

NURSING CARE ABOUT THE PATIENT IN GYNECOLOGY AND OBSTETRICS

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Nursing care about the patient in gynecology and obstetrics

Study support

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The aim of the chapter



Keywords



Control questions



Comment



Introduction

Dear students,

we would like to present you a study support, which deals with selected chapters from nursing care in gynecology and obstetrics. Through this support, you should acquire basic and specific theoretical knowledge in the field of gynecology and obstetrics, as well as knowledge in the field of basic nursing care focused on women throughout life, at all stages of development.

Study support Nursing care for women in gynecology and obstetrics is divided into subchapters, which contain basic information from individual areas of care for women in gynecology and obstetrics - inflammatory diseases of the genitals, genital tumors, urinary incontinence, planned parenthood, methods of contraception, surgical procedures in gynecology, physiological pregnancy, high - risk or pathological births, puerperium. So you should get a basic overview of gynecological diseases and obstetrics.

The authors wish you many successes in studying this interesting field

Recommendations for the use of study support:

Study support is not a script or a book.

The study support should educate the student to be active by searching for further information, especially in the field of clinical issues, it should be a guide.

The study support is divided into selected chapters, those are key in the field of obstetrics, where the chapter itself follows its own topic, which ends with control questions.

The study support serves as an orientation recommendation and after supplementing the study of the recommended literature should lead to an understanding of the issues of selected risk and pathological conditions in obstetrics.

Don't underestimate the importance of control questions.

During the study of the text, take notes, record your own observations, study materials.

1 Characteristics of the field of gynecology and obstetrics

Annotation, abstract

The aim of the chapter is to define the concept of the field of gynecology and obstetrics. It introduces with the care organization for a women at various levels of the health care system with a special focus on the prevention of sexually transmitted diseases, unwanted pregnancies, cancer prevention and care for pregnant women, including prenatal screening.

The aim of the chapter

- Get acquainted with the system of care about the women in the Czech Republic
 - Orientation in the organization of care and professional guarantee of the field
-

Key words: gynecology, obstetrics, prevention, care system

The medical field of gynecology and obstetrics deals with professional care for a woman's reproductive system throughout her life. Gynecology and obstetrics cannot be separated, because the nature of both fields is based on the care of a woman's reproductive organs.

Their main mission is primarily preventive activities in the field of woman care, in which have both the doctor and the midwife a wide field of activity. In addition to prevention, it is the early detection and diagnosis of a woman's health problem, followed by appropriate treatment.

Gynecological and obstetric care takes place on several levels:

1. Primary care (state and private ambulant department of a specialist female doctor)
2. Secondary care (specialized ambulant clinics, inpatient workplaces)
3. Tertiary care (so-called superconciliary workplaces, centralizing women with highly specialized issues – e.g. trophoblastic disease)

Personnel, technical and material equipment of individual levels of provided care corresponds to the standards for ensuring optimal health care for women in individual facilities.

Methodologically, the field is led by the Ministry of Health of the Czech Republic, the guarantor of the field is the Czech Gynecological and Obstetrical Society J. E. Purkyně, which is a representative of experts in negotiations at the highest level.



Areas of prevention in individual developmental stages of women

Prevention in the prenatal period

- Monitoring of mental and physical condition during the mother's pregnancy and childbirth, psychoprophylactic preparation of the woman for childbirth.
- Diagnosis of problems resulting from a woman's illness or genetic burden.

Prevention in children (up to 10 years)

it is a period of sexual peace

- Monitoring the physiological development of reproductive organs.
- Elimination of risk factors threatening fertility.
- Elimination of injuries.
- Adequate sexual education, education in the principles of personal hygiene,...

Prevention during puberty (10 - 15 years)

it is the period of sexual maturation

- Education before the first menstruation.
- Anatomical-physiological assessment of reproductive organs.
- Treatment of reproductive disorders.
- Sex education, education for marriage, parenthood and child care.
- Education about the principles of personal hygiene, healthy lifestyle.

Prevention during adolescence (15 - 20 years)

is the period of adolescence, the first sexual contacts

- Sex education (sexual abstinence), prevention of pregnancy using contraception.
- Treatment of reproductive disorders.
- Education of a healthy lifestyle (attitude to life in all daily activities).
- Education for marriage and parenthood.
- Treatment of gynecological diseases.

Reproductive prevention (20 - 45 years)

fertile period, realization in work and family life

A. Prevention in the psychological field

- Psychoprophylactic preparation for childbirth, influencing the perception of the somatic state in pregnancy, influencing the mental states accompanying pregnancy.

B. Prevention in the physical field

- LTV in developmental defects, gynecological diseases.
- Special TV during pregnancy, childbirth, the puerperium.
- Education in child care, breastfeeding.
- Detection of lifestyle risk factors.
- Early detection of health problems.
- Spa treatment.

Prevention in menopause (45 - 65 years)

it is a transition from sexual maturity to the cessation of ovarian function

- Elimination of problems caused by reduced estrogen production.
- Early detection of oncogynecological diseases.
- Prevention of hormonal imbalance (HRT use).
- Educational programs on lifestyle modification.

Prevention in the elderly (from 65 years)

period of involution of organism functions

- Prevention in the field of improving the quality of life, implementation of educational programs (exercise, osteoporosis, diet,...)

Prevention and education is the cornerstone of PA's activities.

Control questions

Do you know the scope of care for a woman in individual developmental stages of her life?

What is the difference between primary, secondary and tertiary prevention?

Comments



2 The work of a midwife in ambulance care

Annotacion, abstract

The chapter introduces students to the operation of gynecological and obstetric clinics from the perspective of a nurse, midwife. The range of activities that are legislatively determined by the competencies of the nurse and midwife is relatively extensive and is based on the current requirements for quality, highly professional and responsive care for women and her entire family. Gets acquainted with the peculiarities of pediatric gynecology.

The aim of the chapter

- To get acquainted with the complexity of care for women in the field of primary care
- Know the role and scope of work of a midwife in a gynecological clinic
- Know the specifics of treatment and approach to pediatric patients

Key words: primary care, prevention, competence, gynecological outpatient clinic, pediatric gynecology

The midwife occupies an important place in the gynecological clinic, where she has a wide field of activity thanks to her competencies. Education of clients in the field of reproductive health care, planned parenthood, contraception, prevention of inflammatory diseases and sexually transmitted diseases, lifestyle in various life stages of women and care for pregnant women, postpartum women and many other activities that make up the profession of midwife.

2.1 Providing outpatient gynecological care for women

Medical care for a woman in the outpatient field is provided by a doctor - gynecologist with the first or second attestation in the field of gynecology and obstetrics.

Nursing care for women of the gynecological outpatient clinic is in the competence of the midwife, who together with the doctor forms a team whose goal is not only therapy of the disease, but especially human approach to women, communication skills, patience and empathy, which lead to building trust in professional authority. is a prerequisite for successful practice and patient satisfaction.

Possibilities of women in outpatient care:

- Choice of doctor and ZP
- Possibility to change the doctor once every 3 months
- Possibility to change ZP once a year
- Possibility of telephone order higher.
- Consultation with a doctor, event. PA (telephone, personal)
- Information on results (by phone, in person)



Doctor gynecologist x midwife

From the point of view of professionalism and legal responsibility, the midwife is completely subordinate to the doctor, but in terms of operation and functionality of the outpatient clinic, the midwife is an equal partner of the doctor and often the doctor is completely dependent on the midwife.

Midwife x woman

A midwife is the first person who comes into the contact with a woman. The first impression is important. It can be both positive and negative and significantly affects a woman's satisfaction and confidence.

A sign of high professionalism is such an appearance and the approach of a midwife, which clearly contributes to the good reputation of the surgery.

In addition to professional knowledge (clinical knowledge, examination methods, treatment options), the midwife should have communication skills, control assertive behavior, have a sufficient degree of empathy, be a good psychologist and, above all, a person.

Midwife x ambulance operation

The competence and scope of work of a midwife is the preparation and care of all parts of the gynecological clinic. The readiness, functionality and sufficient number of necessary aids guarantee the smooth and trouble-free operation of the ambulance and is the business card not only of the doctor but especially of "his" nurse, midwife.

Parts of a gynecological clinic

- Doctor's office
- Midwife office
- Waiting room

The doctor's office - gynecologist has an administrative and examination part. Equipment:

- Gynecological examination table
- Examination couch
- Colposcope
- Sonographer (UZV)
- Investigation aids
- Administrative part of the ambulance, including the computer

The connecting part between the working doctor and the midwife are the booths, where the clients store their clothes

Midwifery office, equipment:

- File (according to personal identification number, alphabetical list)
- Work table and collection point
- Weight (calibration), tonometer (calibration), altimeter (calibration)
- Deck chair
- Cardiotocograph

Waiting room - is a illustration of the overall level of the ambulance:

- Pleasant environment
- Sanitary facilities (toilet + bidet)

The woman's first visit in a gynecological ambulance

A newly registering woman undergoes a comprehensive examination, in which a midwife also participates in her activities:

- Client registration - registration ticket
- Preparation of documentation - card, filling in identification data, taking a family, personal, gynecological and obstetric, work and social history
- Measurement of physiological functions
- Information about the practices of the ambulance (office hours, small procedures, results, the possibility of purchasing disposable vaginal examination mirrors)

Repeated visits

- Preparation of documentation - data control, health insurance, complete the event. changes
- Reason for visit (discretion)
- FF measurement

Reasons for visiting a gynecological ambulance

Determining the reason for a patient's visit falls within the competence of the midwife, who often has to decide on the priority treatment of a woman that requires her current condition. A woman's wish for a confidential conversation with a doctor must always be respected.

What are the reasons for the visit that the midwife most often encounters:

- Preventive examination (paid by ZP once a year)
- Prescription HAK, HRT (HM, weight, laboratory)
- Urgent treatment
- Inflammation (vulvovaginitis)
- Bleeding (MC irregularities, menopause)
- Pelvic pain (acute, chronic)
- Failure of contraception

By moving the maximum scope of care to the outpatient sphere, the midwife becomes the doctor's right hand in providing minor vaginal procedures that are minimally burdensome for the woman.

Small outpatient procedures performed in a gynecological outpatient clinic:

- Introduction and extraction of IUDs
- Introduction and extraction of subcutaneous contraception – Inplanon
- Biopsy (cervical sampling)
- Excision of small skin formations

Performing outpatient procedures requires appropriate instrumentation, local anesthetics, fixative solution for histological material. Knowledge of basic instruments and care for it belongs to the basic knowledge of a nurse in an outpatient facility.

In addition to the conditions mentioned above, which the midwife most often encounters during her practice, there is also a whole range of diseases and problems from gynecology subfields such as reproductive medicine, senology or urogynecology.

Activities of a midwife in a gynecological clinic:

- Collection of biological material, provision for processing (removal)
- Provision of sterile aids - sterilization in suitable packaging
- Disinfection - aids, furniture according to the established disinfection program
- Performance assistance
- Orientation examination of urine
- CTG shooting
- Listing recipes – header
- Writing requests for examinations
- Telephone ordering
- Work with computer
- Application of injectable drugs
- Ordering and sorting material
- Sorting mail, examination results
- Preparation of the surgery for operation
- Surgery cleaning

Superstructure activities of a midwife:

- Conducting pregnancy courses
- Exercise for pregnant women
- Participation in childbirth
- Visiting activities in the household
- Advice on contraception, breastfeeding, child care
- Professional lectures at primary and secondary schools in the catchment area of the ambulance

The list of activities, duties and competencies of a midwife shows the complexity and diversity of work in a gynecological clinic. Current legislation on the profession of midwife extends the activities of midwives also in the field of lifelong self-education

2.2 The work of a midwife in the pediatric gynecology

The pediatric gynecology clinic is very specific with its clientele. Patients can be from a very young age and all efforts in diagnosis and treatment are aimed at maintaining physiological reproduction in later life of girls and women.

The outpatient clinic is run by a gynecologist specializing in pediatric gynecology and works with a midwife who has expertise as well as experience with pediatric patients.

The most common problems that can be encountered are inflammations (vulvovaginitis) caused by eg poor hygiene, parasites (scabs) or a foreign body in the vagina (sand, small objects), bleeding, synechia vulvae (sticking of small labia), congenital birth defects and etc.

Pediatric gynecology clinic equipment

Their premises and equipment do not differ from the usual gynecological clinic, but there are differences that are based on the needs of caring for children's clients.

- Instrumentarium (vag. Mirrors) - are adapted to the anatomical conditions of young girls)
- Dg. devices - UZV, vaginoscope, colposcope
- Decoration of the ambulance, walls - to distract the child, there may be a children's corner
- Overall a stress-free environment

If the operation of the ambulance and the doctor's access allow it, it is advisable to use civilian clothes rather than a white coat, taking into account the child's psyche.

The skills determining the work of a midwife in the field of pediatric gynecology are appropriate expertise and further self-education in the field, knowledge of specific examination procedures and equipment, sensitive approach to pediatric clients, sensitive communication with the girl.

Examination methods in pediatric gynecology:

- History: RA, OA, NO (midwife with escort)
- Physical exam:
 - view: appearance, figure, hair, secondary sexual characteristics (midwife notices in direct contact with the girl)
 - Touch: high. per rectum (in intact hymn)
- Laboratory high methods:
 - Blood - hormone levels
 - inflammatory markers - CRP, FW, leukocytes
 - hematological examination - KO
 - Urine - sediment, cultivation
 - Vaginal cultivation - inflammation
 - Lepex - parasitological examination for robes
- Imaging methods - UZV (1st choice examination) X-ray, CT,...
- Endoscopic methods – vaginoscopy

The sensitive approach of all involved is important!

Explain all performances in advance of age. There is increased patience, empathy. Do not use violence!

Therapeutic measures in pediatric gynecology

Conservative therapy - application of drugs into the vagina (tbl., Supp., Foam). By small girls, use tweezers to gently educate older girls with a broken hymen about the technique of introducing vaginal medications and following the necessary measures.

Surgical therapy - outpatient or hospitalized in CA. Some minor procedures (especially partial synechiae or removal of a foreign body from the vagina) can be performed on an outpatient basis, but the condition is

do not stress the child. If there is a risk of poor cooperation on the part of the child, or if it is a larger procedure - it is always necessary to perform the procedure under general anesthesia!

Control questions

Define the basic areas of activity of a midwife in outpatient care.
Determine which examination methods used in pediatric gynecology are different from the methods used in the gynecological outpatient clinic for adult women.

Comments



3 Nursing care for a woman with inflammatory diseases of the reproductive organs

Annotation, abstract

The chapter introduces the issue of inflammation in gynecology, describes the specifics of care for women with inflammation of the external genitalia, internal genitalia and pelvic inflammatory disease.

The chapter also includes the treatment and care of women with selected sexually transmitted diseases.

The aim of the chapter

-
- The student is able to identify the risks of inflammation and educate the woman about preventive measures in inflammatory diseases of the uterus
 - The student knows the symptoms of deep pelvic inflammation and the specifics of care for such a sick woman
 - Orients in the issue of sexually transmitted diseases and their prevention
-

Key words: inflammation of external genitalia, inflammation of internal genital organs, pelvic inflammatory disease, sexually transmitted diseases

Inflammation of a woman's reproductive organs accounts for approximately half of all gynecological diseases in gynecology and, if left untreated, can cause infertility.

In practice, the midwife meets in women the gynecologist's office with women suffering from inflammation of the external genitalia (vulvitis, vulvovaginitis) by patients who are hospitalized for inflammation in the external or internal genitalia exceptionally. Most women with inflammatory disease in the area of the birth can not be hospitalized, treatment for them is managed at the level of outpatient care. However, in the event of worsening of the condition, increased pain and impending complications, the woman must be hospitalized in the conservative treatment department of the gynecological department.

During hospitalization, the midwife most often encounters inflammation of the Bartholini gland, tuboovarial inflammation and abscess, and pelvic inflammatory disease (PID).

Natural barrier against birth control

- The labia and muscles of the pelvic floor
- Hymen
- Acidic environment of the vagina, estrogen – progesterone
- Closed outer gate
- Mucus plug in the throat cavity
- closed inner gate



- Vibration of the cilia in the tube towards the uterine cavity
- Fimbria fallopian tube

Causes of inflammation:

1. Endogenous: hormonal influences, pregnancy, ovulation and premenstrual, DM, AIDS,...
2. Exogenous: drugs (contraception, corticoids, chemotherapy, ATB ...), nutrition (diet, habits, obesity), hygiene (hot baths, alkaline soaps), sexual promiscuity, airtight underwear, stress, invasive procedures,...

Division of inflammation of reproductive organs:

1. Inflammation of the external genitalia:
 - Vulvitis - of the entire external genitalia
 - Bartolinitis - Bartolini's glands
 - Herpes genitalis - blisters can be on the external genitalia, in the vagina, on the cervix
2. Inflammation of the internal genitalia
 - Colpitis - inflammation of the vagina
 - Cervitis - inflammation of the cervix
 - Endometritis - inflammation of the uterus
 - Salphingitis - inflammation of the fallopian tubes
 - Adnexitis - inflammation of the uterine pendants (ovaries and fallopian tubes)

General diagnosis of inflammatory diseases of the reproductive organs

- a) History (associated diseases, medication use, sexual life, level of hygiene)
- b) Gyne. (per vaginam, per rectum)
- c) Colposcopy
- d) Cytological higher, venereological higher
- e) Higher urine, blood (FW, CRP, KO,...)
- f) SONO, CT of the small pelvis, laparoscopy
- g) Urogynecological higher

Prevention of inflammatory disease

1. Proper lifestyle (diet, rest, exercise, elimination of stress and harmful habits)
2. Appropriate dressing
3. Protection against cooling
4. Appropriate intimate hygiene
5. Healthy sex life (without promiscuity)
6. Use of barrier contraception
7. Regular visits to a gynecologist
8. Consistent treatment of any inflammation
9. Not underestimating the suspicious discharge

3.1 Inflammation of the external genitalia

General symptoms of inflammation

The range of symptoms is very varied, but inflammation can also occur asymptomatic - discharge from the vagina (MOP different appearance, odor and the presence of impurities), pain in the lower abdomen and

external genitalia, anorexia, nausea, vomiting, swelling, swelling, redness of the vagina. Entrance, itching, burning in the area of births, frequent urination, pain during sexual intercourse, bleeding, febrile, fatigue, bowel disorders, fear, anxiety.

Vulvitis, vulvovaginitis

The vulva is part of the outer skin, therefore it is equally susceptible to typical skin diseases (contact eczema, toxic dermatitis, seborrheic eczema, psoriasis, microbial eczema, neurodermitis circumscripta vulvae, intertrigo).

In the area of the vulva, there is an increased excretion of fluids (after the axilla, the vulva is the site of the highest sweat production), in addition, secretion from the vestibule and vagina is present. These factors allow the formation of a so-called "wet chamber", which results in permanent irritation of the vulva and its surroundings. Psychogenic factors also have a significant effect on recurrent inflammatory diseases.

Symptoms of vulvitis: redness, swelling of the genitalia, feeling hot, burning pain, distressing itching, dysuria, impossibility of coitus.

Pruritus of the vulva

Innervation of the vulva and dense nerve plexuses determine the importance of pruritus, which is at the forefront of all vulvar diseases

Types of pruritus:

- a) Separate disease (idiopathic pruritus)
- b) Symptomatic pruritus

The most common cause of vulvar pruritus is dystrophy, mycosis, allergies or diabetes mellitus. Other causes may be: mechanical or chemical irritation, general disease (liver disease, uremia, hyper / hypothyroidism, pernicious anemia, avitaminosis, DM), hygiene deficit, precancerous lesions or cancer (VIN I, II, III - Ca in situ, Carcinoma vulvae)

It is always necessary to rule out Ca in situ and invasive cancer!

Limited inflammatory processes of the vulva: folliculitis et furunculosis, Bartholinitis, cystitis gl. Bartholinitis

Inflammation of the Bartholini gland

Inflammation usually affects younger women during the reproductive period. Microorganisms enter the outlet of this vestibular gland in the lower part of the small labia. The duct closes with inflammation, edema occurs, very painful resistance in the area of the vaginal entrance. A woman can't sit, she's having a hard time. Resistance can reach the size of a smaller chicken egg. The affected area shows signs of inflammation, after the coquence (liquefaction) of the contents a retention cyst is formed. For a cyst, it is advisable to make an incision, drain the contents and establish a drain. If inflammation recurs, it is recommended that the cyst be extirpated. The midwife meets the patient in the acute phase of inflammation, when discomfort in the area of the birth can lead her to treatment with a subsequent incision ev. hospitalizations. Incisions and other treatments for inflammation are primarily performed under general anesthesia.

Nursing history and physical examination for inflammation of the external genitalia:

- Identification data, anamnesis
- Weight, height, physiological functions
- Evaluation of individual areas important for nursing care (habits, hygiene, medication, sexual life,...)
- Evaluation of the area of external genitalia (pain, swelling, color, temperature, the presence of colication)

The midwife continuously monitors the development of the disease, possible changes in the field of births, the mental state of the woman and her self-sufficiency.

Nursing problems occurring in inflammation of the Bartholini gland: acute pain in the area of the labia, fever, discomfort in the area of external genitalia, lack of information about the disease, its prevention and treatment regimen, reduced self-sufficiency.

3.2 Inflammation of the internal parent

Pelvic inflammatory disease (PID)

It is one of the inflammatory sudden gynecological events, the infection passes from the adnexa to the pelvic peritoneum - pelveoperitonitis to diffuse peritonitis occurs. The most common agents are Chlamydia trachomatis, Neisseria gonorrhoea, E. coli. It occurs mainly in women of childbearing age, may be related to sexual intercourse / promiscuity, the risk factor is the new introduction of IUDs, undergoing intrauterine procedures.

PID classification according to Monif

- 1) Acute salpingitis (simple inflammation of the fallopian tube)
- 2) Parametritis, cellulitis (inflammation with symptoms of pelveoperitonitis)
- 3) tuboovarian complex (abscess)
- 4) impending rupture or rupture of the tuboovarian abscess and contact of the material with the peritoneal cavity (becomes NPG)

Clinical manifestations

Abdominal pain (menstrual-related), pain on settling, vaginal fluoride, irregular bleeding, subfebrile to febrile, nausea, vomiting, polakisuria, fatigue.

In the advanced stage of the disease: general appetite, paleness, défense musculaire, peristalsis arrest - peritonitis.

Caring for a woman with PID

Save to a smaller and quiet room, relief position, information about treatment and nursing regimen, monitor ff (tt, p, tk), monitor pain (scale, propagation, type), monitor nausea, vomiting - evaluate (loss), monitor urination, heat, monitor signs of peritoneal irritation, provide a venous line (control), provide i.v. therapy, hydration of the client, administration of

prescribed medications, control of adverse reactions and effects, collection of biological material, evaluation and inclusion of results in documentation, Do not unnecessarily burden the patient - calm! Assistance in activities of daily living (diet, defecation, hygiene).

3.3 Sexually transmitted sexually transmitted diseases

STD (Sexual Transmitted Disease) - some (so-called classic) are subject to active prevention and dispensarization (syphilis, gonorrhea, Lymphogranuloma venereum, soft ulcer, granuloma inguinale - Donovanosis, hepatitis, AIDS). The doctor who diagnoses classic STD will refer the patient to the care of a dermatovenerologist. These diseases are serious due to their epidemiological etiology and both partners must be treated simultaneously.

Today, so-called "second generation" venereal diseases are also described, which are not so well known to the general public (Chlamydia, Mycoplasma, HPV, moluscum contagiosum, Trichomoniasis, fungal infections (scabies), scabies, pediculosis pubis).

STDs affect women more often, men are more common carriers.

Distribution of STD

- Bacterial (Syphilis, Gonorrhea, Chlamydia, ...)
- Viral (Human papillomavirus HPV, Herpes genitalis, HIV, Hepatitis B,...)
- Parasitic (mucus, scabies,...)
- Fungal (candidiasis, vulvitis,...)
- Protozoal (trichomoniasis)

Chlamydia trachomatis

In the Western world, the most commonly sexually transmitted infection. Symptoms are inflammation of the urethra in men and women non-gonorrheic urethritis, 40 to 70% of infections without symptoms, in case of illness necessary treatment of a partner, treatment - antibiotics.

Complications: inflammation of the cervix (uterus and fallopian tube, followed by problems with pregnancy), conjunctivitis or pneumonia (newborns), pneumonia.

Genital herpes virus (herpes simplex hominis virus 2)

The manifestation of the infection is cold sores in the genital area, chronically persistent infections with frequent recurrences, transmission with direct contact, sexual intercourse, incubation period: 2-7 days.

Symptoms: redness and swelling of the cervix, after the latent phase lesions are formed in the form of ulcers or blisters in the genital area - penis, vulva, dam, anus. Swelling of the lymph nodes, mucopurulent discharge from the uterus, clumps of blisters, itching, burning, soreness. The blisters are first filled with a clear liquid, later turbid, crusts, the possibility of secondary infection. 2/3 pac. he has increased TT, headache, photophobia, stiff neck and painful muscles and spine.

The treatment lasts for days and months: antiphlogistics, nonsteroidal antirheumatic drugs and analgesics (but the virus remains), administration of antiviral drugs for complications, other treatment is not yet known, sexual abstinence.

Human papillomavirus (HPV)

The most frequently observed manifestations of human papillomavirus infections are the skin (verruca vulgaris, 2,4, 1,7,26,29, verruca plana 3,10,27,28,41, verruca plantaris 1,2,4, epidermodysplasia verruciformis 5,8, 17, 20, 36, 9, 12, 14-15, 19,21-25, 38, 46), anogenital area (condyloma acuminatum, 6, 11, 1, 2, 10, 16, 30, 44, 45, 54, 55), cervical adenocarcinoma dysplasia (16, 18), oral cavity (epithelial hyperplasia, 13, 32), larynx (papilloma, 6, 11), conjunctiva (papilloma 11).

Symptoms of HPV:

Condylomata accuminata - initially we observe pigment spots the size of a pinhead, later they enlarge

Condylomata gigantea - spots of various character (pointed, planar, papillary) occur in the vagina, vulva, cervix and perineum

Bovenoid papulosis - there are numerous flat pigmented papules in the area of the external genitalia, it has the character of a CIS vulva (carcinoma in situ) but it is benign

Nursing problems:

Increased TT due to the presence of infection in the body

Pain for inflammatory changes at the site of disability

Total fatigue due to the complexity of treatment

Stud for smelly discharge

Restlessness for constant itching

Fear of the unpleasant course of him.

Potential risk of transmitting infection to partner due to lack of information

Development of complications due to non-compliance with the principles of therapy

Sexual abstinence for pain

Control questions

Describe the areas of education of a woman with recurrent vulvovaginitis.

Describe comprehensive nursing care for a woman with a tuboovarial complex.

Do you know the symptoms and treatment of compulsorily reported sexually transmitted diseases?



Comments

4 Care for a woman undergoing gynecological surgery

Annotacion, abstract

The chapter acquaints the student with the issue of surgical procedures in the field of gynecology and their division. Describes preoperative, intraoperative and postoperative patient care. It deals with postoperative complications and their prevention. An important part of caring for a woman after surgery is communication and education.

The aim of the chapter

-
- The student knows the types of operations in gynecology and the specifics of woman care after each operation.
 - The student describes possible postoperative complications and possibilities of their prevention.
 - The student is able to apply the educational process in women after gynecological surgery.
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Key words: large gynecological operation, small gynecological operation, preoperative preparation, postoperative complications, education

The need for surgery is usually decided in the gynecologist's office or directly during hospitalization.

The effort of health professionals is to shorten the stay of a woman in hospital to the necessary time. Women arrange the necessary preoperative examinations on an outpatient basis, but they must not be older than 14 days. They start the operation the day before the planned operation. Only in justified cases (old and sick women, pregnant women and serious conditions) are they hospitalized a few days in advance and undergo the necessary examinations during hospitalization.

The patient is acquainted by the doctor with the reasons for the operation, the type of operation, the scope of the operation, the consequences of the operation and the probable length of hospitalization.

Types of small gynecological procedures (per vaginam):

- curettage of the uterine cavity (curative effect, diagnostic)
- cervix curvature (dg)
- revision of the uterine cavity (RCUI-abortion)
- vacuum aspiration (UPT)
- puncture ovar. cysts
- incision of cystic formations
- laying of growths around the vagina, rectum (condylomata)



- cerclage of the cervix
- excision of the Bartolini's gland abscess

Major gynecological operations:

- wide conization of the cervix
- ovariectomy
- salpingectomy
- salpongo-ovariectomy
- hysterectomy
- panhysterectomy

By these operations it is used laparotomy, laparoscopic approach or a combination of these methods (eg laparoscopically assisted vaginal hysterectomy - LAHV) is used in these operations.

4.1 Peroperative preparation of the woman

The purpose of preoperative preparation is the maximum elimination of complications of the operation. It is divided into three parts: long-term, short-term and immediate preoperative preparation.

Long-term preoperative preparation

After the decision on the operation and the woman's consent, she is ordered to the catchment hospital, the midwife explains and plans the procedure for obtaining preoperative examinations, and informs about the rules during hospitalization.

The woman is informed about the possibility of autotransfusion, which is recommended for operations with greater blood loss (HYA). Minimizes post-transfusion complications. The woman arrives at the transfusion station in advance, where 1-2 TUs are taken from her.

Preoperative examinations depend on the type of operation / disease and according to the habits of the medical facility. Laboratory hematological examinations (KO + diff, FW, APTT, QUICK - INR, KS - Rh factor), biochemical examinations - urine (sediment), blood serum (basic biochemical set, TU - markers), serological examination (BWR, HBsAg, HIV), microbiological examination (urine, vaginal secretion), imaging methods (UZV, CT, MR, X-ray of the lungs) and conciliar internal examination. All examinations must not be older than 14 days.

Short-term preoperative preparation

It takes place the day before the operation after admission to hospital. The midwife introduces herself to the patient and establishes contact with the woman, helps to change the woman into institutional underwear, checks, or performs the preparation of the operating field, measures FF, weight. He places the patient in a room and a bed, acquaints him with the organization of the ward and the patients' rights, and announces the probable time of the procedure. The midwife will arrange a preoperative counseling.

If necessary, it blocks blood, establishes nursing documentation, checks

signed informed consent (with performance, giving information, participation of other people in the procedure x treatment), provides space for questions, uses its communication skills to explain the course hospitalization, possible risks of surgery, possibilities of active participation of the patient in the treatment.

Regime before surgery - the day before noon lunch, solid food for the last time around 4 pm, drinking regime possible until midnight. Colon emptying according to surgery (before abdominal surgery - evening and morning, LAHV - evening and morning, laparoscopy - morning).

During a one-day hospitalization (admission of the patient on the day of the operation), this preparation is omitted and the necessary operations are performed as part of the immediate preparation.

Immediate preoperative preparation

It takes place on the day of the operation before the patient is taken to the operating room.

Midwife activities:

- verify hunger (by asking)
- genital hygiene (shower)
- the client urinates (empty MM x catheterization, vaginal tamponade as indicated)
- remove valuables in the safe
- remove make-up (watch out for face cream)
- denture, if out
- DK bandage in high-risk women
- heparinization, if indicated
- premedication - learn about the effects
- surgical shirt, rubber pad in the bed
- preparation of complete documentation (indications for performance, vaginal examination, examination results, current FF, signed informed consent, application of premedication - date, time, composition and signature)
- hand over the patient together with the documentation in person to the nurse in the operating rooms

4.2 Intraoperation care for a woman

The task is to prevent possible complications during the operation itself:

- Fluid replenishment - crystalloids, colloids, transfusions
- Care for the stability of blood circulation
- Adequate ventilation
- Maintaining body temperature
- Administration of additional medication - ATB, heparin...

The woman is transferred from the operating room to the dormitory after a full awakening from the anesthesia (she raises her head, sticks out her tongue), after the anesthesiologist's decision.

4.3 Postoperative care for a woman

Postoperative care can be divided into two phases - immediate postoperative care and subsequent postoperative care.

Immediately after the operation - until the CA disappears 2 hours dormitory - anesthesiology nurse, availability of an anesthesiologist, nurse from the operating field → ICU - after major operations or ARO - if it is necessary to support basic vital functions.

Monitoring: ventilation
respiratory rate
saturation o₂
blood circulation (heart rate + regularity blood pressure, ECG)
lab. control
measure diuresis (permanent catheter) – fluid intake and dispensing
adequate fluid intake (dehydration leads to acidosis)

Immediate local monitoring: wound - cover - bleeding
drains - dispensing
catheters - dispensing fluids

Follow-up: prevention of paralytic ileus, vomiting, parenteral nutrition, pain relief, adequate sleep. Depending on the status, in about 48 hours a translation to the standard department.

Postoperative care after a small gynecological procedure

The procedures are usually performed during a one-day hospitalization.

The role of the midwife immediately after the operation: cleanse the blood and attach a sterile pad, move the woman to bed and arrange transport to the room, mark and send the collected material, provide care for aids, clean the room.

Control: immediate state of consciousness - we address the client, evaluate the reaction, physiological functions - blood pressure, pulse, breathing, TT, bleeding from the birth canal (high risk), pain, patient safety (mainly restless women) back position, pillow after complete recovery from anesthesia, control of heat losses - heated bed, another blanket, cleanliness of the bed (disposable absorbent pad, a sufficient number of sanitary napkins and their replacement - number records), nothing per os! - risk of nausea, vomiting and subsequent aspiration.

The midwife looks in to the documentation, follows the doctor's instructions, ev. anesthesiologist (further infusion, maintains a venous line, applies medication, provides and assists in the examination)

If the postoperative course is problem-free - the same day home treatment. Instructed, medical discharge report, LPN, departure with escort.

If the overall condition of the woman requires further treatment - she remains hospitalized as needed.

4.4 Postoperative complications

Each operation carries a high risk of perioperative and postoperative complications. These can be eliminated by thorough preoperative examination of the woman, possibly by compensating for existing health problems. The occurrence of postoperative complications is influenced by many factors, such as: the woman's health condition, the complexity of the operation, the length of the operation, the body's reaction to the surgical burden and general anesthesia.

Postoperative complications worsen the patient's physical and mental condition, increase the cost of treatment and can disability the patient (possibly death). In terms of time, we divide them into immediate, early and late.

Immediate postoperative complications

They may appear in the operating room or immediately after surgery in the dormitory.

Among these complications we dilute laryngospasm (spasm of the main muscle of the larynx) manifested by stridor, cyanosis and restlessness. If laryngospasm occurs, it is usually still in the operating room (necessary for a few minutes in the preparation room of the observation room). Immediately call a doctor, the nurse, meanwhile, performs a head tilt with the lower jaw forward.

Respiratory depression after anesthetic administration. Call a physician, meanwhile administer inhaling oxygen.

Circulatory failure - arises on the basis of the operational load. Follow FF, appearance (cyanosis).

Complications during the first 24 hours: bleeding - failure or imperfect hemostasis in the surgical field, tachycardia, apnea, hypotension, prolonged capillary return, vomiting, confusion of the patient...

Postoperative bleeding is manifested by rapid leakage of the bandage or filling of the vacuum drainage with blood or from loose drains. The nurse monitors the FF (BP, P) If the blood pressure drops and the pulse accelerates - contact a doctor immediately to assess the situation. It may be bleeding into the abdominal cavity from an approved ligature, in which case it is necessary to transport the woman back to the operating room, revise the surgical wound and stop the source of bleeding (it may be after vaginal conization surgery, LAVH).

Postoperative vomiting - as a reaction to anesthetics, beware of fluid loss, minerals, watch!

Early postoperative complications

They usually appear by the 7th day after the operation. Includes:

Damage to the laryngeal mucosa by intubation

Aspiration

Pulmonary edema

IM, arrhythmia, failure

Urine retention

Ileus

Allergic reaction

Respiratory insufficiency

Singultus

DIC

CMP

Mental disorders by older women are due to CA. They are manifested by restlessness, disorientation of time and place, there can also be aggression.

TEN, pulmonary embolism - prevention before surgery, monitoring after surgery, mobilizing in time if the client's condition allows. Practicing with DK.

Late postoperative complications

They appear after the 7th day of surgery.

Stagnant bronchopneumonia - threatens in older women, asthmatics, smokers. Aspiration pneumonia - after aspiration of gastric contents.

Urinary tract infections - from an established permanent catheter. Monitor urination, evaluate urine macroscopically, purposefully search for dysuric problems.

Other possible late complications include: urinary tract infections, catheter fever, renal failure, liver failure, thrombophlebitis, phlebothrombosis, anemia, toxic brain damage, adhesions.

Thromboembolic disease (TEN)

Clinical signs of massive embolism: severe chest pain, dyspnoea, cough, increased filling of the jugular veins, cyanosis of the face and neck, tachycardia, tachypnoea, cold sweat, fear, general alteration, impaired consciousness, early death.

Clinical signs of microembolization: asymptomatic, or just cough and bloody sputum. Repeated minor embolizations (successive embolizations) gradual development of respiratory failure - dyspnea, hypoxia...

PP at TEN

1. Put on the bed
2. Fowler position
3. O2 application
4. Calling a doctor (ARO resuscitation team)
5. Ensuring venous access
6. KPR
7. Then - by survival (heparinization, streptokinase, embolectomy)

TEN prevention

- Rehabilitation training and exercises with DK before the procedure
- Preventive miniheparinization: 2-3 times a day 2500 -5000 IU heparin s.c., first dose 2 hours before the procedure; low molecular weight Heparin once a day s. c. 0.1 / 10 kg - Fraxiparine, Clexane, Clivarin, Fragmin,...
- Bandages of the lower limbs
- Gentle surgical technique, minimal tissue trauma
- Normovolemic hemodilution - hematocrit during the operation around 30% (slightly "diluted" blood - replenishment of blood loss by electrolytes)
- Early mobilization after exercise

Complicated healing of the surgical wound - per second

A surgical wound with complicated healing is a wound that is:

- contaminated with an infectious agent
- shows symptoms of inflammation - redness, secretion, edema, pain, fever, twitching in the wound... ..
- various degrees of dehiscence are present

The woman is informed by the doctor about the complication of healing and the necessary prolongation of hospitalization, during which the wound must be regularly evaluated and treated.

Taking care of a woman's mental state - a health problem is potentiated by disillusionment with prolonged hospitalization, prolonged wound healing. The effect after healing is not usually cosmetically good!

Educate the patient about the possibilities of care for the surgical wound in the home environment, about the possibilities of subsequent correction of an unsightly scar (massage, Contratubex, laser, cosmetic correction).

Surgical treatment itself

1. Remove wound dressing (very contaminated)
2. Evaluation of the wound - odor, coating, effusion, wound edges, necrotic areas, describe the wound in the documentation (special records for wound healing)
3. Rinsing x rinsing of the surgical wound - prescribed solution (warmed to body temperature)
4. Treat the wound - clean, remove necrotic tissue
5. Sterile wound dressing.

The trend of simultaneous treatment of secondary healing wounds is the wet healing method. New epidermal cells have been shown to form faster in a humid environment than in a dry environment. The wound must remain moist, free of infection, necrotic tissue. Any additional dressing must not disturb the newly formed granulation tissue.

The new dressing materials make it possible to change the dressing in 24 hours at the earliest and then to extend it individually for up to 7 days, depending on the aids used and the type of wound.

Adequate nursing care occupies a very important place in the prevention of many postoperative complications. The nurse, midwife is in constant contact with the client and can estimate the potential risk. Identification of possible complications and nursing interventions aimed at their early prevention belong to professionally provided nursing care.

Control questions

Explain the cause of orthostatic hypotension, what preventive measures can you take as a nurse, midwife to avoid this problem?

Indicate the areas you will observe for the woman after the translation to a standard bed.

List the non-pharmacological methods of pain relief that you use in your practice.

What are the stages of wound healing? (repeat from Nursing in Surgery)



Comments

5 Care for a woman with cancer

Annotacion, abstract

The aim of this chapter is to acquaint students with the most common gynecological tumors that a midwife encounters in her practice. Oncological treatment brings with it many nursing problems of a somatic and psychological nature, which can be compensated to an acceptable level by adequate nursing care.

The aim of the chapter

- The student is familiar with the female cancer classification in the field of gynecology.
 - The student knows the treatment options by the cancer patient and knows the possible side effects of this treatment.
 - The student knows the importance of psychological support of the women by letting her know oncological diagnosis and treatment.
-

Key words: benign tumor, malignant tumor, oncological treatment, palliative care, actinotherapy, chemotherapy, pain treatment

Oncological diseases are on second place in mortality. It brings fear of pain and death, social and psychological problems.

Basic classification of cancer:

1. Benign
2. Malignant
3. Benign with malignant placement

Malignant tumors of the female genital organs are a very serious problem today. Despite great advances in treatment options, these tumors are not declining and treatment results are not very satisfactory. The basic problem is as usual in oncology, that there is still low diseases proportion detected in an early stage. Gynecological malignant tumors create up to 40% of all cancers by the women.

Among Gynecological tumors can also be attributed tumor disease, which is the most common by women and is also in the first place in the statistics of death causes - breast cancer.

Typically, gynecological malignancies are uterine cancer, cervical cancer and ovarian cancer. Screening is developed and functional by a cervical cancer and breast cancer.



The diagnosis is ruled out or confirmed by histological examination of the affected tissue. Patients expect the result of this examination with impatience and apprehension. Information about the result of the operation and histological examination falls exclusively to the competence of the doctor.

Treatment options for cancer

Surgical treatment

- A. radical (the whole tumor + adjacent structures are removed)
- B. palliative (only relief surgery is performed, the tumor can not be removed)

Conservative treatment

- A. chemotherapy (cytostatics)
- B. actinotherapy (teletherapy - external irradiation, brachytherapy - internal irradiation)
- C. hormonal treatment
- D. enzyme therapy as adjuvant therapy

The basis of the treatment of gynecological tumors is a surgical solution. Depending on its outcome and the presence of a residual tumor, methods of actinotherapy or chemotherapy are introduced, either individually or simultaneously (as adjuvant therapy).

5.1 Care for a woman with a surgical solution of the tumor disease

Nursing care for a woman undergoing surgery is the same as for all surgical procedures. It consists of preoperative preparation (remote, short-term, immediate) and postoperative care (immediate, follow-up care - see previous chapters).

5.2 Care for a woman with the conservative treatment of tumor disease

Chemotherapy - treatment with cytostatics (drugs against cancer) can be given during outpatient treatment, when the patient receives cytostatics at certain intervals to the clinic of clinical oncology and after its completion goes to home treatment. Treatment can also take place during hospitalization as a follow-up after surgical treatment.

Chemotherapy is usually given in the form of infusion solutions, which are unstable to light, so it is necessary to cover the infusion bottle with a cloth wrapper after dilution. The solutions are applied i.v. to the peripheral or central stream. Peripheral veins are i.v. stressed and damaged by the applied cytostatics, therefore they are preferably applied via the venous port to the

superior vena cava. CIS platinum (platinum with cyclophosphamide) is most often used to treat gynecological malignancies (mostly ovarian).

Work with cytostatics is subject of the strict safety and hygiene rules. The nurse who applies them must be trained.

Duties of a midwife in the care of a woman during chemotherapy

- a. Patient preparation - according to the doctor's indication, laboratory tests and mental preparation of the patient are performed.
- b. If possible, the woman is in a single room.
- c. Preparation of devices for i. v. administration, prepared infusion solution with cytostatics - in the package
- d. Preparation of other aids - emission bowl, enough pulp, glass with water
- e. Preparation and inspection of the signaling device
- f. The nurse works in gloves, she should have a protective coat, a mouthpiece
- g. Ideal injection sites - dorsal side of the forearm (exceptionally the elbow socket)
- h. Peripheral venous catheter inserted strictly intravenously - risk of necrosis during extravascular administration
- i. Adjusts the number of drops
- j. Instructs the woman to report any problems during the application

The midwife provides active nursing care, monitors the condition of the woman, places of application, FF, the overall response of the organism to the administration of cytostatics, fluid intake and output, food intake, vomiting, diarrhea at regular intervals.

Complications - paravenous application: act fast! (cytostatics cause tissue necrosis)

1. Stop the infusion
2. To keep the venous catheter (i.v. needle), connect the syringe and aspirate the maximum cytostatic from the tissue
3. Remove the venous catheter
4. Attach a bag of ice
5. Inform the doctor immediately
6. Subsequently topically Yellon gel or alcohol compresses, ice, spraying around the intravenous catheter physiol. solution or Mesocaine (doctor)
7. Checking the location of the orthogenic application
8. Write everything in to the woman's documentation

Other nursing problems resulting from the side effects of cytostatic treatment. Administered CIS platinum is hematotoxic (anemia), neurotoxic (paraesthesia, instability, dizziness), nephrotoxic (possible renal impairment), ototoxic (hearing impairment - hearing loss, effervescence, wheezing).

Care after chemotherapy application - women suffer after the cytostatic application with nausea, headaches, general weakness, anorexia and vomiting repeatedly. It is necessary to administer simultaneously the setronic antiemetics - they are very effective (Kitril, Zofran - a group of serotonin receptor inhibitors).

Gentle and helpful care makes it easier for women to cope with this difficult period. We offer a sparing diet, but we do not force it. We ensure sufficient fluid intake, cold fluids, ice and ice cubes (coca-cola, beer, pineapple juice) are better handled. Due to the overall weakness, we must reckon with reduced self-sufficiency and actively offer women Help. We monitor diuresis. All immediate nursing care for the patient should be performed in protective equipment - the patient still secretes cytostatics for 48 hours after application (patients very often report a metallic taste in the mouth). If the woman feels well, she goes home the next or third day after application. It is necessary for the woman to be informed about the onset of alopecia as a result of the application of cytostatics (contribution of VZP to the wig 1000 CZK per year).

All waste contaminated with cytostatics in a plastic bag and label as "cytostatics". Also put bedding, personal laundry separately in the bag and mark again.

One of the newer methods in the application of cytostatic treatment is the application of intraperitoneal, ie a thin cannula directly into the abdominal cavity. The overall response of the body is not so intense, it is easier for women to tolerate it.

Actinotherapy (radiotherapy) - in oncogynecology it is used either alone, in inoperable tumors, or in combination with a surgical drug, most recently as concomitant radiotherapy (combination with chemotherapy). It has its place in the adjuvant treatment of tumors of the cervix and uterus, in which the intracavitary form (brachytherapy) is used, ie the introduction of a radiator into the uterus or vagina. Subsequent external irradiation (teleteradiotherapy) is also used after surgery for breast, vulva and vaginal cancers, or as a palliative procedure in inoperable conditions. It has no significant effect in the treatment of ovarian cancer.

Actinotherapy takes place in specialized workplaces. For a woman, this period is extremely demanding both mentally and somatically, and it is necessary to properly instruct the patient about the method of application and side effects of actinotherapy, as they significantly affect the quality of further life. Actinotherapy is characterized by a number of side effects, both early and late (depending on the irradiated part of the body). **Post-radiation symptoms** include:

Acute symptoms (early)

- tiredness, weakness, mood swings, skin erythema

Chronic symptoms (late)

- skin changes (↑ sensitivity, possibility of injury - recommend loose clothing, do not use any cosmetics, not the sun, solarium, wash only with lukewarm water).

When irradiating the abdomen and pelvis often - diarrhea, painful tenesmus, frequent urination with diuretic problems, care for these problems are in the competence of the midwife.

Upon discharge to home care, the woman is instructed in the diet and drinking regime, the necessary physical examination, care for irradiated skin and possible complications of treatment.

5.3 Treatment of the oncological pain

One of the most important treatments for cancer patients is the treatment of pain. The nurse must be able to evaluate the intensity of the pain experienced by the woman and is used for this by a number of evaluation techniques (VAS - visual analog scale according to Melzack).

The treatment of pain is governed by the WHO scale, where 3 levels of medication are applied:

- 1st degree - non-opioid analgesics + adjuvant drug
- 2nd degree - weak opioid drug + adjuvant drug
- Third degree - a strong opioid drug

It progresses from the weakest link to the strongest.

Beware of side effects of drugs (MO - suppresses the respiratory center, constipation), Long-term administration of opiates can cause physical dependence, but their role in pain relief is significant. They should be administered at regular intervals and with sufficient dosing. Fentanyl is 40 times more effective than MO,

Application forms: injection, drops, tablets, transdermal patch (Durogesic).

5.4 Nutrition of the oncological clients

Significant weight loss due to cytokines (metabolites of tumor cells) that cause anorexia, appetite and changes in taste). There is a failure between the centers of hunger and satiety.

Recommendation:

- Adjustment of the menu - cooperation with a dietitian
- Consume high-calorie foods - chocolate, cream, pastries, mayonnaise
- Forget about healthy eating!
- Eat in small portions but often and slowly
- Sipping - NUTRIDRINK liquid nutrition (various flavors, over-the-counter in pharmacies) FRESUBIN - also as a dietary supplement
- To increase the taste of aperitifs - beer, wine and other digestive
- If you are very sick and reluctant to eat (during chemotherapy) - avoid your favorite foods (do not dislike them)
- Plenty of liquids - sparkling, with ice, lemon, fruit juices - pineapple (crushed ice, suck ice cubes)
- MEGACE® preparation - megestrol acetate (gestagen): in case of anorexia. Increases muscle toning, subcutaneous fat within 2-3 months. Available in tablet or suspension form - 400 to 800 mg once a day, no more.

5.5 Psychological problems of malignant gynecological diseases

The disease and its treatment will deeply affect the life of every woman, very significantly the role of woman, mother and wife and thus the life of the whole family. In addition to surgery, women often undergo adjuvant treatment, which means a change in appearance (eg after breast amputation or hair loss) and the associated loss of self-confidence, sexual cohabitation and, in some cases, the loss of a partner. The woman should be informed of all aspects of oncological treatment by her doctor. The question remains how and when to communicate a serious diagnosis to the patient. It should be noted that this falls exclusively within the competence of the doctor!

The nurse can supplement the information provided by the doctor (according to her competencies) or initiate further clarification from the doctor. The nurse should always be informed of what the doctor has told the woman so that possible misunderstandings can be avoided. Furthermore, it is necessary to respect the woman's wish to provide information to loved ones, the so-called informed consent. A woman must always have hope of recovery.

Communication of a serious (oncological) diagnosis

It is based on the Public Health Act No. 20/1966 - the doctor's obligation to inform the patient about his health condition

Convention for the Protection of Human Rights and Human Dignity with regard to the Application of Biology and Medicine (1998) - The right of patients to information.

1. The full responsibility for the truth lies with the physician
2. The professional role of the nurse is important but limited
3. The nurse only adds information or initiates further clarification from the doctor
4. The patient has the right to information, but also to give it up
5. He has the right to a uniform flow of information
6. The midwife should always be informed of the extent to which the doctor has informed the patient and when
7. It is not desirable for the nurse to speak differently than the doctor
8. It is not tolerable for the doctor not to say anything significant to the patient and for the nurse to be forced to answer the patient's serious questions
9. It is possible to inform family members and relatives with the patient's consent

It is necessary to develop a strategy for communicating important information, WHEN, WHO, WHERE, TO WHOM, WHAT and HOW to communicate.

The competencies of individual workers must be clearly defined with regard to their professional category.



Control questions

From available sources, study the current incidence and prevalence of the most common oncogynecological diseases in women.
Think about and state in points the topics of the educational process that must be implemented in the client after actinotherapy after breast surgery.
What is adjuvant and neoadjuvant therapy?

Comments

6 Care for a woman with urinary incontinence

Annotation, abstract

The chapter introduces the student to the issues of urogynecology, clarifies the causes of incontinence, introduces the risk factors and classification of individual types of incontinence. Describes the role of a midwife in dealing with incontinence and caring for a woman after surgical treatment of incontinence using TVT tape.

The aim of the chapter

- The student is familiar with the classification of incontinence
 - The student knows the causes and treatment of various types of incontinence
 - The student knows regimen measures in the treatment of incontinence
-

Key words: urinary incontinence, stress incontinence, urge incontinence, TVT and TOT tape, regimen measures

The relatively new medical field of Urogynecology deals with urinary incontinence. It was created in the 60s min. century as a new interdisciplinary field with an effort to find a comprehensive solution to female urinary incontinence. It deals with the diagnosis and treatment of urinary disorders, the issue of inflammation of the lower urinary tract, the treatment of fistulas and, last but not least, the reconstructive treatment of the pelvic floor.

Urinary incontinence is defined as uncontrollable leakage of urine, which is a serious health and social problem does not mean a separate disease, it is only the result of certain pathological - anatomical and functional changes.

Urinary incontinence affects about 14% of women after the age of 30, with increasing age this percentage increases especially in the postmenopausal period and reaches up to 50% of incontinent women.

Worldwide, 13 million people suffer from various types of incontinence, 85% of whom are women.

Basic types of incontinence:

- A. stress (SI) - 33%
- B. urgent (UI) - 29%
- C. mixed - 19%
- D. reflex
- E. from overflow



Risk factors for incontinence:

limited mobility, drugs (hypotensive, diuretics), smoking, delirious states, increased frequency of births, births of heavier children, obesity, diabetes mellitus, central stroke, nocturna enuresis in childhood.

6.1 Stress incontinence

- is the most common type of incontinence, affects all age groups.

Causes: strenuous exercise, childbirth, loss of pelvic floor muscle tone, estrogen deficiency (menopause), gynecological operations, hysterectomy, colorectal surgery, vag. operation). It causes a deterioration in the quality of life, disrupts work, social and personal activities, causes social isolation.

Treatment options: aids to capture urine, strengthening the pelvic floor muscles, electrical stimulation to strengthen the muscles, drugs to increase or decrease muscle activity, surgery (conventional - according to Burch, TVT technique (1995) and TOT (2002)).

TVT and TOT tape is designed to address stress incontinence: I. - III. type (hypermobility of the throat muscle) and mixed (SI + hyperactivity of the detrusor). The tape raises the neck of the m. M. And m. Tube to the natural position. Contraindications to the introduction are pregnancy (even planned), growth period, urinary tract infections and vaginal infections. It is performed under local, regional or general anesthesia.

Advantages of the method: less invasive, possibility of epidural, spinal or local anesthesia, short hospitalization x outpatient procedure, shortened PN period (1-2 weeks), high efficiency, possibility of solving otherwise unsolvable cases (contraindications).

The role of a midwife in the surgical treatment of incontinence

Upon receipt:

1. Fill in the admission documentation for the doctor who will be the pac. to receive
2. the nursing documentation is written
3. Doctor will acquaint the patient again with the course of the operation and will write a consent to the planned operation with her
4. The doctor at his discretion will prescribe ATB, Fraxiparine, DK bandages, if the pac. Diabetic, prescribes 10% glucose with insulin on the day of surgery
5. 5th patient learns - do not eat, drink or smoke from midnight
6. We shave the genitals, the patient can do it herself after agreement with the nurse (it is necessary to check)
7. The anesthesiologist prescribes premedication, event. other suitable surgeries
8. 19.00 - application of Fraxiparine 0.4 ml s. C.

On the day of surgery:

1. on the 1st morning, the patient takes a shower, puts on elastic stockings on the DK (if prescribed) and puts on an operating shirt
2. ATB application, event. 10% glucose with insulin

3. premedication

After surgery:

1. measure FF, control of vaginal bleeding, control of surgical wounds
2. if the patient needs to urinate, urinate on a bowl - check if there is no hematuria (it must not be large)
3. measure the amount of urine
4. patient gets up at 5 pm
5. urine residue - by catheterization, SONO
if the patient urinates without problems, we measure only in the evening and the next morning (it should not be larger than 70ml)
6. if the patient does not urinate spontaneously - we catheterize once

First postoperative day:

if the urine residue is not larger than 70 ml and the patient urinates without problems, she is usually released for home treatment, oper. we rub the wounds with Novikov and pac. can take a shower, he will come to the extraction of stitches on an outpatient basis a week after the operation. If the residue is larger than 150 ml, we measure it after each spontaneous urination.

Second postoperative day:

the residue should not be larger than 70 ml of urine, if the patient does not urinate spontaneously - we insert a permanent catheter, if the residue is larger than 150 ml the second day after the operation, we insert a permanent catheter for a period determined by the doctor (usually 4 days)

Discharge of the patient:

1. Spontaneously urinate, has no residue
2. He has no signs of infection
3. She is educated about exercises to strengthen the pelvic floor, wound care, genital hygiene
4. Knows the date of the next examination (urologist, gynecologist)
5. If the course is smooth - the second day after dimise surgery

6.2 Urgent incontinence

- leakage of urine associated with a feeling of strong compulsion to urinate, functional impairment, the cause is increased irritability of the bladder wall. Pathophysiologically, it can be caused by excessive sensory impulses from receptors in the bladder wall or insufficient inhibition of the micturition reflex, division into UI with uninhibited contractions of the detrusor and SENSOR UI without uninhibited contractions.

The treatment of urge incontinence consists of drug treatment consisting in reducing the irritability of the detrusor.

6.3 Education of the woman with the incontinence

When diagnosing incontinence, regimen measures should be

recommended to improve the patient's quality of life until drug treatment or surgery is performed.

Recommendations given by the midwife:

- Weight loss
- Use incontinence pads, not menstrual pads
- Always urinate when leaving the house
- Limit coffee drinking
- Introduce a drinking regime
- Increase intimate hygiene
- Plan a trip with a view to visiting the toilet
- Use incontinence aids - FEMCOM cones, pessary, urethral closure, cube pessary, urethral closure, urethral cap

Control questions

Explain the differences between different types of incontinence.
How will mixed incontinence be treated, how will you educate a woman?
Get acquainted in the literature with incontinence aids and their use.
Educate the woman about regimen measures in newly diagnosed incontinence.

Comments



7 Care about the woman with the physiology pregnancy

Annotacion, abstract

The content of the chapter is to acquaint the student with the development of pregnancy and childbirth. Pregnancy is the period when a fetus develops in a woman's body. It begins with fertilization and ends with the birth of the fetus and amniotic sac. Pregnancy is divided into fertilization (fertilization), implantation (immersion), nidation (nesting) and development of the fetal egg. By the transition from intrauterine life to the extra-maternal environment at the time of birth, the fetus becomes a newborn.

The aim of the chapter

- To acquaint students with the physiology of fertilization
 - To acquaint students with the prenatal development of the fetus
-

Key words: pregnancy, fertilization, prenatal development

7.1 Prenatal development and pregnancy

Pregnancy begins with the fusion of a female egg (oocyte) germ cell with a male sperm germ cell. Fertilization most often occurs in the ampular part of the fallopian tube. Germ cells always contain half the number of chromosomes than all cells in the body. There are 22 somatic chromosomes and 1 sex chromosome in the egg, the sperm contains 22 chromosomes and 1 sex chromosome X or Y, which determines the sex. The combination of sperm and egg in the case of combinations XX is a female fetus, on the contrary in the combination of XY it is a male fetus.

Sperm enter the woman's body after ejaculation during sexual intercourse, they are able to fertilize the oocyte 24-72 hours, after which they degenerate. The oocyte has the ability to be fertilized for 24 hours. Only one sperm is needed to fertilize an egg. Sperm enter the fallopian tube within five minutes after ejaculation. When the egg connects to the sperm, the sperm head enters the egg, the flagellum remains outside the egg. The egg eventually becomes impermeable to other sperm. Fertilization becomes a zygote egg, duplication of chromosomal equipment, 46 chromosomes (46 XX or 46 XY).

After fertilization, the fertilized egg is rapidly divided (grooved) and a morula (a formation of 16 cells) is gradually formed. During division, the fertilized egg moves (migration) through the fallopian tube towards the uterus. The morula transforms into a hollow structure that is formed by a fluid, a blastocyst, in which two types of cells are formed, the embryoblast



(for fetal formation) and the outer trophoblast (for placental formation and

fruit packaging). On the sixth day after fertilization, it enters the lining of the uterus and gradually plunges into it - implanted. In 10 days the nidation is completed and nidation, nesting takes place. Eventually, the fetus, amniotic sac, and placenta develop, and then other pregnancy changes occur.

Fruit packaging:

Decidua - pregnancy-altered uterine mucosa, perfused, forms the outer shell of the fetal egg, is of maternal origin. Provides the first nutrition of the fruit egg.

Chorion - fibrous membrane that merges with the amniotic shell.

Amnion - the inner shell of a fruit egg. It is a vascular translucent membrane that covers the fetal part of the placenta and passes to the umbilical cord. Produces amniotic fluid.

Amniotic fluid - clear, slightly milky, microbially sterile, fills the fruit eggs and creates optimal conditions for the fetus. At the end of pregnancy, its amount is 800 - 900 ml. Amniotic fluid is formed in the early beginning of pregnancy by maternal blood and secretion of amniotic cells, later by urine through the fetus, which the fetus excretes. The function of amniotic fluid is: it suppresses the uterine cavity, part of the internal environment of the fetus, dampens shocks, allows the fetus to move, bactericidal effects, protects the mother from painful movements, during childbirth serves as a dilator of the fetal tract.

Placenta - an organ that mediates contact between the mother's body and the fetus during pregnancy, supplies the fetus with oxygen and nutrients and removes the products of its metabolism. It is a temporary endocrine gland. In the 20th week of pregnancy, the placenta covers half of the uterine cavity. At the end of pregnancy, the placenta weighs 500 g. The fetal part of the placenta is shiny, gray, covered with amnion. The maternal part consists of cotyledons (functional units) in the number of 15 - 20, which form placental villi. The maternal part is red, rough. The placenta begins to form in the 12th week of pregnancy and has a hormonal function (hCG secretion - chorionic gonadotropin, estrogens and progesterones), protective, provides metabolism, nutrients and oxygen, production of enzymes and metabolites.

Umbilical cord - provides a connection between a woman and a fetus. In the ripe fruit, it measures 50 cm and has a diameter of 1-2 cm. It clamps in the middle of the placenta. It is covered with a blue-gray membrane of amniotic acid and contains a jelly-like mass (Wharton's jelly), in which the vessels of the umbilical vein run, which supply oxygen and nutrients, and aa.umbilicalis, which drain deoxygenated blood and metabolites.

Embryo and fetal development

Blastogenesis - the development of a fertilized egg during the first three weeks.

Embryogenesis - begins around 22 days after fertilization, it is a period of organogenesis development. The basis of the brain and heart is quickly formed. At the end of the second month since the last menstruation, there is a development of other parts of the fetus, such as the limbs, nose, mouth, eyelids, and the external genitalia and other organs begin to differentiate.

Fetogenesis - from the 9th week we are talking about the fetus, the fetus. Fetogenesis is characterized by fetal growth and differentiation of the functions of all organs.

Week 12 - The embryo resembles a human being, the head is larger, the external genitals are differentiated. The fetus measures 9 cm.

Weeks 13 - 16 - the rapid growth of the fetus continues, after the body of the fetus there is lanugo, fetal hair. The intestinal tract of the fetus produces meconium, stool formed during pregnancy. The fetus has swallowing reflexes.

17 - 20 weeks - the mother is very receptive to movement, hair, eyelashes, eyebrows begin to grow. The sebaceous glands of the fetus are activated, the fetus is covered with a sebaceous layer called vernix, which protects the fetus from maceration of amniotic fluid. Lung development continues.

Weeks 21 - 24 - there is a significant increase in weight. The skin is wrinkled due to lack of subcutaneous fat, red, blood is visible in the capillaries. The eye is structurally developed and the eye slit soon opens.

Weeks 25-28 - Subcutaneous fat begins to fill some skin folds. In this period, the fetus reaches the stage of extrauterine viability, the ability to survive outside the mother's body. However, the lungs are still immature. In males, the testicles partially descend through the inguinal canal into the scrotum. The fetus weighs 1000 - 1200 g.

Weeks 29 - 32 - fat and muscle tissue develop, bones are fully developed, but they are soft and flexible. The skin is less wrinkled, the fetus gets a newborn look.

Weeks 33 - 36 - the lanugo begins to disappear, the fetus is in most cases capable of extrauterine life.

Week 37 - 40 - the fetus is ripe, if it is born, we are talking about timely, term birth.

Signs of fetal maturity

Anatomical: pink color, developed subcutaneous fat, lanugo only on the shoulders, nails over the edges, grooves visible on the entire surface, well-developed nipples, earlobe, hardened cartilage, descended testicles in boys, large lips overlap small in girls.

Functional: active muscle tone, constant TT, well-developed reflexes (search, swallow, grip, tonic-neck, gait automation).

7.2 Characteristic changes in the parent organism

Pregnancy is a burden on a woman's body and causes a number of changes in it, which are related to ensuring the development and nutrition of the fetus, preparation for childbirth and breastfeeding.

Reproductive system

Uterus - due to hormones there is an increase in blood circulation, thus changes in consistency (the uterus is soft, soaked, has a poor tone), colors (throat-colored blue-violet), fetal eggs grow in the uterine cavity, which changes its shape and changes in deposition in the small pelvis and later in the abdominal cavity. The growth of the uterus has a certain sequence and we can assess the age of pregnancy according to the size of the uterus during the palpation examination.

Cervix - undergoes changes in pregnancy that lead to its shortening and softening. The cervical glands produce dense mucus, which accumulates in the cervical canal, where a mucus plug later forms, closing the canal and thus forming a protective function against the transmission of infections.

Vagina - increased blood flow changes the color of the vaginal mucosa, which is caused by hormonal changes. There is an increased vaginal secretion manifested by discharge.

External genitalia - increased pelvic blood flow, relaxation of the pelvic veins, increased pressure of the growing uterus, constipation and obesity can cause varices of the external genitalia and rectum.

Mammary gland - due to the hormones estrogens, progesterones, they enlarge and strain, the sensitivity of the nipples. Gradually the pigmentation of the areola darkens, the nipple enlarges. After the tenth week, the woman can watch the formation of colostrum, a yellowish fluid that can be expelled from her nipples.

Ovaries - ovulation of the hormones FSH and LH by placental hormones is blocked.

7.3 Extrareproduction systems

Cardiovascular system - with an increase in the uterus, the minute volume of the heart increases by 50%, ie by 1-2 within the entire blood volume. The heart is moved up and to the left, at the same time it rotates around its axis, the pulse accelerates by 10-15 beats per minute. The position of the mother has a positive effect on blood pressure, because in the supine position there is a syndrome of the inferior vena cava, when the uterus presses on the inferior vena cava and thus limits the return of blood to the heart. Hypotension occurs, which is manifested by nausea, sweating, paleness, and exceptional loss of consciousness. The ideal position in the second half of pregnancy is on the left side. By increasing the pressure on the venous system, it affects the formation of swelling of the lower limbs and in the area of the rectum the formation of vulvar varices and hemorrhoids.

Respiratory system - enlarging the uterus shifts the diaphragm by 4 cm, increases oxygen consumption and increases the respiratory volume to maintain respiratory rate. Towards the end of pregnancy, women may therefore have a problem with dyspnoea, which is caused by uterine pressure on the diaphragm.

Blood system - increases by 1 - 1.5 l, when the total hematocrit of the blood changes, in some cases only the plasma increases compared to the same ratio of blood elements, especially erythrocytes, so some women may suffer from anemia. Production of other elements such as are leukocytes, increases as well as blood clotting, while decreases the consumption of plasma proteins.

Uropoietic system - there is an expansion of the urinary tract, thus physiological hydronephrosis, urinary stasis and vesicuterin reflux, which is caused by uterine pressure. By increasing the volume of the urinary tract, a woman is more prone to urinary tract infections, increasing glomerular filtration.

Gastrointestinal tract - the oral cavity is more prone to injury, the production of saliva and its composition increases, which makes there a more frequent occurrence of caries. The esophagus, stomach and intestine are slowed down in the function of progesterones, the woman is endangered by constipation or heartburn. Women experience changes in taste. Women are more susceptible to odors and tastes, which can lead to early morning sickness at the beginning of pregnancy.

Musculoskeletal system - posture and walking are affected by a change in body weight and a change in the woman's center of gravity, lumbar lordosis changes and the pelvic girdle relaxes, which can result in back pain.

Skin and pigmentation - many women develop yellow-brown skin pigmentation on the face, upper lip, so-called chloasma gravidarum. Darkening of the areola, linea fusca appears on the abdomen. Within the connective tissue, increasing corticosteroid levels disrupt collagen fibers and cause stretch marks.

Women have shinier hair, but in the postpartum period, a change in hormones causes hair loss.

Woman's metabolism - increases by 15 - 20% due to oxygen consumption depending on the growth of the fetus and maternal tissues increased load on the blood circulation and respiration. Body weight increases during pregnancy, by an average of 12 - 15 kg. The highest weight gain occurs in the second half of pregnancy and contributes to fluid retention in the tissues.

Mental changes - are affected by physical changes, on the other hand, they are influenced by socio-economic influences. It also depends on the situation

whether the pregnancy is desired, on the personality qualities and the influence of the environment.

Control questions

- How does fertilization, fetal development occur?
- How can we divide the changes in pregnancy, describe it individually?
- Describe the fruit wrappers?

Comments



8 Characteristics of pregnancy and prenatal care

Annotacion, abstract

Pregnancy is a time-limited, physiological process that affects a woman physically and emotionally. All systems adapt and serve the growing fetus. Pregnancy lasts 40 weeks (280 days).

The length of pregnancy is given in completed weeks and days, eg 28 weeks and three days (28 + 3). We consider a terminated pregnancy in the period from the 38th week to the 42nd week to be a timely delivery. If the birth occurs before the 38th week, it is a premature birth. If a woman does not give birth by the 42nd week, it is a prolonged pregnancy.

The aim of the chapter

- To acquaint students with the characteristics of prenatal care.
 - Describe individual regular and irregular examinations of a woman.
-

Key words: *prenatální péče, vyšetření ženy, screening*

We divide the period of pregnancy into three trimesters:

First trimester - until the 12th week

Second trimester - from the beginning of the 12th week to the 27th week

Third trimester - from the 28th week of childbirth

The number of previous births, their course and outcome play an important role in determining the strategy and prognosis of birth.

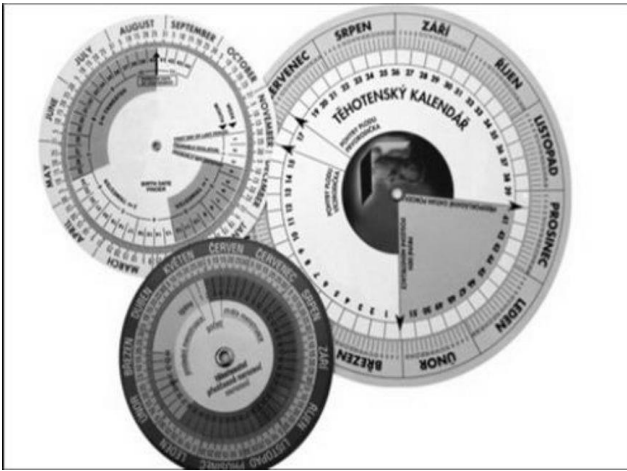
The term parity of a woman means how many in a row the current birth is. Gravidity indicates how many times a woman has been pregnant.

Calculation of the due date:

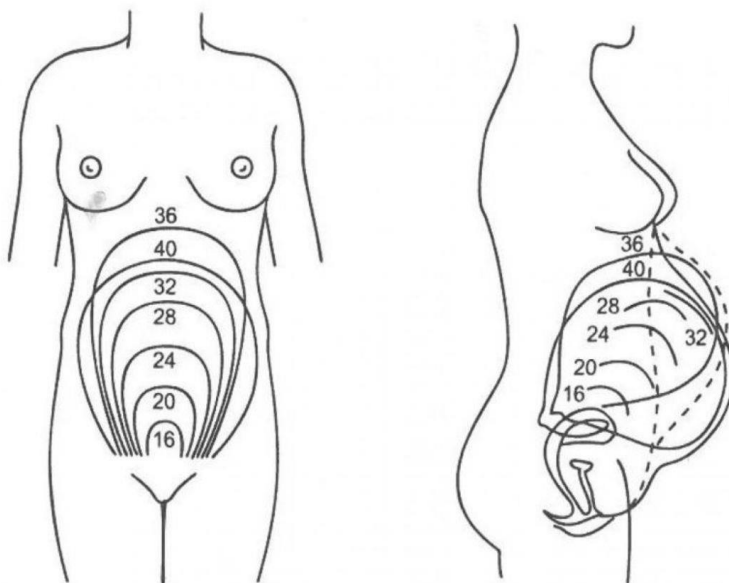
- Determine according to the first day of the last menstrual period - add 7 days to the day of the last menstrual period and subtract 3 calendar months.
- Furthermore, the date of delivery can be determined with a special wheel - a gravidometer.
- Alternatively, there are special computer programs.
- The oldest method is to calculate the date according to the day of fertilization and to this day we add 38 weeks



Pic. 1 Gravimeter



Pic. 2 Growth of the uterus during pregnancy



Symptomatology of pregnancy:

Signs and symptoms of pregnancy are based on changes in individual organs. One of the first symptoms is the omission of menstruation (amenorrhea). Many women experience increased tenderness and tension in the beginning of pregnancy, especially in the area of the nipples. Nausea, which can be accompanied by vomiting, is an unpleasant manifestation. Due to hormonal

changes, uterine growth and fetal oppression, there is a more frequent urination frequency. Women feel increased fatigue, especially in the first trimester and at the end of pregnancy. The mother's perception of fetal movements occurs in the 18th week of pregnancy.

Diagnosis of pregnancy

The diagnosis is based on the detection of the hormone hCG in the blood and urine (pregnancy tests), followed by an ultrasound examination, which shows 100% fetal heart rate around the 6th week. An integral part of the confirmation of pregnancy is a gynecological vaginal examination.

Prenatal care

The purpose of prenatal care is the comprehensive provision of a pregnant woman, especially the consistent prevention of possible conditions and the early detection of risk factors that may be predisposing to deviations from normal pregnancy. We divide pregnant women according to the occurrence of risks into three groups:

1. **Pregnant with low risk** - physiological pregnancy, no history of risk factors, results in normal, care is provided until the 28th week after 4 6 weeks and then until the due date after 4 weeks.
2. **Medium-risk pregnant women** - high-risk pregnancies where there is a history of risk factors that require more frequent check-ups during prenatal care and their recurrence.
3. **High-risk pregnant women** - pathological pregnancies, with a history of risk factors and pre-existing pathologies both prenatally and peripartally.

Each workplace has its own habits and schemes of prenatal care. During pregnancy, women undergo individual laboratory and clinical examinations, which can be divided into:

Regular - performed at each visit to the gynecologist: taking a nursing history, risk levels, external examination of the woman, determination of body weight, blood pressure, evaluation of swelling and varices, chemical analysis of urine (presence of pH, sugar, proteins), determination of cervix score , dilatation of the throat, dilation, opening of the pathways, shortening of the cervix, consistency of the cervix, localization of the cervix - criterion 0 - 2 points), cardiac action of the fetus.

Irregular - they are performed only during a certain week of pregnancy. A comprehensive basic examination should be performed no later than the 12th week of pregnancy. It includes an important history, measurement of the external pelvic dimensions of the pregnant woman, examination of the breast, height of the woman, initial weight and issuance of a pregnancy certificate - proof of pregnancy, in which the doctor records all results and examinations during pregnancy, the overall course of pregnancy. Afterwards, the woman undergoes individual examinations in individual weeks of pregnancy.

11th - 13th week: determination of blood group, Rh factor, KO, Serological examinations of HIV, HCV, HBsAg, BWR, urinary sediment, fasting blood glucose, combined ultrasound screening.

Week 16: biochemical screening of VVV in II. trimester (triple test) is performed only if a combined biochemical test has not been performed. It is performed by taking AFP alpha-fetoprotein, hCG, free estriol. Evaluation of VVV, chromosomal aberrations - M. Down.

Weeks 18 - 22: Ultrasound examination, evaluation of the condition of the fetus, measurement of its dimensions, evaluation of the development of organ systems, the condition of the placenta, its placement.

Weeks 24 - 28: screening examination of glucose tolerance disorders oGTT, for the diagnosis of gestational diabetes and its early detection. Gestational diabetes mellitus can worsen the course of pregnancy, so women are monitored.

Week 28: screening of Rh antibodies in women with Rh-, examination of KO, syphilis antibodies.

30th - 32nd week: until this time, women visited a gynecologist at 4-week intervals; from the 36th week, they go to the date of childbirth every week.

Weeks 36-38: GBS culture collection (detection of group B streptococcus. If the results evaluate a positive incidence of streptococcus, the woman receives antibiotic prophylaxis during childbirth.

Weeks 38 - 40: cardiotocographic examination, method evaluating fetal heart rate and its general condition. The heart rate of the fetus is 110 - 150 beats / min.

40th - 41st week if the woman does not give birth on time, she goes to 41 + 3 twice a week, then the woman is prepared for childbirth and its induction.

Genetic screening tests:

Combined screening in the first trimester: genetic examination of ultrasound and biochemical examination of blood.

Fetal echocardiography: performed in weeks 20-23 under fetal ultrasound.

Invasive prenatal examination: aminocentesis - collection of amniotic fluid or cordocentesis - collection of fetal blood from umbilical vessels, collection of chorionic villi CVS - performed between 16 and 21 weeks, and are associated with risks of premature birth or miscarriage.

Laboratory and clinical examinations in pregnancy	
Regular examinations	
– supplementation of anamnestic data – body weight – blood pressure, pulse – chemical examination of urine (protein, pH, blood, sugar) – external obstetric examination – vaginal examination, determination of cervix score (performed by a doctor) – from the 24th week of pregnancy detection of signs of fetal vitality	
Irregular examinations	
until 16th week	– blood type + Rh factor – blood count (KO) - hemoglobin level, hematocrit, number of erythrocytes, leukocytes and platelets – erythrocyte antibody titre – serological examination of HbsAg and HIV – antibodies against syphilis – fasting blood glucose – combined VVV screening (11-13. g. t.)
16+	– biochemical screening of VVV (triple test)
18th – 22th week	– the first ultrasound screening of the fetus
24th – 28th week	– gestational diabetes screening (oGTT)
30 – 32 week	– second ultrasound screening – blood count (KO) - hemoglobin level, hematocrit, number of erythrocytes, leukocytes and platelets – erythrocyte antibody titer in Rh negative and blood group 0 women – serological examination of HbsAg and HIV (only selectively in risk groups) – syphilis serology
36 – 37 week	– detection of group B streptococci (vagina, rectum)
38.; 39. and 40th week	– cardiotocographic non-stress test - exceptionally (for risk groups) recommended earlier, in the 36th or 37th week

Tab. 1 Examination in pregnancy

Psychoprophylactic preparation for childbirth

Prenatal care consists of monitoring the health of a woman and the development of the fetus, in order to detect in time any complications that disrupt the course of pregnancy. The second goal of prenatal care is to prepare the woman, but also the partner and her family for a new role in a woman's life, motherhood, to inform women about pregnancy, childbirth, the puerperium and newborn care. It aims to reduce the fear of pregnancy, childbirth, promote a realistic attitude to childbirth, reduce the fear of labor pains and eliminate concerns about newborn care and parental roles. Women obtain this information in a antenatal clinic or as part of special prenatal courses, which they can attend, where they can learn all about pregnancy, childbirth, the postpartum period and newborn care.

Control questions

-
- Describe the physiological, risk, pathological characteristics of pregnancy?
 - How does he diagnose pregnancy?
 - How do you determine the date of birth or the age of a woman's pregnancy?
 - Name what you do during a regular examination of a woman?
 - Describe individual irregular examinations of a woman?
-

Comments



9 Nursing care for a woman during childbirth

Annotacion, abstract

In this chapter, the student gets acquainted with physiological childbirth and its definition and then with individual times of childbirth. Childbirth is a physiological process in which a fetal egg (fetus, placenta, amniotic sac) is expelled from the mother's body.

The aim of the chapter

- To acquaint students with the physiology of childbirth - individual periods of childbirth.
 - Describe nursing care for a woman during childbirth.
-

Key words: childbirth, labor pain, periods of labor

Childbirth is a physiological process in a woman's life. We consider the birth of a live fetus weighing more than 500 g and with a gestational age of 22 weeks. Under the fetus with these signs there are no signs of life (heart rate, muscle tone, breath, color) it is a dead fetus. If the fetus weighs less than 500 g, it is a miscarriage of the fetus.

According to the length of pregnancy, we distinguish:

Early childbirth (partus maturus) - this is the termination of the pregnancy between the 38th – 42th week of pregnancy

Premature birth (partus praematurus) - termination of pregnancy by the 38th week

Delayed delivery (partus postmaturus) - termination of pregnancy after the 42nd week.

Method of delivery:

Spontaneous childbirth - spontaneous, the onset of regular processes in the body of a woman without the intervention of an obstetrician leading to the expulsion of the fetus.

Medication - with the help of an obstetrician, pharmaceutical interventions occur to speed up childbirth, alleviate labor pains, strengthen uterine activity, etc.

Induced labor - induced, affecting uterine contractions, processes leading to fetal delivery. In some cases, it may be a programmed delivery - to take place under ideal conditions.



Surgical delivery - termination of pregnancy by caesarean section due to planned termination of pregnancy for certain reasons or acute caesarean section if complications occur during pregnancy or childbirth. Another possibility is the acute termination of pregnancy by the vaginal route, extraction procedures - VEX (vacuum extractor) or forceps (obstetric forceps).

Placement of the fetus in the uterus

Fetal placement can be evaluated by palpation of the abdomen or ultrasound examinations, it is evaluated - position, position, holding, urging.

Fetal position - determined by the longitudinal axis of the uterus to the longitudinal axis of the fetus. We recognize longitudinal, transverse or oblique positions. The longitudinal head can be divided by the head or the end of the pelvic fetus.

Fetal posture - determined by the relationship of the fetal back to the uterine edge. We most often distinguish I. position (back of the fetus on the left front) or II. position.

Fetal urgency - determined by the relationship of the urgent part of the fetus (most often the head) to the pelvic entrance.

Fetal holding - the relationship of individual parts of the fetus to each other. The fetus is in the flexion of the foot, to the abdominal wall, hands together.

The fetus as an object of birth:

The leading part of the fetus is mainly the head or pelvic end. On the head we distinguish between the hard and soft part of the skull. The cranial part consists of two frontal bones, two parietal and two temporal bones and one occipital and two collarbones. The boundaries between the individual bones are formed by seams and fountains. On the header we distinguish small (fontanela minor) and large fontanella (fontanela major). On the head, we also distinguish between transverse and longitudinal diameters and penetrating circuits, where the head of the pelvis then passes through its smallest diameters during the mechanism of childbirth.

Birth canal:

During childbirth, the fetus passes from the uterine cavity to the external environment during childbirth. The birth canals are divided into hard birth canals - formed by a bone pelvis, which distinguishes the pelvic canal from the entrance, width, strait and pelvic exit, through which the fetus passes during the mechanism of childbirth. The soft pathways of the birth are formed by the pelvic floor abutting the pelvic girdle and in the lower part of the lower uterine segment, the cervix, vagina and external birth.

Childbirth forces:

The birth forces include uterine contractions, the abdominal press and, in a sense, the earth's gravity. Uterine contractions are designed to reduce the

contents of the uterus and push the fetus out of the uterine cavity. The mother usually perceives this force painfully, which we call labor pains. The abdominal press is an active, clearance-controllable muscle contraction of the transverse striated abdominal and diaphragm muscles. Earth's gravity helps the passive opening of the birth canal and the entry of the head into the pelvis. The course of childbirth, its length lasts on average 6 - 12 hours for the first-born, and 3 - 9 hours for the multiple-born. The duration is individual. In terms of time, we divide childbirth into phases.

Stages of childbirth

Preparatory period - the period before the onset of labor, when between 39 and 40 weeks of pregnancy, the frequency of uterine contractility increases, which eventually leads to changes in the cervix. Uterine contractility can be irregularly assessed by a woman as so-called messengers (*dolores praesagiales*). During the last month, the header begins to enter the plane of the pelvic entrance. If the outer gate opens with the pressure of the head, the mucus plug leaves. All these factors are applied to the development of uterine contractions, which develop the lower uterine segment and thus initiate the first period of labor. But how does a woman know childbirth from the preparatory period? Regular contractions occur, which differ from the messengers in that they have an effect on the lower uterine segment. Their intensity decreases every 5 minutes. Childbirth begins subsequently, if amniotic fluid drains, by spontaneous conduction of the membrane sac. Alternatively, if a woman starts bleeding, she should be admitted to childbirth for any complications.

I. period of labor - the opening period, begins with regular uterine contractions, which change the birth finding on the birth canal and ends with the complete opening of the uterine gate.

II. delivery period - expulsion, is the period of opening the uterine gate until the expulsion of the fetus.

III. childbirth - begins with the birth of the fetus and ends with the birth of the placenta.

IV. labor period - the postpartum period, when a woman remains in the delivery room 2 hours after the placenta is expelled and is observed and monitored as part of the adaptation together with the newborn.

Admission of a woman to the delivery room and examination

At the mother's admission, we take a nursing history, additional information to the pregnancy certificate, the course of childbirth, the reason for admission, examination of blood pressure, P, TT, weight gain, evidence of amniotic fluid outflow (Timișoara test - chemical agent) are recorded, doctors perform comprehensive examinations, Ultrasound examination, CTG examination - proof of fetal vitality, vaginal examination, here it is necessary to follow the principles of sterile environment. The vaginal entrance, the arch,

the entrance of the head, the part urging to the hard birth canals are assessed, we evaluate its shortening, consistency, dilatation (opening), localization on the cervix. Another part is the assessment of the level of entry of the head into the birth canal. Afterwards, the mother's administrative reception takes place. If the woman agrees, the woman is given an cleansing enema and then a hygienic cleanse of the woman. The woman then goes to the maternity ward, where she is close together with a person in case of her interest.

9.1 I. labor period

- **begins with the onset of regular contractions, which affect the development of the lower uterine segment and lead to the full development of the birth canal.**

10% begin childbirth by spontaneous amniotic fluid outflow. If regular contractions do not occur within 1 hour, it is a PROM - preterm rupture of membranes. The frequency of contractions is usually 1-2 / 10 minutes. Gradually, the intervals between contractions shorten, the intensity increases. This leads to the escalating pain that a woman feels. During contraction, the pressure of the pressing part of the fetus is pushed towards the lower uterine segment, which moves upwards over the head. This shortens the throat and opens the obstetric gate. The progress of the obstetric finding is monitored gradually by vaginal examination during childbirth, which we perform once every 2 hours. The size of the dilatation is evaluated in 1 - 8 cm, the subsequent phase is called the hem and the phase is the final "sent" goal (10 cm), when during the vaginal examination the proper part of the goal is not palpable, only the head of the fetus. The birth canals are ready to expel the fetus, beginning II. childbirth.

The shortening of the birth canal occurs differently in first-time and multiple mothers. In first-time mothers, the cervix is first shortened and a thin obstetric gate is formed, and then the uterine gate begins to open. In multiple mothers, these processes occur simultaneously. **Examination during childbirth**

During the first period of labor, attention is focused on the somatic and mental state of the mother, sufficient oxygen supply to the fetus and evaluation of adequate labor. uterine contractility is monitored during the first period of labor. If their function is insufficient, it is a condition of primary or secondary weak contraction, which may be supported by Oxytocin infusion therapy. Depending on the evaluation of uterine contractions, the pain of the mother is evaluated. Pain can be influenced by medication, application of analgesics, application of epidural anesthesia, or hydrotherapy, shower, bath, aromatherapy, relaxation, positioning of a woman, etc. are used in a non-drug way. Psychoprophylactic preparation of a woman for childbirth and also a person close to childbirth also play an important role. Furthermore, fetal heart

sounds are monitored every 15 minutes. It is evaluated by cardiotocographic recording, probe. Cardiotocographic recording is performed every 2-3 hours. The midwife monitors the progress of the vaginal finding on the cervix and the entry of the fetus into the birth canal every 3 hours. It also monitors the outflow of amniotic fluid, its quality. If there is no spontaneous outflow of amniotic fluid, mechanical conduction of the membrane sac is performed when a birth gate of 3 - 5 cm is found. Evaluation is important not only the somatic state of the woman such as later blood pressure, P, TT, urination, fluid intake, but mainly the mental state of the woman.

9.2 II. labor period

- begins with the extinction of the goal and ends with the birth of the fetus

During the II. During labor, uterine contractions occur every 2-3 minutes and last for approximately 60-90s. the mother feels the need to engage the abdominal press and is forced to push, which is affected by the pressure of the descending head of the fetus on the nerve plexus in the pelvic floor. With the correct connection of the abdominal press, the head progresses towards the pelvic exit, passes through the lower uterine segment and cuts the head, stretching the perineum (dam). The header begins to prune. The mechanism of childbirth takes place, when the fetus has penetrated passive movements through the birth canals of the pelvis. In the pelvic position, the head, straps and then the body of the fetus penetrate.

Mechanism of childbirth

Flexion of the head - the chin is attracted to the chest, the head is lowered, the leading point is a small fontanelle.

Internal rotation - the head rotates 90 degrees during the delivery. In the plane of the pelvic exit, the head is at the end of the internal rotation with an arrow seam in a straight diameter.

Head Deflection - Pruning the head through the perineum. The occiput rests on the lower edge of the labia and performs a deflection. First, a small fontanelle, a head, a head area, a forehead, a face, and then a chin are cut.

External rotation - the head with its head rotates to the other side, where the unborn back of the fetus is directed. The mechanism of delivery of the arms occurs.

Delivery of arms - first the front arm is born under the symphysis and then the second arm without a special mechanism, followed by the trunk of the fetus.

The main task in II. During childbirth, the fetus is monitored by CTG (cardiotocographic monitor), preparation of the mother for childbirth (appropriate position, preparation of aids, training of pushing and breathing, preparation of the environment), evaluation of the overall condition of the

woman, fatigue. The support of a woman is important at all times.

Preparation of aids: obstetric package (according to custom, sterile pad under the woman, sterile veil to protect the dam, sterile gloves, protective coat), identification bracelets for woman and fetus, disinfection, sterile instruments (obstetric sieve, 2 scissors, 2 pianos to break the umbilical cord, sterile suturing in case of birth injury, obstetric mirrors). Umbilical cord blood collection aids and documentation.

We prepare the environment, especially the heat after the birth of the fetus, dim light and calm. During the birth itself, we calm the mother, we choose suitable position with regard to the wishes of the mother (a half-seat is suitable, on the back), we will disinfect the birth field. Verbal contact, monitoring the condition of the fetus is important, we repeatedly encourage a woman to push. We protect the dam with a sterile drape with back pressure so that it is not injured, if necessary, an episiotomy is performed - cutting the dam. After the birth of the head, we still protect the dam and wait for the external rotation of the fetus, then we help the head of the fetus by pulling downwards to give birth to the upper arm and then during the birth axis to give birth to the second arm and give birth. If it is OK, place the fetus on the woman's abdomen to better adapt the fetus. We wait 2 minutes to warm up the umbilical cord, it is cut. The newborn is treated and marked. Blood samples are taken from the umbilical cord. Begins III. childbirth.

9.3 III. labor period

- begins with the birth of the fetus and ends with the birth of the placenta.

The third labor period takes about 5-10 minutes, assuming the active childbirth leading, which is supported by the application of methylergometrine i.v. (or oxytocin 2–5 j), immediately after the childbirth. Without active birth leading, the birth of the placenta takes longer, up to 30-60 minutes, when it is expected, the woman is at risk of blood loss, which is about 300 ml. Waiting for the placental abruption requires patience without intervention to the process. Signs of placental abruption - the uterine fundus rises above the navel, has a roof-like shape, we feel a soft bulge above the clasp. When the placenta is abrupted, by the pushing over the symphysis, it slides out of the vagina (Kustner's maneuver), equipped with the rotation of the placental sheaths and a slight pull down (Jakobson's maneuver). The mother pushes out the placenta, which is checked for integrity, we check the length of the umbilical cord and blood vessels. Finally it is made the treatment of birth injuries.

9.4 IV. labor period

- the period after the birth of the placenta, when the woman stays in the delivery room for 2 hours due to postpartum adaptation with the newborn.

The woman is most endangered mainly by postpartum hemorrhage. The woman is placed in a rest position. The baby nurse will help the woman to bring the newborn to the breast within 30-60 minutes if possible. Blood pressure, P, and 15 minutes are evaluated, the state of bleeding, birth injuries, uterine retraction is monitored. We pay attention to the overall condition of the woman. After that, the woman is released into the home environment or on the ward, where she is hospitalized for 2-3 days.

9.5 First aid during childbirth in terrain

Calling first aid 155, then it is important to reassure the woman, to detect from her important information - how many times a woman gives birth, in what months of pregnancy is whether she is bleeding or her amniotic fluid has run off. Afterwards, it is important to ensure privacy, preferably a clean and warm environment. We will detect the woman and perform a vaginal examination. If we see the head in the birth canal, we hold it. If possible, we will provide clothing and a shoelace (if it is a home birth, prepare warm towels, warm water, a cord to break the umbilical cord, which should be sterile, boiled in hot water). We encourage the woman to push. After delivery, however, it is not necessary to immediately cut the umbilical cord until the arrival of the emergency room. We monitor the state of bleeding. We carry the woman with the placenta. It is necessary to provide warmth for the newborn and to dry and wrap it. After that, the woman is handed over to the care of a doctor RSZ.

Control questions

Define childbirth. When does it start?

Characterize the mechanism of childbirth.

Describe the individual periods of childbirth and nursing care for women.

Comments

10 Nursing care for a woman in puerperium

Annotacion, abstract

The puerperium is the period up to the 42nd day after the childbirth finish, which is characterized by the gradual remission of previous anatomical and physiological changes associated with the adaptation of the organism to pregnancy and childbirth. He returns to the state in which he was before the pregnancy, however, the woman's body is still quite vulnerable. However, it should be emphasized that pregnancy and childbirth leave the woman, in addition to reversible changes, many changes that persist forever and indicate previous pregnancies, such as skin changes, especially stretch marks, cracks and changes in the cervix, etc.

The aim of the chapter

- To acquaint students with the physiology of childbirth - individual periods of childbirth.
 - Describe nursing care for a woman during childbirth.
-

Key words: childbirth, labor pain, periods of labor

Definition of the physiological puerpetium

The puerperium is the period since the end of childbirth, which is characterized by the gradual remission of previous anatomical and physiological changes associated with the adaptation of the organism to pregnancy and childbirth.

The woman returns to the state in which she was before pregnancy, there are changes in the genitals, but also in the field of mental changes, social, getting acquainted with a new role in a woman's life and the development of lactation. The physical area is dominated by the risk of infectious complications and late postpartum hemorrhage. This period is also very challenging mentally. New life roles, child care and breastfeeding can reveal mental disorders.

From a clinical point of view, the following are divided:

- A. The postpartum period, ie about 2 hours after the birth of the placenta (more part II.)
- B. Early puerperium, 1st week of puerperium.



C. Late puerperium, 2nd - 6th to 8th postpartum week.

Changes taking place in the puerperium

1. Reproductive organs (uterus, vagina, vulva, pelvic floor, dam)

Involutionary changes – Fault of the uterus is conditioned by the contraction of smooth muscle. The uterus returns from the same shape from 1000 g to 80 g. The uterine fundus decreases about 1 cm in 24 hours. With the contraction of the uterus, purges leave after childbirth and bleeding. The appearance of the purges changes physiologically over the course during puerperium. In the first three days, blood predominates, the purges are bloody (**lochia rubra**). After 3-4 days, the blood admixture decreases, the tissue fluid increases, the brownish color (**lochia fusca**). At the end of the first and the beginning of the second week after birth, their character is **seropurulent (lochia flava)**. In the second week, they get a gray-white color (**lochia alba**). Over the next few days, it turns into mere mucus (**lochia mucosa**).

The cervix gradually closes after 3 weeks. The cervix is reepithelialized. The uterine pendants, blood circulation and leakage of organs change, which return to the small pelvis. The vagina remains flexible.

Healing of obstetric injuries - minor injuries heal quickly on their own, major injuries and episiotomies require proper treatment and adherence to the principles of hygiene.

2. Extragenital organs

- cardiovascular system, blood and coagulation system, gastrointestinal tract, uropoietic system, endocrine system), female psyche.

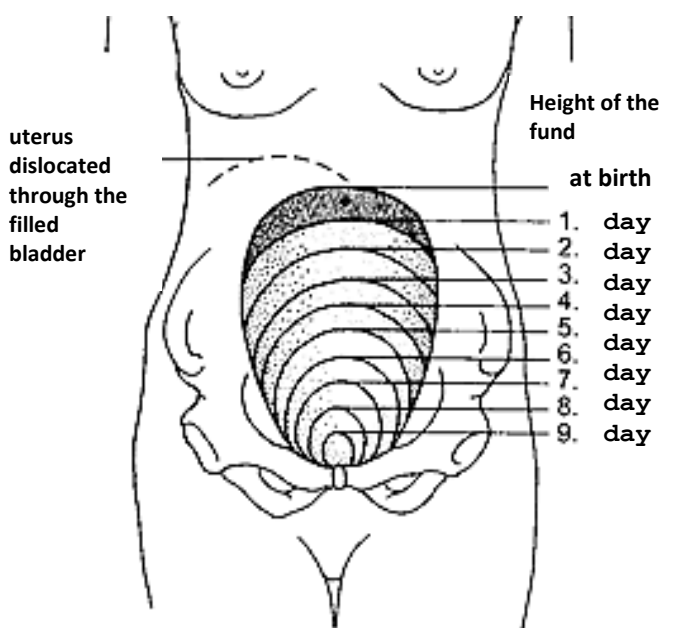
Within the general condition of the woman, there is a decrease in blood by the kidneys and glomerular filtration, which has the effect of reducing extracellular fluid and eliminating swelling. The diaphragm descends and the frequency of pulses and breaths per minute decreases, the total blood volume decreases from 5-6 l to 4 liters. The normalization of the hypercoagulable state occurs. Hormonal changes occur - hCG decreases to 0 in 16 days, prolactin levels depend on the intensity of breastfeeding. The abdominal wall returns in 6-7 weeks. There comes to a weight loss. And in the last, there are changes in the psyche of the women due to hormonal and somatic changes and from adaptation to the role of the mother. In the first days after birth, the mother has a feeling of relaxation and increased self-confidence, but this is followed by a temporary vegetative and emotional lability, which is manifested after the birth by crying, insomnia, sadness. This condition is called postpartum blues or postpartum depression. Adequate help should be

provided to women, as there is a risk of the condition deepening to depressive to suicidal conditions, which are already a pathological condition of the woman's psyche. As part of the support of the connection between the mother and the newborn, the so-called rooming-in system helps (the newborn's stay with the mother in one room immediately after birth).

Nursing care for women in the puerperium

Changes, fundamental height, uterine retraction, the nature of purges that change, the state of healing and childbirth injuries, the state of the breasts, the state of the lower limbs, urination, stool, the overall physical and mental state of the woman are monitored

Pic. 3 Fund height after birth



Release from the obstetric facility depends on the process of the birth, the physical and mental condition of the mother and especially the health of the child. Even though the mother is already fine, in some cases she can wait for her child and conversely. After a spontaneous birth, it is possible to release the mother at the earliest 72 hours after the birth, women after a caesarean section on the 4th day.

Control questions

- What is the definition of the puerperium?
- Which physiological changes come in during the puerperium?
- Which changes come in by extragenital organs?



Comments

11 Nursing care for a woman with high-risk and pathological pregnancy, childbirth and the puerperium

Annotacion, abstract

The chapter acquaints the student with the pathologies during pregnancy, childbirth and the puerperium and the role of the midwife in dealing with complications in these periods.

The aim of the chapter

-
- To acquaint students with the characteristics of high-risk and pathological pregnancy, childbirth and the puerperium.
 - Describe nursing care for a woman with high-risk and pathological pregnancies, birth and the puerperium.
 - Familiarize yourself with the risks and possible pathologies that may occur during antenatal care.
-

Key words: complications of pregnancy, complications during childbirth, complications in the puerperium

The process of pregnancy can be complicated by many risk factors or pathological conditions requiring therapeutic interventions or increased monitoring. The most common risks or pathologies of pregnancy include a number of mothers illness, irregular development of the fetal egg and amniotic sac. Irregularities in the duration of pregnancy can also be included in this chapter, which is a condition that can occur if there is a risk or pathology in pregnancy. We can also include irregularities in pregnancy, which occur most often, and we have not deal with them yet.

11.1 Complications during pregnancy

Illness of the mother: Hypertension in pregnancy, diseases of the heart, blood vessels, endocrine diseases in pregnancy, diseases of the kidneys and urinary tract, diseases of the GIT system, liver, blood diseases, neurological and psychiatric diseases in pregnancy, lung diseases, autoimmune diseases, cancer.

Fruit egg irregularities: multiple pregnancies.

Irregularities of the amniotic sac: bedside, placenta praevia, premature separation of the bed, risk of injury during pregnancy and childbirth.



Irregularities in gestational age: premature birth, fetal abortion, prolonged pregnancy.

11.2 Risky and patologic birth

In connection with the birth, we can meet with a number of irregularities, deviations or pathologies. For the purposes of the textbook, the following causes of risky or pathological birth were selected:

Irregularities of the birth canals: changes in the anatomy of the pelvis, pathophysiology of the pelvic planes preventing spontaneous delivery, narrowed pelvis occurring in short women, flat pelvis, transverse pelvic narrowings, posttraumatically and postoperatively altered pelvis, symphysis pathology, which may cause fetus and hard birth canals. Causes can be congenital, pelvic injuries, orthopedic surgery, pelvic disease (rickets).

Irregular fetal positions: irregular positions include longitudinal pelvic, transverse and oblique positions. In all of these positions, the symptoms are described in the diagnostic. The causes are often small fetuses, immature, congenital malformations of the uterus, short umbilical cord of the fetus, oligohydramnios, bedspread, which can be all complications during childbirth and non-delivery position to birth traumas.

Disorders of expulsive forces: excessive uterine activity, which may be caused by excessive application of uterotonics to support uterine activity, on the contrary primarily or secondarily weak contractions, weakness of the abdominal press.

Irregularities III. periods of labor: in normal conditions, there is a significant uterine retraction after delivery, which ruptures the uteroplacental vessels and, with subsequent uterine contractions, the placenta separates from the uterine wall. This process must be respected and not interfere with it, not to pull on the umbilical cord, not perform uterine massage, etc. Irregularities III. periods of labor can lead to excessive bleeding, non-separation of the uterine bed and the penetration of infection.

11.3 Risky and pathological puerperium

During the postpartum period, the incidence of serious and fatal complications has decreased in today's modern obstetrics, even so it can't be guaranteed a completely smooth process of the puerperium. Appropriate care for women in the puerperium and the detection of pathological conditions play a crucial role in prevention. During the puerperium, we may encounter complications: subinvolution of the uterus, which may be caused by insufficient function of the uterine muscle or lochiometry, which are the remnants of the uterine sheaths in the uterine cavity. In some cases, the infection may be transmitted and in others it is a source of excessive bleeding during the puerperium. Other risk conditions include thromboembolic disease, psychosis during the puerperium, or lactation disorders due to

hormonal changes.

Control questions

Describe the physiological, risk, pathological characteristics of pregnancy?

Which complications can appear up by the woman during pregnancy?

Which complications may you encounter during childbirth?

Which complications can appear by the woman in puerperium?

Comments



List of abbreviations

ADA American diabetologic asociation

AFP alfafetoprotein

CNS central nervous system

CTG cardiotocograph

DM diabetes mellitus

EPH edems, proteinuria, hypertension

DNA deoxyribonucleic acid

GDM gestational diabetes mellitus GIT gastrointestinal tract Hb hemoglobin

hCG human choriogonadotropin

HELLP hemolysis elevated liver enzymes, low platelet count syndrome IgG immunoglobulin G

IUGR intrauterine growht retard ICU intensive care unit mmHg millimeters mercury column NaCl sodium chloride

PIH hypertension induced by pregnancy

RDS respirators distress syndrome

Rh agglutinogen in red blood cells of Rhesus monkeys TEN thromboembolic disease BP blood pressure

UZV ultrasound, ultrasound examination of VVV congenital malformations

WHO (WHO) World Health Organization

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