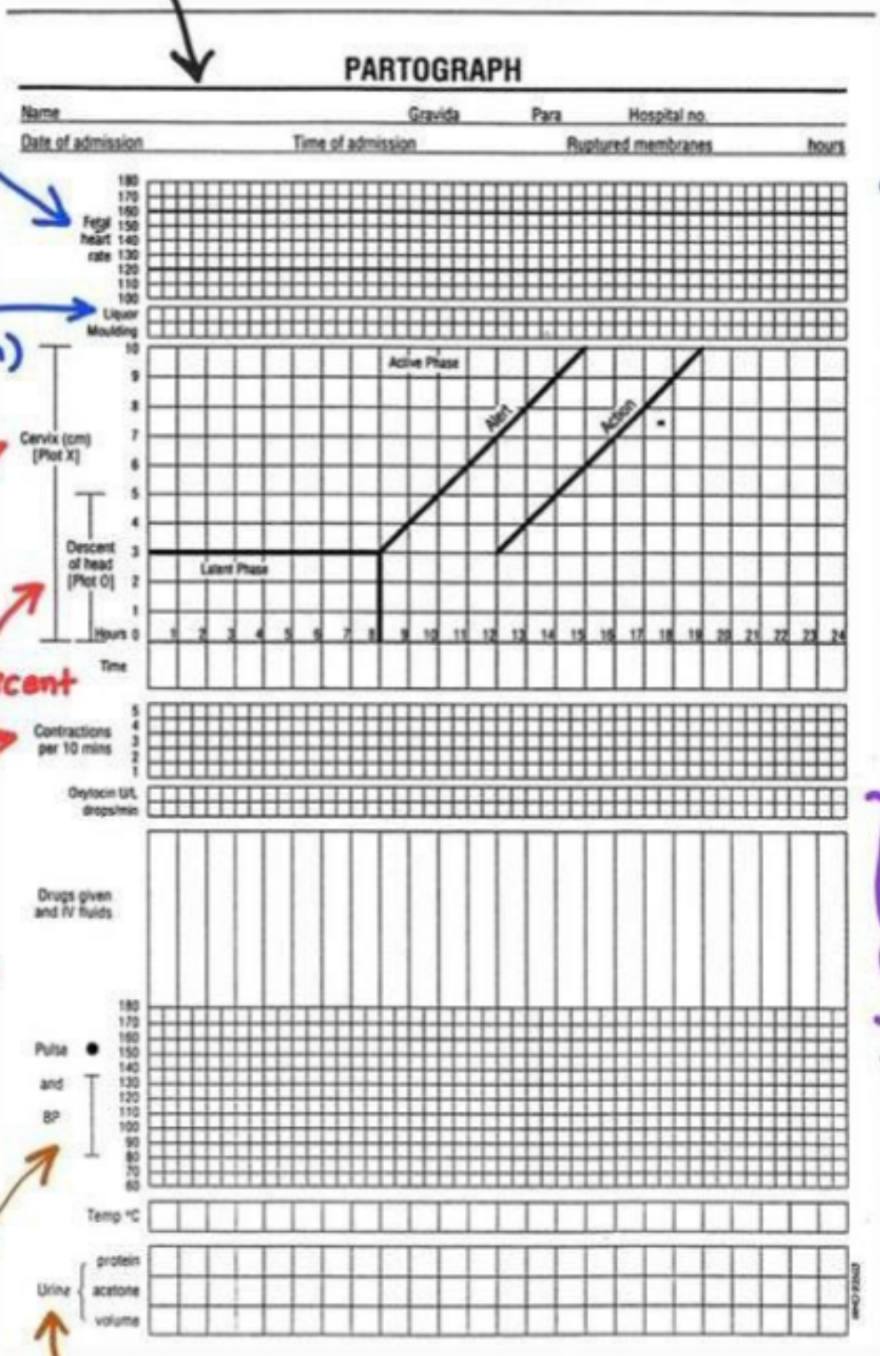
Partogram

مربع كبير = مربعين صغار

كل مربع كبير يمثل ساعة

كل مربع صغير يمثل نصف ساعة

① Name & I/C
② Gravida Para
③ Date of admission
④ Time of rupture membrane
⑤ Antenatal care
⑥ Height, weight, BMI, TWC, Hb, Plt



mother's ① information

fetal ② well-being

labour ③ progress

④ medication
- IV Pitocin
- IV hydration 100 cc NS/hourly
- analgesic

⑤ maternal well-being

FHR

membrane intact (I)

liquor clear (C)

meconium stained (M)

latent (0-3)

active (4-10)

X - dilatation

O - descent

assess the frequency & duration

1 □ = 1 contraction in 10 min

< 20s

20-40s

> 40s

SYS

BP

DIA

Pulse

urine analysis by dipstick

GDM — glucose (nil or +)

HPT — albumin (nil or +)

nabil azhar

★ Partograph : A graphical record of the progress of labor, maternal condition & fetal well-being during the active 1st stage of labor.

★ Helps in → early detection of abnormal labor (prolonged, obstructed)

★ Record :

① **Record foetal condition including:**
- Foetal heart beat rate
- Moulding of the foetal head
- Condition of amniotic fluid

② **Record maternal condition:**
- Pulse and blood pressure
- Body temperature
- Urine (quantity, presence of protein and acetone)
- Drugs administered including Oxytocin.
- IV fluids.

③ **Record progress of labor:**

- Cervical dilatation
- Descent of the head
- Uterine contractions:

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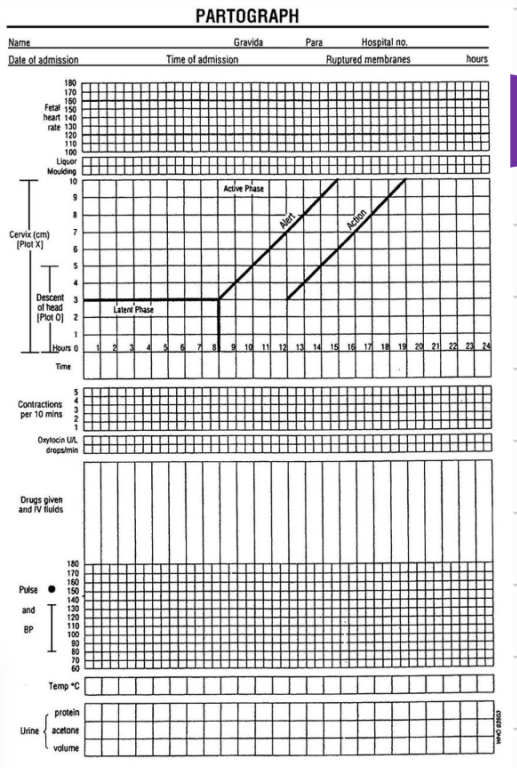
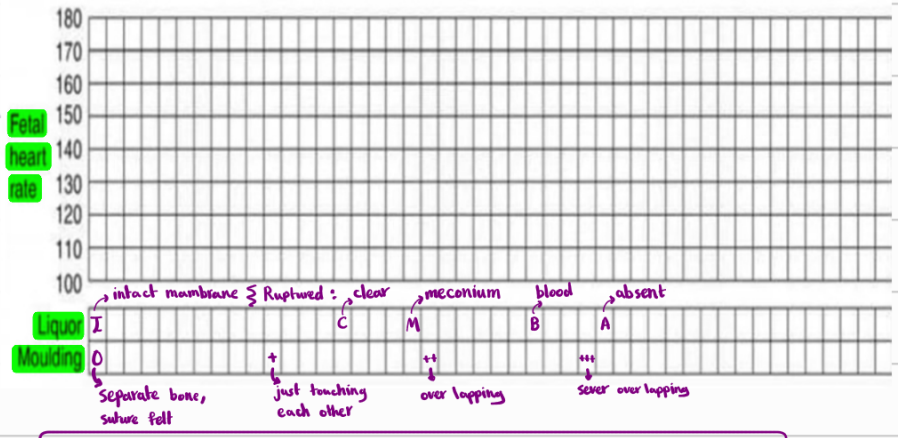
* Abdominal Examination Finding : ① Fetal heart rate
② Descend of the head
③ Contractions

* Vaginal Examination Finding : ① Cervical dilatation
② Moulding
③ Liqour
④ Station

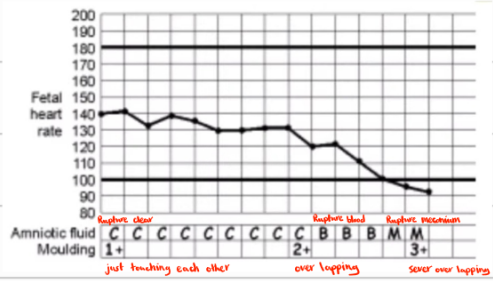
① Fetal Condition :

كل مربع يمثل نصف ساعة





Example



* يتم قياس FHR كل نصف ساعة بعد الـ Contractions

* لو كانت high risk pregnant أو كان فيه fetal distress بنعمل continuous auscultation by CTG

1. **Fetal heart;**

   It is taken 1/2 hourly unless there is need to check frequently i.e. if abnormal every 15 minutes and if it remains abnormal over 3 observations, take action. The normal fetal heart rate is 110-160b/m. below 110b/m or above 160b/m indicates fetal distress.

2. **Molding;**

   This is felt on VE. It is charted according to grades.

   State of moulding Record

   Absence of moulding. (-)

   Bones are separate and sutures felt (0) (no molding)

   Bones are just touching each other (+)

   Bone are over lapping but can be Separated (++)

   Bones are over lapping but cannot be separated (+++) ⟸ Intra cranial hemmorrhage

   * لو الـ fetal وصل لنهاية المرحلة ممكن يجيب عنده ⟵

3. **Liquor amnii;** by pelvic exam

   This is observed when membranes are raptured artificially or spontaneously.

   It has different colour with different meaning and meconium stained liquor has grades.

   State of liquor Record

   liquor clear record as "C"

   meconiun stained liquor "M"

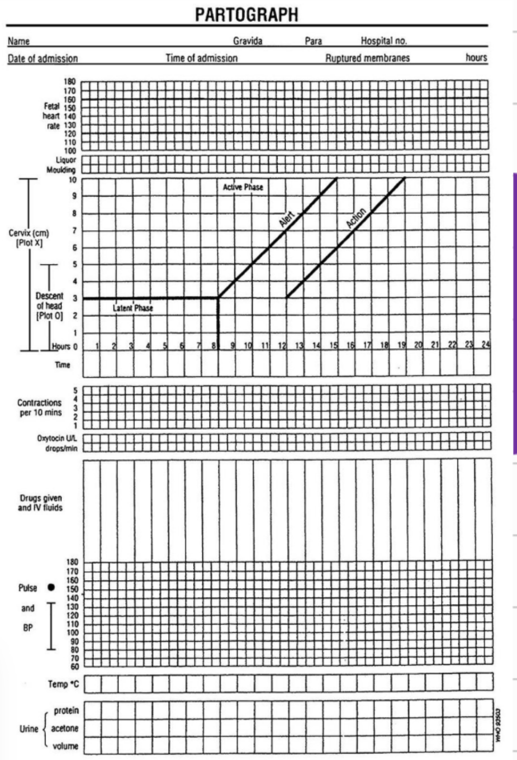
   liquor absent record as "A"

   Blood stained liquor "B"

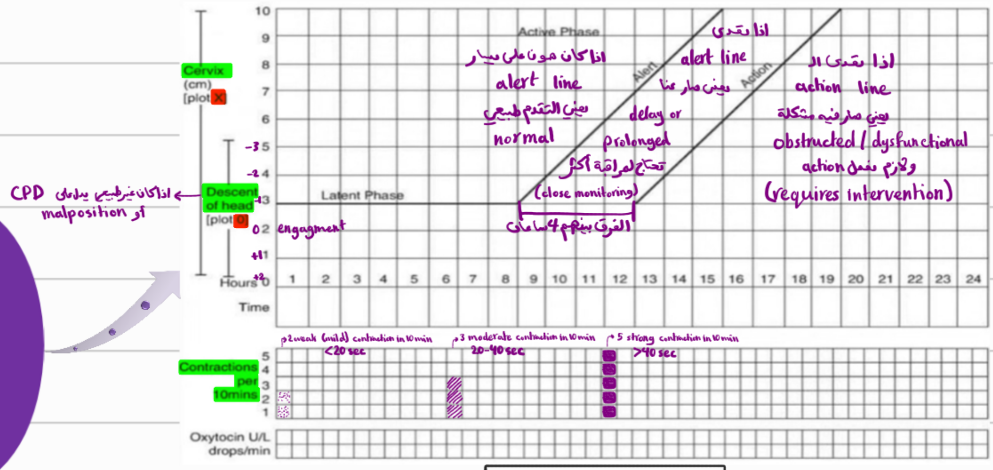
4. **Membranes;State of membranes** Record

- Membranes intact (I) ⟵ بنكتبها بالمربع
- Membranes raptured (R) ⟵ مابنكتبها بالمربع ⟵ بنكتب B, A, M, C

② Progress of Labor :



كل مربع يمثل ساعة



كل مربع يمثل نصف ساعة

(أول قراءة في active phase نفسها آخر قراءة في latent phase (بنعمل shift))

5. Cervical dilatation, على الجدول بطلع طلوع

The dilatation of the cervix is plotted with an "X". Vaginal examination is done at admission and once in 4 hours. Usually we start recording on a partograph at 4cm.

Alert line starts at 4cm of cervical dilation to a point of expected full dilatation at a rate of 1cm per hour

Action line– parallel and at 4 hours to the right of the alert line.

* Latent phase: dilatation (0-3 cm) for 8 hours
* نبدأ partograph بعد الدخول في active phase (≥4cm)
* Multipara → dilation increase 1.5cm/hour
* Primigravida → dilation increase 1.2 cm/hour

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6. Descent of presenting part. على الجدول بنزل نزول

Descent is assessed by abdominal palpation. It is measured in terms of fifths above the brim.

The width of five fingers is a guide to the expression in the fifth of the head above the brim.

A head that is ballotable above the brim will accommodate the full width of five fingers.

As the head descends, the portion of the head remaining above the brim will be represented by fewer fingers.

It is generally accepted that the head is engaged when the portion of the head above the brim is represented by 2 or less fingers.

Descent is plotted with an "O" on the graph (دائرة مفرغة)

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7. Uterine contractions This is done ½ hourly for every 30 minutes. The duration, frequency and strength of contraction is observed. Observe the contractions within 10 minutes.

* كل نص ساعة بنسجل ال contractions لمدة 10 دقائق

-Mild contractions last for less than 20 seconds.

-Moderate contractions last for 20-40 seconds.

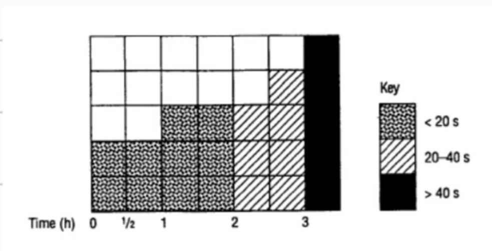
-Strong contractions last for 40 seconds and above.

When plotting and shedding contractions use the following symbols.

Dots for mild contractions

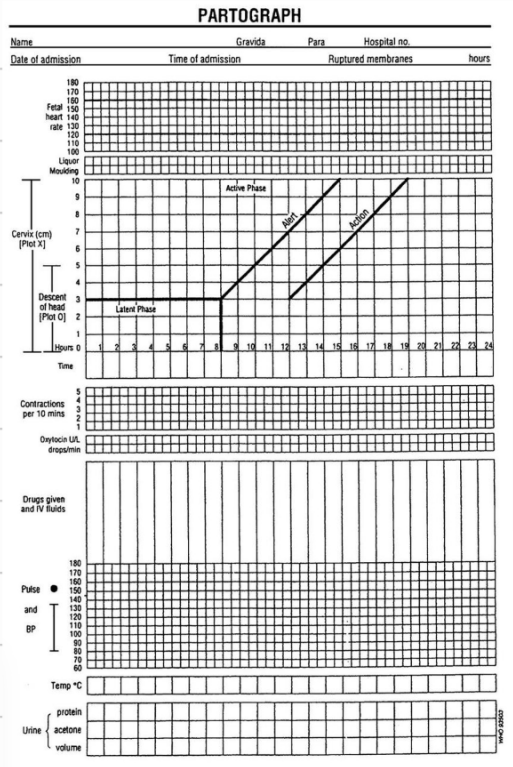
Diagonal lines for moderate contractions

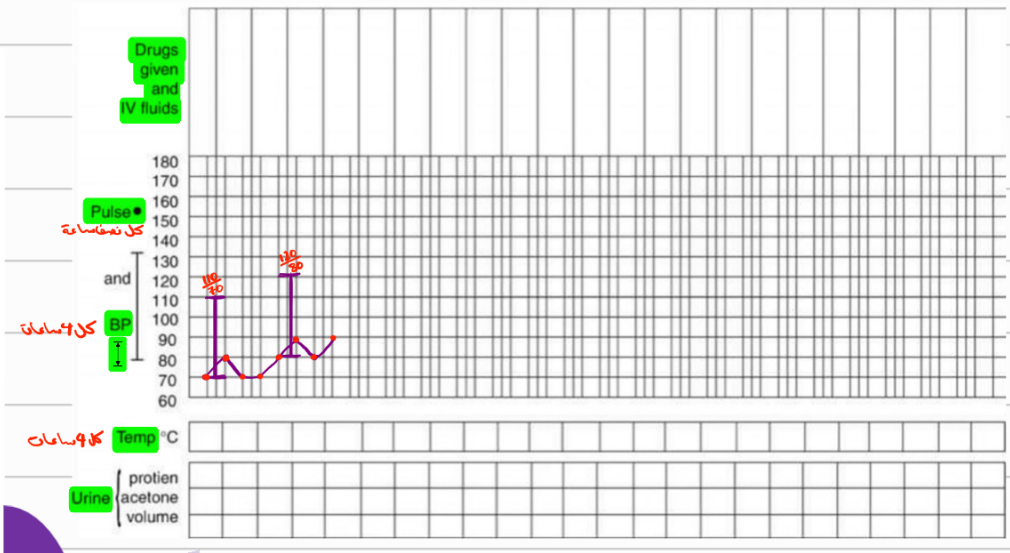
Shade for strong contractions

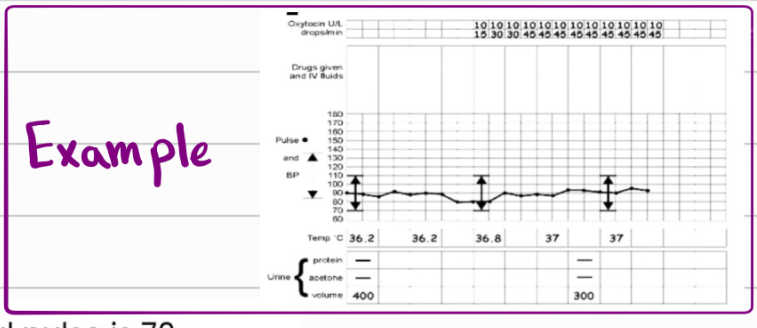


frequency, duration, intensity

③ Maternal Condition :







1. **Pulse**; this is checked every 30 minutes. The normal pulse is 70-90b/min. دائرة ممتلئة

   The raised pulse may indicate maternal distress, infection especially if she had rapture of membranes for 8-12 hours and in case of low pulse, it can be due to collapse of the mother.

2. **Blood pressure**; it is taken 4 hourly. The normal is 90/60-140/90mmHg. Any raise of 30mmHG systolic and 20mmhg diastolic from what is regarded as normal or if repeated over 3 times and remains high, test urine for albumen to rule out pre-eclampsia.

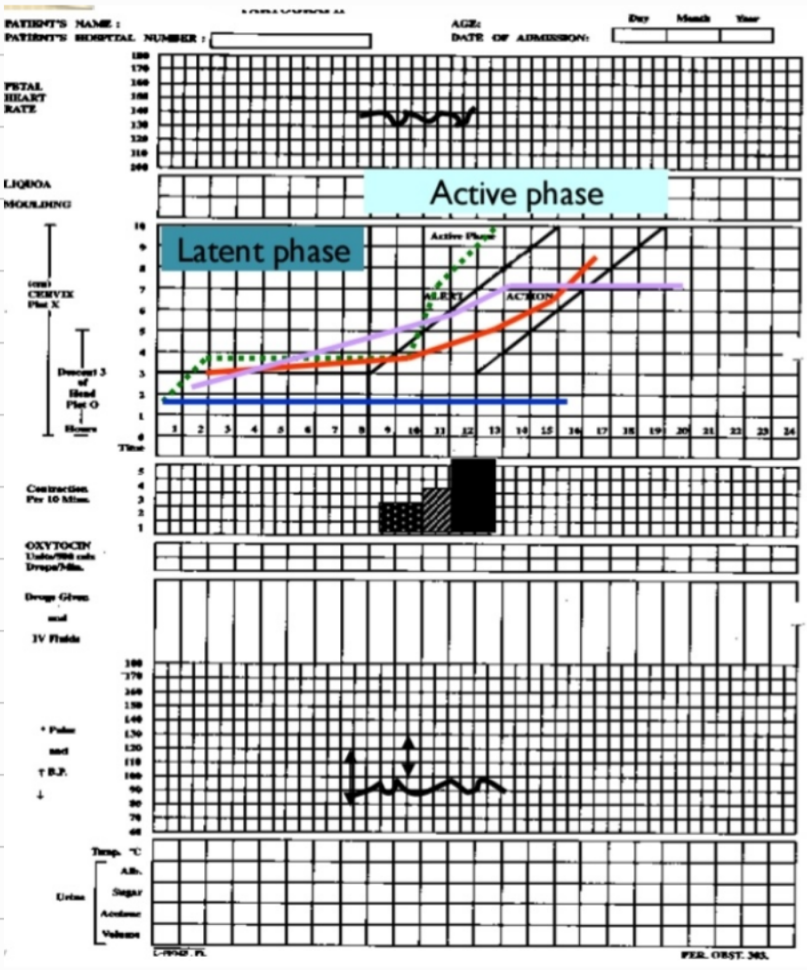
3. **Temperature**; this is taken 4 hourly. The normal range is between 37.2 0 c to 37.5 0 c. Any raise in temperature may be due to infections, dehydration as a sign of maternal distress or if a mother had early rapture of membranes.

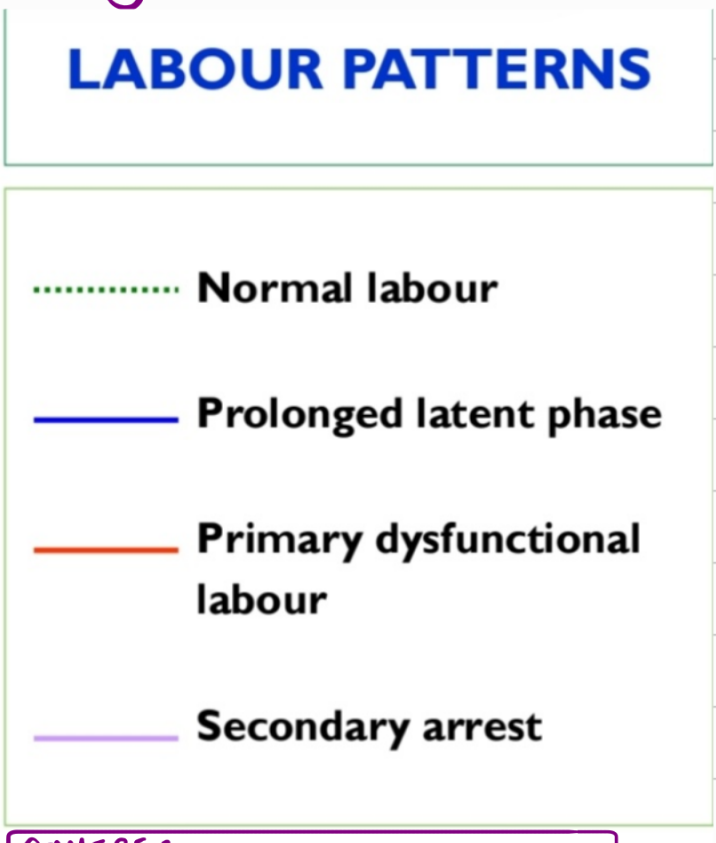
4. **Urine**; the mother should pass urine atleast every after 2 hours and urine should be tested on admission.

   * acetone → Nil or +
   * albumin → Nil or +
   * glucose → Nil or +
   * urine volume

5. **Fluids**; she should be encouraged to take atleast 250-300 mls every 30 minutes. Any type of fluid can be given hot or cold except alcohol. The fluid should be sweetened in order to give her strength.

★ Abnormalities of the Partogram :





Causes :-
① CPD (large head, small pelvis)
② Malposition (occipito-posterior)
③ Malpresentation (face, brow, shoulder)

1 False Labor :-

Finding → ① cervix not dilated ② No/infrequent contractions

Management → discharge from labor

2 Prolonged Latent Phase :-

Finding → latent phase is longer than (20 hours in nullipara, 14 hours in multipara)

Management → analgesia, mobilization, reassurance

3 Primary Dysfunctional Labor :- (Primary Arrest)

Finding → poor progress in the active 1st stage of labor (<2cm dilatation/4 hours)

Management → ROM, Oxytocin

Most common cause → Insufficient uterine contraction

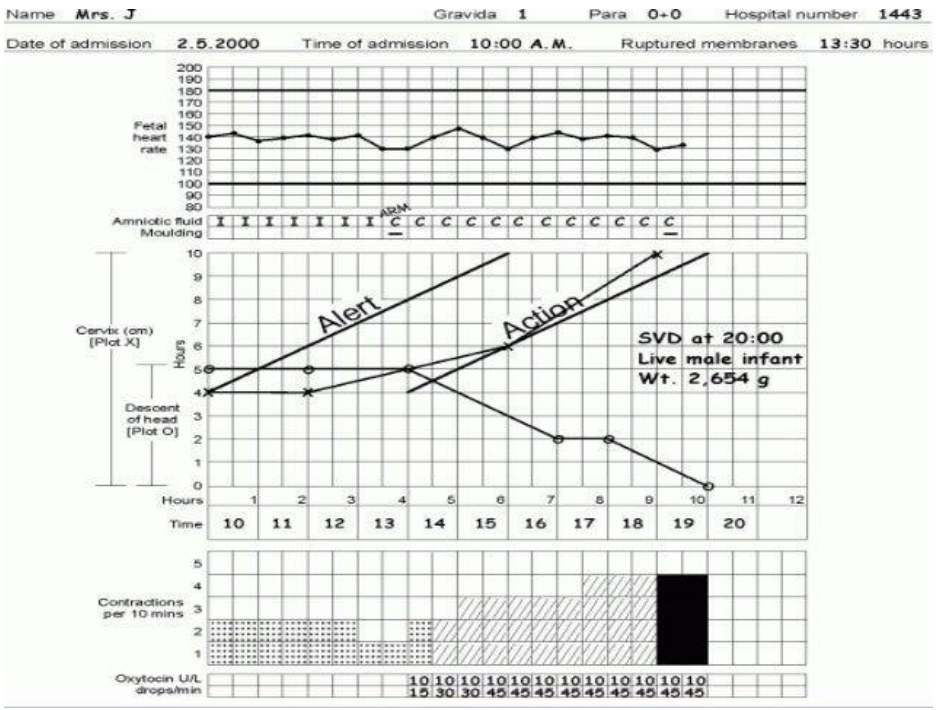
4 Secondary Arrest :-

Finding → when progress in active 1st stage of labor is initially good but then slow or stop (after 7cm dilatation)

Management → exclude CPD & malposition, CS

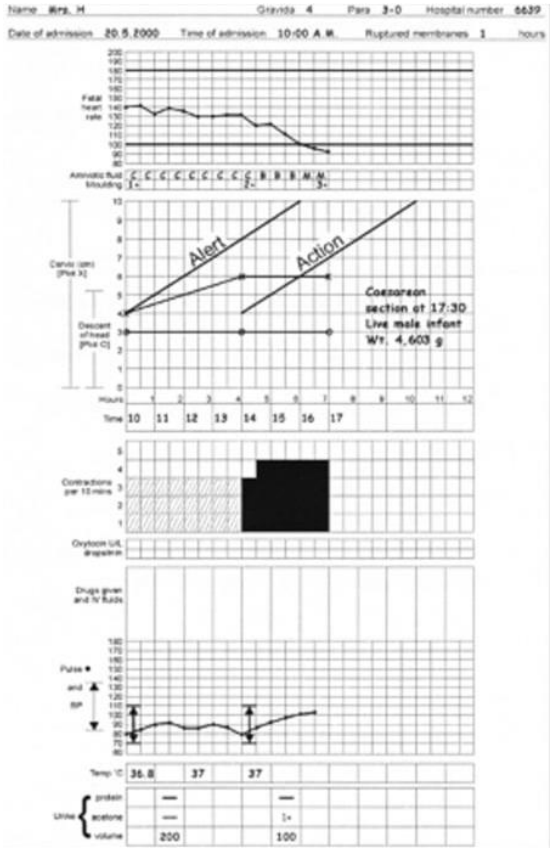
What is your interpretation regarding [redacted] well-being ?

- **Fetal heart rate**
  - FHR is between 130-150 through out labor (reassuring FHR)
- **Character of amniotic fluid**
  - Membranes were ruptured artificial at 4h past admission
  - Liquor is clear
- **Molding of fetal skull**
  - Not recorded



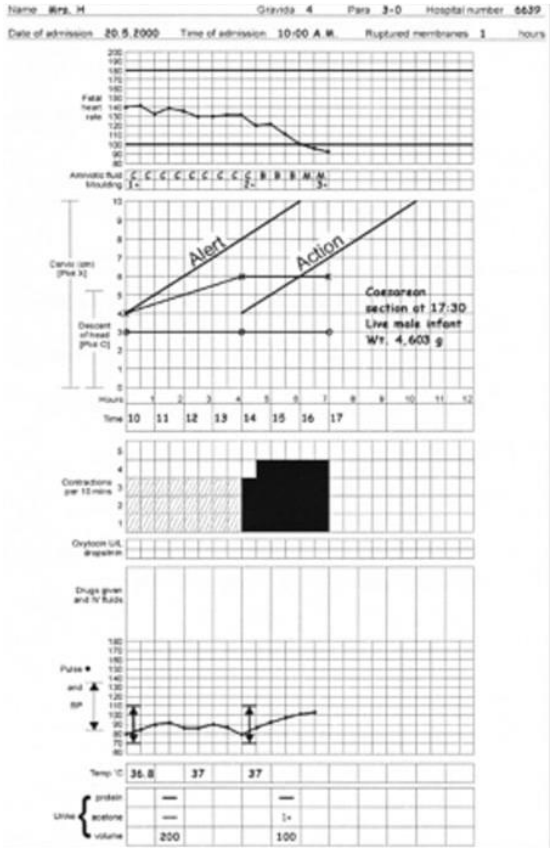
Mini-OSCE Q1

- **At admission, describe the following**:
  - **Dilation**: 4cm
  - **Head descent**: 3/5
  - **Amniotic fluid**: Clear fluid
- **Describe uterine contraction after 2 hours of admission**
  - Moderate
- **When did rupture of membranes happened ?**
  - 1 hour prior to admission



Mini-OSCE Q1 cont.

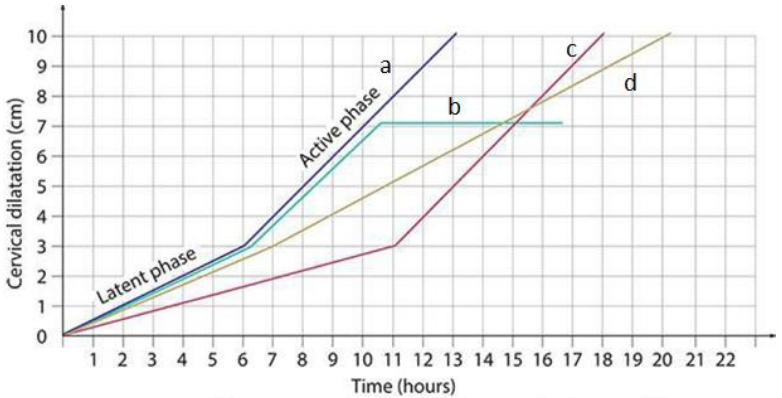
- **What is you interpretation about labor progress ?**
  - Primary dysfunction of labor
- **What points on partogram support your interpretation ?**
  - Cervical dilatation less than 1 cm/h
  - No descent
  - FHR worsening
- **What are the causes ?**
  - Cephalopelvic disproportion (CPD)
  - Malposition or malpresentation



Mini-OSCE Q2

❖**Write what represented in each line ?**

a. Normal labor
b. Secondary arrest
c. Latent phase
d. Primary dysfunction



❖**What is the management of line c ?**

- Simple analgesics, mobilization, reassurance and discharge patient from labor

❖**What is the causes of line b ?**

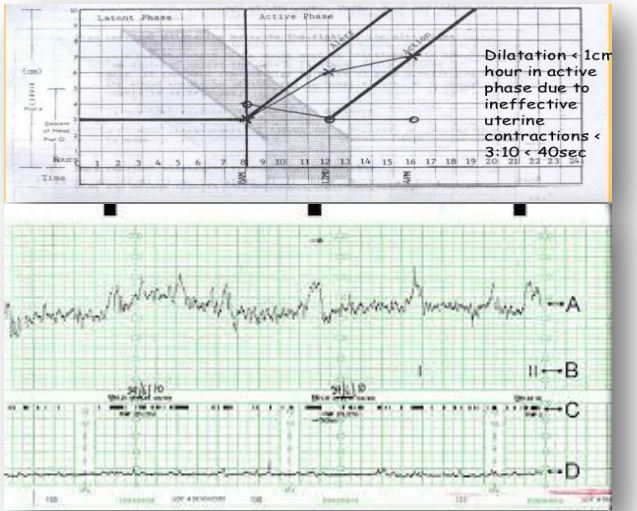
- CPD (most common), inefficient uterine contraction, malposition or presentation

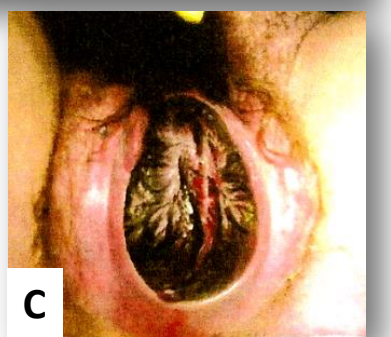
❖**What is the most important things you should look for in the partogram of the patient represented by line b ?**

- Molding, amniotic membrane (liquor), uterine contraction

Mini-OSCE Q3

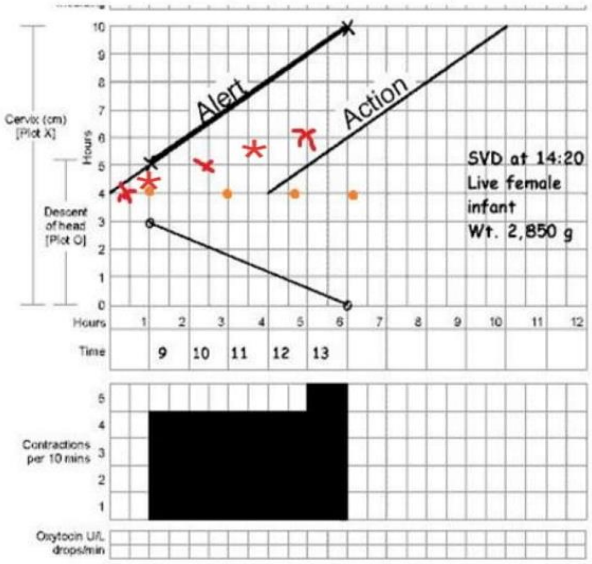
- **Regarding this partogram what is your interpretation ?**
  - Primary dysfunctional labor
- **Describe CTG with explanation**
  - Normal CTG
- **What is the stage according to picture C ?**
  - Extension, Second stage
- **What is your management of picture C ?**
  - Encourage the mother to push down
  - Continue to monitor the mother and fetus
  - Controlled delivery of the head is needed by pushing the hand against the perineum





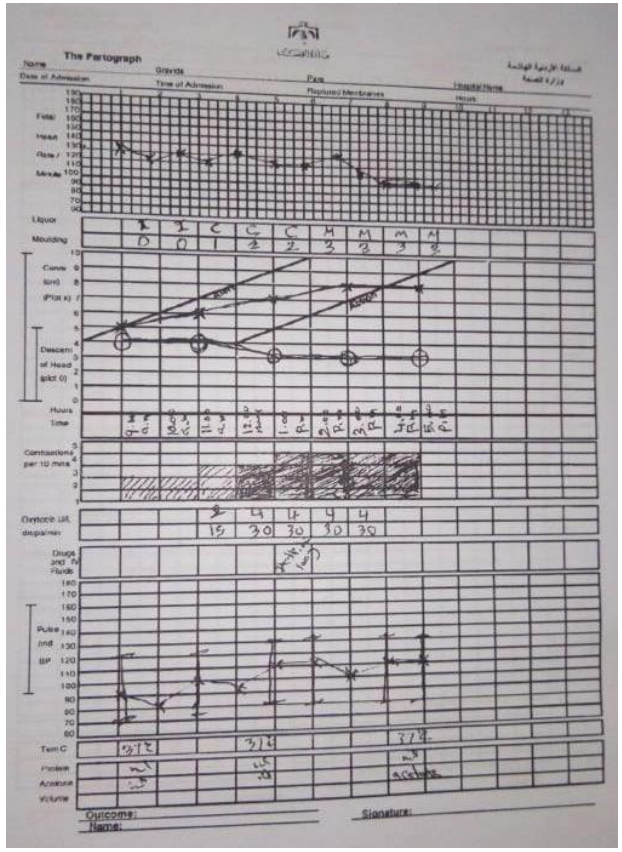
Mini-OSCE Q4

- **At admission, describe the following**:
  - **Dilation**: 4cm
  - **Head descent**: 4/5
- **What is you interpretation about labor progress ?**
  - Primary dysfunction of labor
- **Mention 3 findings from Partogram support your**
  - Cervical dilatation less than 1 cm/h
  - No descent
  - FHR worsening



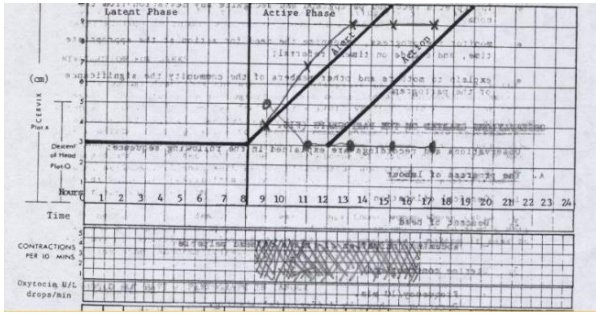
Mini-OSCE Q5

- **What is the examination finding on admission ?**
  - Intact membranes
  - No molding
  - Cervical dilation = 5cm
- **what are the physical findings in vaginal exam at 5 pm that indicate obstructed labor?**
  - Fetal bradycardia
  - Meconium-stained amniotic fluid
  - Severe head molding
  - Arrest of cervical dilation at 8 cm
- **What is the action you would do to the pt now?**
  - Cesarian section

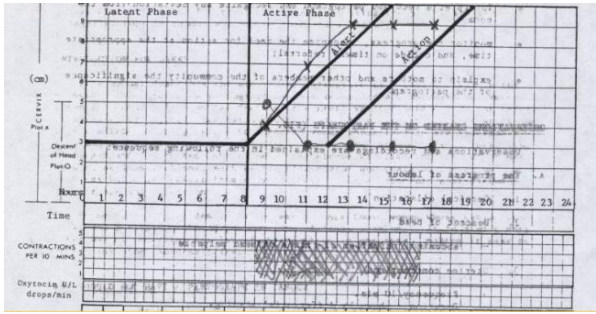


Mini-OSCE Q6

- **Describe the following**:
  - **Dilation at admission** : 4cm
  - **Head descent at admission** : 5/5
  - **Uterine contractions after 3 hr of admission**: 4 moderate contractions
- **How to assess the progress of labor regarding what points ?**
  - Descent, Dilatation, Molding, Uterine contractions
- **What is the name of this problem in the partogram ? And what is the most common cause?**
  - Secondary arrest, Cephalopelvic disproportion
- **What is the management in this situation ?**
  - C/S Delivery



Mini-OSCE Q7



- **What is your diagnosis ?**
  - Secondary arrest
- **What are the causes ?**
  - Cephalopelvic disproportion, malposition, malpresentation insufficient uterine contractions
- **If you came to examine this patient at 6 hours, what do you want to assess ?**
  - Assess the adequacy of the pelvis via clinical pelvimetry, assess for any signs of obstruction like excessive molding and caput, and assess uterine contractions along with position and the presentation of the baby
- **If there was inadequate uterine contraction, what do you want to do ?**
  - Exclude CPD
  - Augmentation of labor via amniotomy and oxytocin

Mini-OSCE

Case about Partogram:

1-Primary dysfunctional labor

Causes: insufficient uterine contraction

(dr alaa say this is the prefect answer and

if you write 3 causes it's wrong)

2- Management:What is Dilation after – hour?

Duration of active phase from second stage

Mention