[redacted]

EXAMINATION TO COVER TRAINING ON CAESAREAN SECTION

NAME OF TRAINEE [redacted] DATE Jan 11, 2022

Time needed for examination is 1.5 hours

1. Please answer true or false next to the statements below regarding delivery by Caesarean section (CS):

   1.WHO suggests that systems should be in place to ensure that Caesarean section is performed in a minimum of 10% of all expected births False

   2. CS should NOT routinely be undertaken for preterm birth, small for dates fetuses or post-term pregnancy, unless fetal distress is detected, or other signs of placental compromise are present ~~False~~ True

   3. For Category 1 CS, decision to delivery time should be 60 minutes or less. False

   4. For Category 2 CS, decision to delivery time should be 75 minutes or less. True

2. In the box below list at least 15 reasons why CS should be undertaken.

- Failed Induction or Augmentation
- Previous c/s x 2 or more
- placenta previa
- Ruptured Uterus
- Fetal distress
- mid- Presentation or position
- multiple gestation with the first twin is breech
- prolonged or obstructed labor
- ~~Abruto~~ placenta abruption. where cervix is not fully dilated and with heavy vag. bleeding
- Failed vacuum delivery
- heart failure.
- Pre-eclampsia or eclampsia where delivery is not done in 24 hrs and 12 hrs

[redacted]

3. In the box below describe the most important actions you **must undertake** before a CS is undertaken

- Inform consent
- Know patient name
- Know allergic reaction
- Know the fetal presentation
- Do not do c/s for dead fetal
- Do FHR before taking the patient to the OR and before started the procedure
- Inserted IV cannula G 14 - 18 G cannula on both hand.
- Do Hb and cross match 2 to 4 unit of blood
- Insert foley catheter,
- Do the 7 minutes blood clotten test where there Placenta abruption or eclampsia.
- Start 72 hrs before skin incision
- ~~Set the neonatal resuscitation table~~ and inform neonatal clinician
- Emergency anaesthetist drug should be present and useful

[redacted]

4. In the box below **list additional measures** that are important before undertaking CS

> preload pt. with NS or RL;
> Shape the pubic hair if interfer with the incision
> Share white board ~~pate~~ paper and record all instruments that you are use
> All Surgical instrument should be present
>

5. In the box below describe the performance of urinary catheterisation and CS. When do you undertake it and when do you remove the catheter?

> Urinary catheter is inserted to prevent bladder damage, and to monitor urine out, it should be undertaking before the CSection and should be removed 8hours after the CSection, or more than 48hrs if suspect bladder damage, rupture Utrus etc

[redacted]

6.In the box below describe how you would prepare the skin for a CS.

> use chlorhexidine, Povidine to prepare the skin.

7. In the box below describe how you would give antibiotics prior to CS and which antibiotic would you use?

Antibiotic should be giving immediately before skin incision. Ampicillin 2g IV, IF not avilable give ceft. 1g.

8.in the box below describe how you would choose the possible ways in which you could undertake the **skin** incision and describe the two main transverse skin incisions you could use. Also describe when you might use a vertical **skin** incision.

> You can undertake the skin incision base on your experine, previous scar, gestational age and the presentation of the fetal.
>
> The Joe cohen incision is 3cm above the symphysia pubic and
>
> the pfannestiel incision is 2 fingers above the symphysia pubic. Both of these incision is good ~~be~~ because it reduce blood loose. Surgical time, oral fluid intake and early ambulation.

[redacted]

9. In the box below describe for each of the two main transverse incisions used for CS on how you would undertake the opening of the fascia, rectus muscles and peritoneum.

To open the Fascia, rectus muscles and the peritoneum, For the Fascia make 3cm incision and use ~~the~~ your Finger and sessor to broden it and use the Same 3cm incision on the peritoneum and use your Finger and sessor to open.

10. Describe how you would open the uterus when undertaking one of the main two transverse incisions described above. Also describe how you would protect the bladder.

The uterus cem be open by making 3cm incision C Skalpel do not broken the Fluid, use you Fingers to pull up ward and leteriallyto extent the Incision, be careful not to extent it in to the broad legment and other velsef.

Protect the bladde by retracting it with the bladder retracted.

[redacted]

11. In the box below describe when 1) it would be appropriate to undertake a high vertical uterine incision and then 2) when it would be appropriate to perform a low vertical uterine incision (De Lee's incision)

1) A high vertical uterine incision, When there is adhesion to the lower segment of the uterus, In preterm, where the lower segment is not well form. In transverse position, and where there is Carcinoma of the cervix.

2) A low vertical uterine incision When the lower uterine segment is well form, No adhesion and full term pregment. No Carcinoma of the cervix

12. Please answer TRUE or FALSE next to the statements below regarding CS

1. It is not necessary to ensure that there is no dead space left after surgery False
2. It is safer to transfer sharp instruments directly into a basin/tray True
3. It is best to retract tissue with instruments, True
4. It is best to reposition suture needles with forceps True
5. Ideally you should remove the needle before the final tying of sutures. True
6. You must be aware of the closeness of the uterine arteries to the ends of the uterine incision and be very careful not to extend the incision by tearing it and damaging these arteries. True
7. An infusion of oxytocin is **not** needed after every CS. False
8. There is **no** increased risk of PPH after a CS undertaken for placenta praevia False

13. In the box below describe how you would deliver the fetus and placenta at CS.

>To deliver the fetal, you place your fingers between the uterine cavity and the fetal head and feel the head in the incision to deliver it, after you deliver the fetal, ask anesthetist to give the pitocin,

>Deliver the placenta by controlled cord traction, if difficulty in the cord traction, deliver by manual extraction.

14. Describe in the box below how you would deliver a breech at CS

>TO beliver a breech in cs, you grup the foot and deliva. the foot, body ang shoulder, use the love set mena to deliver the head of the baby. use this MSV to del the head.

15. In the box below describe the manoeuvres you could use to help situation where the delivery of the fetal head may be difficult and, in particular, describe how you would deliver a fetal head deeply engaged in the pelvis.

~~Use the~~ place your hand in to the utens between the fetal head and the utens, ask, helper to wear sterile glove, and ~~use~~ use disinfectant solution to clean the vagina, heper insert, forcep into the vagina to pull the fetal head in to the utens, and you grasp it, and deliver it.

16. In the box below describe how you would manage a transverse lie before you open the uterus at CS and then describe how you would manage this after the uterus has been opened

Before you open the utenp in transverse lie, you should turn the fetal presentation to early cephalic or breech. but when the utens is already ~~ope~~ open, deliver the fetal by breech, look for the foot and grasp it, and deliver the fetal.

17. In the box below describe possible problems that may occur with a low lying anterior placenta and how you would manage this situation.

PPH, Fetal distress, DIC,

to manage this problem, call neonatal Clinican For the fetal distress

Pitocin, 40 unit in NS 500ml to go at 1mg 4hrs

Give Fresh blood if anemic

18. In the box below describe how you would manage placenta praevia at CS. Describe the possible problems and how you would deal with them.

> Delivery of the fetal will be difficulty
> Expect PPH after delivery.
> Look for the edg of the Placenta Place you hand and deliver the baby if difficult, go through the Placenta to deliver the baby.
> BE fast to avoid fetal distress
> Neonatal clinical should be present

19. In the box below, describe in detail how you would suture the uterus after a CS.

> To Suture the utens, you extensized it, clean, and vicol #2, is use, Sutured the utens in 2 ~~layer types~~ layers, make sure to avaid strong tiring of the muscle. Heat Cem ~~crease~~ give the patient pain. Clean all bleeding point, and ligate all bleeding pain before continue the Suturing. After Suturing check for bleeding if no bleeding, Placed the utens back in to the abdominal cavity.

[redacted]

20. In the box below describe how you would close the rest of the abdomen after the uterus has been sutured. What precautions must you take during this closure of the abdomen.

> Closed the abdomen in anatomical layers. Perineum, muscle, Fascial, Subcutaneous, Skin are the anatomical layers of the abdomen.

> make sure all surgical instrument are correct.

> All Guze, sponge should be correct before closing the abdomen.

[redacted]

21. In the box below describe the main possible complications of CS

- Atonic Uterus
- Broad legement hematoma
- Uncontrolled bleeding
- Bladder adherence

[redacted]

22. In the box below describe how you would manage heavy bleeding **during the surgical performance of a CS.**

- Call For Help Include anesthetist
- Lagute all blood vessel
- give pitocin 5 to 10 IU IV
- Do Controlled cord traction if Placenta not delivery yet.
- Check For the cause of the bleeding
- Repaired any tear if Found.
- NIS or R/L 500ml to 1000 ml
- Cytotec 800mg retally
- monitor pt VIS regullarly and report any Finding.

[redacted]

23. In the box below describe the patients most at risk after a CS.

- Multiple Sestational
- Anemia
- Abruption of Placenta
- Polyhydramnio
- ~~Placen~~ Previous C/S Scare.
- Prolonge ~~obstructed~~ labor

24. In the box below describe in detail how you would manage every patient following CS. In particular describe the use of antibiotics, the management of the wound, the detection of sepsis, fluid intake and nutrition, the prevention of DVT and pulmonary embolus and the management of analgesia and urinary catheter. Also describe how you would manage the discharge home process.

- place the pt on 72 hrs antibiotic
- Change dressing after 72 hrs if Soid Change, dressing daily, pt. Should Start liquid diet when bowel movement, with in 12hrs
- Early ambulation, wear ~~stroth~~ sock.
- Remove Catheter after 24hrs if Urine is ~~bleed~~ clear
- Counsel pt on Planning ~~Planent~~ Planning, ~~comm~~ to ~~midwife~~ to ~~Child~~ for pt

14

- Domadol Should be given For pain

[redacted]

25. Describe in the box below in detail how you would monitor vital signs after every CS. How often and what would you measure?

- monitor Vs after c/s For 15 minutes For 2 hour, 30mins For One hour, and one hour For 3 hours.
- measure the following
- Temperature
- Pulse
- Respiration
- urine out put
- SpO2
- Blood pressure
- Surgical site For bleeding
- Vagina For bleeding

[redacted]

26. In the box below describe your diagnosis and emergency management of 17-year-old primigravida patient who has undergone a CS for CPD and who was in good condition immediately following her return from the operating theatre. Her baby is well and has begun sucking at the breast. However, despite oxytocin IV boluses and an oxytocin infusion, 1 hour after delivery she has become distressed and is showing signs of shock. There is no obvious increase in vaginal bleeding and the uterus is 2 cm above the level marked on the abdomen immediately after the end of the CS. Her heart rate is 120 bpm, her respiratory rate is 28 per minute, BP is 85/40 mmHg, her conscious level is decreasing and she is pale and sweaty (CRT is 5 seconds).

- This pt is in Shock
- call For help, Include Sr. OBC
- put up Fluid
- Do Hb, Cross match 4-6 unt
- Insert Foley catheter
- Ant. Shock gurment
- Tranexamic acid
- Posible re-look.
- monitor all Vita Signs closely
- O2 at 100%
- Spo2