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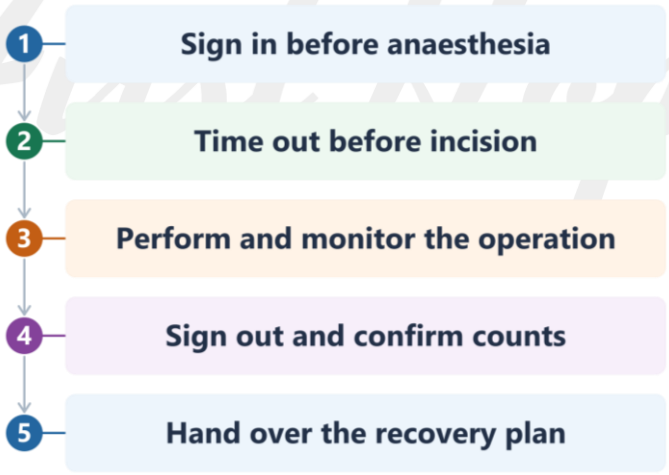
Obstetrics & Gynaecology - Topic 37 - Obstetrics & Gynecological skills-III

Learning in the Operating Theatre

The Role of an Observer and Assistant

Prepare Before the Procedure

- Read the clinical record and understand the indication, alternatives, consent and expected steps before entering theatre.
- Introduce yourself to the team and ensure that the patient has agreed to student involvement.
- Identify the supervising clinician and clarify which tasks you may perform.
- Use appropriate theatre clothing, hand preparation and sterile technique when assisting.
- Observe the sterile field carefully and report contamination immediately rather than trying to hide it.
- Recognise important anatomy, but do not handle tissue, apply traction or use an instrument without instruction.



Participate in Safety Checks

- Before anaesthesia, confirm identity, the planned procedure, consent, allergies and important anaesthetic or bleeding risks.
- Before incision, the team confirms the operation, expected critical events, antibiotic prophylaxis and equipment readiness.
- Before leaving theatre, confirm counts, specimen labels, procedural findings and the recovery plan.
- A student should speak up if a mismatch, missing count, contamination or unexpected deterioration is noticed.
- Maintain confidentiality when discussing the case and never photograph a patient or record without appropriate permission.

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Caesarean Birth

Indications, Preparation and Urgency

Understand Why Surgery Is Needed

- Caesarean birth may be planned or required because vaginal birth is unsafe or cannot be completed in time.
- Examples include selected malpresentations, placenta praevia, obstructed labour and persistent fetal compromise.
- The reason, urgency and maternal and fetal condition guide preparation and the choice of anaesthesia.
- Category 1 indicates an immediate threat to maternal or fetal life, while category 2 indicates compromise that is not immediately life-threatening.
- Category 3 needs early delivery without current compromise, and category 4 is planned at a suitable time.
- Urgent birth should occur as quickly as clinically necessary; a time target must not replace judgement or safe preparation.

Check Preparation

- Confirm consent, gestational age, fetal presentation, placenta-related concerns and the indication for surgery.
- Review haemoglobin, blood group, relevant antibodies, allergies and the need for crossmatched blood according to risk.
- Check IV access, monitoring, bladder drainage, anaesthesia, prophylactic antibiotics before incision and an appropriate neonatal team.
- Use a thrombosis-prevention plan suited to bleeding risk, mobility and the woman's clinical factors.
- Regional anaesthesia is usually preferred when appropriate, but anaesthetic choice depends on urgency and contraindications.

Observe the Main Operative Sequence

1. Entry and Delivery

- The surgeon opens the abdominal wall and enters the peritoneal cavity while protecting underlying bowel and bladder.
- A lower-segment transverse uterine incision is common, but a different incision may be required in selected circumstances.
- The team delivers the baby carefully, records the birth time and provides immediate neonatal assessment and thermal care.
- An impacted head, abnormal placental attachment or unexpected bleeding requires experienced assistance and a modified plan.

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- A uterotonic supports contraction after delivery, and the placenta and membranes are removed and checked.

2. Repair and Completion

- The surgeon checks the uterine incision for extensions and bleeding before repairing it.
- Inspecting adjacent structures and confirming haemostasis help detect injury before abdominal closure.
- The team completes swab, needle and instrument counts and records any discrepancy before the patient leaves theatre.
- Document the indication, incision type, findings, blood loss, medicines, complications and implications for future pregnancy.

Postoperative Care and Complications

Routine Postoperative Recovery

- Monitor vital signs, uterine tone, vaginal bleeding, urine output, pain and recovery from anaesthesia.
- Support early feeding, skin-to-skin contact when appropriate, hydration and mobilisation according to recovery.
- Remove unnecessary catheters and review analgesia, thromboprophylaxis and wound care.

Complications, Warning Signs and Discharge Advice

- Excessive bleeding, tachycardia, hypotension, fever, increasing pain, breathlessness or reduced urine output requires prompt assessment.
- Complications include haemorrhage, infection, urinary tract injury, thromboembolism and anaesthetic problems.
- Before discharge, explain warning symptoms, follow-up and the operation's relevance to future birth planning.

Laparotomy

- Laparotomy provides open abdominal access for diagnosis or treatment when required by urgency, disease extent or surgical complexity.

Purpose and Preparation

- Examples include major bleeding, suspected rupture, a large pelvic mass or surgery that cannot safely be completed by a less invasive route.
- Preoperative assessment includes haemodynamic stability, pregnancy status, anaesthetic fitness, blood availability and the likely extent of surgery.
- Consent should address the planned procedure and foreseeable additional steps without using an unlimited blanket permission.

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Observe and Assist Safely

- Observe how the incision provides adequate exposure while protecting abdominal wall vessels and underlying organs.
- Assist with suction, gentle retraction or instrument handling only as directed, maintaining awareness of bowel, bladder and ureters.
- The surgeon systematically identifies the pathology, controls bleeding and selects treatment based on the operative findings.
- Communicate measured loss, fluid use and specimens clearly with the theatre team.
- Before closure, check haemostasis, relevant organ integrity and all counts.

Recognise Problems After Surgery

- Increasing abdominal distension, persistent vomiting or failure to recover bowel function may indicate ileus or obstruction.
- Unexpected pain, fever, tachycardia or peritonism can signal bleeding, infection or missed visceral injury.
- Reduced urine output may reflect hypovolaemia, obstruction or urinary tract injury and requires assessment.
- Wound infection, dehiscence and thromboembolism are important additional complications.

Abdominal and Vaginal Hysterectomy

Understand the Decision

Extent of Uterine Removal

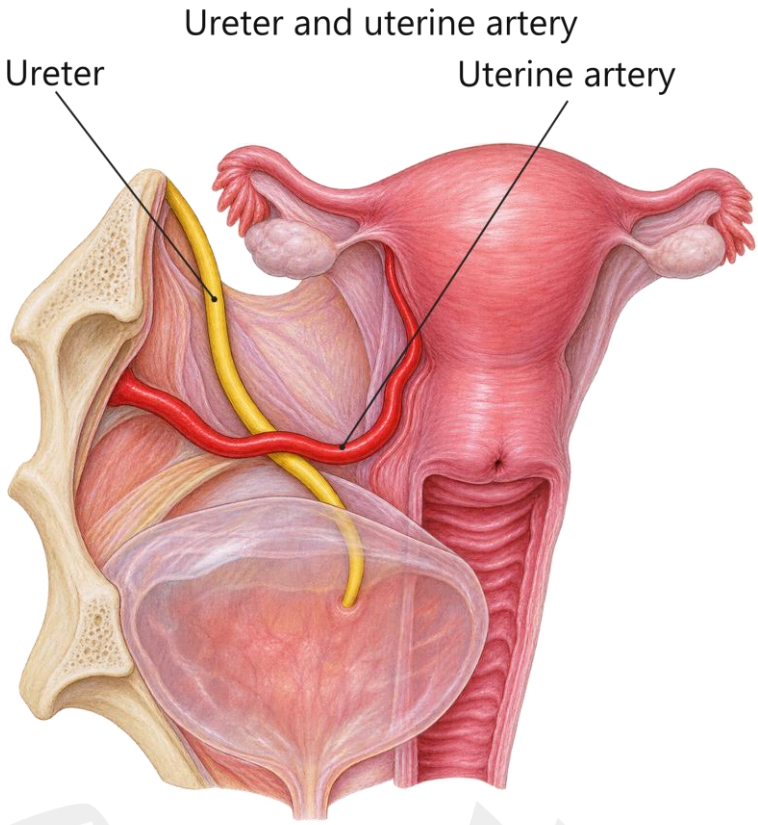
- Hysterectomy removes the uterus and permanently ends the ability to carry a pregnancy.
- Total hysterectomy removes the cervix as well, while subtotal hysterectomy retains it.

Separate Adnexal Decisions and Benign Alternatives

- Removal of the tubes or ovaries is a separate decision and must be discussed explicitly.
- Healthy ovaries are often conserved before menopause unless a clear indication supports removal.
- Consider effective alternatives before hysterectomy for benign disease, and choose the route according to anatomy, indication and expertise.

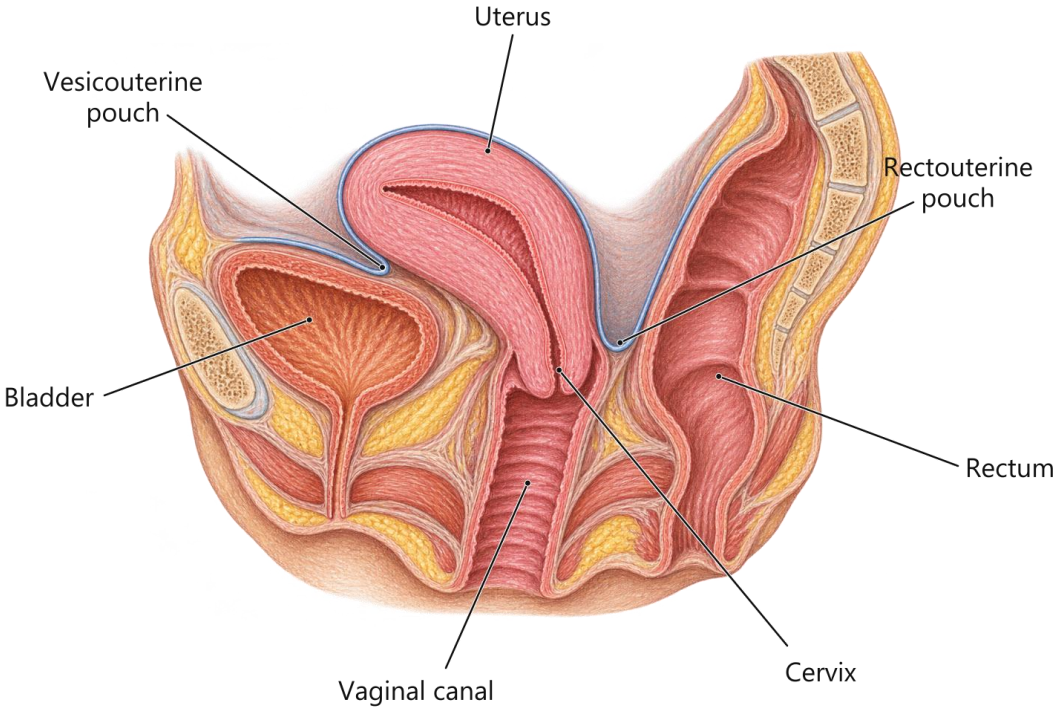
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Recognise Important Relations



The ureter passes beneath the uterine artery near the lateral cervix before entering the bladder

- The bladder lies close to the anterior cervix and upper vagina, while the rectum lies posteriorly.
- The ureter passes near the uterine artery and must be protected during vascular control and dissection.
- Previous operations, endometriosis and malignancy can distort these relations and increase injury risk.



The bladder, uterus and rectum have close pelvic relations that matter during hysterectomy and other pelvic operations

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