the small pelvis (with an occipital presentation).

Standard of skill: half of the sacral cavity and two-thirds of the inner surface of the pubic symphysis are occupied by the head. The ischial spines and the IV and V sacral vertebrae are palpable. The head is bent, the small fontanel is located below the large fontanel. Arrow-shaped seam in oblique size.

19. During vaginal examination, identification of the head in the narrow part of the small pelvis (with an occipital presentation).

Standard of skill: two thirds of the sacral cavity and the entire inner surface of the pubic symphysis are occupied by the head. The ischial spines are not palpable. The ischial tuberosities are difficult to palpate. The head is bent, the small fontanel is located below the large fontanel. A swept seam is close to straight size or in straight size.

20. During vaginal examination, identification of the head in the plane of the pelvic outlet (in case of occipital presentation).

Standard of skill: the entire sacral cavity and the inner surface of the pubic symphysis are occupied by the head. The ischial spines and tuberosities are not palpable. Sagittal suture in the direct size of the pelvic outlet.

21. Determination of the onset of the phase of separation of the placenta and membranes from the uterine wall using the Kustner-Chukalov sign.

Standard of skill: pressing with the edge of the hand on the suprapubic area of the woman, the body of the uterus is pushed upward with the placenta not separated and a section of the umbilical cord is retracted. When the placenta separates, it does not retract.

22. Determination of the onset of the phase of separation of the placenta and membranes from the uterine wall using Klein's sign.

Standard of skill: we ask the patient to push and when the placenta separates, the umbilical cord lengthens.

23. Inspection of the born placenta.

Standard of skill: after complete birth of the placenta, it is necessary to ensure the integrity of the placenta and membranes. First, the maternal surface is examined, lobule by lobule (the afterbirth lies on a smooth surface). To evaluate the membranes, the placenta is turned to the fetal side. The afterbirth is then measured and weighed.

24. Conducting Abuladze's reception.

Standard of skill: this technique is performed when the placenta has separated. The abdominal wall is grasped with both hands in a longitudinal strip (this eliminates the discrepancy of the rectus abdominis muscles) and the woman in labor is asked to push.

25. Carrying out Genter's reception.

Skill Standard: This technique is performed when the placenta has separated and the bladder has emptied.

With a light massage, the uterus is brought to the midline of the abdomen and the back of the fists is pressed on the bottom of the uterus in a downward and inward direction. The woman in labor should not push.

26. Carrying out the Credet-Lazarevich technique.

Skill Standard: This technique is performed when the placenta has separated and the bladder has emptied.

With a light massage, the uterus is brought to the midline of the abdomen and 4 fingers are placed behind the back surface of the uterus, placing the thumb in front. Squeezing the uterus with your fingers while simultaneously pressing it downwards, squeezes out the placenta.

27. Suturing a rupture in the vaginal mucosa.

Standard of skill: sutures are placed 0.5 cm above the edge of the wound and at a distance of 1 cm, picking up the bottom of the wound.

28. Suturing a 1st degree cervical rupture.

Standard of skill: expose the cervix in the speculum and fix it with window clamps or bullet forceps. Pull it towards you and tilt it in the opposite direction. Apply 1 suture above the upper corner of the tear, then apply sutures every 1 cm.

29. Suturing a 2nd degree perineal rupture.

Standard of skill: first, suturing the perineal muscles (muscle levator ani), then sutures are placed on the vaginal mucosa. After this, the skin of the perineum is sutured.

30. Examination of the birth canal in the early postpartum period.

Standard of skill: examine the birth canal using mirrors. The cervix is inspected using fenestrated forceps. The edges of the cervix are grasped with clamps one at a time and the cervix is pulled up at the same time.

PK-3

1. Instrumental method of amniotomy.

Standard of skill: the index and middle fingers of the left hand are inserted into the vagina. With the right hand, take the jaw of the bullet forceps, insert it along the palm between the fingers and bring it to the fold (formed by the fingers) of the amniotic sac and open the amniotic sac outside the contraction, the water is released slowly.

2. Perineotomy.

Skill standard: the surgeon inserts the index and middle finger of the left hand between the fetal head and the posterior commissure. Outside the attempt, the jaws of the scissors are inserted under the control of the fingers (the length of the scissors corresponds to the size of the incision), the incision is made at the height of the attempt.

3. Performing an episiotomy.

Standard of skill: the surgeon inserts the index and middle finger of the left hand between the fetal head and the perineum, retreating 2-3 cm from the midline. Outside the pushing, the jaws of the scissors are inserted under the control of the fingers (the length of the scissors corresponds to the size of the incision), the vulvar ring incision is made towards the ischial tuberosities 2-3 cm long at the height of the pushing.

4. Carrying out external rotation of the fetus onto its head during breech presentation according to B.A. Arkhangelsky.

Skill Standard:

I moment: removal of the buttocks from the plane of entry into the pelvis. The palm is inserted between the patient's womb and the fetus's buttocks. The pelvic end of the fetus is retracted from the entrance to the small pelvis.

Second moment: rotation of the fetus into the first oblique position. With friendly movements of the doctor's hands, covering the head and pelvic end, they begin to gradually rotate the fetus. Left hand in first position

cover the head from the suboccipital region and are shifted to the right side of the mother. With the other hand, the buttocks are shifted upward towards the back of the fetus.

III moment: rotation of the fetus into a transverse position. The head moves down and the buttocks move up at the same time.

IV moment: rotation of the fetus into the second oblique position. The head moves down and the buttocks move up.

V moment: rotation of the fetus into a longitudinal position.

VI moment: normalization of fetal position. Both hands move to the sides of the abdomen and squeeze the uterus from the sides and move them from front to back.

5. Classic manual guide to freeing the arms during pelvic insertion of the fetus.

Skill Standard:

1st moment: releasing the rear handle

Birth occurs to the lower angle of the scapula, we convert the shoulder girdle to straight size. The rear handle is released first (right - with the right hand, left - with the left hand). With your free hand, the legs of the fetus are grabbed in the lower leg area and moved anteriorly and upward. The index and middle fingers of the other hand are inserted into the vagina from the back of the fetus to the elbow bend and the handle is extended at the elbow joint.

Second moment: rotation of the fetus by 180^0.

Then the hands cover the body of the fetus. The thumbs are located along the spine, and the other four are on the chest and move the “front” handle to the “back” when turning the fetus 180^0.

Point III: releasing the second handle.

The second handle is released in the same way.

6. Classic manual manual (Morisot-Levre-Lachapelle method) for removing the subsequent head during pelvic insertion of the fetus.

Standard of skill: The fetus is placed on top of the palm and forearm of the obstetrician’s hand, the nail phalanx of the index finger is inserted into the fetal mouth and the head is bent. The other hand grabs the fetal shoulders with the index and middle fingers bent in a hook-like manner. This hand plays the role of a driving force. At the entrance to the small pelvis, the head is inserted obliquely, and the driving force is directed downwards towards the toes. When moving the head into the pelvic cavity, traction is directed towards the knees of the sitting doctor. As soon as the suboccipital fossa appears under the lower edge of the symphysis pubis, traction is continued by the inner arm. Tractions are performed horizontally and upward.

7. Manual manual according to N.A. Tsovyanom with a purely breech presentation.

Standard of skill: the buttocks have erupted in the direct size of the outlet from the pelvis. The obstetrician covers the fetal hips with his thumbs, pressing the legs to the anterior abdominal wall, the remaining fingers are at the level of the sacrum. We maintain erection by moving our hands towards the entrance to the vagina. At birth, up to the umbilical ring, the buttocks change from oblique to transverse. The next stage is until the lower angle of the shoulder blades and buttocks become

in straight size. To facilitate birth, the front handles point the buttocks towards you and towards the corresponding thigh (according to the position). For the birth of the lower handle, the buttocks are directed upward. To birth the head, the buttocks are directed toward themselves and upward.

8. Manual N.A. Tsovyanov with foot presentation.
   Standard of skill: when the fetal heels appear, they are covered with a sterile diaper and counteracted during each contraction. As the uterine os opens, the buttocks begin to descend, forming a mixed breech presentation.
9. Application of exit obstetric forceps.
   Standard of skill: before applying the forceps, they are folded. The left spoon of the forceps is inserted first with the left hand into the left side of the woman in labor. On the inner surface of the left spoon, the thumb on the outer one, all the rest are in the recesses on the handle. The handle should lie parallel to the right groin fold. A control right hand is inserted into the vagina. The left spoon goes in the beard between the index and middle fingers of the control hand along the back wall of the pelvis and should go beyond the parietal tubercles. Then the right spoon is inserted in the same way. When applied correctly, the handles of the tongs are in a horizontal position and the tongs are lowered and locked.
   A test traction is carried out: the index and middle fingers are placed on the lock, the left one is on top and the index finger reaches the fetal head, this distance should not increase. The head is removed by traction from bottom to top.
10. Vacuum extraction of the fetus.
   Standard of skill: before the operation, the bladder is emptied, the external genitalia are treated with an antiseptic. The woman in labor lies on her back with her hips pulled up to her stomach. With the right hand, insert the cup of the vacuum extractor with its side surface in the direct dimension of the pelvis, then turn it transversely and press it with the hole to the fetal head closer to the small fontanelle, 3 cm from the corner of the large fontanelle, and the sagittal suture should divide the cup in half. Create the necessary vacuum in the vacuum extractor system using a hand pump to 450-600 mm Hg. (green zone of the vacuum indicator scale). Tractions are carried out synchronously with pushing strictly along the pelvic axis.
11. Inferomedian laparotomy.
   Standard of skill: an incision of the skin and subcutaneous fat is made along the white line of the abdomen from the womb to the navel. The aponeurosis is exposed. A small incision is made in the middle of the aponeurosis, which is extended upward and downward. The left rectus muscle is separated from the linea alba, exposing the transverse fascia and peritoneum and preperitoneal tissue. The peritoneum is opened in the upper corner of the wound, the incision is extended. The edges of the peritoneum are fixed with clamps.
12. Pfannenstiel laparotomy.
   Standard of skill: dissection of the skin and subcutaneous fat is carried out in an arcuate manner along the line of the suprapubic skin fold 2-3 cm above the pubis.

The aponeurosis is incised on both sides along the midline, then dissected in an arcuate manner. The aponeurosis peels off from the linea alba, the rectus and oblique abdominal muscles to the umbilical ring. The medial sections of the rectus abdominis muscles are separated in a blunt and sharp way. Then the transverse fascia, preperitoneal tissue, and peritoneum are dissected high.

13.Dissection of the lower segment of the uterus according to Gusakov.

Standard of skill: after opening the abdominal cavity and delimiting the abdominal cavity with napkins, the body of the uterus is rotated to the left. The vesicouterine fold is dissected transversely with scissors at the site of its greatest mobility. The bladder is dullly displaced downwards. At the level of the largest diameter of the head, a small incision is made with a scalpel, which is extended with the index fingers of both hands.

14. Removal of the fetus during cesarean section with cephalic presentation.

Standard of skill: The surgeon's hand is inserted into the uterine cavity so that its palmar surface is adjacent to the fetal head. This hand turns the head with the back of the head or the face anteriorly and extends or bends it, depending on the type, the head is removed from the uterus.

Then the index fingers are inserted into the armpits and the entire fetus is removed.

15. Removal of the fetus during caesarean section in breech presentation. Standard of skill: with breech presentation, the index finger is inserted into the anterior inguinal fold or the fetus is removed by the leg.

16. Extraction of the fetus during cesarean section in the transverse position. The standard of skill: the hand inserted into the uterus finds the pedicle, the fetus is rotated onto the pedicle, and then removed.

17. Separation of placenta during cesarean section.

Standard of skill: the placenta independently separates from the wall of the uterus and the afterbirth is released by gently pulling the umbilical cord.

18.Uterine dissection during corporal caesarean section.

Standard of skill: the uterus is not removed from the abdominal cavity; rotation of the uterus to the right should be eliminated. An incision 12-14 cm long is made along the anterior wall of the uterus in the midline. A shallow incision is made along the entire line, then a 3-4 cm section is completely dissected and the incision is extended with scissors, controlling the fingers inserted into the uterus.

19. Suturing the uterus with a corporal incision.

Standard of skill: the first row of mucomuscular continuous sutures, 1 cm between injections, the second row of muscular-muscular sutures is applied in the form of a continuous suture or individual sutures with absorbable modern suture material.

20. Balloon technique for stopping bleeding.

Standard of skill: an elastic balloon is placed in the uterine cavity and filled with 500 ml of saline solution.

21.Technique of bimanual compression of the uterus.

Standard of skill: one hand is inserted into the anterior vaginal fornix, the other presses the body of the uterus to the womb from the anterior abdominal wall.

22.Technique of compression of the abdominal aorta.

Skill standard: the pressure point is above the navel and slightly to the left. Press down on it with your fist through the anterior abdominal wall.

23. Technique for manual examination of the uterine cavity.

Standard of skill: the right hand is inserted into the uterine cavity, the second hand fixes the fundus of the uterus through the anterior abdominal wall. All walls of the uterus are inspected, starting from the fundus, clots and placenta remnants are removed, and a light massage of the uterus is performed on the fist.

24. Technique for manual separation of placenta.

Standard of skill: with his left hand, the obstetrician spreads the labia of the woman in labor. The right hand, folded in the form of an “obstetrician’s hand,” is inserted into the vagina and along the umbilical cord into the uterine cavity to the placenta attachment. The left hand fixes the fundus of the uterus through the anterior abdominal wall. The right hand, using “sawing” movements, separates the placenta from the wall of the uterus. The left hand pulls the umbilical cord and removes the afterbirth.

25.Technique of external - internal massage of the uterus on a fist.

Standard of skill: the inner hand (in the uterine cavity) is clenched into a fist, and the uterus is massaged on the fist with the outer hand. Having reached a good degree of contraction of the uterus, the hand is removed from it.

26. Technique of external uterine massage.

Skill standard:Use your palm to grasp the fundus of the uterus through the abdominal wall 2. Lightly massage and squeeze the uterus so that it begins to contract 3. During this, blood clots may be released.

27. Mazzanti external technique for shoulder dystocia.

Standard of skill: a woman’s hips are brought to her stomach. Strong pressure is applied above the womb to the shoulder of the fetus in the direction from top to bottom.

28. Rubin’s external technique for shoulder dystocia.

Standard of skill: with the fingers of both hands, press firmly above the pubis in an oblique direction (from the back of the fetus towards its chest).

29.McRoberts external technique for shoulder dystocia.

Standard of skill: a woman lies on the edge of a table. Bend your knees and bring your hips as close to your stomach as possible, then vigorously straighten your legs and lower them down to the floor.

30.Technique for repositioning a prolapsed umbilical cord loop.

Standard of skill: grasping all the loops of the umbilical cord with your fingers, set them as far behind the head as possible.