МИНИСТЕРСТВО НАУКИ И ВЫСШЕГО ОБРАЗОВАНИЯ РОССИЙСКОЙ ФЕДЕРАЦИИ,
МИНИСТЕРСТВО НАУКИ, ВЫСШЕГО ОБРАЗОВАНИЯ И ИННОВАЦИЙ КЫРГЫЗСКОЙ РЕСПУБЛИКИ
МОО ВО Кыргызско-Российский Славянский университет
имени первого Президента Российской Федерации Б.Н. Ельцина

УТВЕРЖДАЮ
декан факультета
АБИЛОВА С.С.

ПРОФЕССИОНАЛЬНЫЙ ЦИКЛ
Гинекология

рабочая программа дисциплины (модуля)

Закреплена за кафедрой **Акушерства и гинекологии**

Учебный план 310501_25_1 лд ин.plx
560001 Лечебное дело (Для иностранных студентов)

Квалификация **врач**

Форма обучения **очная**

Программу составил(и): к.м.н., зав. кафедрой акушерства и гинекологии, Сарымсакова Т.А.; к.м.н., доцент, Долгая Г.В.

Распределение часов дисциплины по семестрам

Семестр (<Курс>.<Семестр на курсе>)	7 (4.1)		8 (4.2)		Итого	
Недель	17		17			
Вид занятий	УП	РП	УП	РП	УП	РП
Лекции	16	16	16	16	32	32
Практические	16	16	32	32	48	48
Контактная работа в период теоретического обучения	0,3	0,3	0,3	0,3	0,6	0,6
В том числе инт.	3	3	4	4	7	7
Итого ауд.	32	32	48	48	80	80
Контактная работа	32,3	32,3	48,3	48,3	80,6	80,6
Сам. работа	27,7	27,7	11,7	11,7	39,4	39,4
Итого	60	60	60	60	120	120

MINISTRY OF EDUCATION AND SCIENCE OF THE KYRGYZ REPUBLIC

Government-run Educational Institution of Higher Professional Education
Interstate Educational Organization of Higher Education
Kyrgyz-Russian SlavicUniversity named after the First President
The Russian Federation of Boris Yeltsin

«ENDORSED» BY
Vice-rector Saamai Abilova

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OBSTETRICS
Course Outline (Module)

Assigned to
Academic Curriculum

Qualification **Specialist**
Mode of Study **Intramural**
Total Credit Value **6 credit points**

Course Hours 216
including:
in-class learning 128
individual work 69,7
monitoring hours 17,5

Scope of Testing Semesters:
exam 6
credit 5

Course Hours Scheduling (per semester)						
Semester Academic Year	**5 (3.1)**		**6 (3.2)**		Total	
Weeks	18		18			
Type of Traning	AC	CO	AC	CO	AC	CO
Lectures	16	16	16	16	32	32
Practical Session	32	32	32	32	64	64
Including Interactive Session	4	4	4	4	8	8
Total In-class Session	48	48	48	48	96	96
Individual Work Assessment			0.5	0.5	0.5	0.5
Face-to-face Learning	0.3	0.3			0.3	0.3
Individual Work	11.7	11.7	12	12	23.7	23.7
Monitoring hours			29.5	29.5	29.5	29.5
Total	60	60	90	90	150	150

The Course outline developed by:
Candidate of medical science, ass.prof., head of the obstetrics and gynecology department Sarymsakova T.A., candidate of medical science, , ass.prof. Umarbaeva D.A., ass.prof. Dolgaya G.V.

Reviewers:
Candidate of medical science, ass.prof. of the obstetrics and gynecology department KRSU named after B.N.Eltzin Imankazieva F.I.

Candidate of medical science, ass.prof. of the obstetrics and gynecology department KSMA named after I.K. Akhunbaev Nasridinova J.M.

The Course Outline
_ of obstetrics and gynecology

in accordance with Academic Curriculum:
_31.05.01 Medical matter
confirmed by KRSU Board of Academics in 30.06.2025y. record № 13.

The Course Outline endorsed by obstetrics and gynecology Department Meeting

Record of 24.10.2025y. № 3
Valid for: 2025 – 2030 academic year
The Head of Department , phd, ass.prof. Sarymsakova T.A.

The course outline endorsed for the following academic year

Chairman of the Educational and Methodological Board
__ _____ 2026

The course outline has been revised, considered and endorsed for implementation in 2026-2027 Academic Year at the Staff Meeting of obstetrics and gynecology department

Record of _____2026 г. № __
The Head of Department: candidate of medical science, ass.prof. Sarymsakova T.A.

The course outline endorsed for the following academic year

Chairman of the Educational and Methodological Board
__ _____ 2027

The course outline has been revised, considered and endorsed for implementation in 2027-2028 Academic Year at the Staff Meeting of obstetrics and gynecology department

Record of __ _____ 2027г. № __
The Head of Department: candidate of medical science, ass.prof. Sarymsakova T.A.

The course outline endorsed for the following academic year

Chairman of the Educational and Methodological Board
__ _____ 2028

The course outline has been revised, considered and endorsed for implementation in 2028-2029 Academic Year at the Staff Meeting of obstetrics and gynecology department

Record of __ _____ 2028 г. № __
The Head of Department: candidate of medical science, ass.prof. Sarymsakova T.A.

The course outline endorsed for the following academic year

Chairman of the Educational and Methodological Board
__ _____ 2029

The course outline has been revised, considered and endorsed for implementation in 2029-2030 Academic Year at the Staff Meeting of obstetrics and gynecology department

Record of __ _____ 2029 г. № __
The Head of Department: candidate of medical science, ass.prof. Sarymsakova T.A.

The course outline endorsed for the following academic year

Chairman of the Educational and Methodological Board
__ _____ 2030

The course outline has been revised, considered and endorsed for implementation in 2030-2031 Academic Year at the Staff Meeting of obstetrics and gynecology department

Record of __ _____ 2030 г. № __
The Head of Department: candidate of medical science, ass.prof. Sarymsakova T.A.

1. COURSE OUTLINE OBJECTIVES
1.1 The goal of this course is to train a qualified physician to provide obstetric care, understand the symptoms of obstetric and gynecological diseases, and take steps to promptly refer patients for specialized medical care.

2. PLACE OF THE COURSE IN THE EDUCATIONAL PROGRAM	
Educational Program Units:	B1.B
2.1	Students' Preliminary Training Requirements:
2.1.1	Normal physiology
2.1.2	Clinical pharmacology
2.1.3	Endocrinology
2.1.4	Pathological anatomy
2.1.5	Pathophysiology, clinical pathophysiology
2.1.6	Propaedeutics of internal diseases
2.1.7	Pharmacology
2.1.8	Topographical anatomy and operational surgery
2.1.9	Histology, embryology, cytology
2.1.10	Immunology
2.1.11	Anatomy
2.1.12	Biology
2.1.13	Biochemistry
2.1.14	Urology
2.2	Course Units and Practical Sessions imposing the prior Proficiency
2.2.1	Clinical internship
2.2.2	Clinical practice (Medical assistant)
2.2.3	Clinical practice (Medical assistant of out-patient and polyclinic establishment)
2.2.4	Preparation for delivery and delivery of state exam

3. STUDENTS' COMPETENCIES RESULTING FROM THE COURCE UNIT (MODULE)
a) universal:
- *General scientific competencies (GS):*
GS-3 - is able and ready to collect, process and interpret with the use of modern information technologies the data necessary to form judgments on relevant social, scientific and ethical issues;
GS-4 – is able and ready to work in a team, tolerant to perceive social, ethnic, religious and cultural differences.
- *Instrumental competencies (IC):*
IC-1- is capable and ready to work with computer equipment and software for system and application purposes to solve professional tasks;
IC–2 - is capable and ready to use information, bibliographic resources and information and communication technologies, taking into account the basic requirements of information security;
IC-3 - is capable and ready for written and oral communication in the state language and official languages, is able to master one of the foreign languages to solve professional tasks;
- *Socio-personal and General cultural competencies (SPC):*
SPC-1 - is capable and ready to implement ethical, deontological and bioethical principles in professional activity;
SPC-2 - is capable and ready to master the techniques of professional communication; to build interpersonal relationships, work in a group, constructively resolve conflict situations, to perceive social, ethnic, confessional and cultural differences with tolerance;
SPC-3 - is capable and ready for continuous professional development, self-knowledge, self-development, self-actualization; manage your time, plan and organize your activities, build a strategy for personal and professional development and training;
SPC-4 - is capable and ready to carry out its activities taking into account the moral and legal norms accepted in society, comply with laws and regulations on working with confidential information, bear social and ethical responsibility for the decisions taken;
SPC-5 - is capable and ready for logical and reasoned analysis, for public speech, discussion and polemics, for the implementation of educational and educational activities, for cooperation.

b) professional:

- *general professional competencies (PC):*

PC-1 – is able and willing to comply with the rules of medical ethics, laws and regulations on working with confidential information, to maintain medical secrecy ;

PC-2 - is capable and ready to analyze the results of its own activities to prevent medical errors, while being aware of disciplinary, administrative, civil, criminal liability;

PC-3 - is able and ready to analyze socially significant problems and processes, use methods of economic relations in the healthcare system;

PC-4 - is capable and ready to conduct pathophysiological analysis of clinical syndromes, to justify pathogenetically justified methods (principles) of diagnosis, treatment, rehabilitation and prevention among the population, taking into account age and gender groups;

PC-5 - is capable and ready to conduct and interpret a survey, physical examination, clinical examination, the results of modern laboratory and instrumental studies, write a medical record of an outpatient and inpatient patient of an adult and a child;

PC-6 - is capable and ready to apply methods of asepsis and antiseptics, to use medical instruments, to master the technique of patient care;

PC-7 - is capable and ready to work with medical and technical equipment used in working with patients, to use the capabilities of modern information technologies to solve professional tasks;

PC-8 - is able and ready to apply up-to-date information on the health indicators of the population at the health care facility level;

PC-9 - is able and ready to know the basic issues and to conduct an examination of working capacity (temporary) and prevention of disability among adults and children;

- *preventive activities:*

PC 10 - is capable and ready to carry out preventive measures to prevent infectious, parasitic and non-communicable diseases,

PC-11 - is capable and ready to carry out sanitary and educational work among the population to eliminate modified risk factors for the development of diseases, to give recommendations on healthy nutrition;

- *diagnostic activity:*

PC-14 - is capable and ready to make a diagnosis based on the results of biochemical and clinical studies, taking into account the course of pathology in organs, systems and the body as a whole;

PC-15 - is able and ready to analyze the patterns of functioning of individual organs and systems, use knowledge of anatomical and physiological features, basic methods of clinical and laboratory examination and assessment of the functional state of the body of an adult and children, for timely diagnosis of diseases and pathological processes;

PC-16 - is capable and ready to use the algorithm of diagnosis (main, concomitant, complications) taking into account the ICD, perform basic diagnostic measures to identify urgent and life-threatening conditions;

- *medical activity:*

PC-17 - is capable and ready to perform basic therapeutic measures for the most common diseases and conditions in adults and children in outpatient and hospital settings;

PC-18 - is capable and ready to provide medical care for acute diseases, conditions, exacerbation of chronic diseases that are not accompanied by a threat to the patient's life and do not require emergency medical care;

PC-19 - is capable and ready to provide first aid in case of emergency and life-threatening conditions, to send patients to hospital on a planned and emergency basis;

PC-21 - is capable and ready to conduct physiological pregnancy, delivery;

- *rehabilitation activities:*

PC-22 - is capable and ready to apply rehabilitation measures (medical, social and professional) among the population with the most common pathological conditions and injuries of the body;

PC-23 - is able and ready to give recommendations on the choice of regimen, to determine indications and contraindications for the appointment of physical therapy, physiotherapy, non-drug therapy, to use the main resort factors in the treatment of adults and children;

- *educational activities:*

PC-25 - is capable and ready to teach the population basic hygiene measures and educational activities for the formation of healthy lifestyle skills;

- *organizational and managerial activities:*

PC-26 - is capable and ready to use the regulatory documentation adopted in the healthcare of the Kyrgyz Republic, as well as used in international practical medicine;

PC-27 - is able and ready to use the knowledge of the structure of healthcare organizations, the referral and redirection system;

- *research activities:*

PC-31 - is capable and ready to analyze and publicly present medical information based on evidence-based medicine.

Final Students' Competences

3.1	Knowledge:
3.1.1	- pregnancy diagnostics methods, clinical manifestations of pregnancy by means of laboratory and tool methods of research;
3.1.2	- ways of determination of terms of pregnancy, date of childbirth, prenatal holiday;
3.1.3	- determination of critical terms of pregnancy, stages of development of an embryo/fetus;
3.1.4	- about the changes happening in the woman's organism during pregnancy;
3.1.5	-about the complicated course of pregnancy (early toxicosis, gipertenzive violations of pregnant women, anemia, infections);
3.1.6	- determination of level of need for adjacent experts during pregnancy;
3.1.7	- about features of a course of somatic diseases during pregnancy;
3.1.8	- about the factors influencing somatic health of women during pregnancy;
3.1.9	- about change of the general and local immunity at pregnant women at the gipertenzive violations pregnant women and influence on the somatic status of the woman and condition of a fetus;
3.1.10	- about change of a mineral exchange during pregnancy and influence on a condition of bone system of a fetus;
3.1.11	- about nature of the damaging effect of medicines in the antenatal period;
3.1.12	- about methods of application of local anesthetics, the general anesthesia at pregnancy;
3.1.13	- about volumes of surgical interventions in various terms of pregnancy;
3.1.14	- an etiology, pathogenesis and measures of prevention of the most often found gynecologic diseases;
3.1.15	- modern classification of gynecologic diseases;
3.1.16	- a clinical picture, features of a current and possible complications at women;
3.1.17	- modern methods of clinical, laboratory and tool inspection of women;
3.1.18	- basic principles of diagnosis of gynecological diseases of women;
3.1.19	- methods of treatment and the indication to their application;
3.1.20	- bases of the organization of the out-patient and polyclinic help to women;
3.1.21	- bases of surgical treatment of gynecologic diseases;
3.1.22	- principles of medical examination and rehabilitation of patients;
3.1.32	- ethical and deontological aspects in obstetrics and gynecology.
3.2	Skills:
3.2.1	- to direct pregnant women on carrying out preventive procedures;
3.2.2	- correctly and in due time to carry out prevention, diagnostics and treatment of obstetric complications at pregnant women and the feeding women;
3.2.3	- to consider factors of an adverse effect of surgical interventions on a condition of mother and a fetus;
3.2.4	- to collect the full medical (obstetric and gynecologic) anamnesis of the patient, to conduct survey of women, them relatives (biological, medical, psychological and social information);
3.2.5	- to conduct objective examination of the patient (survey, a palpation, an auscultation, measurement the blood pressure, definition characteristics of pulse, breath frequency, etc.) to direct it on laboratory and tool inspection, on consultation to experts;
3.2.6	- to keep medical documentation;
3.2.7	- to form groups of risk among women taking into account a hormonal background;
3.2.8	- to make recommendations about food of pregnant women and the feeding women taking into account change of a mineral exchange in time of pregnancy and during breastfeeding;
3.2.9	- to give emergency aid at childbirth;
3.2.10	- to carry out promotion of breastfeeding for the purpose of the general favorable impact on growth and development newborn.
3.2.11	- to collect the anamnesis, to conduct examination, to interpret results of researches (laboratory, radiological, tool) gynecological of patients;
3.2.12	- to formulate the preliminary diagnosis;
3.2.13	- to formulate indications to the chosen method of treatment;
3.2.14	- to apply prevention methods;
3.2.15	- to fill in the clinical record
3.3	Expertise:
3.3.1	- by methods of rendering the first pre-hospital aid at medical emergencies at pregnant women (a preeklampsy, bleeding);
3.3.2	- by assistance methods in emergency situations the pregnant and gynecological patient;
3.3.3	- by assistance methods at childbirth and in the postnatal period, maintaining a partogramma;
3.3.4	- by methods of training of patients in rules of medical behavior and personal hygiene;
3.3.5	- by various methods of treatment of gynecological diseases;
3.3.6	- in the ways of surgical treatment at gynecological diseases.

4. COURSE (MODULE) STRUCTURE AND CONTENT							
Class Code	Subject Name /Type of Class/	Semester / Academic Year	Hours	Competencies	Literature	Interactive Sessions	Notes
	Module 1. Physiology of pregnancy						
1.1	Anatomy and physiology of the female reproductive organs in different periods of live. The menstrual cycle. /L/	5	2	PC-14	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
1.2	Fertilization and embryogenesis periods. Development of the ovum. Critical periods of embryogenesis. Effect on embryo and fetus damaging environmental factors. Changes in a woman's body during pregnancy. /L/	5	2	PC-14	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
1.3	The menstrual cycle. Regulation of menstrual function. Cyclical changes in the reproductive system. /P/	5	2	PC-14	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
1.4	Gonadotropic hormones. Folliculogenesis, steroidogenesis. Action of sex steroid hormones /P/	5	2	PC-14	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
1.5	Anatomy and physiology of the female reproductive organs. Regulation of menstrual function. General changes in the body. Fertilization, nidation, embryogenesis . The structure and basic functions of the placenta, cord and fetal membranes./P/	5	2	PC-14	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5	2	
1.6	Physiological changes during pregnancy. Laboratory, instrumental and additional methods of research of pregnant patients./P/	5	2	PC-14	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
1.7	The menstrual cycle. Regulation of menstrual function. Cyclical changes in the reproductive system /SW/	5	2	PC-14	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		Create a diagram of the direct and feedback relationships between the levels of the reproductive system. Describe the biological roles of FSH, LH, and prolactin.
1.8	Gonadotropic hormones. Folliculogenesis. Steroidogenesis. Action of steroid hormones. The menstrual cycle and its regulation. Fertilization and development of the fetus and fetal membranes. /SW/	5	2	PC-14	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		Create an algorithm for steroidogenesis. Describe the biological role of estradiol and progesterone. Describe functional diagnostic tests. Describe the phases of the uterine cycle.
	Module 2. Fundamentals of perinatology. Pueperium.						
2.1	Multiple pregnancy. Diagnostics.	5	2	PC-14, PC-5	L1.2 L1.3		

	Features of pregnancy and labour (delivery). The management of labour. Tactics of conducting multiple pregnancy. /. /L/				L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
2.2	Fundamentals of perinatology. Pathology of the afterbirth and early postpartum periods. Fetoplacental system. Placental dysfunction. Fetoplacental insufficiency and methods of diagnosis. Birth asphyxia and respiratory distress syndrome. Diagnostics. Principles of therapy depending on the severity of the condition (ABCD-resuscitation, mechanical ventilation, infusion therapy, cranio-cerebral hypothermia). Prevention. /L/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
2.3	Regulation of labour. The concept of the body's readiness for delivery. The maturity of the cervix. labor pains and labour. Periods of labour. Duration of labour. /L/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
2.4	Obstetric benefits. Postpartum period. /L/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
2.5	The fetus as an object of labor. Stages. The head of a mature newborn. /L/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
2.6	Concept of placental insufficiency. Classification. Etiology. Pathogenesis. Diagnosis. Gravidogram. CTG. Dopplerometry. Treatment of placental insufficiency. Tactics. Indications for preterm delivery. Complications for the fetus and newborn. Threatening fetal condition. Assessment of the newborn using the Apgar scale. Resuscitation and intensive care of the newborn. /Pr/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
2.7	Dominance of pregnancy; Dominance of labor; Mechanisms of the onset of labor; Regulation of labor./Pr/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5	1	
2.8	Criteria for physiological labor; Cervical maturity, signs of labor; Stages of labor, Phases of labor, Assessment of the activity and effectiveness of labor forces; Partogram; Management of physiological labor (stages I, II, III); Biomechanisms of labor in anterior and posterior	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5	1	

	occiput presentation. /Pr/						
2.9	Postpartum period. Classification; Involution of the uterus. Changes in the mother's body. /Pr/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
2.10	Lactation, the benefits of breastfeeding; the lactational amenorrhea method; the nursing woman's regimen. /Pr/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
2.11	Placental insufficiency. Fetal threatening conditions. Neonatal asphyxia. /SW/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		- Write down the classification of placental insufficiency. - Create an algorithm for resuscitation of newborns.
2.12	The dominant features of pregnancy and childbirth. Mechanisms of labor. Regulation of labor. Labor stages. Phases of labor. Labor management: stages I, II, and III. Partogram recording. /SW/	5	0,7	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		• Record the criteria for physiological birth. • Solve problems In keeping a partogram. • Record the steps of active labor management. Complete the partogram. • Record the principles of breastfeeding
2.13	The fetus as the object of labor, cycles. Development by trimester. The head of a mature newborn. /SW/	5	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		Draw and record the dimensions of the fetal head.
2.14	Classification of the postpartum period. Involutional processes of organs and systems in a woman's body during the postpartum period. /SW/	5	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
2.15	/CP/	5	0,3	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
	Module 3 Biomechanisms of labour						
3.1	The mechanism of labor in various types of presentation. Malpresentation of the fetal head (extension insertions). Malposition of the fetus (transverse and oblique presentation). Diagnosis and treatment of cephalopelvic disproportion during childbirth. Shoulder dystocia. /L/	5	2	PC-21, PC-6, PC-19, PC-5.	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
3.2	The mechanism of labor in various types of cephalic presentation. Correct presentation of the fetal	5	14	PC-21, PC-6, PC-19, PC-5.	L1.2 L1.3 L1.4L2.1 L2.3L3.1		

	head (anterior and posterior occipital presentation). Incorrect presentation of the fetal head (extension insertions). Incorrect positions (transverse and oblique fetal presentation). Classification, etiology, diagnosis, and typical complications of breech presentation. Biomechanism of labor and assistance with breech presentation. Diagnosis and treatment of cephalopelvic disproportion during childbirth. Shoulder dystocia /P/				L3.2 L3.3 E1 E2 E3 E4 E5		
3.3	Multiple Pregnancy. Diagnosis. Features of pregnancy and Labor (delivery). Labor Management. Tactics for managing of the multiple pregnancy./SW/	5	2	PC-21, PC-6, PC-19, PC-5.	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		To write down classification of placental insufficiency. To make algorithm of reanimation of newborns.
	Credit						
	Module 4. Extragenital Pathology. Risk Factors and Pregnancy.						
4.1	Pregnancy and childbirth with multiple pregnancies. Pregnancy and childbirth with breech presentation. Diagnosis and classification. Characteristics of the course of pregnancy and childbirth./L/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
4.2	Hypertensive disorders of pregnancy. Forms. Clinical presentation. Tactics./L/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
4.3	Extragenital diseases and pregnancy. /L/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		• To write down sequence of actions at an Eclampsia. • To write down pathogenic action of MgSO4. • To prepare solution for intravenous administration of MgSO4.
4.4	Concept of multiple pregnancy, Classification of multiple pregnancies; Diagnosis; Complications, including specific ones; Management tactics for multiple pregnancies; Indications for operative delivery. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5	1	
4.5	Breech presentation. Classification. Etiology. Epidemiology; Diagnosis. Differential diagnosis of breech presentation; Biomechanisms of labor in breech presentation; Aids for breech presentation;	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5	1	

	Labor management. Indications for cesarean section. /Pr/						
4.6	Hypertensive disorders in obstetrics. WHO Classification. Etiopathogenesis of hypertensive disorders. Diagnostic Criteria for Preeclampsia. Preeclampsia. Management. Eclampsia. Management. complications. Prevention of complications. Delivery of pregnant women with hypertensive disorders. Risk groups for hypertensive disorders. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5	1	
4.7	Cardiovascular diseases and pregnancy; Hemodynamics during normal pregnancy; Risk levels for cardiovascular diseases; Care of pregnant women with cardiovascular diseases; Methods of delivery. Indications for cesarean section. Rehabilitation of pregnant women Contraception. Urodynamics of urinary system; Asymptomatic bacteriuria. Diagnosis. Treatment. Gestational pyelonephritis. Etiology. Clinical presentation. Diagnosis. Treatment. Effect on the fetus. Treatment by trimester. Indications for surgical treatment. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
4.8	WHO Classification of Diabetes Mellitus. The Course of Diabetes Mellitus during Pregnancy. Complications. Gestational Diabetes Mellitus. Management. Diabetic Fetopathy. Labor Management. Indications for Surgical Delivery. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		• Graphically to represent gestation terms. • To write down indications and contraindications to induction of labour. • To write down methods of induction of labour
4.9	Features of basal metabolic rate during pregnancy. Thyrotoxicosis. Impact on reproductive function and pregnancy. Complications. Tactics. Hypothyroidism. Course of pregnancy and childbirth. Impact on the fetus and newborn. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
4.10	Definition of multiple pregnancy. Ultrasound diagnostics of chorionicity and amniotic fluid. Management tactics of multiple pregnancies./SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		Demonstrate 4 techniques of external obstetric examination. • Record complications specific to multiple pregnancies.
4.11	Breech presentation. Classification. Diagnosis. Differential diagnosis. Complications. Labor management in breech presentation. Biomechanisms of	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		• Create a table of differential diagnostics for breech and cephalic presentations. • Demonstrate on a

	labor. Indications for cesarean section. /SW/						phantom the biomechanisms and aids for breech presentations.
4.12	Diagnostic criteria for hypertensive disorders.Severe preeclampsia and eclampsia. Tactics and treatment of hypertensive disorders. /SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		• Write down the classification of hypertensive disorders according to ICD-10. • Write down the sequence of actions for eclampsia. • Write down the pathogenetic effect of MgSO4. • Prepare a solution for intravenous administration of MgSO4.
4.13	Cardiovascular diseases and pregnancy. Features of cardiovascular system function during physiological pregnancy and acquired and congenital heart defects. Urinary system diseases and pregnancy. Asymptomatic bacteriuria – diagnosis, treatment strategies. Gestational pyelonephritis – diagnosis, treatment strategies depending on the trimester of pregnancy. /SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		Record the risk levels according to Vanina. • NYHA classification of heart failure. • List medications for the treatment of pyelonephritis, their doses, and duration. • Record the signs of diabetic fetopathy.
4.14	Endocrine system diseases and pregnancy. Diabetes and pregnancy. Thyroid diseases and pregnancy. Thyrotoxicosis. Hypothyroidism. Anemia of pregnancy. /SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		• Write down an algorithm for examining pregnant women with thyroid diseases.
	Module 5. Complications during pregnancy, labor and the postpartum period. Placental pathology.)						
5.1	Narrow pelvis in modern obstetrics. Classification, diagnosis, and management tactics. Pre-term labor and post-term pregnancy. /Lecture/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
5.2	Anomalies of labor. Anomalies of fetal position. Anomalies of head insertion. Extension insertions. /L/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
5.3	Obstetric hemorrhages: placenta previa, premature detachment of a normally located placenta, postpartum bleeding. Hypovolemic shock. DIC syndrome. /L/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
5.4	Postpartum purulent-septic diseases. /L/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3		

					E1 E2 E3 E4 E5		
5.5	Definition of miscarriage. WHO classification, risk factors. Early termination of pregnancy. Etiopathogenesis. Treatment of first-trimester termination of pregnancy depending on the etiological factors. Management of preterm labor. Prevention of fetal respiratory distress syndrome. Care of the premature newborn. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
5.6	Causes of post-term pregnancy. Diagnosis, labor induction. Indications. Conditions. Methods. Complications of labor induction. Indications for cesarean section. Post-term newborn. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
5.7	Classification of uterine contractile activity anomalies according to the WHO and in the Russian Federation. Risk factors. Pathogenesis. Pathological preliminary period. Tactics. Weakness of labor forces. Clinical presentation. Diagnosis. Tactics. Excessive labor. Labor incoordination. Indications for operative delivery. Prevention. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
5.8	Fetal position anomalies. Classification. Causes. Diagnosis of fetal position anomalies. Management of pregnancy and childbirth. Indications for operative delivery. Obstetric delivery surgeries. Conditions. Indications. Contraindications. Technique. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
5.9	Anomalies of head insertion. Types. Causes. Diagnosis. Differential diagnosis. Biomechanism of labor brow presentation, and face insertion. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5	1	
5.10	Anatomically contracted pelvis. Classification. Basic and additional measurements of the pelvis. Biomechanisms of labor with various forms of contraction of the pelvis. Clinically contracted pelvis. Causes. Diagnosis of clinically contracted pelvis. Degrees of discrepancy. Tactics for clinically contracted pelvis. Complications. Prognosis. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
5.11	Definition of septic syndrome , sepsis. Risk factors in	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1		

	obstetrics. Etiology, pathogenesis. Classification. Sepsis diagnostic criteria: MBS, MVR, SIRS, SFS, severe sepsis, septic shock, refractory septic shock. Obstetric sepsis. Endometritis after cesarean section. Clinical and laboratory criteria. Instrumental research methods. Treatment: at the first level; second level; third level. /Pr/				L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
5.12	Pre-term labor. Etiopathogenesis, classification, diagnosis, management tactics. Management of post-term pregnancy. Complications. Indications for cesarean section. /SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		Graphically represent the gestational ages. • Record indications and contraindications for labor induction. • Record methods of labor induction.
5.13	Diagnostic criteria for uterine contractility anomalies. Management strategies for various forms of uterine contractility anomalies. /SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		Record risk factors for the development of uterine contraction abnormalities. • Record the medications, doses, and administration schedule of uterotonics.
5.14	Diagnosis and management of abnormal fetal position and head placement. /SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		Draw a table of differential signs of cephalic and breech presentations.
5.15	Contracted pelvis. Cephalopelvic disproportion. /SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		• Record the classification of contracted pelvises by shape and degree of narrowing. • Record signs and degrees of clinical disproportion
5.16	Risk factors for obstetric sepsis. Prevention of septic complications. Postpartum endometritis. Postcesarean peritonitis. /SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		• Write down the classification of sepsis. •Classification of peritonitis after cesarean section. • Algorithm for the treatment of septic obstetric complications.
	Module 6. Obstetrics' surgery procedures						
6.1	Injures to the birth canal. Caesarean section /L/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
6.2	Uterine ruptures. Classification. Etiopathogenesis. Clinical presentation. Diagnostics.	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1		

	Tactics. Cervical ruptures. Classification. Etiopathogenesis. Clinical presentation. Diagnostics. Tactics. Vaginal and perineal ruptures. Classification. Clinical presentation. Diagnostics. Treatment. Rehabilitation. Uterine inversion. Indications and contraindications for cesarean section. Stages of cesarean section. Complications of cesarean section. Care of women with a uterine scar after cesarean section. Care of women with a uterine scar after cesarean section. Signs of uterine scar failure. /Pr/				L3.2 L3.3 E1 E2 E3 E4 E5		
6.3	Bleeding in the first half of pregnancy: - miscarriage; - trophoblastic disease; - cervical pregnancy. Bleeding in the second half of pregnancy: - placenta previa; - abruptio of the placenta. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
6.4	Postpartum hemorrhage: - prevention (active management of the third stage of labor); - conservative methods to stop bleeding; - surgical methods to stop bleeding. Hypovolemic shock. DIS syndrome. /Pr/	6	2	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		
6.5	Bleeding in the first half of pregnancy. Bleeding in the second half of pregnancy. Postpartum hemorrhage. Conservative and surgical methods for stopping bleeding./SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		Record the stages of abortion. • Record the steps for active management of the third stage of labor. • Describe methods for temporarily stopping bleeding.
6.6	Uterine and cervical trauma. Vaginal and perineal trauma. Surgical delivery. Care of women with uterine scars after cesarean section and uterine surgery. /SW/	6	1	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		• Write down the classification of cervical ruptures. • Write down the classification of perineal ruptures. Schematically depict the principles of suturing grades III and IV perineal ruptures. Write down the indications and contraindications for cesarean section. Write down the stages of a cesarean section.
6.7	Control exam	6	0,5	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1		

					L3.2 L3.3 E1 E2 E3 E4 E5		
6.8	Exam	6	29,5	PC-14, PC-5	L1.2 L1.3 L1.4L2.1 L2.3L3.1 L3.2 L3.3 E1 E2 E3 E4 E5		

5. ASSESSMENT FUND
5.1. Advancement Questions and Assignments
5.2. Course Papers Themes
Course papers aren't provided.
5.3. Assessment Fund

THEORETICAL TASK:
The list of theoretical questions from item 5.1. according to subject.

KURATION OF THE PATIENT:
1. Each student receives for a curation of one patient.
2. On the example of the supervised patient the student has to do the following:
1) To examine subject;
2) To come into confidential contact;
3) To make collecting complaints. The complaints relating to a disease are described;
4) To collect the anamnesis of a disease of the patient (the beginning of a disease, the course of process, treatment in the past, the reasons, on which the patient connects the disease, the hospitalization reasons);
5) To collect the anamnesis of life (the disease postponed in the past, the family anamnesis);
6) To make survey and inspection of the patient;
7) To describe the clinical status;
8) To analyze laboratory and tool these researches;
9) To make the preliminary diagnosis;
10) To carry out the differential diagnosis;
11) To make the clinical diagnosis;
12) To define tactics of alleged treatment;
13) To write diaries of a landmark or summary epicures in the educational clinical record;
14) Briefly to summarize an etiology, pathogenesis, clinic and treatment.

CLINICAL RECORD:
The student fills in the clinical record according to the scheme below:
1. General information about the patient;
2. Complaints.
3. Anamnesis of an illness (anamnesis morbi).
4. Anamnesis of life (anamnesis vitae).
5. Objective research.
6. Laboratory, tool and additional methods of research.
7. Clinical diagnosis.
8. Justification of a clinical diagnosis.
9. Differential diagnosis.
10. Etiology. pathogenesis.
11. Treatment.
Diary.
The used literature.
Methodical recommendations about filling of the clinical record in the APPENDIX No. 2.

THE REPORT WITH PRESENTATION:
The student independently chooses a report subject according to a section subject.
Subject of reports on obstetrics:
1. Levels of regulation of menstrual and reproductive function.
2. Influence of female sexual hormones on development of a fetus and health of the child.
3. Multiple pregnancy.
4. Changes in systems and bodies at pregnancy.
5. Hypertensional violations during pregnancy. Their influence on Mother — a Placenta — a Fetus system
6. Pregnancy dominant. Dominant of labour (delivery). Mechanisms of unleashing of patrimonial forces.
7. Anomalies of patrimonial activity.
8. The reasons of obstetric bleedings during pregnancy, labour (delivery) and the postnatal period.
9. Preterm birth.

10. Postterm pregnancy
11. Pharmacodynamics of medicines in an organism of the pregnant woman and a fetus. Transition of medicinal substances through a placentary barrier.
Subject of reports on gynecology:
1. Levels of regulation of menstrual and reproductive function.
2. Endoscopic methods of inspection in gynecology.
3. Congenital dysfunction of bark of adrenal glands.
4. Steroidogenesis in ovaries.
5. Hyper menstrual syndrome.
6. Syndrome of polycystous ovaries.
7. Hyperprolactinemia.
8. Metabolic syndrome.
9. Premenstrual syndrome.
10. Climacteric syndrome.
11. Hypomenstrual syndrome.
12. Sexual transmitted infections

TESTS:
The list of test questions according to subject of the section in the APPENDIX No. 3.

CLASSES/SITUATIONAL TASKS:
I distributed the list of situational tasks in the APPENDIX No. 4 according to subject.
Intermediate certification (OFFSET, OFFSET WITH the ASSESSMENT, EXAMINATION):
The list of questions in the APPENDIX No. 5.

5.4. List of Assessment Tools

1. Theoretical task.
2. Kuration of the patient.
3. Clinical record.
4. The report with presentation.
5. Tests.
6. Situational tasks.
Estimation scales by types of estimated means in the APPENDIX No. 6.

6. COURSE (MODULE) METHODOLOGICAL AND INFORMATIONAL SUPPORT

6.1 Recommended Reading

6.1.1 Required Reading List

	Authors, Compliers	Title	Book publisher, Year
L1.1	D.C. Dutta (edited by H. Konar)	Text Book of Obstetrics	2004
L1.2	Elmar P. Sacala	Obstetrics and Gynecology	2004
L1.3	V.G. Padubidri, Shirish N. Daftary	Shaw`s Textbook of Gynecology	2009
L1.4	D.C. Dutta (edited by H. Konar)	Text Book of Gynecology	2004

6.1.2 Advanced Reading

	Authors, Compliers	Title	Book publisher, Year
L2.1	Barbara R.Stright, Lee-Olive Harrison	Maternal-Newborn Nursing	1996
L2.2	James E. Dimmick, Dagmar K. Kalousek	Developmental Pathology of the Embryo and Fetus	1992
L2.3	John P. Cloherty, Ann R. Stark	Manual of Neonatal Care	1997
L2.4	Jonathan Carter	An Atlas of Transvaginal Sonography	1994
L2.5	Richard Jaffe, Roger A. Pierson, Jacques S. Abramowicz	Imaging in Infertility and Reproductive Endocrinology	1994
L2.6	Elmar P. Sacala	Obstetrics and gynecology	1997

6.1.3 Guidance Papers

	Authors, Compliers	Title	Book publisher,Year
L3.1	Dolgaya G.V., Umarbaeva D.A., Potylitsyna N.V., Asymbekova A.S.	Textbook for practical training in obstetrics	2022
L3.2	Umarbaeva D.A.	Course of lectures on obstetrics. Textbook	2022
L3.3	Dolgaya G.V.	Course of lectures on gynecology. Textbook	2022

6.2 Online Resources

E1	Publishing group "GEOTAR-Media"	www.geotar.ru
E2	Female Health Internet magazine	www.womanill.ru
E3	Vebmedioinfo	www.webMedInfo.ru
E4	Medical Internet magazine	www.medlinks.ru
E5	Electronic Library KRSU	www.lib.krsu.edu.kg

E6	Electronic Library System Znanium	www.znanium.com
6.3. List of Information and Education Technologies		
6.3.1 Competence-based Educational Technologies		
6.3.1.1	Traditional educational technologies: lectures, the practical training focused on the message of the knowledge and ways of the actions taught to students in finished form and intended for assimilation. Lecturing provides use of the multimedia equipment. Carrying out a practical training with application of tables and visual aids. Occupations begin with introduction lecture in which it is necessary to explain the purposes and problems of this discipline; to declare requirements to performance of the current and total control of knowledge; to point to types of the given classes (lecture and practical), including carried out in an interactive form.	
6.3.1.2		
6.3.1.3	Innovative educational technologies - occupations which form system thinking and ability to generate ideas at the solution of various situational tasks.	
6.3.1.4	The following types of occupations are assumed:	
6.3.1.5	- survey lectures in an interactive form (with use of the computer PowerPoint program);	
6.3.1.6	- role-playing games;	
6.3.1.7	- Case-study - the analysis of concrete practical situations;	
6.3.1.8	- discussion;	
6.3.1.9	- working in small groups.	
6.3.1.10		
6.3.1.11	Information educational technology: independent use by students of the computer equipment and Internet resources for performance of practical tasks and independent work. And also for acquaintance with Internet sources, photo video records on appropriate section. Preparation by the teacher of lectures presentations.	
6.3.2 List of Information Reference Systems and Software		
6.3.2.1	Publishing group "GEOTAR-Media" (www.geotar.ru)	
6.3.2.2	Female Health Internet magazine (www.womanill.ru)	
6.3.2.3	Vebmedioinfo (www.WebMedInfo.ru)	
6.3.2.4	Medical Internet magazine (www.medlinks.ru)	
6.3.2.5	Electronic KRSU library (www.lib.krsu.edu.kg)	
6.3.2.6	Electronic and library «Znanium» system (www .znanium.com)	

7. COURSE (MODULE) LOGISTICS	
7.1	1. Theoretical preparation of studying of the program in obstetrics and gynecology is carried out on bases of town clinical maternity hospital No. 2, clinic of the prof. Asymbekova G .U. , the city perinatal center, Chuy regional maternity hospital in lecture halls.
7.2	2. The Simulation center (Alamedin-1 case) equipped with the interactive and medical equipment (an anatomic table), the robotized dummies simulators, the modern resuscitation equipment, phantoms, exercise machines, tools and an expendable material.
7.3	1. Lecture hall "Clinic of the prof. Asymbekova G .U." on 100 seats. In a set: interactive board, multimedia equipment (projector, DVD, TV), whiteboard marker, video movies of obstetric and gynecologic operations.
7.4	2. Base of Clinic of the prof. Asymbekova G .U. Educational room No. 1. Audience for carrying out practical (seminar) training. In a set: computer, model: a basin, a doll,
7.5	Training tables, the training material for carrying out interactive occupations, a training material for carrying out a practical training.
7.6	Video movies of obstetric and gynecologic operations.
7.7	3. Base of Clinic of the prof. Asymbekova G .U. Educational room No. 2. Audience for carrying out practical (seminar) training. In a set: computer, board cretaceous, model: the basin, a doll training tables, the training material for carrying out interactive occupations, a training material for carrying out a practical training, obstetric and gynecologic tools, visual aids on planning of a family and methods of contraception, video movies of obstetric and gynecologic operations a dummy - a gynecologic simulator.
7.8	4. Base of Clinic of the prof. Asymbekova G .u. Educational room No. 3. Audience for carrying out practical (seminar) training. In a set: laptop, model: a basin, a doll, a board cretaceous, the training tables, the training material for carrying out interactive occupations, a training material for carrying out a practical training, video movies of obstetric and gynecologic operations, a dummy for reanimation of the newborn.
7.14 7.15	5 GKRD№2 base. Educational room No. 1. Audience for carrying out practical (seminar) training. In a set: netbook, board cretaceous, model: the basin, a doll training table the training material for carrying out interactive occupations, a training material for carrying out a practical training, obstetric and gynecologic tools, video movies of obstetric and gynecologic operations.
7.16 7.17	6. GKRD base No. 2. Educational room No. 2. Audience for carrying out practical (seminar) training. In a set: netbook, board cretaceous, model: the basin, a doll training table the training material for carrying out interactive occupations, a training material for carrying out a practical training, obstetric and gynecologic tools, video movies of obstetric and gynecologic operations.

8. COURSE (MODULE) PROFICIENCY METHODICAL GLUIDELINES (FOR STUDENT)

Flow charts of discipline in the APPENDIX No. 1.

METHODICAL INSTRUCTIONS ON the ORGANIZATION of STUDYING of DISCIPLINE:
Training consists of classroom occupations (342 h.), including a lecture course and a practical training, and independent work (144 h.). The main school hours are allocated for practical work on certain diseases. The curation of patients, clinical analyses and development of practical skills of work with women in labor and gynecologic patients is widely used. A practical training is given in the form of work at a bed of the patient, demonstration of the thematic video record and other visual aids, the solution of situational tasks, test tasks, analysis of clinical examples. Work of the student in group forms feelings of a collectivism, a personal responsibility and skill to communicate. It is necessary to pay attention to formation of skills of communication with the patient. Work with patients promotes formation of deontological behavior, accuracy, discipline.

At analysis of nosological forms on certain diseases it is recommended to adhere to the following sequence:
- definition;
- relevance of the studied nosological form and history of the studied question;
- etiology;
- pathogenesis, including genetic factors in development of a disease, existence of the accompanying pathology, a pathomorphology;
- clinical picture;
- criteria of an assessment of severity of a current during the different periods of an illness;
- complications;
- possible outcomes, criteria of recovery, development of a chronic current, reason of lethal outcomes;
- laboratory and tool diagnostics;
- criteria of statement of the diagnosis during the different periods of a disease;
- differential diagnosis;
- treatment: etiological, pathogenetic, symptomatic taking into account age and weight of a course of a disease, rendering the emergency medical care at medical emergencies, treatment of heavy forms of diseases, treatment and prevention of possible complications, treatment in the conditions of a hospital and in out-patient conditions;
- medical examination, rehabilitation;
- prevention.

According to requirements of FGOS IN wide use in educational process of active and interactive forms of carrying out occupations (business role-playing games, analysis of concrete clinical situations, performance of tasks of search and research character is necessary with the help the Internet – resources, etc.). Specific weight of the classes given in interactive forms has to make not less than 10% of classroom occupations.

MODULAR CONTROL ON DISCIPLINE INCLUDES:
1. Current control: assimilation of a training material on classroom occupations (lectures, practical, including visit and activity is considered) and performance of obligatory tasks for independent work.
2. Border control: check of completeness of knowledge and abilities on module material in general. Performance of modular control tasks is carried out in writing and is obligatory component of modular control.
3. Intermediate control - the complete documented part of a subject matter – set of the test modules which are closely connected among themselves.

MAIN REQUIREMENTS TO the CURRENT CONTROL:
At creation of practical occupation teachers hold to the following general indicative plan:
1. An organizational stage of occupation (time - to 2%);
1) muster;
2) task for the house of the following subject;
3) motivation of a subject of this practical occupation;
4) acquaintance of students with the purposes and plan of occupation;
2. Control and correction of initial level of knowledge (time - to 20%):
1) theoretical poll on the current subject;
2) correction by the teacher of theoretical knowledge of students;
3) a stage of demonstration by the teacher of practical skills (time - to 15%)
4) a stage of demonstration of independent work of students (protection of the report with presentation) (time - to 45%)
5) the final stage of occupation (time - to 18%):
a) total final control of the created theoretical knowledge and abilities by means of the solution of situational tasks;
b) summing up practical occupation (characteristic teacher of performance by students of all purposes of occupation and individual assessment of knowledge and skills).

INDEPENDENT WORK of STUDENTS
means preparation for a practical training and includes studying of special literature on a subject (the recommended textbooks, methodical grants, acquaintance with the materials published in monographs, specialized magazines on the recommended medical sites); performance of tasks of search and research character by means of Internet resources; preparation of abstracts, performances at a seminar, papers, multimedia presentations; carrying out business games. Independent work is considered as a type of study on discipline and carried out within the hours which are taken away on SRS. Each trained is provided with access to educational methodically office of chair and library stocks of HIGHER EDUCATION INSTITUTION. According to each section on chair methodical recommendations for students, and also methodical instructions for teachers are developed. Recommendations about planning and organization of time necessary for studying of discipline.

1.It is recommended to organize as follows time necessary for studying of discipline: Studying of the abstract of lecture on the same day, after lecture – 10-15 minutes.
Studying of the abstract of lecture in a day before the following lecture – 10-15 minutes. Studying of theoretical material according to the textbook and the abstract – 1 hour per week. Preparation for practical occupation – the 2nd hour.
In total in a week – 3 hours 30 minutes.
2. Description of sequence of actions of the student:
For understanding of material and its high-quality assimilation such sequence of actions is recommended: After listening of lecture and the termination of studies, by preparation for occupations of the next day, it is necessary to see and consider at first the text of the lecture listened today (10-15 minutes).
By preparation for lecture of the next day, it is necessary to see the text of the previous lecture, to think of what can be a subject of the following lecture (10-15 minutes).
Within a week to choose time (1 hour) for work with the recommended literature in library.
By preparation for a practical training of the next day, it is necessary to read at first the basic concepts and approaches on a homework subject. When performing exercise or a task it is necessary to understand at first that is required in a task, what theoretical material it is necessary to use, draw up the plan of the solution of a task.
3. Recommendations about use of materials of an educational and methodical complex. It is recommended to use methodical instructions at a course and the text of lectures of the teacher.
4. Recommendations about work with literature:
Theoretical material of a course becomes more understandable when in addition to listening of lecture and studying of the abstract, also books are studied. It is easier to master a course, adhering to one textbook and the abstract. It is recommended to achieve, except material "learning", a condition of understanding of the studied discipline subject. It is for this purpose recommended to execute after studying of the next paragraph some simple exercises on this subject. Besides, it is very useful mentally to ask itself the following questions (and to try to answer them): about what this paragraph?, what new concepts are entered, what their sense?, what it will give in practice?.
5. Councils for preparation for border and intermediate control:
In addition to studying of abstracts of lecture it is necessary to use the textbook. Except material "learning", it is very important to achieve a condition of understanding studied by that disciplines. It is for this purpose recommended to execute after studying of the next paragraph some exercises on this subject. Besides, it is very useful for to ask mentally the following questions (and to try to answer them): about what this paragraph?, what new concepts are entered, what their sense?, what it will give in practice?. By preparation for intermediate control it is necessary to study the theory: definitions of all concepts and approaches to estimation to a condition of understanding of material and independently to solve some standard problems from each subject. At the solution of tasks it is always necessary to be able to interpret a decision result qualitatively.
6. Instructions on the organization of work on performance of homeworks. When performing homeworks it is necessary to read at first the basic concepts and approaches on a task subject. When performing exercise or a task it is necessary to understand at first that is required in a task, what theoretical material it is necessary to use, draw up the plan of the solution of a task, and then to start calculations and to draw a qualitative conclusion.
7. By preparation for intermediate and border control it is necessary to study the theory: definitions of all concepts and approaches to estimation to a condition of understanding of material and independently to perform some standard tasks.
8. Working off of the skipped classes:
Control over digestion of material of the training program of discipline by students is exercised systematically by the teacher of chair and reflected in the magazine of the teacher and in points. The student who received an unsatisfactory assessment on the current material is obliged to prepare this section and to answer on it to the teacher on individual interview.
The lecture missed without valid excuse has to be fulfilled by method of oral poll by the lecturer or preparation of the paper on materials of the missed lecture within a month from the date of the admission. Also other methods of working off of the missed lectures are possible (poll on practical, test control, etc.). Working off of a practical training.
- Each class skipped by the student without good reason is fulfilled without fail. Working off are carried out according to the schedule of chair coordinated with dean's office.
- The skipped classes have to be fulfilled within 10 days from the date of the admission. The seminar classes skipped by the student without good reason are fulfilled no more than one occupation in day. The skipped classes for a good reason (due to illness, admissions with the permission of dean's office) are fulfilled on thematic material without hours.
- The student who didn't work the admission in established periods is allowed to the next occupations only in the presence of permission of the dean or his deputy in writing. Elimination from the next seminar occupation of the students who are poorly prepared for these occupations isn't allowed.
- For the students who skipped seminar classes because of a long illness, working off has to be carried out after permission of dean's office according to the individual schedule coordinated with chair.
- In exceptional cases (participation in interuniversity conferences, competitions, the Olympic Games, watch, etc.) the dean and his deputy in coordination with chair can exempt students from working off of some skipped classes.

ORDER of CARRYING OUT CURATION BOLNY.
1. Theoretical preparation for the patient's curation (acquaintance with subject of the patient).
2. Distribution of patients among students.
3. Establishment of confidential contact with the patient.
5. Collecting complaints and anamnesis of an illness and patient's life.
6. Survey and inspection of the patient on systems of internals.
7. Survey and description of the clinical status.
8. Statement of the preliminary diagnosis.
9. Collecting laboratory data of research of the patient.
10. Carrying out the differential diagnosis.
11. Statement of the clinical diagnosis.

12. Definition of tactics of alleged treatment.
13. Writing of diaries, a landmark or clinical summary in in educational history of the patient.
14. The short summary on an etiology, pathogenesis, clinic and treatment according to modern data of references.
15. Discussion of the educational clinical record in group among students and with the teacher of chair.

CLINICAL RECORD.
The student fills in the clinical record according to the specified scheme:
1. General information about the patient;
2. Complaints.
3. Anamnesis of an illness (anamnesis morbi).
4. Anamnesis of life (anamnesis vitae).
5. Objective research.
6. Traumatological (orthopedic) status.
7. The preliminary diagnosis with justification.
8. Laboratory, tool and additional methods of research.
9. Clinical diagnosis.
10. Justification of the clinical diagnosis.
11. Treatment.
12. Diary.
13. Epicrisis.
14. The used literature.

The REPORT WITH PRESENTATION. Rules of preparation and writing:
Oral performance - the report has to represent not retelling of foreign thoughts, but attempt of an independent problematization and conceptualization of a certain, rather narrow and concrete subject. All footnotes which are available in work carefully are verified and supplied with "addresses". Is inadmissible to put into the operation excerpts from works of other authors without instruction on it, to retell others work closely to the text without sending to it, to use foreign ideas without indication of the primary source. It concerns also the sources found in the Internet. It is necessary to specify the full address of the site. All cases of plagiarism have to be excluded. At the end of work the exhaustive list of all used sources is given.
Preparation of the report for occupation.
Main stages of preparation of the report:
• subject choice;
• consultation of the teacher;
• preparation of the plan of the report;
• work with sources and literature, collecting material;
• writing of the text of the report;
• registration of the manuscript and granting it to the teacher prior to the beginning of the report that defines readiness of the student for performance;
• performance with the report, answers to questions.
The subject of the report is offered by the teacher in FOS.
Multimedia presentations are a type of independent work of students on creation of the visual information aids executed by means of the multimedia computer PowerPoint program. This type of work demands coordination of skills of the student on collecting, systematization, processing of information, its registration in the form of a selection of the materials briefly reflecting the main questions of the studied subject in electronic form. That is creation of materials presentation expands methods and means of processing and submission of educational information, forms at students skills of work on the computer.
Materials presentations prepare the student in the form of slides with use of the Microsoft PowerPoint program. The requirement to students on preparation of presentation and its protection on occupations in the form of the report.
1. The subject of presentation gets out the student of the offered FOS list and has to be coordinated with the teacher and correspond to an occupation subject.
2. Stages of preparation of presentation Scheduling of presentation (problem definition; the purposes of this work)
Premeditation of each slide (at the beginning it can be done manually on paper), thus is important to answer questions:
- how the idea of this slide opens the main idea of all presentation?
- what will be on a slide?
- what will be told?
- how transition to the next slide will be made?
3. Production of presentation by means of MS PowerPoint:
- It makes sense to be accurate. Carelessly made slides (a disparate in fonts and spaces, typographical errors, typographical mistakes) cause suspicion, as the student - the speaker approached substantial questions carelessly.
- The title page is necessary to present to audience you and a subject of your report.
- Quantity of slides no more than 30.
- Optimum number of lines on a slide — from 6 to 11.
- The widespread mistake — to read a slide literally. It is best of all if on a slide detailed information is written, and words will tell their substantial sense. Information on a slide can be more formal and strictly stated, than in the speech.
- Optimum speed of switching — one slide in 1–2 minutes.
- It is welcomed in presentation to use more drawings, pictures, formulas, schedules, tables. It is possible to use effects of animation.
- At an explanation of tables it is necessary to speak to that there correspond lines and to that — columns. - You enter only those designations and concepts without which the understanding of the main ideas of the report is impossible.
- In short performance it is impossible to repeat the same thought even if in other words — time is expensive.

- The last slide with conclusions in short presentations shouldn't be pronounced.
- The body type in the text and formulas is recommended to be changed to Arial or to it similar; the Times font badly looks from far away. Surely establish in MathType the main font size equal to the main font size in the text.
4. The student is obliged to prepare and make the report in strictly allowed time the teacher, and in time.
5. Instruction to speakers.
- to give new information;
- to use technical means;
- the nobility and it is good to be guided in a subject of all presentation;
- to be able to discuss and quickly to answer questions;
- accurately to carry out the established regulations: the speaker - 10 min.; discussion - 5 min.;
It is necessary to remember that performance consists of three parts: introduction, main part and conclusion. The introduction helps to provide success of performance on any subject. The introduction has to contain:
- name of presentation;
- message of the main idea;
- modern assessment of a subject of a statement;
- short transfer of cases in point;
- live interesting form of a statement;
The Main part in which the acting has to open deeply an essence of the touched subject, usually is under construction by the principle of the report. A problem of the main part - to submit enough data in order that listeners both became interested in a subject and wanted to examine materials. Thus logical structure of the theoretical block shouldn't be given without visual aids, audio - visual and visual materials. The conclusion is a clear accurate generalization and short conclusions for which listeners always wait.
MAIN REQUIREMENTS TO WRITING of TESTS:
1. In one test task of 100 closed questions.
2. To questions ready answers to a choice, one of which correct and other wrong are given.
3. For each correct answer – 1 point.
4. The general assessment is defined as the sum of the gained percent.
5. The gathered number of percent is transferred to points.

REFERENCE VERSION of the TEST:
At a fruit and stimulation of oxidizing reactions of a cycle of Krebs apply to normalization of exchange processes:
1. glucose (5-10%) solution with insulin
2. tocolytic
3. spasmolytic
4. sedative preparations
5. all listed.

SITUATIONAL TASK IN OBSTETRICS. REFERENCE VERSION of the ANSWER.
CONDITION: The maternity hospital received the primipara, 24 years old. Within several days - a headache, feeling sick. Before emergence of complaints I felt the healthy. At survey: hypostases of the lower extremities and forward belly wall. At urine boiling - a big flaked deposit. Arterial pressure is 180/100 mm Hg. External research: pelvic presentation, fights in 4-5 minutes, hurdles a fruit at the left, above a navel, 140 уд. in a minute. Basin sizes: 25-28-31-20 см. Vaginal research: opening full, the fetal bubble is whole, at the left and the left leg is in front probed. The back surface of a bosom and a sacral hollow are free. When carrying out vaginal research there were spasms proceeding 3-4 min. with loss of consciousness.
1) Estimate a condition of the woman in labor at receipt.
2) Define the period of childbirth.
3) To what existence of a fetal bubble at the moment of childbirth testifies?
4) The reason which provoked spasms?
5) What tactics of the doctor?
ANSWERS:
1) Eclampsia.
2) II period of childbirth.
3) About a physiological current of the I period of childbirth.
4) Vaginal research without inhalation anesthesia.
5) Cesarean section.

SITUATIONAL TASK IN GYNECOLOGY. REFERENCE VERSION of the ANSWER.
CONDITION: The patient 45 years old, came to gynecologic office on May 12 with complaints to pains on all stomach, nausea, vomiting, a liquid chair. Objectively: integuments pale, cold sweat. Pulse - 100 уд. in a min. HELL - 70/30mm.rt.st. Language dry, is laid over. The stomach is blown moderately up, sharply painful in all departments, Shchetkin-Blyumberg's Symptom positive in all departments. Blood test: leukocytes - 560, Hb-89g/l. Vaginal research: uterus neck not an eroded, body of a uterus of the normal sizes, movably. In the field of appendages at the left education to 6sm. without accurate contours, sharply painful, the arches are condensed.
1) Your diagnosis.
2) Estimate a condition of hemodynamics.
3) Estimate blood test and interpret it.
4) What methods of research are necessary in this case?
5) Make the plan of treatment of the patient.
ANSWERS:

1) Poured purulent peritonitis against perforation of abscess of the left appendages.
2) Bacterial shock.
3) Lack of a leukocytosis, perhaps, at the expense of exhaustion of immune system. Anemia of average weight. 4) The general blood test, a blood type, Rh-a factor, the curtailing system of blood.
5) Expeditious treatment in the emergency order, removal of the left appendages, broad drainage, an unleavened wheat cake, complex anti-inflammatory therapy.

Initial level of knowledge of students is defined by testing and obligatory oral interview, the current control of assimilation of a subject is defined by oral poll during a practical training during clinical analyses, at the solution of standard situational tasks and modules.
At the end of a cycle carrying out test control on all passable subjects in combination with oral interview is provided. Total control includes:
- interview on theoretical questions;
- control of practical skills;
- solution of situational tasks.

The MAIN REQUIREMENTS TO INTERMEDIATE CONTROL
At an appearance on the differentiated offset or examination students are obliged to have at themselves record books which they show to the examiner at the beginning of examination.
On intermediate control the student has to answer truly theoretical questions of the ticket and perform situational tasks.
Students can use technical means, help and standard literature, visual aids, training programs.
Assessment of intermediate control:
- min of 20 points - Questions for check of level of proficiency the NOBILITY (in case at answers to the asked questions the student correctly formulates the basic concepts)
- 20-25 points – Tasks for check of level of proficiency to be ABLE and OWN (in case the student correctly formulates essence of the problem set in the ticket and makes recommendations about its decision)
- 25-30 points - Tasks for check of level of proficiency to be ABLE and OWN (in case of full implementation of a control task).
Questions on obstetrics and gynecology are included in Total state certification of graduates.

APPENDIX 1

FLOW CHART OF DISCIPLINE
"OBSTETRICS »
Course 3, 5 semester, 3 Credit points.

Name of modules disciplines according to WPD	Control	Control form	Minimum credit	Maximum credit	Schedule of control	
					1 cycle	2 cycle
Module 1						
Module 1. Physiology of pregnancy	the current control	Theoretical survey; Clinical case; Check of SWS. Protection of presentation. Activity: *- For active participation on practical occupation 0,5 points are added.* *- For active participation at research work of students – 3 points.* Attendance: *For each skipped and not fulfilled lecture and practical class 0,5 points are removed.*	5	9	3 week	12 week
	border control	Oral survey Solution of situational tasks	3	5		
Module 2						
Module 2. Physiological mechanism of labour (delivery).	the current control	Theoretical survey; Clinical case; Check of SWS. Protection of presentation. Activity: *- For active participation on practical occupation 0,5 points are added.* *- For active participation at research work of students – 3 points.* Attendance: *For each skipped and not fulfilled lecture and practical class 0,5 points are removed.*	5	9	7 week	16 week
	border control	Oral survey Solution of situational tasks	3	5		
Module 3						
Module 3. Fundamentals of perinatology. Pueperium.	the current control	Theoretical survey; Clinical case; Check of SWS. Protection of presentation. Activity: *- For active participation on practical occupation 0,5 points are added.* *- For active participation at research work of students – 3 points.* Attendance: *For each skipped and not fulfilled lecture and practical class 0,5 points are removed.*	5	9	9 week	18 week
	border control	Oral survey Solution of situational tasks	3	5		
IN TOTAL for a semester					9 week	18 week
Intermediate control (credit)	Oral survey Solution of situational tasks			30		
Semestrial rating on discipline						

"OBSTETRICS AND GYNECOLOGY»
Course 3, 6 semester, 3 Credit points, Reporting - credit with the assessment.

Name of modules disciplines according to WPD	Control	Control form	Minimum credit	Maximum credit	Schedule of control	
					1 cycle	2 cycle
Module 4						
Module 4. Diseases and complication in Pregnancy.	the current control	Theoretical survey; Clinical case; Check of SWS. Protection of presentation. Activity: *- For active participation on practical occupation 0,5 points are added.* *- For active participation at research work of students – 3 points.* Attendance: *For each skipped and not fulfilled lecture and practical class 0,5 points are removed.*	5	9	26 week	36 week
	border control	Oral survey Solution of situational tasks	3	5		
Module 5						
Module 5. Pathological pregnancy and labor (delivery)	the current control	Theoretical survey; Clinical case; Check of SWS. Protection of presentation. Activity: *- For active participation on practical occupation 0,5 points are added.* *- For active participation at research work of students – 3 points.* Attendance: *For each skipped and not fulfilled lecture and practical class 0,5 points are removed.*	5	9	29 week	39 week
	border control	Oral survey Solution of situational tasks	3	5		
Module 6						
Module 6. Obstetrics' surgery procedures	the current control	Theoretical survey; Clinical case; Check of SWS. Protection of presentation. Activity: *- For active participation on practical occupation 0,5 points are added.* *- For active participation at research work of students – 3 points.* Attendance: *For each skipped and not fulfilled lecture and practical class 0,5 points are removed.*	5	9	32 week	42 week
	border control	Oral survey Solution of situational tasks	3	5		
IN TOTAL for a semester					32 week	42 week
Intermediate control (credit)	Oral survey Solution of situational tasks			30		
Semestrial rating on discipline						

APPENDIX 6

SCALE of ESTIMATION of THEORETICAL POLL (current control)

№	Name of an indicator	Mark (in %)
1.	Persuasiveness of the answer	0-10
2.	Understanding of a perspective	0-30
3.	Reasonable attraction of medical terminology (relevance and reliability of data)	0-30
4.	Keywords: their importance for the declared subject, the competent use, quantity.	0-15
5.	Logicality and sequence of the oral statement.	0-10
	In total points	Score

SCALE of ESTIMATION of the SITUATIONAL TASK (rubezhny control)

№	Name of an indicator	Mark (in %)
1.	Correctness of statement of the diagnosis	0-30
2.	Correctness of a choice of algorithm of actions	0-20
3.	Correctness of a choice of additional methods of diagnostics.	0-20
4.	Correctness of purpose of tactics of treatment.	0-30
	In total points	Score

SCALE of ESTIMATION of the REPORT WITH PRESENTATION (the current control)

№	Name of an indicator	Mark (in %)
		70
1.	The title page with heading	0-4
2.	Design of slides and use of additional effects (change of slides, sound, drawings)	0-10
3.	The text of presentation is written shortly, well and the created ideas clearly are stated and structured.	0-40
4.	Slides are presented in logical sequence.	0-10
5.	Slides are unpacked.	0-6
REPORT		30
1.	Correctness and accuracy of the speech during protection	0-12
2.	Breadth of vision (answers to questions)	0-10
3.	Implementation of regulations	0-8
	In total points	Score

SCALE of ESTIMATION of KURATION BOLNY (the current control) in %.

№	Name of an indicator	Mark (in %)
1.	Observance ethic deonto;ogical principles and an individual approach to the patient.	0-5
2.	Correct performance of a technique of survey of the patient. Correct description of the obstetric or gynecologic status.	0-20
3.	Correct interpretation of complaints, anamnesis of an illness and patient's life.	0-10
4.	Correctness of statement of the preliminary diagnosis.	0-10
5.	Correctness of interpretation of ultrasonography, external obstetric research, vaginal research, KTG, dopplerometriy.	0-20
6.	Correctness of reading of results of laboratory researches.	0-5
7.	Correctness of statement of the clinical diagnosis.	0-10
8.	Correct definition of tactics of alleged treatment	0-20
	In total points	Score

SCALE OF ESTIMATION OF INTERMEDIATE CONTROL:

SCALE of ESTIMATION of the CLINICAL RECORD: (intermediate control) in %.

№	Name of an indicator	Mark (in %)
1.	General information about the woman in labor or the gynecologic patient.	0-5
2.	Complaints (all complaints of the patient are briefly and accurately listed now)	0-5
3.	Anamnesis of an illness	0-5
4.	Anamnesis of life	0-5
5.	Objective research.	0-10
6.	Preliminary diagnosis	0-15
7.	Laboratory, additional methods of research.	0-10
8.	Clinical diagnosis and justification of the clinical diagnosis.	0-15
9.	Etiology, pathogenesis	0-5
10.	Treatment	0-10
11.	Diary	0-5
12.	Epikriz and forecast	0-5
13.	Use of modern these references.	0-5
	In total points	Score

SCALE OF ESTIMATION OF DOUGH:
1. In one test task of 100 closed questions.
2. To questions ready answers to a choice, one of which correct and the others are given
the wrong.
3. For each correct answer – 1 point.
4. The general assessment is defined as the sum of the gained percent.
5. The gathered number of percent is transferred to points.
0-60% - (0-60 correct answers);
61-70% - (60-74 correct answers);
71-89% - (75-84 correct answers);
90-100% - (85-100 correct answers).

SCALE of ESTIMATION of DIFZACHET, EXAMINATION (intermediate control):

№	Name of an indicator	Mark
1.	Question 1.	0-100
2.	Question 2.	0-100
3.	Situational task	0-100
	In total points	Average the arithmetic (score/3)

At an assessment of the ORAL RESPONSE to check of level of proficiency the NOBILITY the following criteria are considered:
1. Knowledge of the main processes of the studied subject domain, depth and completeness of disclosure of a question.
2. Ability to explain essence of the phenomena, events of processes. To draw conclusions and generalizations, to give the reasoned answers.
3. Possession of terms framework and its use at the answer.
3. Possession of the monological speech, logicality and sequence of the answer, ability to answer the questions posed, to express the opinion on the discussed problem.

The mark of 85-100% **(16-20 points)** estimates the answer which shows strong knowledge of the following questions: etiology, pathogenesis of women in labor.
etiology, pathogenesis and measures of prevention of the most often found gynecologic diseases;
biomechanisms of childbirth;
modern classification of gynecologic diseases;

clinical picture, features of a current and possible complications in obstetrics or gynecologic diseases at women of various age groups;
the basic principles of diagnostics in obstetrics or gynecology;
modern methods of clinical, laboratory, tool inspection of patients;
methods of treatment and the indication to their application;
bases of the organization of the out-patient and polyclinic help to the population;
principles of medical examination and rehabilitation of patients;
ethical and deontologichesky aspects in obstetrics and gynecology.
The student showed logicality and sequence of the answer.

The mark of 75-84% **(10-15 points)** estimates the answer finding strong knowledge of the following questions:
etiology, pathogenesis of women in labor. an etiology, pathogenesis and measures of prevention of the most often found gynecologic diseases;
modern classification of gynecologic diseases;
clinical picture, features of a current and possible complications in obstetrics or gynecologic diseases at women of various age groups;
the basic principles of diagnostics in obstetrics or gynecologic diseases;
modern methods of clinical, laboratory, tool inspection of patients;
methods of treatment and the indication to their application;
bases of the organization of the out-patient and polyclinic help to the population;
principles of medical examination and rehabilitation of patients;
ethical and deontologichesky aspects in obstetrics and gynecology.
The student shows logicality and sequence of the answer, however one is allowed - two inaccuracies in the answer.

The mark of 60-74% **(5-10 points)** estimates the answer testifying generally to knowledge of the following questions:
etiology, pathogenesis of women in labor. an etiology, pathogenesis and measures of prevention of the most often found gynecologic diseases;
modern classification of gynecologic diseases;
clinical picture, features of a current and possible complications in obstetrics or gynecologic diseases at women of various age groups;
the basic principles of diagnostics in obstetrics or gynecologic diseases;
modern methods of clinical, laboratory, tool inspection of patients;
methods of treatment and the indication to their application;
bases of the organization of the out-patient and polyclinic help to the population;
principles of medical examination and rehabilitation of patients; ethical and deontologichesky aspects in obstetrics and gynecology.
Some mistakes in contents of the answer are made.

The mark of 0-59% **(1-4 points)** estimates the answer finding ignorance of the theory practically on all subjects, inability to give the reasoned answers, weak possession of the monological speech, lack of logicality and sequence. *Serious mistakes in contents of the answer are made*.

SCALE of ESTIMATION of PRACTICAL TASKS (intermediate control – "To be ABLE and OWN")
At an assessment of responses to check of level of proficiency to be ABLE and OWN the following criteria are considered:

The mark of 85-100% **(8-10 points)** estimates the answer, at which student:
owns medical terminology, skills of the analysis of various medical facts;
quickly finds and accepts solutions on collecting the anamnesis at the woman in labor and the patient with gynecologic pathology;
conducts independently inspection of obstetric and gynecologic patients; is able to interpret results of researches (laboratory, ultrasonography, KTG, tool);
competently formulates the clinical diagnosis of the indication to the chosen method of treatment;
correctly applies methods of prevention and will organize transportation of obstetric and gynecologic patients;
correct filling of clinical records.
Shows full understanding of a problem. Professionally owns various methods of survey and inspection of obstetric and gynecologic patients.
Professionally owns various methods of treatment. All requirements imposed to a task are executed completely.

The mark of 75-84% **(4-7 points)** estimates the answer, at which student:
- is able to put statement of a problem own words;
- insufficiently well owns medical terminology, skills of the analysis of various medical facts;

- not really quickly finds and accepts solutions on collecting the anamnesis at the woman in labor or at the patient with gynecologic pathology;
- not quite professionally conducts independent examination of obstetric and gynecologic patients;
- poorly interprets results of researches (laboratory, ultrasonography, KTG, tool) and formulates the clinical diagnosis of the indication to the chosen method of treatment;
- not absolutely correctly applies methods of prevention and will organize transportation of obstetric and gynecologic patients;
- thus earlier fully and correctly I filled in the clinical record.
Shows considerable understanding of a problem. Allows the insignificant mistakes in methods of survey and inspection of obstetric and gynecologic patients. In the general owns various methods of treatment. The majority of requirements imposed to a task are executed.

The mark of 60-74% **(1-3 points)** estimates the answer, at which student:
doesn't put statement of a problem own words and doesn't estimate alternative solutions;
not rather well owns medical terminology, doesn't own skills of the analysis of various medical facts;
slowly finds and accepts solutions on collecting the anamnesis at obstetric gynecologic patients;
insufficiently well conducts independently inspection of obstetric gynecologic patients;
very poorly interprets results of researches (laboratory, ultrasonography, KTG, tool) and doesn't formulate the clinical diagnosis of the indication to the chosen method of treatment;
- not absolutely correctly applies methods of prevention and will organize transportation of obstetric and gynecologic patients;
earlier not rather fully and correctly I filled in the clinical record.
Shows partial or small understanding of a problem. Poorly owns methods of treatment of obstetric and gynecologic patients.
Many requirements imposed to a task aren't executed.

The mark of 0-59% **(0 points)** estimates the answer at which the student shows misunderstanding of a problem or not the answer and there was even no attempt to solve a problem. Earlier badly I filled in the clinical record.

APPENDIX 7

EXAMPLE OF INTERACTIVE OCCUPATIONS.

WORK IN SMALL GROUPS

Process of preventive training needs to be built with orientation to the trained. The most effective in this situation is work in groups. In this case the teacher provides diagnostics and monitoring, will organize the educational environment, carries out support (gives advice, explanations) when available there are no other resources. Such form of work is applied when it is necessary to show similarity or distinctions of certain phenomena to develop strategy or to develop the plan, to find out the relation of various groups of participants to the same question. What gives introduction of the interactive mode to group as to the subject of educational process?
It, first of all:
• Development of skills of communication and interaction in group.
• Formation of valuable and orientation unity of group.
• Encouragement to flexible change of social roles depending on a situation.

ROLE-PLAYING GAME

The role-playing game is a playing by participants of group of a sketch with in advance distributed
roles in interests of mastering a certain behavioural or emotional party of life situations.
The role-playing game is held in small groups (3-5 participants). Participants receive a task on cards (on a board, sheets of paper, etc.), cast, beat a situation and represent (show) to all group. The teacher can cast itself taking into account characters of students. Advantage of this method that each of participants can present himself in the offered situation feel these or those states more really, to feel consequences of these or those actions and to make the decision. This form of work is applied to modeling of behavior and emotional reactions of people in these or those situations by designing of a game situation in which such behavior is predetermined by the set conditions.

The list of sections and topics of training programs, the practical implementation of which should be carried out at the Center for Integrative and Practical Training (CIPT)

Theme	Program section	Type of simulator, mannikins	
3d year Obstetrics. **5th semester 5-6 / 14-15 weeks of the calendar plan**	Methods of external obstetric examination according to Leopold (4 grIps) Auscultation of fetal heart tones	• Simulator for practicing the skills of examination of a pregnant woman • Dummy of the cervix (5 pcs.) • Multifunctional mannequin imitation of childbirth (woman in labor and newborn) VIII Noelle Noelle. • Moulage simulator of a woman in labor for practicing obstetric, gynecological, neonatological skills, as well as emergency care skills in childbirth and newborns Advanced Childbirth Simulator Advanced Child-birth Simulator S500 • Moulage of a newborn	**3-6 hours per 1 group**
	Vaginal examination with an assessment of the cervix on the Bishop scale, the location of the sutures and fontanelles of the fetal head		
	Management of physiological childbirth with occipito-anterior l presentation		
	Assessment of the newborn on the Apgar scale. The primary toilet of a newborn.		
	Prevention of early postpartum bleeding		
TOTAL hour: 5-10 hours per 1 group			

CLINICAL HICTORY OF LABOR

I. General information

1. Patient (A.A. B. or another).
2. Age.
3. Parity (for example: pregnancy is the third - the second birth)
3. The time of receipt (number, month, hour, minutes).
4. Complaints of admission, or the reason for hospitalization.

II. ANAMNESIS OF LIFE

1. Transferred diseases in childhood and in adults (for example - rickets, diphtheria, tuberculosis, kidney diseases, viral hepatitis, etc.).
3. Were there a history of injuries, fractures of the bones of the pelvis, spine.
4. The presence of a high degree myopia, operations in the eyes.
5. Transferred operations and types of anesthesia.
6. Whether allergic reactions were noted to any medicinal drugs? If so, on which one?
7. Did hormonal drugs take, and for what reason.
8. Whether there were blood transfusions and blood substitutes, reactions to them.
9. Harmful habits: smoking, at what age and how much, alcohol (including Beer), drug addiction (what kind) and how long.
10. The age of the husband (partner), his health, bad habits.

III. Gynecological history

Menstrual function

1. The time of the appearance of the first menstruation, after how many days are repeated, duration, regularity, amount of blood lost, pain.

Whether the menstrual cycle has changed after previous births and abortions.

2. The start and end time of the last menstruation.

Sexual function

The age of the beginning of sexual activity.

It is marriage or not.

It is protected from pregnancy or not. How?

Transferred gynecological diseases

Including inflammatory diseases, cervical diseases,

Disorders of the menstrual cycle of operations on the genitals. What it was treatment?

Whether there were SPPPs (sexually transmitted infections) - gonorrhea, chlamydia, syphilis, trichomoniasis?

IV. Generative function

List in order all pregnancy, starting with the first:

I - when was it? How is it over? What complications?

II- When was it? How is it over? What complications?

III- ... (and so on up to the present).

Note
- (if the pregnancy was interrupted, then find out the reason (medical indications, spontaneous abortion or at will).
- (if by childbirth, then indicate in what period of pregnancy; the method delivery; The weight of newborns, birth rating.
- (if there were complications -their description, what treatment was carried out).

V. The course of this pregnancy

- Indicate in what period was the first turnout in the railway.
- Indicate all cases of stationary treatment and in what period; Causes and treatment,
- Indicate the identified complications of pregnancy,
- Indicate which risk group is classified.
- Indicate the total weight gain at the time of the curation.

VI. Objective output

General objective study
- Height,
- Weight, body weight index (BMI)
- Body temperature.
- The presence of edema.
- The presence of scars on the abdomen (CS).
- Condition of subcutaneous veins (varicose extensions).
- BP, pulse.
- Status of breathing.
- The state of the urinary system.
- The state of the digestive system.

Special obstetric research

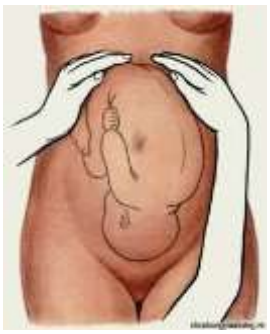
1) - Pelvis measurement:
- Distantia spinarum =25-26cm
- Distantia Cristarum =28-29cm
- Distantia trochanterica =30-31cm
- Conjugata externa =20-21cm

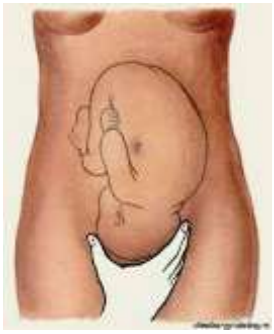
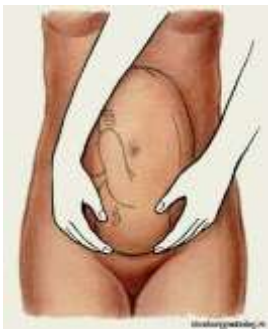
Give an assessment of the size of the pelvis: for example, "normal pelvis." “Generally actually Putted pelvis. " "Simple flat pelvis." "Transversely narrowed pelvis."

2) - Study of the abdomen:
a) the measurement of the abdomen (coolant) at the navel;
b) measuring the height of the fundus of the uterus (HFU) from the pubis;
c) calculate the estimated mass of the fetus (PMP) (apply one or more well-known formulas).

3) - Palpation according to the Leopold method (with pictures):

- The first grip	*- The second grip*	*- The third grip*	*- Fourth grip*
- fundal grip	*- lateral(umbilical) grip*	*- 1-st pelvic grip*	*- 2-nd pelvic grip*



4) - auscultation of the fetal heartbeat (where, frequency, character)
5) - vaginal research:
a) the state of the external genitalia;
b) vagina (giving birth or not giving birth);
c) the cervix - (saved, or shortened, or smoothed).
d) the edges of the cervix - (thin, thick, extensible, dense);
e) the degree of rip cervix (or closes, or passes Fingertip).
f) the condition of the amniotic fluid - (intact, absent, good or bad expressed, tensed during the fight, does not strain, tense all the time);

g) the previous part - (its exact description indicating the plane of the pelvis, in which is located and the location of identification points);

VII. Clinical diagnosis.

Rules for constructing an obstetric diagnosis:

1. In the first place is the presence of pregnancy and its period: “Pregnancy .... weeks ".
2. Next, indicate the presentation of the fetus (head or pelvic) and its options: “Head (occipital) presentation” or “pelvic (breech) presentation ".
3. The following are complications of pregnancy (for example: preeclampsia, polyhidroamnion, etc.).
4. Then somatic or neuroendocrine diseases are carried out, Genital pathology (for example: uterine fibroids). The presence is noted burdened obstetric (gynecological, somatic) history.
5. Last, but also in detail, assess the condition of the fetus (USD, hypoxia - chronic, acute; large fetus, suspicion of intrauterine infection, etc.).

VIII. The plan of conducting labor

- examination and preparation for labor.
- delivery in a planned manner or at a spontaneous beginning of labor.
- method of delivery: through natural birth canal or through surgery Cesarean section.

IX. Clinical protocol

The course of labor

P.S. (not required if the operation of the Cesarean section is planned)

I period of labor. The time of the beginning of labor. The moment of retreat amniotic fluid, their character. Time and reason for the use of pain relief. Efficiency. Complications during the first period, events, conducted in the fight against them. The condition of the fetal (according to KTG and character heartbeat).

Duration of the first period of labor.

II period of labor. The time of the beginning of attempts, their character. The dynamics of promotion presenting part.

Complications during the second period. What are they connected with and Measures held to combat them. Reflect the time of the birth of the fetus, male or female, appraisal on the Apgar system, weight, size, maturity. The first toilet newborn. Prevention of bleeding.

Duration of the II period of labor.

III period of labor. Time and nature of the separation of the placenta. Blood loss with the placenta. The tone of the uterus. The integrity of the placenta, size, weight. The length of the umbilical cord.

Prevention of bleeding.

Duration of the III period.

The total duration of labor.

Early postpartum period. General condition (blood pressure, pulse, breathing,

Temperature, skin covers). The tone of the uterus. The number of discharges. Inspection the birth canal in the mirrors. In the presence of injury - restoration of fabrics, hemostatic sutures. Blood loss in the early postpartum period. General blood loss.

The decision to transfer to the postpartum department.

X. The course of the postpartum period

Write three consecutive observation diaries. Daily is described the condition of the puddle. Only appropriate changes are made.

Sample:

1 day after childbirth. General condition satisfactory, wellbeing good. It does not make complaints. AD - 110/70 mm Hg, pulse 68 beats per min., Body temperature - 36.7.

The skin is natural. Breasts are not loaded, painless. Nipples are intact. The discharge of colostrum is scarce, thick, yellowish white. Applying the baby to the breastfeeding about 8 times /day. The baby sucks actively.

The uterus is dense, painless. On palpation comes in tone. HFU (height of the uterus) - 16 cm.

Lochia is bloody, in moderate quantities, without a pathological smell.

The sutures on the perineum are in satisfactory condition. It is carried out 4 times a day with a solution of chlorhexidine.

Urination every 5 hours. There were no bowel movements.

XI. Epicrisis

TESTS

Obstetrics:

1. At pregnancy, the following physiological changes occur in the external genital organs:

1) the mucous membrane at the entry of vagina is cyanotic;
2) increased secretion of the sebaceous glands of vulva;
3) external genitals are loosened;
4) all of the above.

2. Obstetric perineum is a region:

1) between posterior commisure and coccyx;
2) between posterior commisure and anus;
3) between anus and coccyx;
4) from the lower edge of pubis (loin) up to anus;
5) from the lower edge of coccyx up to anus.

3. The major features of the structure of vagina are:

1) the wall is covered by multilayered squamous epithelium;
2) glands and submucous layer are absent in the mucous membrane;
3) contents of vagina is just the result of contraction of cervical glands, fallopian tubes, desquamated epithelial cells of vagina;
4) all are incorrect;
5) all are correct.

4. At pregnancy, the following physiological changes occur in vagina:

1) the blood supply of the vaginal walls increases sharply;
2) loosening of the vaginal walls;
3) hyperplasia and a hypertrophy of muscular elements of vagina;
4) the pH in vagina is alkaline.

5. External genital organs include:

1) labia major;
2) labia minor;
3) major glands of vestibulum;
4) clitoris;
5) all are incorrect.

6. The internal genital organs include:

1) uterus;
2) fallopian tubes;
3) ovaries;
4) vagina;
5) all are incorrect.

7. The primary direction of the muscular fibres in the body of uterus is:
1) oblique;
2) circular;
3) obliquo-longitudinal;
4) longitudinal;
5) none of the above.

8. The main direction of the muscular fibres in cervix is:
1) oblique;
2) circular;
3) obliquo-longitudinal;
4) longitudinal;
5) none of the above.

9. Ovary is supported in the abdominal cavity by:
1) ligamentum ovary propria;
2) ligamentum latum of uteri;
3) infundibulopelvic ligamentum;
4) ligamentum sacro-uterina;
5) all are correct.

10. What hormone is used as a marker for normal progressing pregnancy?
1) estradiol;
2) hypophyseal gonadotropin;
3) progesterone;
4) prolactin;
5) chorionic gonadotropin.

11. Name the process which helps the embryon to create a contact with the body of mother (uterus).
1) gastrulation;
2) implantation;
3) histogenesis;
4) fertilization;
5) placentation.

12. When does the embryonic period end and begin the fetal period of the intrauterine development?
1) at the end of the first month;
2) at the end of the second month;
3) at the beginning of the third month;
4) at the end of the third month;
5) at the beginning of the fourth month.

13. The first trimester of pregnancy is named as a period of:
1) organogenesis;
2) placentation;
3) fetal;
4) fertilization;
5) implantation.

14. The probable sign for diagnosis of pregnancy is:
1) change of mood;
2) change of smell;
3) auscultation of fetal heart beats;
4) enlarged uterus.

15. The positive sign of pregnancy is:
1) absence of menses;
2) increased size of uterus;
3) dyspeptic disturbances;
4) presence of fetus in uterus;
5) abdominal enlargement.

16. Early diagnosis of pregnancy is made by.
1) change in basal temperature;
2) detection of HCG (human chorionic gonadotropin) in urine;
3) USG;
4) all of the above.

17. Assumed date of labour can be known in all the given statements, except:
1) regular menstrual cycle;
2) continuation of pregnancy for 280 days;
3) ovulation occurs around the 14th day of cycle;
4) use of oral contraceptives before pregnancy;
5) conception occurred in the middle of cycle.

18. Most often a pregnant woman complains on:
1) gastrointestinal disorders;
2) pain in the lower abdomen;
3) stop of menses;
4) bloody discharges from vagina;
5) all of the above.

19. Which among the following is not the common complication occurring in the first trimester of pregnancy?
1) threatened abortion (miscarriage);
2) early gestosis;
3) anaemia;
4) hypotonia;
5) nephropathy.

20. During pregnancy, the predisposition to edema of the lower extremities is caused by:
1) decreased osmotic pressure in the blood plasma;
2) compression of the inferior vena cava by the pregnant uterus and the increase of the venous pressure in the lower extremities;
3) retension of sodium in the body;
4) increased secretion of aldosterone;
5) all of the above.

21. Frequency of what pathology increases in the aged primapara?
1) breech presentation;
2) weakness of labor strength;
3) detachment of normally placed placenta;
4) placenta prelying;
5) transverse position of fetus.

22. Most favourable sign for the prognosis of present pregnancy is the completion of the previous pregnancy by:
1) pathological labor with surgical delivery;
2) artificial abortion;
3) habitual miscarriage;
4) normal labor;
5) all of the above.

23. Term of pregnancy and the date of labour cannot be defined by:
1) last menstruation;
2) first fetal movement;
3) size of fetus;

4) USG data;
5) data obtained during the first attendance of the female consultation on the proposed pregnancy.

24. What is the estimated date of labour if the first day of the last menstruation is the 1st of May?
1) the 6th of February;
2) the 8th of August;
3) the 24th of April;
4) the 8th of February;
5) the 3rd of October.

25. The reason of the premature labour may be:
1) rhesus conflict;
2) gestosis (toxicosis);
3) multiple pregnancy;
4) gestational pyelonephritis;
5) all of the above.

26. In obstetrics, USG helps to determine:
1) position of placenta and its pathology;
2) condition of the fetus;
3) non progressive pregnancy;
4) anomaly of the development of the fetus;
5) all are correct.

27. Amnioscopy helps to estimate:
1) quantity of amniotic fluid;
2) staining of amniotic fluid;
3) presence of flakes of vernix caseosa;
4) all are correct;
5) all are incorrect.

28. In normal position of fetal parts, the head is located at the position of:
1) maximum flexion;
2) moderate flexion;
3) moderate extension;
4) maximum extension.

29. Fetal position is:
1) relation of the fetal back to the sagittal plane;
2) relation of the fetal back to the frontal plane;
3) relation of the fetal axis to the length of uterus;
4) interrelation of various parts of fetus.

30. Position is called as longitudinal, when the fetal axis is:
1) located under the right angle to the longitudinal axis of uterus;
2) located under the acute angle to the axis of uterus;
3) coincides with the length of uterus;
4) located under obtuse (broad) angle to the axis of uterus.

31. Fetal presentation is the relation of:
1) head of fetus to its entry in the pelvis;
2) pelvic end to the entry in pelvis;
3) most lower part of fetus to the entry in pelvis;
4) head of fetus to the fundus of uterus.

32. Head presentation of fetus in physiological labour is:
1) anterior head (cephalic) presentation;
2) occipital presentation;
3) frontal presentation;
4) facial presentation.

33. The most common presentation of fetus is:
1) complete breech presentation;
2) breech with flexed legs (frank breech);
3) footling presentation;
4) cephalic presentation;
5) transverse presentation.

34. Fetal position means:
1) relation of the fetal back to the lateral walls of uterus;
2) relation of the fetal head to the entry in pelvis;
3) relation of the fetal axis to the length of uterus;
4) interrelation of various parts of uterus.

35. Kind of the fetal position is the relation between:
1) fetal back to the sagittal plane;
2) fetal head to the plane of entry in the small pelvis;
3) fetal back to the anterior and posterior walls of uterus;
4) fetal axis to the length of uterus.

36. At the first position, the back of fetus is turned:
1) to the right;
2) to the fundus of the uterus;
3) to the left;
4) to the entry in the small pelvis.

37. At the second position, the back of fetus is turned:
1) to the right;
2) to the fundus of uterus;
3) to the left;
4) to the entry in the small pelvis.

38. When fetus is lying transversely, the position of fetus can be determined by the position of:
1) fetal back;
2) fetal head;
3) small fetal parts;
4) pelvic end of the fetus;
5) cannot be determined.

39. Objective examination of the pregnant woman or woman in labor starts with:
1) palpation of the abdomen;
2) auscultation of the abdomen;
3) measurement of the pelvis;
4) objective examination by systems;
5) all of the above.

40. By the first method of the external obstetric examination may be defined:
1) position of the fetus;
2) occipito-anterior or occipito-posterior vertex position;
3) height of the uterine fundus;
4) prelying part of the fetus.

41. By the second method of the external obstetric examination may be defined:
1) prelying part of the fetus;
2) disposition of the fetal parts;
3) height of the uterine fundus;
4) position of fetus;
5) head of fetus.

42. By third method of the external obstetric examination may be defined:
1) prelying part of the fetus;

2) disposition of the fetal parts;
3) height of the uterine fundus;
4) position of fetus;
5) type of position.

43. By the fourth method of the external obstetric examination may be defined:
1) prelying part of the fetus;
2) position of the fetal parts;
3) height of the uterine fundus;
4) position of fetus;
5) relation of the prelying part to the entry in the pelvis.

44. External obstetric examination at the second half of pregnancyincludes all the following, except:
1) determination of location, position and size of fetus;
2) anatomic estimation of pelvis;
3) determination of the term of pregnancy;
4) functional estimation of pelvis;
5) estimation of frequency and rhythm of the fetal heart beats.

45. Circumference of abdomen can be measured:
1) on the middle of the distance between umbilicus and xiphoid process;
2) on the level of umbilicus;
3) randomly;
4) on two transverse fingers above umbilicus;
5) on three transverse fingers above umbilicus.

46. At a women of normal constitution, the lumbar rhombus has the following form:
1) triangular;
2) geometrically correct rhombus;
3) correct quadrangular;
4) triangular, stretched in vertical direction;
5) quadrate (square form).

47. The method of instrumental examination used during pregnancy and at delivery is:
1) probing of the uterus;
2) examination of the uterine cervix by speculum;
3) biopsy;
4) histerography;
5) hysteroscopy.

48. Vaginal examination is not used for:
1) determination of stage of opening of the uterine cervix;
2) estimation of integrity of the amniotic sac;
3) estimation of condition of fetus;
4) determination of features of insertion of the fetal head;
5) estimation of the size of pelvis.

49. Diagonal conjugate can be defined:
1) on the external conjugate;
2) on the height of pubis symphysis;
3) on the lateral conjugate;
4) on vaginal examination.

50. Diagonal conjugate is the distance between:
1) ischium tubercles;
2) iliac crests;
3) lower edge of symphysis and promentorium;
4) major trochanters of femur bone;
5) umbilicus and xiphoid process.

51. Diagonal conjugate is equal to:
1) 31-32 cm;
2) 12-13 cm;
3) 12-15 cm;
4) 28-29 cm;
5) 9-12 cm.

52. True conjugate is the distance between:
1) the middle of the upper edge of pubis and promentorium;
2) the maximum protruding point of symphysis and promentorium;
3) the lower edge of symphysis and protruding point of promentorium;
4) iliac crests;
5) umbilicus and xiphoid process.

53. True conjugate is equal to:
1) 13 cm;
2) 11 cm;
3) 10 cm;
4) 20 cm;
5) 9 cm.

54. The normal fetal heart rate per minute is:
1) 80-90 beats;
2) 100-110 beats;
3) 120-140 beats;
4) 100-200 beats;
5) 170-180 beats.

55. Where the fetal heart beats are the best heard in the 1st position of anterior type of occipital presentation?
1) on the right below umbilicus;
2) on the left below umbilicus;
3) on the left above umbilicus;
4) on the left at the level of umbilicus;
5) in any point.

56. Which of the reasons can conduct to the decrease in amniotic fluid in pregnant women?
1) microcephalia;
2) abnormalities of urinogenital tract of the fetus;
3) teratoma of sacrococcygeal region;
4) virus and bacterial infection.

57. The average duration of the first stage of labour in primigravidae is:
1) 3-5 h;
2) 6-9 h;
3) 10-14 h;
4) 15-18 h;
5) 19-24 h.

58. Unlike nephropathy, in arterial hypertensia the presence of the following symptoms is characteristic:
1) edema;
2) proteinuria;
3) oliguria;
4) all listed;
5) none of the above.

59. The excessive increase in body weight at a woman of second half of pregnancy, most likely it should be suspected:
1) large fetus;
2) toxicosis (preeclampsia);
3) increased volume of amniotic fluid;
4) multi pregnancy;
5) all listed.

60. In diagnostics of prolonged pregnancy the following methods are helpful:
1) amnioscopy;
2) electrocardiogram and FCG of a fetus;
3) dynamics of measurement of an abdomen circle and height of the bottom of uterus;
4) colpocytology;
5) all listed above.

61. Amniscopy allows, generally, to estimate:
1) quantity of amniotic fluid;
2) colour of amniotic fluid;
3) presence of flakes of vernix caseosa;
4) all listed;
5) nothing from the listed.

62. What method should be used in anaesthesia for amniocenthesis:
1) the general anaesthesia;
2) local anaesthesia;
3) sacral blockade;
4) without anaesthesia and analgesic;
5) light analgesia.

63. The labour pain arises owing to:
1) irritation of the nervous terminations of uterus and patrimonial ways;
2) decrease of a threshold of pain sensitivity of the brain;
3) decreased production of endorphines;
4) all listed;
5) nothing from the listed.

64. Pudendal anaesthesia is most often applied:
1) at the second stage of premature labour;
2) at distructive operations of fetus;
3) at the extraction of fetus for the pelvic end;
4) at all listed;
5) nothing from the listed.

65. At the first stage of labour, all the listed preparations are applied for anaesthesia, except:
1) inhalation anasthetics;
2) the narcotics;
3) oxitotics;
4) analgesics.

66. The indication for the appointment of anesthetics at the first stage of labour is:
1) opening of cervix to 4 cm;
2) weak contraction of uterus during labour ;
3) discoordination of patrimonial activity;
4) absence of the fetal sac.

67. At the end of pregnancy of a primigravida women, cervix of uterus is normally:
1) extended;
2) truncated (shortened);
3) smoothed partially;
4) smoothed completely;
5) kept.

68. For a mature cervix of uterus it is characteristic:
1) its disposition along the conductive axis of pelvis;
2) softening on all its length;
3) passability of the cervical channel for 1-1,5 fingers;
4) shortening of cervix to 1-1,5 cm;
5) all the listed.

69. Name signs of the beginning of the first stage of labour:
1) efflux of amniotic fluid;
2) presence of "mature" uterine neck;
3) occurrence of regular birth pangs ;
4) head insertion into the entrance of the minor pelvis.

70. The first stage of labour comes to an end always:
1) by the full disclosure of the uterine cervix;
2) by occurrence of attempts;
3) by efflux of amniotic fluid;
4) in 6-8 hours from the beginning of regular birth pangs;
5) all listed.

71. In labour, at head prelying of a fetus, the following basal frequency of heart beats is considered to be normal:
1) 120-160 beats per minute;
2) 110-150 per minute;
3) 100-180 per minute;
4) more than 200 per minute.

72. Name signs of the beginning of the second period of labour:
1) presence of attempts;
2) efflux of amniotic fluid;
3) full opening of the uterine os;
4) insertion of the fetus head.

73. Vaginal examination in labour is carried on purpose:
1) detection of the integrity of the uterine sac;
2) assessment of the degree of disclosure of the uterine cervix;
3) estimation of features of insertion of fetus head;
4) estimation of the sizes and condition of osteal pelvis;
5) all listed above.

74. In what situation it is possible to speak about engagement of the fetus head into the entrance of the pelvic:
1) the head is in the pelvic cavity;
2) bisparietal size of the head is in an entrance plane of small pelvis;
3) the prelaying part is at the level of sciatic axis;
4) arrow-like suture is in the cross-section size of the pelvis;
5) the fetus head is bent.

75. In what plane of the minor pelvis the internal rotation of the head takes place?
1) over an entrance to the pelvis;
2) in an entrance plane of the minor pelvic;
3) in a plane of the wider part of the pelvic cavity;
4) in a plane of a narrow part of the pelvic cavity;
5) in a plane of the exit of the pelvis.

76. The major movements of a fetus during labour occur in certain sequence. What of the following sequences is correct?
1) descent, internal rotation, flexion;
2) engagement, flexion, descent;
3) engagement, internal rotation, descent;
4) engagement, flexion, internal rotation, extension;
5) descent, flexion, engagement.

77. A leading point at the occipital prelying of a fetus is:
1) big fontanel;
2) small fontanel;
3) the middle of the frontal suture;
4) the middle of the distance between big and small fontanel.

78. An indicator for the beginning of the second stage of labour is:
1) descending of a prelaying part into the minor pelvis;
2) attempts;
3) internal turn of a head;
4) full disclosure of the uterine cervix;
5) baby birth.

79. In the 2nd period of labour the heart beats are supervised:
1) after each attempt;
2) every 5 mines;
3) every 10 mines;
4) every 15 mines;
5) every 20 minute.

80. Vaginal examination in labour is made:
1) before labour stimulation;
2) at admission in a hospital;
3) at occurrence of bleeding discharges;
4) at efflux of amniotic fluid;
5) all listed is true.

81. Conduction of labour in the second period of labour includes, mainly, the control:
1) for the condition of woman and fetus;
2) for the engagement and crowning of the prelaying part of the fetus;
3) for the condition of fetoplacental circulation;
4) for the pressure in the antervillum space;
5) all answers are wrong.

82. The indication to the section perineum in labour is:
1) rupture threat of perineum;
2) a large fetus;
3) premature labour (a small fetus);
4) pelvic fetus prelying;
5) all answers are correct.

83. Episiotomy is for the prevention of:
1) bad healing of perineum;
2) rupture of muscles of perineum;
3) development of rectocele and cystocele;
4) contraction of musclus levator ani.

84. Indications to perineotomia:
1) high rigid perineum;
2) rupture threat of perineum;
3) premature labour;
4) acute hypoxia of a fetus;
5) all listed is true.

85. For the prevention of bleeding in labour at a moment of crowning of the head, it is often applied:
1) promedol;
2) methylergometrin;
3) pregnantol;
4) mammophizin;
5) quinine.

86. Volume of physiological blood loss in labour:
1) 100 - 150 ml;
2) 200 - 300 ml;
3) 300 - 400 ml;
4) 400 - 500 ml;

5) less than 100 ml.

87. Tactics of conducting the third stage of labour depends on:
1) degree of the blood loss;
2) duration of labour;
3) presence of signs of the afterbirth detachment;
4) conditions of the newborn;
5) duration of labour without amniotic fluid.

88. The major mechanisms of the afterbirth detachment and the afterbirth discharging are:
1) the increase of the intrautrine pressure;
2) the decrease of the size of a uterus and the sizes of placentary platform;
3) retraction and contraction of myometrium;
4) all listed above;
5) nothing from the listed.

89. Ways of removal of non-detached afterbirth from the uterus:
1) Abuladze's method;
2) pull for an umbilical cord;
3) method of Krede-Lazarevich;
4) manual afterbirth detachment andafterbirth discharging.

90. Characteristic signs of the total tight attachment of placenta are:
1) pain in the abdomen;
2) bleeding;
3) height of standing of the uterine bottom above the navel after a child birth;
4) absence of signs of afterbirth detachment.

91. The bleeding at the postpartum period is possible in all cases, except:
1) at thrombocytopenia;
2) at long (prolonged) labour;
3) at muli fetus and hydramnion;
4) at labour in the back type of facial prelying.

92. Indications for the manual inspection of the uterus:
1) application of prostaglandins in labour;
2) long labour;
3) labour at pelvic prelying;
4) labour in the presence of a scar on uterus after cesarean sections;
5) none of the above.

93. What is indicative during jointing of placenta?
1) manual afterbirth detachment;
2) introduction of contraction drugs;
3) curettage of cavity of uterus;
4) to put cold on the abdomen;
5) extirpation or amputation of uterus.

94. The prolonged pregnancy is characterized?
1) oligoamnios;
2) increased basal tonus of uterus;
3) decreased excitement of myometrium;
4) decreased circumference of the abdomen;
5) all the above are right.

95. To diagnose the prolonged pregnancy, it is necessary:
1) to do USG to confirm the position of fetus;
2) to determine exact duration of pregnancy;
3) to measure the heart rate of fetus;
4) to determine the volume of amniotic fluid;

5) to carry out the stress contraction test.

96. Major symptoms of the overmaturity of fetus are:
1) dry skin;
2) absent of vernix caseosa;
3) narrow sutures and fontanels;
4) dense bones of scull;
5) all is true;
6) all is false.

97. Indications for cesarean section during the prolonged pregnancy are:
1) pelvic prelying;
2) big size of fetus;
3) old age of women;
4) narrow pelvis;
5) all is false;
6) all is true.

98. The term "afterbirth period" usually means:
1) first 2 months after labour;
2) period of the breast feeding of a newborn;
3) period of afterbirth amenorrhea;
4) all above.

99. The term "lochi" means:
1) the afterbirth secretion from uterus;
2) the wound secretion from the afterbirth uterus;
3) detachment of the decidual membrane;
4) all of the above;
5) none of the above.

100. Management and care of women in the early afterbirth period implies the control of:
1) arterial blood pressure, pulse, respiration;
2) contraction of uterus;
3) blood loss;
4) colpocytological examination;
5) all of the above.

101. In the early afterbirth period, the following changes occur in the genital system of women:
1) involution of uterus;
2) formation of the cervical canal of the uterine cervix;
3) regeneration of muscular tonus of the pelvic bottom;
4) retraction, contraction of uterus and thrombus formation of vessels of placental site;
5) all is true;
6) all is false.

102. Healing of the placental site takes place due to:
1) destruction and rejection of fragments of the decidual membrane;
2) regeneration of endometrium from the fundal glands;
3) epithelization of endometrium;
4) formation of granulations from leukocytes;
5) all of the above.

103. Joint stay of both mother and child in postpartum department furthers:
1) the decreased rate of purulent-septic diseases;
2) establishment of steady lactation;
3) formation of psychoemotional tie between mother and her child;
4) all the above;
5) none.

104. What is predisposed to the blood loss in the early post-partum period:
1) weakness of labour activity;
2) increased volume of amniotic fluid;
3) multi pregnancy;
4) large fetus;
5) all the above.

105. What is necessary to undertake first of all in the starting blood loss in post-partum period:
1) manual detachment of placenta;
2) introduction of uterus contraction preparations;
3) examine of patrimonial ways;
4) define signs of the placenta detachment;
5) ice on the lower abdomen.

106. Pathological blood loss in the early post-partum period demands:
1) press of aorta;
2) injection of drugs contracting the uterus;
3) manual examination of uterine cavity;
4) examine patrimonial ways;
5) all the above.

107. During bleeding in the 3rd period of labour and presence of symptoms of the placental detachment it is necessary to:
1) make the detachment of the afterbirth by the outer approach;
2) inject the contracting drugs for uterus;
3) put ice on the lower abdomen;
4) all of the above.

108. Most usual cause of the late postpartum bleeding is:
1) disturbance in contraction of uterine muscles;
2) hemostatic disturbances;
3) trophoblastic diseases;
4) retention of fragments of placental tissue in uterus;
5) none;
6) all.

109. Tactics of a doctor during hemorrhage in the 3rd period of labour in the absence of symptoms of placenta detachment:
1) to inject drugs causing the uterine contraction;
2) to use the Krade-Lazarevich's method;
3) to use Abuladze's method;
4) to make the manual detachment of placenta and discharge of afterbirth;
5) to inject spasmolytics.

110. Most usual cause of bleeding in the early afterbirth period:
1) hypotonus of uterus;
2) retention of fragments of the afterbirth tissue in uterus;
3) disturbance of blood coagulation system;
4) long period without amniotic fluid.

111. In diagnosis of the premature detachment of the normally located placenta, the most informative methods include:
1) external obstetrics examination;
2) vaginal examination;
3) USG;
4) estimation of heart activity;

112. Complicated form of the detachment of the normally located placenta can cause everything except?
1) intrauterine fetal death;
2) pallor of skin;
3) anemia;
4) Rh-sensibilization.

113. Premature detachment of the normally located placenta is complicated by:
1) appearance of Couvelaire uterus;
2) intranatal fetal death;
3) development of DIC (disseminated intravascular coagulation) syndrome;
4) hemmorhagic shock;
5) all of the above.

114. The major reason of the premature detachment of the normally located placenta is:
1) trauma of the abdomen;
2) gestosis;
3) prolonged pregnancy;
4) hydramnion, multi pregnancy;
5) short umbilical cord.

115. For the clinical picture of premature detachment of the normally located placenta is not characteristic:
1) abdominal pain;
2) absent abdominal pain;
3) hemorrhagic shock;
4) change in the heart beat of fetus;
5) change in shape of uterus.

116. Most usual cause of the detachment of the normally located placenta is:
1) powerful hit on abdomen;
2) powerful birth pangs;
3) late gestation;
4) short umbilical cord;
5) early efflux of the amniotic fluid.) investigation of blood coagulation system.

117. For the prelying of placenta the following positions are characteristic:
1) on the anterior wall at the bottom;
2) on the bottom of uterus;
3) on the posterior wall of uterus;
4) partial or total covering of the internal os;
5) at the lower segment of uterus.

118. The prelying of placents is the pathology at which placenta is located:
1) at the body of uterus;
2) at the lower segmentl;
3) at the lower segment of uterus, partial or total covering of the internal os;
4) on the posterior wall of uterus;
5) on the bottom of uterus.

119. In the prelying of placenta, bleeding is usually appeared at the term of pregnancy of:
1) 8-12 weeks;
2) 16- 20 weeks;
3) 22- 24 weeks;
4) 28 – 32 weeks;
5) 36 – 40 weeks.

120. The most characteristic clinical sign of the prelying of placental is:
1) chronic intrauterine hypoxia of fetus;
2) decreased Hb levels and RBCs in the blood;
3) repeted bloody discharges from genital organs;
4) arterial hypotension;
5) threat of abortion.

121. The prelying of placenta should be differentiated with:
1) torsion of the pedicle of cystoma ovari;
2) rupture of uterus;
3) necrosis of myomatous nodule;

4) strangulation of myomatous uterus in the small pelvis;
5) none of above.

122. Characteristic features of bleedings in the prelying of placenta include:
1) sudden occurrence of bleeding;
2) their repeatability;
3) anemization of a pregnant woman;
4) all are wrong;
5) all are right.

123. In what cases the vaginal investigation is indicative in suspicion of the placenta prelying?
1) at the term of 27 weeks on admission in the hospital;
2) after admission in hospital and stop of bleeding;
3) before the localizing of placenta with USG;
4) only for selection of the method of delivery.

124. Clinical symptom of the placenta prelying:
1) pains in the lower abdomen;
2) changes in the heart beat of fetus;
3) changes in the form of uterus;
4) bleeding of different intensity;
5) efflux of amniotic fluid.

125. The most characteristic features of preeclampsia include:
1) shin edema;
2) albuminuria;
3) subjective complaints: headache, eye sight disturbances;
4) all of the above.

126. Eclampsia can be differentiated with:
1) epilepsy;
2) hypertension;
3) brain tumours;
4) stroke;
5) all above listed.

127. The manifestations of the late gestosis include:
1) oedema;
2) proteinuria;
3) hyperglycemia;
4) hyperinsulinemia;
5) all answers are wrong.

128. Complications of eclampsia:
1) neurologic complications;
2) fetal death;
3) pulmonary oedema;
4) premature detachment of the normally located placenta;
5) all listed above.

129. The possible cause of death in eclampsia is:
1) cardiac arrest during convulsions;
2) pulmonary oedema;
3) stroke, coma;
4) all listed above.

130. The most typical cause of maternal death in eclampsia is:
1) renal-hepatic insufficiency;
2) stroke;
3) lung oedema;

4) infection.

131. The optimal variant for delivery in severe form of gestosis is:
1) application of obstetrical forcepses;
2) self supporting delivery;
3) cesarean section;
4) vacuum-extraction of fetus;
5) fetus destructing operation.

132. Anatomically narrow pelvis is considered to be any pelvis which in comparison with normal:
1) all the sizes are reduced by 0,5-1 cm;
2) at least one size is reduced by 0,5-1 cm;
3) all the sizes are reduced by 1,5-2 cm;
4) at least one size is reduced by 1,5-2 cm;
5) all answers are not true.

133. Generally and equally narrowed (justo minor) pelvis is characterized by:
1) shortening only of the direct size of entry to the small pelvis;
2) equal decrease of all sizes of the small pelvis;
3) lengthening of the sacrum;
4) all listed are correct.

134. Characteristic for the biomechanism of labour in generally and equally narrowed (justo minor) pelvis is:
1) acynclytic insertion;
2) placing of the sagittal suture at the transverse size;
3) extension of the head is in the entry to the small pelvis;
4) maximum flexion of the head.

135. Simple flat pelvis is characterised by:
1) the decrease of all direct sizes of the cavity of the small pelvis;
2) increase in height of the pelvis;
3) the decrease of the transverse size of the sacrolumbal rhombus;
4) all listed is true;
5) nothing from the listed.

136. Clinically narrow pelvis is:
1) one of the forms of anatomically narrow pelvis;
2) absence of ascending of the head of the fetus due to weakness of labour activity;
3) non-compliance of the head of the fetus and pelvis of the mother, revealed during pregnancy;
4) all listed above;
5) nothing from the above listed.

137. For evenly narrowed pelvis is characteristic:
1) the normal form;
2) thin bones;
3) uniform reduction of all sizes;
4) sharp subpubical corner;
5) all listed is true.

138. For the treatment of discoordination of the labour activity, as a rule, are used:
1) promedol;
2) morphine;
3) tocolytics;
4) spasmolytics;
5) all listed above.

139. Discoordinated labour activity is characterised by:
1) irregularbirth pangs;
2) various intensity ofbirth pangs;
3) painful birth pangs;

4) poor dynamics of the opening of the uterine cervix;
5) all listed above.

140. For the course of rapid labour the most typical is:
1) raised body temperature;
2) nausea, vomiting;
3) dry tongue, tachycardia;
4) all listed above;
5) nothing from the above listed.

141. The most important consequences of wide application of cesarean sections:
1) decrease in maternal death rate;
2) decrease in maternal pathologies;
3) decrease in perinatal death rates;
4) decreased blood loss.

142. The cesarean section is indicated:
1) in insufficiency of blood circulation II B - III stages;
2) in septic endocarditis;
3) in acute heart failure at labour;
4) in all listed;
5) nothing from the listed.

143. The cesarean section should be performed in a planned manner (absolute indication) if the following takes place:
1) infertility in the anamnesis;
2) birth of injured children or stillborn in the anamnesis;
3) chronic fetal hypoxia;
4) multiple myoma of the uterus;
5) scar on the uterus;
6) all answers are wrong.

144. The cesarean section is the relative indication in all cases, except:
1) one cesarean section in the anamnesis;
2) fetal hypoxia;
3) umbilical cord prolapse;
4) premature detachment of placenta;
5) presence of a dead fetus.

145. Indications to cesarean sections, as a rule, are taken into account with the following factors:
1) age of the woman;
2) pregnancy term;
3) the anatomic sizes of the pelvis;
4) the obstetrical-gynecologic anamnesis;
5) all answers are correct.

146. Advantages of cesarean sections at the lower segment of a uterus do not include:
1) a cut in the functional less active and less vascularized zone;
2) conformity of direction of the cut on a uterus to a direction of the basic layers of the myometrium;
3) wound healing on the uterus by full regeneration.

147. The most frequent technique of cesarean sections is:
1) corporal cesarean section;
2) extraperitoneal cesarean section;
3) isthmic-corporal cesarean section;
4) a cesarean section in the lower segment (cross-section);
5) vaginal cesarean section.

148. In modern obstetrics the following technique of cesarean sections is not used:
1) classical (corporal) caesarean section;
2) a cesarean section in the lower segment of a uterus;

3) extraperitoneal caesarean section;
4) intraligamental cesarean section;
5) vaginal cesarean section.

149. Choose the basic complication of a classical cut of the uterus in cesarean section:
1) rupture of scar tissue in the following pregnancies and deliveries;
2) formation of postoperative commissure;
3) poor healing of wounds on the uterus;
4) more extended damage of vessels of the uterus.

150. A risk factor of inconsistency of a scar on the uterus after cesarean sections is:
1) performance of cesarean sections at premature labour;
2) the complicated course of the postoperative period;
3) corporal cesarean section;
4) an interval between cesarean sections less than 2 years;
5) all listed above.

151. Quality of a postoperative scar on the uterus after cesarean sections basically depends on:
1) the choice of technique of operation;
2) technics of suturing of a section on the uterus;
3) the cleanliness degree of vaginal dab before operation;
4) the conduction and course of the postoperative period;
5) all answers are correct.

152. Rules of introduction of spoons of obstetrical forceps are the following:
1) the left spoon held by the right hand and enter into the right half of pelvis of mother;
2) the right spoon held by the left hand and enter into the left half
of pelvis of mother;
3) all listed are true;
4) all listed are wrong.

153. What condition does not allow perform operation using obstetrical forceps?
1) alive fetus;
2) opening of the uterine cervix by 4 cm;
3) absence of amnion;
4) head in large part of the pelvic cavity.

154. While applying the exit obstetrical forceps, spoons should lie on
the fetal head:
1) in the right slanting size;
2) in the transverse size;
3) in the direct size;
4) all listed above.

155. In case of head inclination, obstetrical forceps traction should be:
1) periodically rotational;
2) periodically rocking;
3) periodically in the form of jerks;
4) all listed above;
5) nothing from the listed.

156. Placing obstetrical forceps is contraindicated in case of:
1) dead fetus;
2) anatomically and clinically narrow pelvis;
3) incomplete opening of uterine cervix;
4) threaten uterine rupture;
5) all listed above.

157. The main functions of placenta are:
1) respiratory;

2) alimentary;
3) excretory;
4) hormonal;
5) all listed above.

158. Formation of feto-placental system, as a rule ends at:
1) 16 weeks of pregnancy;
2) 20 weeks of pregnancy;
3) 24 weeks of pregnancy;
4) 28 weeks of pregnancy;
5) 32 weeks of pregnancy.

159. Name the correct characteristics of the umbilical cord:
1) the umbilical cord is formed from the allantois;
2) there are 2 arteries in the umbilical cord;
3) there are 2 veins in the umbilical cord;
4) lymphatic vessels go through the umbilical cord;
5) diameter of the umbilical cord is 12 cm.

160. Name the correct characteristics of the amniotic fluid:
1) normal quantity is 4 liters;
2) amniotic fluid is pink in color;
3) by its composition, amniotic fluid may be used for estimation of the condition of the fetus;
4) amniotic fluid exerts high pressure on the fetus;
5) by the end of pregnancy, there is relative decrease of the quantity of amniotic fluid.

161. Name the correct characteristics of the placenta:
1) normal weight of placenta is 1200g;
2) main mass of placenta consists of branched chorion;
3) in placenta chorionic gonadotropin is formed;
4) normally placenta is attached to the internal fauces of the uterine cervix;
5) in placenta erythrocytes are formed.

162. Which objective investigations are compulsory for pregnant women?
1) measurement of blood pressure;
2) determination of particularity of body constitution;
3) measurement of thorax circumference;
4) condition of mammary glands;
5) examination of fundus of eye;
6) urinary Zimnitski's test.

163. Which information helps to determine intrauterine fetal position?
1) determination of ratio of fetal back to longitudinal axis of uterus;
2) place of the attachment of placenta;
3) fundal height of uterus;
4) place in which the fetal heart sounds are heard;
5) disposition of small parts of fetus.

164. Indications for vaginal examinations in women in labor are:
1) life-threatening asphyxia of the fetus;
2) nephropathy of pregnant woman;
3) bloody discharges from genitalia;
4) albuminuria;
5) starting or ending of stimulation of labor;
6) starting of post-natal period.

165. Which changes are characteristics for normal pregnancy?
1) thickening of sacro-iliac joints;
2) increase of body mass by 300g a week in the second half of pregnancy;
3) expressed edema in lower extremities;

4) divergence of the pubic rami to the sides by 0,3-0,5cm;
5) depigmentation of linea alba of the abdomen.

166. Which changes can occur during normal pregnancy?
1) unstable arterial pressure;
2) leucopenia;
3) increase in ESR (erythrocyte sedimentation rate) till 20-25 mm an hour;
4) decrease of erythrocytes count;
5) thrombocytopenia;
6) increase in oxygen saturation of the blood.

167. Changes in cardiovascular system, which are characteristics for normal pregnancy:
1) increase in circulating blood volume;
2) leucopenia;
3) edema of lower extremities;
4) increase in vascularisation of uterus;
5) increase in quantity of fibrinogen;
6) increase of blood oxygenation.

168. Which changes in a woman, caused by pregnancy, are reversible?
1) presence of choriogonin hormone;
2) striae gravidum;
3) lactation;
4) acromegaly;
5) pigmentation.

169. What signs are characteristic for 40-week pregnancy?
1) abdominal circumference of 100cm;
2) albuminuria;
3) height of standing of uterus above pubis is 36 cm;
4) umbilical extrusion;
5) bloody discharges from genitalia.

170. Indicate the characteristics for the 1st type of occipito-anterial position:
1) fetal heart beats are heard on the right;
2) minor fontanel is determined from the left and the front;
3) minor fontanel is determined from the left and the back;
4) back of the fetus is turned to the front and the left;
5) back of the fetus is turned to the uterine fundus.

171. Importance of sutures and fontanels on the head of fetus:
1) determination of size of head of fetus;
2) determination of configuration of head of fetus;
3) determination of type of occipital position;
4) determination of occipito-frontal size of fetus;
5) determination of synclitism and asynclitism insertion of fetal head.

172. Name the main point and the point of fixation during labour in occipito-anterial position:
1) chin;
2) the middle of frontal suture;
3) minor fontanel;
4) major fontanel;
5) sub-occipital fossa;
6) upper jaw.

173. Clinical signs of severe acute hypoxia of fetus do not include:
1) fetal heart rate of 90-100 beats per minute;
2) fetal heart rate of 120-140 beats per minute;
3) muffled fetal heart beats;
4) fetal heart rate of 160-190 beats per minute;

5) arrhythmia.

174. Green color of amniotic fluid indicates:
1) chronic hypoxia of fetus;
2) acute hypoxia of fetus;
3) antenatal death of fetus;
4) hemolytic disease of fetus;
5) disturbance of metabolism of amniotic fluid.

175. Brown color of amniotic fluid indicates:
1) chronic hypoxia of fetus;
2) acute hypoxia of fetus;
3) antenatal death of fetus;
4) hemolytic disease of fetus;
5) disturbance of metabolism of amniotic fluid.

176. Placenta is permeable to:
1) alcohol;
2) morphine;
3) penicillin, Streptomycin;
4) ether;
5) all listed above.

177. Velocity of penetration of medicines through placenta depends on all listed, except:
1) molecular mass of preparation;
2) solubility of medicine in lipids;
3) degree of binding of medical substance with blood proteins;
4) size of molecule of preparation;
5) mass of fetus.

178. Minimal height of a viable fetus is:
1) 30cm;
2) 32cm;
3) 35cm;
4) 50cm.

179. Minimal weight of a viable fetus is:
1) 500g;
2) 600g;
3) 800g;
4) 1000g.

180. In Republic of Belarus, criterion for a viable fetus (newborn) is a term of pregnancy:
1) 20 weeks;
2) 22 weeks;
3) 26 weeks;
4) 28 weeks.

181. Signs of maturity of a newborn are:
1) mass/ height coefficient;
2) disposition of umbilical ring;
3) condition of external genitalia;
4) quantity of vernix caseosa;
5) all listed are correct.

182. Duration of perinatal period is:
1) from conception till delivery;
2) the first 7 days after birth;
3) since the 22nd week of intra-uterine development including 7days after birth;
4) since the 22nd week of intra-uterine development including 10 days after birth;

5) since the 24th week of pregnancy till the 7th day after birth.

183. Most often causes of death of premature newborns are:
1) developmental anomalies;
2) hemolytic disease of newborns;
3) respiratory distress syndrome;
4) jaundice of newborns;
5) infections.

184. On the Apgar scale, mild degree of asphyxia is:
1) 8 points;
2) 7 points;
3) 6-5 points;
4) 4 and less points.

185. Low marks on Apgar scale (3 and 5 points on the 1st and the 5th minute respectively) can be in all listed clinical situations except:
1) prematurity;
2) detachment of placenta;
3) extremely intensive labor;
4) infections in fetus;
5) arterial hypertension in mother.

186. Causes of fetal respiratory distress syndrome are:
1) CNS trauma due to labor;
2) developmental defects of heart;
3) developmental defects of diaphragm;
4) intra-uterine infections;
5) all listed above;
6) none from the listed.

187. Characteristics of recent course of postnatal infection are:
1) polyethiological;
2) often caused by pathogenic flora;
3) light clinical features;
4) high resistance to antibacterial therapy;
5) all listed above.

188. What corresponds to the first stage of infection according to the Sazonov-Bartels' classification of postnatal purrulo-septic infections?
1) lactation mastitis;
2) infection in the area of the postnatal wound;
3) infection is outside the wound's area, but within the small
pelvis;
4) infection is outside the small pelvis, near generalization;
5) generalised infection.

189. What corresponds to the second stage of infection according to the Sazonov-Bartels' classification of postnatal purrulo-septic infections?
1) infection in the area of postnatal wound;
2) infection is outside wound's area, but within the small pelvis;
3) infection is outside the small pelvis, near generalization;
4) generalised infection.

190. What corresponds to the third stage of infection according to the Sazonov-Bartels' classification of postnatal purrulo-septic infections?
1) infection in the area of postnatal wound;
2) infection is outside wound's area, but within the small pelvis;
3) associated with the lactation mastitis;
4) infection is outside the small pelvis, near generalization;

5) generalised infection.

191. What corresponds to the fourth stage of infection according to the Sazonov-Bartels' classification of postnatal purrulo-septic infections?
1) infection in the area of postnatal wound;
2) infection is outside wound's area, but within the small pelvis;
3) infection is outside the small pelvis;
4) infection outside the small pelvis, near generalization;
5) generalised infection.

192. Causes of the rupture of vagina during labor include:
1) infantilism;
2) prompt duration of labor;
3) large fetal head;
4) incorrect presentations of the fetal head;
5) all of the above.

193. Perineal rupture of the second degree is not accompanied by the rupture of:
1) superficial muscles of the perineum;
2) perineal skin;
3) musculus levator ani;
4) uterine cervix;
5) vaginal walls.

194. Which of the following are used for the prophylaxis of suppuration and distension of perineal sutures during rupture of the first and the second degrees?
1) potassium permanganate [local];
2) laser rays on the area of sutures;
3) measures on prevention of defecation during 4-5 days;
4) ultraviolet rays on the area of sutures;
5) all of the above.

195. The most informative for the diagnosis of the beginning of uterus rupture during labor is:
1) pain in the area of the lower segment of uterus;
2) bloody vaginal discharges;
3) rough labor activity;
4) high standing of the contraction ring;
5) all of the above.

196. Causes of the rupture of uterus during labor can be:
1) large fetus;
2) narrow pelvis;
3) incorrect insertion of the head;
4) overdose of oxytocin;
5) all of the above.

197. Methods for the treatment of complete rupture of uterus:
1) adequate anesthesiological manipulation;
2) operation;
3) infusion-transfusion therapy adequate to the blood loss;
4) correction of disturbance of hemocoagulation;
5) all answers are right.

198. Which of the following are the main clinical features of complete rupture of uterus?
1) shock;
2) blood loss;
3) abdominal pain;
4) stop of labour activity;
5) all of the above.

199. The main criterion for viviparity are:
1) fetal mass of 1000 g and more;
2) length of fetus of 35 cm and more;
3) presence of heartbeats;
4) presence of unaided breathing;
5) pregnancy duration of 28 weeks and more.

200. Which signs are characteristics of early gestosis?
1) sialorrhea;
2) loss of body weight;
3) pain in the epigastric region;
4) latent edema;
5) dehydration;
6) skin dryness.

CLINICAL CASES

A woman has just delivered her second baby on the labour ward. She is 37 years old and had a previous premature delivery at 34 weeks. In this pregnancy she went into spontaneous labour at 38 weeks after an uncomplicated pregnancy. The symphysiofundal height was consistent with dates until 37 weeks when the midwife measured it as 41 cm. However, before an ultrasound scan for growth and liquor volume could be arranged the woman went into spontaneous labour. At the time of admission she was 5 cm dilated and spontaneous rupture of membranes occurred soon after. The baby was delivered 30 min later in the direct occipitoanterior position.The placenta was delivered by controlled cord traction, after which the midwife noticed a perineal tear. The tear extended from the introitus in the midline and she could see torn muscle fibres suggestive of the torn ends of the external anal sphincter. She has called you to review the patient.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 39-year-old woman, gravida 2, para 1, at 36 and 4/7th weeks of gestation with a history of prior cesarean section in the setting of placental abruption presents with abdominal pain and vaginal bleeding. Her vital signs are significant for T 37,7C, HR 120, BP 170/100. Fetal heart rate baseline is in the 160s with minimal variability and repetitive late decelerations. Her bloodcount is significant for a hemoglobin of 75g/l , platelets of 110,000, and a fibrinogen level of 250 mg/dL.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 33-year-old woman, gravida 7, para 2-1-3, presents at 28 weeks with complaints of vaginal bleeding. She denies abdominal or back pain. She has had no prenatal care. She reports recent intercourse. On presentation, she has light vaginal bleeding and fetal heart tones are reassuring. Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 32-year-old woman, gravida 5, para 2-0-2, at 36 weeks of gestation with placenta previa presents to labor and delivery with vaginal bleeding. After evaluation, decision to proceed with a cesarean delivery was made. She has a history of two previous low transverse cesarean sections. Delivery by low transverse cesarean section is complicated by placenta accreta. Estimated blood loss was 3.7 L.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 20-year-old woman, gravida 1, para 0, at 33 weeks of gestation arrives to labor and delivery reporting profuse vaginal bleeding and abdominal pain. Her vitals are as follows: T- 36.8C, BP 78/40, HR 78. Her abdomen is firm and tender to touch. Fetal heart tones are in the 160s with minimal variability and late decelerations. Tocometer demonstrates contractions every 1 to 2 minutes.

Ultrasound demonstrates a cephalic fetus, placenta is fundal and free of the os without a retroplacental clot. Cervical examination is 3cm opening.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 34-year-old woman, gravida 5, para 4-0-0, at 30 and 2/7th weeks of gestation presents to labor and delivery reporting vaginal bleeding. She reports vague back pain. Her blood pressure is 110/78 and her pulse is 106. She has slow, continuous bleeding from her vagina. Her cervix appears long and closed on speculum examination. Fetal monitoring reveals one uterine contraction every 30 minutes, and the fetal heart rate is reassuring. Transabdominal ultrasound demonstrates a complete placenta previa.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 26-year-old woman, gravida 2, para 1, at 20 weeks of gestation, sees you in the office for prenatal care. Her fundus measures 18 cm and you are unable to hear fetal heart tone by Doppler. You perform an ultrasound and confirm lack of fetal heart activity and lack of fetal movement. She has had no bleeding or cramping.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

You are monitoring the progress of a woman gravida 2, para 0-1 who has been in labor for the past 24 hours; her membranes have been ruptured for 17 hours. Three hours ago, her cervix was 10 cm dilated and 100% effaced. The fetal vertex had reached the pelvic floor and was in the left occiput anterior position. She has an epidural. The fetal heart rate tracing was reassuring, and she began pushing. Now, the fetal vertex has reached - 2 station though the fetal vertex feels asynclitic.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 32-year-old woman is brought into the delivery suite by ambulance 6 days following a vaginal delivery at 39 weeks' gestation. The pregnancy and labour had been unremarkable and the placenta was delivered by controlled cord traction. Following delivery the woman had been discharged home after 6 h. She reported that the lochia had been heavy for the first 2 days but that it had then settled to less than a period. However today she had suddenly felt crampy abdominal pain and felt a gush of fluid, followed by very heavy bleeding. The blood has soaked through clothes and she had passed large clots, which she describes as the size of her fist. She feels dizzy when she stands up and is nauseated.
She is pale with cool and clammy extremities. She is also drowsy. Her blood pressure is 105/50 mmHg and heart rate is 112/min. On abdominal palpation there is minimal tenderness but the uterus is palpable approximately 6 cm above the symphysis pubis. Speculum examination reveals large clots of blood in the vagina.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 36-year-old female has been in labor for over 12 hours. She has been pushing for 2 hours and on examination the fetal head in determined to be occiput anterior with a cervical examination of complete dilatation, 100% effaced and 2 station. The fetal tracing is becoming less reassuring.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 39-year-old woman in her first pregnancy delivered twin sons 2 h ago. A vaginal delivery was planned and she went into spontaneous labour at 38 weeks and 4 days. The midwife recorded both placentae as appearing complete. The lochia has been heavy since delivery but the woman is now bleeding very heavily and passing large clots of blood. On arrival in the room you find that the sheets are soaked with blood and there is also approximately 500 mL of blood clot in a kidney dish on the bed. The woman is conscious but drowsy and pale. The temperature is 35.9°C, blood pressure 120/70 mmHg and heart rate 112/min. The

peripheries feel cool. The uterus is palpable to the umbilicus and feels soft. The abdomen is otherwise soft and non-tender. The midwife sent blood tests 30 min ago because she was concerned about the blood loss at the time.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

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• What factors predispose to this condition?
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• What factors predispose to this condition?
• How would you manage this patient?

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• How would you manage this patient?

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her vagina. Her cervix appears long and closed on speculum examination. Fetal monitoring reveals one uterine contraction every 30 minutes, and the fetal heart rate is reassuring. Transabdominal ultrasound demonstrates a complete placenta previa.
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• How would you manage this patient?

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Questions
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• What factors predispose to this condition?
• How would you manage this patient?

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Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

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She is pale with cool and clammy extremities. She is also drowsy. Her blood pressure is 105/50 mmHg and heart rate is 112/min. On abdominal palpation there is minimal tenderness but the uterus is palpable approximately 6 cm above the symphysis pubis. Speculum examination reveals large clots of blood in the vagina.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 36-year-old female has been in labor for over 12 hours. She has been pushing for 2 hours and on examination the fetal head in determined to be occiput anterior with a cervical examination of complete dilatation, 100% effaced and 2 station. The fetal tracing is becoming less reassuring.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 39-year-old woman in her first pregnancy delivered twin sons 2 h ago. A vaginal delivery was planned and she went into spontaneous labour at 38 weeks and 4 days. The midwife recorded both placentae as appearing complete. The lochia has been heavy since delivery but the woman is now bleeding very heavily and passing large clots of blood. On arrival in the room you find that the sheets are soaked with blood and there is also approximately 500 mL of blood clot in a kidney dish on the bed. The woman is conscious but drowsy and pale. The temperature is 35.9°C, blood pressure 120/70 mmHg and heart rate 112/min. The peripheries feel cool. The uterus is palpable to the umbilicus and feels soft. The abdomen is otherwise soft and non-tender. The midwife sent blood tests 30 min ago because she was concerned about the blood loss at the time.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 26-year-old G1P0 woman at 39 weeks' gestation is admitted to the hospital in labor. She is noted to have uterine contractions every 2 to 3 minutes. Her antepartum history is significant for a nonimmune rubella status. On examination, her blood pressure

(BP) is 110/70 mm Hg and heart rate (HR) is 80 beats per minute (bpm). The estimated fetal weight is 3000 gr. On pelvic examination, she has been noted to have a change in cervical examinations from 4-cm dilation to 5-cm over the last 2 hours. The pelvis is assessed to be adequate on digital examination.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 26-year-old G2-P1 woman underwent a normal vaginal delivery. A viable 3800 gr male infant was delivered. The placenta delivered spontaneously. The obstetrician noted significant blood loss from the vagina, totaling approximately 700 mL. The uterine fundus appeared to be well contracted.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 29-year-old G5-P4 woman at 39 weeks' gestation with preeclampsia delivers vaginally. Her prenatal course has been uncomplicated except for asymptomatic bacteriuria caused by Escherichia coli in the first trimester treated with oral cephalexin. She denies a family history of bleeding diathesis. After the placenta is delivered, there is appreciable vaginal bleeding estimated at 1000 cc.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 22-year-old G3P2 woman at 40 weeks' gestation complains of strong uterine contractions. She denies leakage of fluid per vagina. She denies medical illnesses. Her antenatal history is unremarkable. On examination, the blood pressure (BP) is 120/80 mm Hg, heart rate (HR) is 85 beats per minute (bpm), and temperature is 98°F (36.6°C). The fetal heart rate is in the 140 to 150 bpm range. The cervix is dilated at 5 cm and the vertex is at –3 station. Upon artificial rupture of membranes, fetal bradycardia to the 70 to 80 bpm range is noted for 3 minutes without recovery.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 30-year-old G5-P4 woman at 32 weeks' gestation complains of significant bright red vaginal bleeding. She denies uterine contractions, leakage of fluid, or trauma. The patient states that 4 weeks previously, after she had engaged in sexual intercourse, she experienced some vaginal spotting. On examination, her blood pressure is 110/60 mm Hg, heart rate (HR) is 80 beats per minute (bpm), and temperature is 37.2°C. The heart and lung examinations are normal. The abdomen is soft and uterus nontender. Fetal heart tones are in the range of 140 to 150 bpm.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A woman presents at 20 weeks' gestation reporting vaginal bleeding. The bleeding occurred2 h ago and was bright red. She reported no abdominal pain with the bleeding and she had not had any previous episodes. She had had intercourse the previous evening. Her last cervical smear was normal 2 years ago. This is her first pregnancy and her current obstetric history is unremarkable with normal first-trimester scan and Down's syndrome screening. She reports that her booking blood tests had been normal. She is extremely anxious when seen, concerned that she is going to have a miscarriage. Examination: The blood pressure is 105/65 mmHg and pulse 86/min. Abdominal examination confirms that the uterus reaches to 1 cm below the umbilicus. The uterus is soft and non-tender. The fetal heart is heard with the hand-held fetal Doppler ultrasound probe. Speculum examin ation reveals a reddened area around the external cervical os, with an inflammatory appearance and a small amount of contact bleeding. The os itself is closed.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 22-year-old G2-P1 woman at 35 weeks' gestation complains of abdominal pain. She states that she has been experiencing moderate vaginal bleeding, no leakage of fluid per vagina, and has no history of trauma. On examination, her blood pressure is 150/90 mm Hg, and heart rate (HR) is 110 beats per minute (bpm). The fundus reveals tenderness, and a moderate amount of dark vaginal blood is noted in the vaginal vault. The ultrasound examination shows no placental abnormalities. The cervix is 1 cm dilated. The fetal heart tones are in the range of 160 to 170 bpm. The urine protein to creatinine ratio is 0.1 (normal < 0.3).
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A woman was admitted from the antenatal clinic two days ago at 38 weeks' gestation. She is 42 years old and this is her second pregnancy. Her first child was born by spontaneous vaginal delivery 13 years ago. She has subsequently remarried. Her booking blood pressure was 138/70 mmHg at 13 weeks. Her booking blood tests were unremarkable. At her 36 week midwife appointment 2 weeks ago, her blood pressure was 140/85 mmHg and the urinalysis was normal. The blood pressure was repeated 2 days later and was 140/82mmHg. Two days ago she saw her midwife for a further appointment and her blood pressure was 148/101 mmHg. Urinalysis showed protein. She feels well in herself except for swollen legs. She denies any headache or blurring of vision.
Examination: She has oedema to the mid calves and her fingers are swollen such that she cannot remove her rings. Abdominal palpation is non-tender and the symphysiofundal height is 39 cm. Reflexes are normal.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 19-year-old G1P0 woman at 29 weeks' gestation arrives to the hospital because of severe dyspnea of 6 hours' duration. Her prenatal course has been unremarkable, and she denies any medical problems. Her blood pressure (BP) is 160/114 mm Hg, heart rate (HR) is 105 beats per minute (bpm), respiratory rate (RR) is 40 breaths per minute and labored, and oxygen saturation is 90%. The fetal heart tones are in the range of 140 bpm. A urine protein to creatinine ratio is 0.6. The serum alanine transaminase (ALT) is 84 IU/L (normal < 35) and aspartate transaminase (AST) is 90 IU/L (normal < 35). The prenatal records show the following:
Gestational Age - BP (mm Hg) - Urine Protein - FHT (bpm) - Fundal Height (cm)
8 weeks - 100/60 - 0 – 140 -*;
12 weeks - 110/70 – 0 – 148 -*;
16 weeks - 100/76 – 0 – 150 -*;
20 weeks - 105/58 – 0 – 138 - 20;
26 weeks - 130/89 - 1+ - 142 – 25.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 17-year-old girl is admitted to the labour ward by ambulance because of a severe headache and reduced fetal movements. This is her first pregnancy. She did not discover she was pregnant until very late and was uncertain of her last menstrual period date so was dated by ultrasound scan at 23 weeks. According to that scan she is now 37 weeks. When she was first booked in the antenatal clinic her blood pressure was 120/68mmHg and urinalysis negative. The blood pressure was last checked 1 week ago and was 132/74 mmHg and urine was negative again. Booking blood tests were all normal. This morning she woke with a frontal headache which has persisted despite paracetamol. She says that her vision is a bit blurred but she cannot be more specific about this. She also reports nausea and epigastric discomfort, but has not vomited. She denies leg or finger swelling.
Examination: The blood pressure is 164/106 mmHg. This is repeated twice at 15 min intervals and is found to be 160/110 mmHg and 164/112 mmHg. She is apyrexial and her heart rate is 83/min. Her face is minimally swollen and fundoscopy is normal. Cardiac and respiratory examinations are normal. Abdominally she is tender in the epigastrium and beneath the right costal margin, but the uterus is soft and non-tender. The fetus is cephalic and 3/5 palpable.
The legs and fingers are mildly oedematous and lower limb reflexes are very brisk, with clonus.
Investigations: Haemoglobin 116 g/L, White cell count 5 x 10^{9}/L, Platelets 126 x 10^{9}/L ; Sodium - 141 mmol/L, Potassium - 4.0 mmol/L, Alanine transaminase - 189 IU/L, Alkaline phosphatase - 74 IU/L, Gamma glutamyl transaminase - 34 IU/L, Bilirubin - 12 .mol/L, Albumin - 24 g/L, Urea – 3.8 mmol/L, Creatinine - 92 μmol/L, Urinalysis: ++++ protein. Cardiotocograph (CTG): baseline 140/min, reduced variability (5–10/min). Variable decelerations, occasional accelerations.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A woman was admitted from the antenatal clinic two days ago at 38 weeks' gestation. She is 42 years old and this is her second pregnancy. Her first child was born by spontaneous vaginal delivery 13 years ago. She has subsequently remarried. Her booking blood pressure was 138/70 mmHg at 13 weeks. Her booking blood tests were unremarkable. At her 36 week midwife appointment 2 weeks ago, her blood pressure was 140/85 mmHg and the urinalysis was normal. The blood pressure was repeated 2 days later and was 140/82mmHg. Two days ago she saw her midwife for a further appointment and her blood pressure was 148/101 mmHg. Urinalysis showed protein. She feels well in herself except for swollen legs. She denies any headache or blurring of vision.
Examination:She has oedema to the mid calves and her fingers are swollen such that she cannot remove her rings. Abdominal palpation is non-tender and the symphysiofundal height is 39 cm. Reflexes are normal.
Investigations: Haemoglobin 124 g/L, White cell count 8 x 10^{9}/L, Platelets 210 x 10^{9}/L ; Sodium - 137 mmol/L, Potassium – 3,9 mmol/L, Alanine transaminase - 37 IU/L, Alkaline phosphatase - 98 IU/L, Gamma glutamyl transaminase - 32 IU/L, Bilirubin – 10 µmol/L, Urea – 2.5 mmol/L, Creatinine – 80 µmol/L, Gamma glutamyl transaminase - 32 IU/L, Urate - 43 mmol/L. Urinalysis: ++++ protein. 24-h urinary protein collection: volume 1.8 L; total protein 2.16 g; protein per litre 1.2 g.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

An obviously pregnant woman is brought to the emergency department having suffered a seizure in the park 20 min ago. She had been alone at the time but the seizure was witnessed by another woman who said that she had stood up from a bench and then suddenly dropped to the ground. She thought she may have hit her head on the side of the bench with the fall. Her arms and legs had been shaking and then were 'stiff and trembling' for about 40 s. The woman's face had gone dusky and there was some frothing at the mouth. She noticed that the woman's trousers were wet afterwards. When the fit stopped the woman had appeared unconscious for a few minutes and then showed some response to being talked to but seemed confused and drowsy.
Examination: She appears to be about 30 years old and in the third trimester of pregnancy. She is now conscious but still drowsy and her Glasgow Coma Scale is 9/15. Her blood pressure is 140/98 mmHg and heart rate 104/min. Examination shows no obvious cardiac or chest abnormality, and on abdominal palpation there is no apparent ten derness. The uterus feels approximately 30-week size (midway between umbilicus and xiphisternum), and a fetus can be palpated, cephalic with 4/5 palpable. Reflexes are brisk and plantar reflexes are upgoing.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A healthy 19-year-old G1-P0 woman at 29 weeks' gestation presents to the labor and delivery area complaining of intermittent abdominal pain. She denies leakage of fluid or bleeding per vagina. Her antenatal history has been unremarkable. She has been eating and drinking normally. On examination, her blood pressure (BP) is 110/70 mm Hg, heart rate (HR) is 90 beats per minute (bpm), and temperature is 37.2°C. The fetal heart rate tracing reveals a baseline heart rate of 120 bpm and a reactive pattern. Uterine contractions are occurring every 3 to 5 minutes. On pelvic examination, her cervix is 3 cm dilated, 90% effaced, and the fetal vertex is presenting at (–1) station.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 28-year-old woman nulliparous woman is admitted to the labour ward at 31 weeks and 6 days' gestation, with abdominal pain. In this pregnancy she has had chronic low back pain for which she has been under the physiotherapist. She has also been treated for confirmed urinary tract infections on two occasions. She underwent two large-loop excisions of the transformation zone (LLETZ) procedures some years ago. Since then her smears have been normal, the most recent being 10 months ago. Yesterday she noticed an increase in her discharge with some dark vaginal bleeding and abdominal discomfort. She thought the symptoms may have related to something she had eaten but she now feels intermittent abdominal pain every few minutes, with no pain in between episodes. Fetal movements are normal. There is no history of leaking of liquor. She has urinary frequency, though this has not worsened recently. She is always constipated.
Examination: The woman is apyrexial with blood pressure 109/60 mmHg and heart rate 96/min. Symphysiofundal height is 30 cm and moderate contractions are palpated lasting approximately 35 s. The fetus is breech on palpation and the presenting part feels engaged. No liquor is visible on speculum examination. On vaginal examination the cervix is effaced and 3 cm dilated, with the breech felt –2 cm above the ischial spines and membranes intact.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?

• How would you manage this patient?

A 40-year-old woman presents with a fever and abdominal pain. She is 18 weeks pregnant in her third pregnancy. The pregnancy has been unremarkable so far and she has no significant gynaecological or medical history. She has felt unwell for 10 days but has become worse in the last 48 h. She is nauseated and has vomited several times. She is intermittently hot and cold. Her abdominal pain is generalized and constant with some right-sided loin pain. She denies any dysuria and says that she has frequency which has been present through Out the pregnancy. She has had no recent change in bowel habit. There has been no vaginal bleeding and she has a mild thin vaginal discharge.
Examination: She appears flushed and unwell. Her temperature is 38.2°C, blood pressure 115/68mmHg and pulse 112/min. Cardiac and chest examination is normal. The fundal height is approximately 2 cm below the umbilicus, and the uterus is soft and non-tender. The rest of the abdomen is tender on deep palpation, maximally in the right lower quadrant. There is right renal angle tenderness. The fetal heart is heard at 160/min with hand-held Doppler.
Haemoglobin 111 g/L, White cell count 18.9 x 10^9/L, Neutrophils 16.2 x 10^9/L, Platelets 346 x 10^9/L ; Sodium - 139 mmol/L, Potassium - 4.2 mmol/L, Urea - 8.1 mmol/L, Creatinine - 68 μmol/L, C-reactive protein - 127 mg/L ; Urinalysis: + protein; + blood; ++ leucocytes; + nitrites.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 20-year-old G1P0 woman at 29 weeks' gestation is hospitalized with back pain and high temperature. She has been receiving intravenous (IV) ampicillin and gentamicin for 48 hours. She complains of acute shortness of breath. On examination, her temperature is 99°F, heart rate is 100 beats per minute (bpm), respiratory rate (RR) is 24 bpm and labored, and blood pressure (BP) is 120/70 mmHg. Right costovertebral angle tenderness is elicited. The fetal heart tones are in the range of 140 to 150 bpm. The urine culture reveals Escherichia coli sensitive to ampicillin.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 29-year-old G2P1 woman at 20 weeks' gestation is seen for her second prenatal visit. Her antenatal history is unremarkable except for a urinary tract infection treated with an antibiotic 2 weeks ago. The patient was noted to be anemic on her prenatal screen with a hemoglobin level of 95 g/L and a mean corpuscular volume (MCV) of 70 fL. On examination, her blood pressure (BP) is 100/60 mm Hg, heart rate (HR) 80 beats per minute (bpm), and she is afebrile. The thyroid gland appears normal on palpation. The heart and lung examinations are unremarkable. The fundus is at the umbilicus. The fetal heart tones are in the 140- to 150-bpm range. The evaluation of the anemia includes: ferritin level: 90 mcg/L (normal 30-100); serum iron: 140 mcg/dL (normal 50-150); hemoglobin electrophoresis: Hb A1 of 95% and Hb A2 of 5.5% (normal 2.2%-3.5%).
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 30-year-old G5P4 woman at 32 weeks' gestation complains of significant bright red vaginal bleeding. She denies uterine contractions, leakage of fluid, or trauma. The patient states that 4 weeks previously, after she had engaged in sexual intercourse, she experienced some vaginal spotting. On examination, her blood pressure is 110/60 mm Hg, heart rate (HR) is 80 beats per minute (bpm), and temperature is 99°F (37.2°C). The heart and lung examinations are normal. The abdomen is soft and uterus nontender. Fetal heart tones are in the range of 140 to 150 bpm.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?

A 30-year-old woman is referred from her general practitioner. She is 11 weeks and 2 days gestation and has noticed dark spotting and mild period-like pains for the last 4 days. Her last period was 4 months ago but she has a history of polycystic ovarian syndrome and has an irregular cycle bleeding for 4–7 days every 5–6 weeks. She had a positive home pregnancy test because she noticed breast tenderness, and came for a dating ultrasound scan 4 weeks ago that confirmed a viable single intrauterine pregnancy. Since then she has had a booking visit with the midwife and all routine blood tests are normal. She is gravida 2 para 0. Her last pregnancy 9 months ago ended in a complete miscarriage at 7 weeks. There is no other medical or gynaecological history of significance.

Examination: She is apyrexial with normal heart rate and blood pressure. The abdomen is soft and non tender. Speculum examination shows a small cervical ectropion but this is not bleeding. The cervix is closed and no blood or abnormal discharge is seen. Bimanual examination reveals an 8–10-week-sized anteverted mobile uterus with no cervical excitation, adnexal masses or tenderness.
Transvaginal ultrasound scan report: the uterus contains a gestational sac measuring 36 mm. A single fetus of crown–rump length 47 mm is visible. Fetal heart beat is absent. The uterus is anteverted. Both ovaries appear normal with no adnexal masses visible.
Questions
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A 41-year-old woman is seen in the early pregnancy unit because of vaginal bleeding. She is gravida 4 para 2 having had two previous normal vaginal deliveries followed by a miscarriage. She has a regular 28-day menstrual cycle and her last period started 9 weeks ago. She had slight vaginal bleeding two weeks ago and on ultrasound scan an early intrauterine pregnancy had been visualized with gestational sac of 22mm diameter and a yolk sac visualized of 5 mm. No fetus was visualized. She was given an appointment for a repeat ultrasound. Four days ago her bleeding became very heavy and she passed large clots which she described as 'like liver'. She developed severe abdominal pain which lasted for about 4 h, and since then the bleeding has become very light and she is now pain free. She has normal appetite and no nausea or vomiting. She has no urinary or bowel symptoms.
Examination: She appears well and is apyrexial. There are no signs of anaemia. The heart rate is 82/min and blood pressure is 132/78 mmHg. The abdomen is soft and mildly tender suprapubically. Speculum shows the cervix is closed with a small amount of old blood in the vagina. There is slight uterine tenderness on bimanual palpation and the uterus feels normal size, anteverted and mobile, with no adnexal tenderness or cervical excitation.
A transvaginal ultrasound scan is shown longitudinal view of the uterus with a thin homogenous endometrium and no evidence of a gestation sac or retained products of conception.
Questions
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A 23-year-old woman is referred by her general practitioner with vaginal bleeding. She noticed that there was blood on the toilet paper 2 days ago, and following this she has had bright red spotting intermittently. She has no pain and there are no urinary or bowel symptoms. Her last menstrual period started 9 weeks and 6 days ago and she has a regular 31-day cycle. She had a positive home urine pregnancy test 3 weeks ago after she realized she had missed a period and was feeling very tired. This is her first pregnancy. She had been using condoms but with poor compliance, so the pregnancy was unplanned but she is now happy about it. She is generally well, only having been admitted to hospital once in the past for an appendectomy at the age of 17 years. She takes no medication, does not smoke and drinks minimal alcohol. She denies any use of recreational drugs.
Examination: The woman is apyrexial. The blood pressure is 120/65 mmHg and heart rate 78/min. The abdomen is soft and non-tender with no palpable uterus or other masses. Transvaginal ultrasound is shown: The crown–rump length is 25mm (equivalent to around 9 weeks' gestation) and the fetal heart beat is seen.
Questions
• What is the likely diagnosis?
• What factors predispose to this condition?
• How would you manage this patient?