CHAPTER 8 - FEMALE REPRODUCTIVE

Terminology p. 265-270. Pathology – pre-eclampsia is now referred to as pregnancy induced hypertension (PIH). Refer back to p. 118 for Rh incompatability

Abbreviations: 282-3. Please note: EDC is now EDD (Estimated Date of Delivery rather than Estimated Date of Confinement). Para 2-0-1-2 is not typical of U.S. (may be Canadian or European). Typically you would see G3, P2, AB 1(see p. 272).

Take a look at the practical applications on p. 283-4 to see terms in context.

Chapter 8 - EXERCISES: E, I, J, K, and N
SAMPLE: Discharge Summary

Discharge Diagnosis: Intrauterine Pregnancy, Stillbirth Term Infant
Operations/Procedures: Spontaneous Vaginal Delivery of Stillborn; Apgar 0/0

History & Physical:

HPI: The patient is a 35-year old female gravida V, para III, Abortion 1 with history of morbid obesity, first delivery of a 13 lb. Infant. Last seen 5 weeks ago. Estimated gestational age of 35 weeks with multiple no shows at clinic visits. Patient last felt baby move the day prior. She presented to labor and delivery after a gush of fluid and blood per vagina with periodic contractions following.

On initial exam she had a fundal height of 35, no fetal heart tones were ausculated. Bedside ultrasound revealed no fetal movement with cardiac asystole. Bimanual exam, 3 cm., 80% effaced. The case was discussed with Dr. Green and treatment plan was to transport patient to Alaska Hospital for induction following fetal demise.

Hospital Course: Above treatment plan was not followed due to active labor and the patient delivered within 2 hours a stillborn, 10 lb. Infant with no external abnormalities seen. Apgar scores were 0 and 0. Autopsy was required and granted for the infant. Multiple lab samples of blood for toxoplasmosis, herpes and rubella screen as well as stomach aspirate were taken. The patient was known to be rubella non-immune.

Discharge Medications: Iron 325 mg. daily 2 months; rubella vaccine IM.

Follow Up Recommendations: Pelvic rest x 4 weeks. Follow up in six weeks (possible bilateral tubal ligation). Diet regular. Activities: no limitations.

Addendum: Culture of the stomach and esophageal aspirate of stillbirth revealed heavy growth of E.coli. Other autopsy results were unremarkable.
ENDOMETRIOSIS

Five million U.S. women have endometriosis. Many are asymptomatic while others suffer symptoms that are disabling. Despite its prevalence, there is no known cause or cure.

The tradition theory about the source of endometriosis is that the condition occurs when tissue that resembles the lining of the uterus implants and grows elsewhere in abdominal cavity. This tissue responds to hormonal cycles by swelling and bleeding along with the uterine lining during menstruation. Since blood shed outside the uterus has nowhere to go, it inflames and irritates the tissues around it, sometimes forming scar tissue that binds various pelvic organs. The displaced blood is probably menstrual blood that travels back through the fallopian tubes and out into the abdominal cavity. Such retrograde bleeding probably happens to every woman at some time, but not all women end up with endometriosis.

Researchers, however, feel the displaced blood theory is only part of the picture. Endometriosis may be the result of abnormal signals from the hypothalamus. Other researchers have linked the condition to dioxin exposure. Surveys show that the risk of developing endometriosis in women whose mothers or sisters are affected is seven times greater than the general population.

Current diagnostic procedures consist of a laparoscopy. Treatment is laparoscopic surgery. Surgery, however, does not offer a permanent cure since microscopic cells can regrow. To combat this, patients usually have hormone treatment as well. The most successful hormonal treatment involves the use of gonadotropin-releasing hormone analogs, which create a type of reversible menopause. Side affects limit the treatment to six months. Once the endometriosis is suppressed, low-dose birth-control pills are very effective in keeping the disease in check as long as they are taken continuously. Such continuous treatment is necessary since endometriosis returns in 20-50% of patients within one to five years of completing the initial treatment. Hysterectomy combined with salpingo-oophrectomy are a last resort for treating the condition.
CHAPTER 9 - MALE REPRODUCTIVE

Combining forms, p. 311-313. Pathology begins on p. 314.

Use the Planned Parenthood list of sexually transmitted diseases rather than those listed in your text as they are outdated and have omitted some STDs.


Chapter 9 - EXERCISES: D, E, G AND J

STDs are probably included in the Male Reproductive chapter because the infection route is frequently male to female or because males are symptomatic while females are often asymptomatic.

TUIP VS. TURP

Transurethral incision of the prostate (TUIP) is now covered by Medicare and is recommended as an alternative to transurethral resection of the prostate (TURP). TUIP involves a few cuts in the prostate to reduce pressure on the urethra and can be performed in an ambulatory surgery center. TURP is the removal of prostate tissue through the urethra and requires a 3-5 day hospital stay.