

Gynaecology notes

THE MENSTRUAL CYCLE

It is the cyclical bleeding from the female genital tract which is due to the cyclical changes during endometrium due to the secretion of ovarian hormones. A cycle is counted from the first day of the menstrual bleeding to the first day of next menstrual bleeding.

Menstrual cycle can be divided into **four phases**.

1. Menstrual Phase- if the ovum is not fertilized, then menstrual bleeding occurs which lasts for about 3-5 days. There is bleeding and shedding of uterine endometrium. An average of 50-200 ml of blood is lost during each menstrual bleeding.
2. Proliferative phase – here damaged endometrial lining is restored. From day 5 to 14, the endometrium thickens and proliferates. Proliferation occurs in the glands, stroma, blood vessels and superficial epithelium. Thickness of uterine endometrium reaches about 4 mm by about 14th day.
3. Ovulatory phase – ovulation occurs about the 14th day. Cervical mucus secretion increases and it becomes thinner which helps the penetration of sperms.
4. Secretory phase / Luteal phase/ progesterational phase – in this phase, the uterine endometrium further thickens, glands increase in length, spiral arteries become coiled and dilated, cervical secretions become thick and tenacious in preparation for implantation of fertilized ovum. These changes end about 28th day of the cycle with the onset of menstruation if the ovum is not fertilized.

Hormonal Control of the Menstrual cycle

The menstrual cycle is regulated by the hormones from the hypothalamus, pituitary and ovaries. The hypothalamus releases gonadotropin releasing hormone which stimulates the synthesis and release of gonadotropins, FSH and LH. Increase FSH helps in the development of ovarian follicles and stimulates the secretion of oestrogen from ovarian follicles. Increase oestrogen levels causes the changes in the proliferative phase. Serum oestrogen levels become peak at about 12 to 13th day. (oestrogen surge) which has a positive feedback on the hypothalamus resulting in increased gonadotropin releasing hormone. This in turn induces a burst of LH secretion (LH surge) from the anterior pituitary which is the cause of rupture of mature graffian follicles to cause ovulation. After ovulation serum LH and FSH decreases in concentration.

The corpus luteum formed from the ruptured follicle secretes progesterone. During the secretory phase, the serum progesterone and oestrogen level rises which reduces the secretion of FSH and LH from the anterior pituitary. Progesterone causes the main changes during secretory phase. If pregnancy occurs, corpus luteum persists and continues to secrete progesterone and oestrogen. But if fertilization does not occur, the corpus luteum regresses into corpus albicans and serum oestrogen and progesterone level decreases which causes the menstrual bleeding.

MENSTRUAL

DISORDERS

1. Amenorrhoea – is the absence of menstruation which may be primary or secondary. PRIMARY amenorrhoea is the condition where menstruation fails to begin by the age of 16 years. Secondary amenorrhoea is the amenorrhoea in a woman after menstruation has been established. (cryptomenorrhoea is where menstrual bleeding occurs but remains concealed due to vaginal occlusion by a congenital septum or atresia)

Amenorrhoea can also be classified as physiological and pathological.

Physiological amenorrhoea

1. Amenorrhoea before puberty
2. Amenorrhoea during pregnancy
3. During lactation
4. After menopause

Pathological Amenorrhoea

A. Defects in the genital tract

1. Vaginal atresia
2. Imperforate hymen
3. Transverse vaginal septum
4. Cervical atresia
5. Genital tuberculosis
6. Ashermann's syndrome (amenorrhoea secondary to the trauma of the endometrium due to vigorous curettage during procedures like abortion and MTP).

B. Defects in the ovaries

1. Ovarian dysgenesis
2. PCOD (Stein –Leventhal syndrome)
3. Premature menopause
4. Surgical removal of both ovaries

C. Chromosomal defects

- Turner's syndrome

D. Pituitary disorders

1. Pituitary tumors
2. Pituitary infantilism
3. Hyper prolactinoma

4. Sheehan's syndrome (post partal pituitary necrosis due to thrombosis of pituitary blood vessels following post partum haemorrhage)
- E. Gonadotropin releasing hormone deficiency causes hypothalamic amenorrhoea.
- F. Disorders of adrenal glands
1. Adrenogenital syndrome (caused by a tumor or hyperplasia of adrenal cortex resulting in excessive androgen production.)
 2. Cushing's syndrome (Cortico steroid hormones are in excess which causes osteoporosis, hirsutism, obesity and amenorrhoea.
 3. Addison's disease.
- G. Thyroid disorders
- H. Nutritional factors
1. Starvation,
 2. Extreme obesity
 3. Anorexia nervosa
- I. Drugs
1. Oral contraceptives
 2. Prostaglandin inhibitors

Management: Depends upon the underlying causes

DYSMENORRHOEA

It is the painful menstruation incapacitating the women in day today activities.

1. Spasmodic dysmenorrhoea (primary dysmenorrhoea)

here there is no identifiable pelvic pathology. May be due to cervical obstruction, psychological factors like low pain threshold, endocrine factors like low progesterone level, intrauterine contraceptive devices and muscular spasms. The pain begins a few hours before or just after the onset of menstruation may last upto 12 hours and accompanied by constitutional symptoms like chills nausea, vomiting and fainting.

2. Congestive dysmenorrhoea (secondary dysmenorrhoea)

Causes:

1. Uterine fibroid
2. Chocolate cyst of ovary
3. Pelvic endometriosis
4. Adenomyosis

5. PID
6. Salpingoophritis

Here the pain starts 3 to 5 days before menstruation and is relieved by the flow..

3. Membraneous dysmenorrhoea

It is a variety of primary dysmenorrhoea characterized by shedding of large endometrial casts during menses.

PMT

It is a condition where women suffer from excessive premenstrual symptoms which are experienced for 7 to 10 days before the onset of menstruation.

Symptoms: Irritability, lassitude, sleepiness, headache, nausea, constipation, frequency of micturition , weight gain, oedema of legs, fullness and tenderness of breast etc. though the exact aetiology is not known, the PMT is said to be due to excess of oestrogen in relation to the progesterone.

MENORRHAGIA

Is excessive menstrual blood loss both in amount and duration.

Pelvic causes:

1. Uterine fibroid
2. Adenomyosis
3. Ovarian tumors
4. Pelvic endometriosis
5. PID
6. Genital TB

Endocrine causes:

1. Hypo and hyper thyroidism
2. General diseases
3. Chronic HTN
4. CCF
5. Leukaemia and purpureas
6. Liver dysfunction

IUCD (Intra Uterine Contraceptive Devices)

METRORRHAGIA

It is a cyclical intermenstrual irregular uterine bleeding.

Causes:

1. Uterine fibroid
2. Uterine polyps
3. Ca cervix
4. Ca endometrium
5. Cervical erosion
6. Cervical polyp

POLYMENORRHOEA

(EPIMENORRHOEA)

It is the frequent menstruation at regular intervals of 2 or 3 weeks due to the shortening of the cycle. If it is associated with prolonged bleeding, it is called Epimenorrhagia.

Dysfunctional Uterine Bleeding : This is abnormal uterine bleeding where no organic cause can be detected and occur at any age between menarche and menopause.

Metropathica haemorrhagica- it is irregular anovulatory prolonged bleeding which may last for many weeks and is painless due to the failure of ovarian response to gonadotropins.

VAGINAL DISCHARGE

A. Physiological :

In healthy women the vagina contains a small amount of watery secretion which contains mucus, desquamated epithelial cells, Döderlein's bacilli and lactic acid. It is usually colorless.

B. Pathological"

To investigate the pathology behind the vaginal discharge, it is necessary to know the colour, quantity, duration of time it has been present, smell, irritating or not and if it is blood stained or not. An irritating discharge may be due to infection by the trichomonas vaginalis or candida albicans. Yellow discharge may be due to bacterial infections, infected cervical polyp or erosion, acute gonorrhoea, puerperal sepsis or pyometra. Offensive vaginal discharge is characteristic of necrotic lesion of genital tract, carcinoma of vagina, foreign bodies retained in the vagina. Blood stained discharges occur with oestrogen deficiency, carcinoma of cervix, any ulcerated lesions and in intra uterine pregnancies.

INFERTILITY

Is defined as failure to conceive even after one year of regular unprotected intercourse. (Sterility is an absolute state of inability to conceive whereas infertility is only a relative state)

Infertility can be primary and secondary.

Causes of infertility

Faults in the Male

1. Defective spermatogenesis
2. Obstruction in the efferent duct
3. Sperm motility
4. Failure in depositing the sperm.

Faults in the Female:

1. Vaginal factors
2. Vaginal atresia
3. Narrow introitus
4. Transverse vaginal septum
5. Vaginal stenosis
6. Vaginismus

2. Cervical factors

1. Elongation of cervical canal
2. Obstruction of cervical canal
3. Uterine prolapse
4. Thick cervical mucus
5. Chronic cervicitis
6. Presence of antisperm antibody in cervical mucus

3. UTERINE FACTORS

1. Congenital malformations of uterus
2. Uterine fibroid
3. Adenomyosis
4. Uterine tuberculosis

Tubal factors

1. Tubal occlusion
2. Tubal adhesions
3. Loss of cilia
4. Congenital tubal defects
5. Tuberculosis
6. Salpingitis

6. Ovarian factors

- Anovulatory cycles
- Ovarian tumors

- PCOD

7. Endocrinal factors

1. Thyroid disturbances
2. Hypogonadotrophism
3. Corpus luteum insufficiency
4. Hyperprolactinaemia

INVESTIGATIONS OF INFERTILITY

MALE

1. Local examinations of genitals
2. Semen analysis
3. Serum hormone levels
4. Testicular biopsy
5. Chromosomal test
6. Immunological test

FEMALE

1. Detailed history taking
2. General systemic and gynaecological examinations
3. Special investigations to assess tubal, cervical, peritoneal and ovarian functions.

URINARY PROBLEMS IN GYNAECOLOGY

Retention of Urine:- the condition where urine collects in the urinary bladder but fails to be voided out leading to stasis of urine in the bladder.

Causes:

1. Postoperative retention : it may be due to oedema, reflex spasm of bladder sphincter, or denervation of bladder.
2. Obstructive conditions like stenosis, cancer of bladder neck retention during Puerperal period.
3. Pelvic tumors
4. Retroverted gravid uterus

DYSURIA

Causes:

1. Cystitis
2. Urethritis

3. Urethral caruncle
4. Carcinoma of urethral meatus
5. Trauma to the urethra
6. Postoperative
7. Vesical calculi
8. Following catheterization
9. Radiation cystitis

INCREASED FREQUENCY OF MICTURITION
Causes:

1. Cystitis
2. Pregnancy
3. Ca Cervix or Vagina
4. Trauma during catheterization
5. Diabetes

STRESS INCONTINENCE
It is the involuntary escape of urine when there is sudden increase in the Intraabdominal pressure

Causes:

1. Incompetent urinary sphincter
2. Post menopausal atrophy
3. Lowered urethral pressure
4. Neurological causes
5. Trauma to the pelvic floor

URGE INCONTINENCE : In this condition , the women experience a sudden desire to pass urine which is unable to control.

Causes

1. Cystitis
2. Trigonitis
3. Bladder stone or foreign body
4. Pelvic tumor
5. Neurological causes

UTI : It is more common in female because of the shorter urethra, proximity of the external urethral meatus to the vaginal and anal openings, sexual intercourse, stasis or urine during pregnancy and perurperium.

e-coli is the most common causative agent

UTERINE

FIBROIDS (FIBROMYOMA/LEIOMYOMA)

Causes:

Exact aetiology is not known. But there is substantial evidence that oestrogen plays an important role in myomas.

Types:

1. Intra mural fibroid (interstitial)
2. Subserous fibroid
3. Submucous fibroid

Clinical

features

Majority are asymptomatic. Symptoms may depend upon the size of the tumor. Abdominal lump. Pressure symptoms, pain, menstrual abnormalities and infertility may be the presenting features.

Diseases of the New born RDS (Respiratory Distress Syndrome)

Aetiology : the basic abnormality is deficiency in pulmonary surfactant. In the absence of surfactant, the surface tension increases and alveoli collapse during expiration.

RDS appears within 6 hours of life characterized by tachypnoea, chest retraction and cyanosis.

Diagnosis can be confirmed by X-ray which shows ground glass mottling.

Meconium aspiration Syndrome

Meconium aspiration causes chemical pneumonitis or blockage of various airways. This is common in small for date and post mature babies. They develop respiratory distress in the first 24 hours of life.

HAEMOLYTIC DISEASE OF THE NEWBORN

The disease is characterized by excessive haemolysis of the foetal RBC. It is mostly due to incompatibility of the foetal and maternal blood groups. They include Rh incompatibility, ABO group incompatibility and other antigen incompatibilities.

CARCINOMAS

1. Ca of Female Genital Organs
2. Ca of Vulva
3. Ca of vulva contributes about 4.8% of total carcinomas of female genital organs. 3 clinical types are there
4. The cauliflower growth, the flat indurations and the excavated ulcer. Pruritus is a very common complaint. Diagnosis is made by lump, pruritus and cytology.

5. Carcinoma Vagina
6. It contributes about 1.9% of all genital carcinomas. Usually seen in the upper 1/3rd of the posterior vaginal wall as cauliflower growth or indurated ulcer.
7. Symptoms are pain, bleeding after coitus and later blood stained offensive discharge.

Ca

Cervix

It is the most frequent of all genital tract cancers (about 30%). Occurs frequently in multiparous women. Average age incidence is between 39 and 57. usually presents as cauliflower like growths or excavated ulcers which causes profuse bleeding on even slightest touch. The four main symptoms of Ca Cervix are

1. haemorrhage
2. discharge
3. cachexia
4. pain.

Ca fallopian tube : This is the rarest type of gynaecological cancer and can be managed by means of radical surgery.

Ovarian carcinoma : This is extremely common and usually metastatic. (Krukenberg tumor- these are bilateral ovarian tumors which have smooth and slightly bossed surfaces and are freely movable in the pelvis.). Ovarian carcinomas usually present with pain and tender swelling.

MEDICAL TERMINATION OF PREGNANCY (ABORTION ACT OF 1967)

According to abortion act of 1967, the circumstances in which abortion may be carried out are as follows.

1. two registered medical practitioners must form in good faith about the abortion.(section 1(1))
2. the continuance of pregnancy would involve risk to the pregnant woman (section 1 (1-a))
3. if cause injury to the physical or mental health of the pregnant woman (section 1 (1-a))
4. if it would cause injury to the physical or mental health of any existing children of the pregnant woman's family. (section 1 (1-a))
5. the child that is to be born would suffer from severe physical or mental abnormalities. (section 1(1-b))

Consent: A written consent of the patient should be obtained before conducting the MTP. If the patient is an unmarried girl between the ages of 16to18, the patient consent is a must rather than the parent's consent.

If the patient is under 16, her parents should always be consulted even if the patient forbids it. Still if the patient's consent is not obtained MTP should not be carried out.

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Endometriosis

Is the presence of ectopic endometrium in any situation other than its normal location. Endometriosis is confirmed when

1. Lining epithelium resembles, should have typical endometrial stroma, should respond to oestrogen, the contents of endometrial glands is dark altered tarry blood
2. The disease is one adult sexual life- peak 30-40 years of age
3. Divided into internal endometriosis or adenomyosis or external endometriosis .eg. ovaries , uterosacral ligament, abdominal scars, umbilicus, bladder etc

Symptoms of adenomyosis

- Menorrhagia in fairly high degree
- Infertility

- Large uterus
- Feeling of weight in the pelvis

CYSTS OF THE OVARIES

1. Chocolate cyst of the ovaries – the important site of extra uterine endometriosis, affected ovary enlarge, outer surface white and thickened. Ovary and fallopian tubes prolapsed and fixed to the pelvis. Rupture is common with chocolate sauce like blood as content.

Symptoms-

1. Pain
 2. Dysmenorrhoea
 3. Dyspareunia
 4. Infertility
 5. Bowel and bladder symptoms
2. Retention cyst of graffian follicle – In case of excess hCG
 3. Follicular cyst – Regarded as pathological if it is more than one inch diameter.

SCLEROCYSTIC DISEASES OF OVARY (PCOD) Stein-leventhal syndrome
Virilising syndrome in young women characterized with infertility obesity hirsutism and acne

Krukenberg tumour: May be primary or secondary . invariably bilateral. Smooth bossed surface with additions.

Clinical features- abdominal swelling pain , alteration in menstrual cycle, ascites, post menopausal bleeding, fixity indicated malignancy.

ABORTION

Classification-

1. degree
 - threatened
 - inevitable
 - incomplete
 - complete
 - missed
2. cause
 - spontaneous
 - habitual

- criminal- legal and illegal

3. infections

- septic
- non septic

Abortion may occur due to

1. abnormalities of foetus
2. abnormalities of placental membrane e.g. hydatidiform mole
3. disease of the mother. E.g. measles, cholera, syphilis,
4. chronic disease like HTN, nephritis
5. local abnormalities in mother.e.g. cervical incompetence, genital hyperplasia
6. drugs
7. endocrine factors
8. psychiatric disturbance
9. faults in the male like low quality sperm

HYDATIDIFORM MOLE (vesicular mole)
Chorionic villi distended with fluid forming translucent vesicles . usually abortion may occur between 4-6th month.

Symptoms- abdominal pain, vaginal bleeding or watery dirty discharge. Complication may follow as haemorrhage, sepsis, perforations ,chorione epithelioma which is pre malignant.

PROLAPSE UTERUS
Normal position of uterus is one of universal anteversion and antifixion with body of the uterus tilted forward.

- First degree prolapse descent of cervix in vagina
- Second degree to the introitus
- Third degree – out side the introitus
- Fourth degree or procidentia – uterus completely out side

ASPHYXIA NEONATORUM
Here heart continues to beat but respiration not established. Diagnosed by APGAR Scoring carried out every one and five minute after birth.

APGAR scoring

1. heart rate
2. respiratory effort
3. muscle tone

4. reflex irritability
5. pallor of the skin

cephal haematoma- may not present in birth but develop within two to three days. Limited by a suture to a particular bone. Soft and elastic. Does not pit on pressure. Gradually increases in size and takes week or months to disappear.

Caput succidenum present at birth not well circumscribed . maximum at birth and gets smaller.

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Questions

1. ————— type pelvis is the type with accepted with female sex characteristics

2. The uterus grows out of the pelvis by _____ week
3. Alphafoeto proteins are synthesized in the _____ and _____ .
4. The bluish discolouration of the vagina during pregnancy is called _____ .
5. Hegar's sign is _____
6. The soft murmur heard rarely synchronous with the foetal heart beat is called _____
7. Aschheim and zondek test detects _____
8. The retention of menstrual fluid in the cavity of uterus leads to _____
9. The most common presentation of the foetus is _____
10. Puerperium is a period following the delivery lasting up to _____
11. Elderly primi is a woman above _____ years of age
12. Vagina is lined by _____ epithelium
13. Vaginal pH is acidic due to the presence of _____
14. Commonest malignancy in women in india is _____
15. Quickening appears at _____ weeks
16. The most common cause of postpartum haemorrhage is _____
17. The weight of non pregnant uterus is _____
18. The involution of uterus is completed by _____ days
19. Other than pre-eclampsic symptoms, eclampsia is characterized by _____
20. The disease due to cystic degeneration of chorionic villi is _____
21. The normal amount of liquor amni at term is _____
22. _____ is the placenta in which the cord is attached to the margin of the placenta.
23. The normal length of the umbilical cord is _____
24. False knots in the umbilical cord are the result of local increase of the _____
25. A woman is said to be habitual aborter if she has undergone _____ consecutive abortions
26. The overlapping of skull bone seen in the x-ray in intrauterine death of foetus is called _____ sign
27. The most common site of ectopic pregnancy is _____
28. The most common form of multiple pregnancy is _____
29. Excessive traction in the delivery of the shoulder results in _____
30. The characteristic oedema in the haemolytic disease of the new born is called _____
31. 'Islands of bones in a sea of membranes' is a particular feature of _____
32. Umbilical cord contains _____ arteries and _____ veins
33. The best speculum for pelvic examination is _____ .
34. The glands of both sexes present in the same individual is called _____
35. The condition , in which the urethra opens below the phallus is _____
36. In turner's syndrome the nucleus has _____ chromosomes
37. Cyclic recurrent ulceration of vulva and mouth with uveitis is called _____
38. Mittelschmers refers to _____

39. The usual position of uterus is _____ and _____
40. The commonest type of fibroid uterus is _____
41. Sharp dorsiflexion of the foot which elicit pain in deep phlebothrombosis is called—
—
42. A baby weighing less than _____ gms at birth is classed as premature according to the international standards
43. 'Phlegmasia alba dolans' is usually associated with _____
44. Snuffles in infants is an important and early sign of _____
45. Formation of an opaque tissue behind the lens of the eyes, a few months after birth especially in premature babies is called_____
46. The normal foetal heart rate is _____
47. The commonest reason for post partem mortality is _____
48. The basic cause of placenta accrete is _____
49. The bimanual examination done to assess the cephalopelvic disproportion is called—
50. The study of nature pf uterine contraction is called _____
51. The most common maternal disease which is associated with hydramnios is _____
52. The colostrums is rich in immunoglobulin _____
53. The most common type of episiotomy applied is _____
54. In cephalic presentation maximum intensity of foetal heart sound is heard _____
55. It is estimated that the mature milk flow is about _____ ml/day
56. The diameter of engagement in a vertex presentation is _____
57. Mac Donald's rule calculates the EDC from calculating the _____
58. Calculate the EDC by Nagetes rule- LMP July 17th
59. In a nulliparous woman the external os of the uterus is _____
60. Active foetal movements are felt during _____ trimester of pregnancy
61. The normal ph of vagina during reproductive period is _____
62. The pouch of peritoneum which separates the bladder from the uterus is _____
63. After ovulation, the ruptured follicle develops in to _____
64. The hormone liberated by graffian follicle is _____
65. Corpus luteum secretes the hormone _____
66. The menstrual blood does not clot, though it contains calcium, because it does not contain —
67. Excessive menstrual loss with preservation of the normal cycle is _____
68. In turner's syndrome the chromosome structure is _____
69. Hyperplasia of adrenal cortex leads to _____
70. A frothy discharge from vagina is the indication of _____
71. The basophil adenoma of the anterior pituitary leads to _____
72. The most frequent type of all genital tract cancer is _____
73. Complete prolapse of the uterus is called_____

74. Relaxin secreted by the —————

75. Presence of ecto endometrium in any site outside normal location is —————

Answers

1. Gynaecoid type
2. 12th week
3. foetal liver and yolk sac
4. Chadwick sign
5. Softening and
6. funic soufflé
7. HCG
8. Haematoma
9. Vertex
10. 6-8 weeks
11. 40 years
12. simple squamous
13. Doderlein's bacilli
14. Carcinoma breast
15. 16th week
16. Uterine atony
17. 50 gms
18. 12 days
19. Convulsions
20. Hydatidiform mole
21. 100 ml
22. Battle dore placenta

23. 50-60 cm
24. Wharton's jelly
25. 3 or more
26. Splading's sign
27. Tubal
28. Twin pregnancy
29. Erb's palsy
30. Hydrops foetalis
31. Hydrocephalus
32. 2 arteries and 1 vein
33. Bivalve speculum of cusco
34. True hermaphroditism
35. Hypospadiasis
36. 45 chromosomes
37. Behcet's syndrome
38. Ovulation pain
39. Anteversion and anteflexion
40. Intramural
41. Homan's sign
42. 2500 gms
43. Thromobophlebitis
44. Congenital syphillis
45. Retrocentral fibroplasias
46. 150/minute
47. Shock

48. Decidual deficiency
49. Munro – Kerr-Muller method
50. Tocography
51. Diabetes mellitus
52. A
53. Mediolateral
54. Below the umbilicus
55. 850 ml/day
56. Suboccipito bregmatic presentation
57. height of the fundus
58. April 24
59. Circular
60. Last / Third
61. 4.5
62. Uterovesical pouch
63. Corpus luteum
64. Oestrogen
65. Progesterone
66. Prothrombin
67. Menorrhagia
68. 44+ X0
69. Adernogenital syndrome
70. Trichomoniasis
71. Cushing's disease
72. Ca Cervix

73. Procidencia

74. Ovaries

75. Endometriosis