

Specialties Block Presentations and Learning Outcomes

Below is a list of common and important presentations you should cover during medicine block in CCE. The presentations are not an exhaustive list; it is to give you an idea of the common conditions that students are expected to come across in the clinical environment.

<p>Child health</p> <ol style="list-style-type: none"> 1. Development in the healthy child / developmental delay 2. Fever in a child 3. Newborn screening / assessment <p>Care of the elderly</p> <ol style="list-style-type: none"> 4. Frailty / Impact of chronic disability 5. Falls <p>Dermatology</p> <ol style="list-style-type: none"> 6. Pruritus / Acute and chronic rashes 7. Skin infections and skin ulcers 8. Skin lesion / Skin lump <p>Haematology</p> <ol style="list-style-type: none"> 9. Anaemia / Pallor 10. Bruising and bleeding tendency / Hypercoagulability <p>Mental health</p> <ol style="list-style-type: none"> 11. Acute Confusion / Delirium 12. Anxiety, Phobias, OCD 13. Low mood / Elated mood / Hallucinations 14. Memory loss, chronic confusion 15. Substance misuse and addiction 	<p>Other</p> <ol style="list-style-type: none"> 16. Acute and chronic pain management <p>Rheumatology</p> <ol style="list-style-type: none"> 17. Chronic joint pain and stiffness <p>Women's health: Gynaecology</p> <ol style="list-style-type: none"> 18. Cervical screening / Cervical smear 19. Contraception request / advice 20. Genital discharge / Genital ulcers and warts 21. Menopausal problems 22. Menstrual problems <p>Women's health: Obstetrics</p> <ol style="list-style-type: none"> 23. Antenatal care, screening / risk assessment 24. Labour 25. Normal pregnancy / physiology of pregnancy 26. Puerperium and difficulty in breast feeding
---	--

The key learning outcomes are:

- To take an adequate history and understand relevant differentials
- Carry out necessary examinations and investigations
- To understand initial management plans for such conditions

Child Health

1. Development in the healthy child / developmental delay

By the end of the block students should be able to:

History

- Take a developmental history covering normal developmental domains / milestones such as vision, hearing, speech, social interaction and walking, as well as social history and safeguarding.

Examination

- Demonstrate key features of the examination to assess normal development.

Differential diagnoses

- Identify failure to thrive, its common causes and other reasons for developmental delay.

Investigations

- Describe the relevant investigations to investigate a child with developmental delay.

Management

- Explain the principles of management of important differential diagnoses of developmental delay.

2. Fever in a child

By the end of the block students should be able to:

History

- Take a history of fever in child including onset, duration, associated symptoms, urinary output, past medical history, illness of other family members, immunisation status, recent travel, etc.

Examination

- Identify key features of the examination which help differentiate between various causes of this presentation. Understand the NICE guidance for the 'Traffic light system' for paediatric examination and the unwell child.

Differential diagnoses

- Describe important causes of fever in children (including viral infection, otitis media, tonsillitis, pneumonia, UTI, septicaemia and meningitis).
- Understand that children of different ages may need different investigations.

Investigations

- Describe investigations appropriate to investigate a child with fever e.g. septic screen (including interpretation), or where a child may not require investigations.

Management

- Explain the principles of management of fever in a child, bearing in mind most febrile children have a brief self-limiting viral infection. Know simple measures of treating a self-limiting viral infection.

3. Newborn screening and assessment

By the end of the block students should be able to:

History

- Take a pregnancy and birth history, including investigations and interventions needed.

Examination

- Understand how to carry out a routine examination of the newborn including measurement of height, weight and head circumference. Carry out a physical examination of heart, eyes, hips and testes (in males) and examine for any abnormal

features such as birthmarks. Be able to identify concerning conditions such as cyanosis, respiratory distress (grunting) and fits in the newborn.

Differential diagnoses

- Describe the screening tests carried out in the newborn including hearing test and Guthrie test (blood spot test) which tests for sickle cell disease, cystic fibrosis, congenital hypothyroidism and inherited metabolic diseases.

Investigations

- Describe the clinical, laboratory and radiological investigations appropriate to investigate a newborn baby, where appropriate.

Management

- Explain the principles of management of common conditions found in the newborn.

Care of the elderly

4. Frailty / Impact of chronic disability

By the end of the block students should be able to:

History

- Identify key features in the history relating to frailty / chronic disability that would support the development of appropriate differential diagnoses.

Examination

- Describe key features in the examination of a frail patient or patient with chronic disability.

Differential diagnoses

- Recognise the possibility of multiple sclerosis, Parkinson's disease, and motor neurone disease in patients presenting with neurological symptoms and relate the major clinical findings to the underlying pathology.
- Consider the clinical frailty scoring system (CFS) and how polypharmacy may affect the patient.

Investigations

- Describe investigations to investigate a patient presenting with symptoms of these conditions (including their interpretation).

Management

- Explain the principles of management of frailty and chronic disability and the role of the multidisciplinary team.

5. Falls

By the end of the block students should be able to:

History

- Take a history of the preceding symptoms, how the fall happened, dizziness, loss of consciousness, any injuries sustained, unsteadiness of gait, risk factors, home environment, medications, social, family, and past medical history, including previous history of falls.

Examination

- Examine a patient with falls and identify clinical features which may help develop appropriate differential diagnoses including complications such as lacerations, fractures, and head injuries.

Differential diagnoses

- Describe possible differential causes of fall including mobility/balance problems, stroke, syncope, arthritis, muscle weakness, visual impairment, cognitive impairment, depression, alcohol misuse, chronic health conditions (e.g. heart disease,

hypotension), medications (e.g. benzodiazepines), polypharmacy, and home hazards.

Investigations

- Describe relevant investigations of a patient with fall including ECG, lying and standing blood pressures, blood glucose, bloods (where relevant), X-rays, MRI scan, LFTs, including their interpretation.
- Also consider doing a CK if long lie.

Management

- Explain the principles of management of falls including, pain relief, falls risk assessment, prevention advice, medication review, occupational and physiotherapy review and social care support (home hazard assessment / adaptations).

Dermatology

6. Pruritus, Acute / Chronic Rashes

By the end of the block students should be able to:

History

- Identify the key features of the history including duration of onset (acute or chronic), triggers and occupational / other risk factors such as systemic disease.

Examination

- Examine a patient with pruritus or skin rash and describe the rash in a systematic way (site / distribution; morphology - shape, pattern); configuration (linear, grouped, annular) to generate appropriate differentials.

Differential diagnoses

- Describe the causes of severe pruritus such as scabies, urticaria, eczema, insect bites, dermatitis herpetiformis, lichen planus and generalised itching (renal, liver, haematological).
- Describe causes of acute skin rashes including erythroderma, dermatitis (contact, atopic seborrheic), drug eruptions (including Stevens-Johnson syndrome, toxic epidermal necrolysis), urticarial, infective (e.g. herpes, varicella, impetigo), and purpuric (meningococcal, septic emboli).
- Describe causes of chronic skin rashes including acne vulgaris, lichen planus, eczema, psoriasis, seborrheic warts, and also infective causes – fungal (tinea pityriasis versicolor, trichophyton, athlete's foot), TB (lupus vulgaris).
- Also consider systemic causes such as coeliac disease, diabetes mellitus, chronic inflammatory condition, autoimmune disease and vasculitis.

Investigations

- Describe clinical, laboratory and radiological investigations appropriate to investigate a patient with pruritus and rash including FBC, LFT, U & Es, patch testing, skin scraping for microscopy/culture and serology for autoimmune disease.

Management

- Describe the principles of management of common skin problems such as eczema and psoriasis.

7. Skin infections and skin ulcers

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration, and progression of the skin lesion/infection, including risk factors for the development of venous, arterial and neuropathic ulcers as well as pressure sores. Consider asking about contacts of infectious skin diseases.

Examination

- Examination of the skin looking for signs of venous or arterial disease as well as general examination.
- Examine a patient and describe the lesion in a systematic way (site / distribution; morphology - shape, pattern); configuration (linear, grouped, annular) to generate appropriate differentials.

Differential diagnoses

- Recognise viral skin infections (e.g. viral warts, molluscum contagiosum, herpes simplex / zoster); bacterial infections (e.g. folliculitis, impetigo, streptococcal cellulitis) and fungal infections (e.g. candida, tinea and pityriasis versicolor).
- Understand how to differentiate between venous and arterial ulcers.

Investigations

- Describe investigations appropriate to investigate skin infections and ulcers

Management

- Describe the principles of management for the common types of skin infection and ulcer.

8. Skin lesion / Skin lump

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration and progression as well as red flags.

Examination

- Describe the anatomy of the skin and its three layers and describe skin lumps in terms of location and morphology
- Describe the examination findings in a patient with skin lump or lesion (**A**symmetry, **B**order irregularity, **C**olour variation, **D**iameter, **E**volving) to generate appropriate differentials.

Differential diagnoses

- Identify common benign skin lumps including warts (verruca), seborrheic warts, lipoma, ganglion cysts, keloids, dermatofibroma and naevi.
- Describe pre-malignant and malignant skin conditions, including basal cell carcinoma, Bowen's disease (intra-epidermal carcinoma), squamous cell carcinoma and malignant melanoma.

Investigations

- Describe relevant investigations appropriate to investigate a patient with skin lump or lesion including biopsy.

Management

- Explain the principles of management of common differential diagnoses.
- Explain the mechanisms by which ultra-violet light leads to the development of skin malignancies.

Haematology

9. Pallor / Anaemia

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration and progression including fatigue, bleeding, palpitations, chest pain, shortness of breath, diet, and red flags such as weight loss and night sweats.

Examination

- Perform a general examination of a patient eliciting clinical signs of anaemia and any other red flags such as lymphadenopathy or cachexia.

Differential diagnoses

- Describe common types of anaemia (iron deficiency, B₁₂ and folate deficiency), the morphological patterns and their underlying causes. Understand the normal requirements of erythropoiesis.

Investigations

- Describe investigations appropriate to investigate a patient with anaemia including FBC, serum B₁₂ and folate levels, potentially blood film, and their interpretation.

Management

- Explain the principles of management of patients with common anaemias (iron deficiency, B₁₂ and folate deficiency).

10. Bruising and Bleeding tendency / Hypercoagulability

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration, medications, social history, past medical history, family history, and risk factors which may help differentiate between causes of bleeding, bruising or hypercoagulability.

Examination

- Make a clinical assessment of a patient with suspected thrombo-embolic disease, and the scoring system used to evaluate risk of thromboembolism (e.g. Wells score)
- Examine for evidence of obvious bruising, pallor, lymphadenopathy and any haemarthrosis.

Differential diagnoses

- Explain the clotting pathways and identify points in the pathways associated with common bleeding and hyper-coagulation disorders.
- Explain the inheritance of common genetic bleeding (e.g. Haemophilia, von Willebrand disease) and the risk factors for hyper-coagulation disorders.

Investigations

- Describe investigations to investigate a patient with bleeding tendency (clotting screen, coagulation factor assay, VWF antigen) and those that would help identify an underlying cause for thrombo-embolism. (autoimmune screen, Factor V Leiden)

Management

- Explain at which point in the pathway common anti-coagulant drugs work; consider their risks, benefits and side effects.

Mental health

11. Acute confusion / Delirium

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration and progression in acute confusion including eliciting red flags such as neurological symptoms or head injury.
- Also consider taking a collateral history from family or NOK.

Examination

- Undertake general and neurological assessment in a patient with confusion / delirium

Differential diagnoses

- Describe common causes of delirium/confusion such as alcohol, pain, drugs (opioids, benzodiazepines, antipsychotics), hypoxia/hypercapnia, metabolic (hypo/hyperglycaemia, hyponatremia, hypercalcemia), constipation, urinary retention, infection (CNS/Non-CNS) and intracranial injury,
- Understand confusion as global impairment of mental function and delirium as an abrupt decline in cognitive function that follows a fluctuating course.

Investigations

- Describe bedside, clinical, laboratory and radiological investigations to investigate a patient with acute confusion / delirium (e.g. Confusion Assessment Method, Abbreviated Mental Test, Mini-Mental State Examination (MMSE), metabolic screen, U&Es, urinalysis, FBCS, U & Es, CRP, Calcium)

Management

- Explain the management of common causes of acute confusion and delirium.

12. Anxiety / Phobias / OCD

By the end of the block students should be able to:

History

- Take a detailed history, characterise risk factors and severity of depression/anxiety symptoms. Be able to assess capacity, and protective/non protective factors.

Examination

- Perform a mental state examination (MSE) and use screening tools for anxiety and depression (eg. GAD-7) - to give diagnosis and severity.

Differential diagnoses

- Understand the definitions of anxiety, phobias and OCD, plus epidemiological classifications and their manifestations.

Investigations

- Describe investigations appropriate to investigate a patient with anxiety, phobias and OCD (including their interpretation). For example, TFTs in a patient with anxiety.

Management

- Explain the principles of management of anxiety, phobias and OCD including the biopsychosocial model to manage generalised anxiety disorder.

13. Low mood / Affective problems / Hallucinations

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration, progression and in particular screening questions that help recognise people at risk of depression or psychosis (those who may have harmful risk factors eg. Isolation). Be aware of the social stigma of mental illness.

Examination

- Assess depression severity using commonly used tools such as PHQ 9. Be able to perform a mini mental state examination.

Differential diagnoses

- Understand that depression is a state of low mood and aversion to activity that can affect a person's thoughts, behaviour, feelings, and sense of well-being. It is a broad and heterogeneous diagnosis, which has depressed mood and/or loss of pleasure in most activities central to it.
- Understand that psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions as well as disturbed, confused, disrupted patterns of thought and/or lack of insight
- Describe the criteria for diagnosis of depression/psychotic disorders using the DSM or ICD classification system/

Investigations

- Describe investigations useful in looking for an organic cause for psychiatric problems. Eg, TFTs for hypothyroidism

Management

- Describe the derangements in neurotransmitters in psychiatric illness
- Explain the principles of management including medication, CBT, social support and the long-term effects of psychiatric illness on physical health.

14. Memory loss, chronic confusion

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration and progression of memory loss and chronic confusion and identify features that supports the development of appropriate differential diagnoses. (eg tremor for FTD)

Examination

- Carry out a general and neurological examination of a patient with memory loss and chronic confusion.
- Do an MMSE or similar scoring system.

Differential diagnoses

- Describe common and important causes of 1) Chronic cognitive impairment (Alzheimer's, vascular disease) 2) Reversible causes (Vitamin B₁₂/ folate deficiency, hypothyroidism, normal pressure hydrocephalus, neurosyphilis, Wilson's disease) and 3) Other less common causes (multiple sclerosis, Korsakoff's psychosis, Huntington's disease, frontal-temporal dementia).

Investigations

- Describe investigations appropriate to investigate a patient with memory loss / dementia including 6CIT, MRI brain, TFTs, serum B₁₂ and folate, and their interpretation.

Management

- Explain the principles of management of common differential diagnoses including medication and social / home support.
- Explain dementia as a chronic progressive decline in cognitive function without disturbance of consciousness.

15. Substance misuse and addiction (including alcohol)

By the end of the block students should be able to:

History

- Describe key features in the history (including the use of CAGE and FAST questionnaires for alcohol) as well as asking for any patient symptoms of liver disease.

Examination

- Do full general, abdominal, and cardiovascular exam. Look for key features in the examination findings that would support the development of appropriate differential diagnoses of drug and alcohol abuse.

Differential diagnoses

- Explain to the patient the risks of alcohol addiction; gastritis, pancreatitis, chronic liver disease, seizures, hypertension.
- Explain to the patient the risk of drug abuse: infections – STDs, HIV, Hepatitis B&C, lung abscess; injury – thrombophlebitis, DVT; overdose – rhabdomyolysis/renal failure and respiratory failure, as well as brain abnormalities with alcohol and substance misuse.

Investigations

- Describe bedside, clinical, laboratory and radiological investigations would be appropriate to investigate a patient with drug and alcohol abuse including LFTs, GGT, amylase, drug screening, infection screen, USS, CT head and endoscopies.

Management

- Explain the principles of management of substance / alcohol abuse (including epidemiology, risk factors), prevention strategies and the support available including neurological intervention.
- Outline the psychosocial perspectives and epidemiology of illegal drugs of abuse (cannabis, heroin, cocaine, 'legal highs'), their sources, symptoms of use, and clinical impact.”.
- Know where to refer for alcohol and drug misuse.

Other

16. Acute and chronic pain management

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration and progression including characterisation of pain (type, location, duration, radiation). Eg SOCRATES

Examination

- Examine a patient to characterise sources and types of pain.

Differential diagnoses

- Explain the pathophysiology of pain, including pain pathways for somatic and neuropathic pain.
- Consider potential underlying causes of pain.

Investigations

- Describe bedside, clinical, laboratory and radiological investigations for various types of pain, as appropriate.

Management

- Describe pharmacological and non-pharmacological interventions for pain relief, and their mechanisms of action.
- Describe which analgesic approach would be most appropriate for common cases of pain using the WHO pain ladder and the principles of management of neuropathic pain.
- Identify drug classes commonly used in the management of pain: their mechanisms of action and common side effects (paracetamol, non-steroidal anti-inflammatory drugs, opiates).

Rheumatology

17. Chronic joint pain and stiffness

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration and progression including family history and past medical history of autoimmune conditions, plus any systemic symptoms (rashes, eyes etc).

Examination

- Describe key features of the examination findings including multi-system manifestations of autoimmune processes (e.g. bowel, skin and eyes) and assess severity of hip/knee degenerative changes.
- In small joint disease, explore handedness and functionality.

Differential diagnoses

- Describe common and important causes of chronic joint pain and swelling including rheumatoid arthritis (RA), osteoarthritis (OA), seronegative spondyloarthropathies (e.g. ankylosing spondylitis, psoriatic arthropathy), crystal arthropathy (chronic tophaceous gout, pseudogout), vasculitides (SLE), and systemic sclerosis.

Investigations

- Describe relevant investigations including autoantibodies (HLA-B27, rheumatoid factor, anti-nuclear antibodies etc), joint aspiration and interpret the major radiological changes of OA (hip and knee) and of RA of the hand.

Management

- Explain the principles of management including pain relief, drugs (steroids, DMARDS, Mabs), physiotherapy, occupational therapy, rehabilitation and surgery.

Women's Health: Gynaecology

18. Cervical Screening / Cervical Smear

By the end of the block students should be able to:

History

- Take a history from a patient with abnormal cervical smear result

Examination

- Understand how examination of the cervix is done

Differential diagnoses

- Describe the role of Human Papilloma Virus (HPV) in the development of abnormal cervical pathology and high-risk HPV (HPV16 and HPV18) link to cervical cancer

Investigations

- Describe the current cervical screening programme, the age group and frequency of screening. Understand the use of liquid-based cytology and the principles of colposcopy

Management

- Understand the role of HPV vaccination in protecting against high-risk HPV and the age group recommended for vaccination (12 -18 years)

19. Contraception request / advice

By the end of the block students should be able to:

History

- Identify key features in the history that would be important for consideration in the choice of contraception including social aspects and risk factors for thrombosis and cancers

Examination

- Describe examination findings which may support contraceptive choice

Differential diagnoses

- Outline the merits and disadvantages of the variety of contraceptive methods available to patients including: natural methods, barrier (male/female condom, diaphragm, caps), hormonal (combined and progesterone-only via oral, transdermal, subdermal, intramuscular routes), intrauterine contraception (copper or progestogen), sterilisation (male/female), post-coital emergency methods (progestogen, intrauterine contraceptive device).

Investigations

- Describe appropriate tests to investigate potential side effects of contraceptives (such as thrombosis, hypertension, etc.)

Management

- Demonstrate a basic knowledge of reversible, irreversible and post-coital emergency contraception including the various methods, their mode of action, efficacy, contraindications and complications.
- Understand the methods by which contraception can be achieved: gamete suppression, modulation of the cervical mucus, endometrial changes, prevention of implantation, and interruption of the communicating tubes.
- Explain why contraception is important on a national and global scale and the need to respect cultural and religious beliefs as well as sexual diversity.

20. Genital discharge / Genital ulcers and warts

By the end of the block students should be able to:

History

- Describe key features of the history (including genito-urinary / sexual history) and findings from the examination which help differentiate between causes

Examination

- Undertake genital examination with sensitivity and dignity to patients

Differential diagnoses

- Describe common and important causes of genital discharge (chlamydia, gonorrhoea, candida, bacterial vaginosis, trichomonas vaginalis) and genital ulcers (herpes, syphilis, reactive arthritis)

Investigations

- Describe relevant investigations in a patient with genital discharge and ulcers

Management

- Explain the principles of management of patients with genital discharge or ulcer including contact tracing and ways of limiting the spread of infection

21. Menopausal problems

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration and progression including recognition of the need for oestrogen replacement in the individual patient based on symptomatology and/or future risk of degenerative disorders.

Examination

- Identify key features in the examination including general, cardiovascular and thyroid examinations.

Differential diagnoses

- Discuss appropriate differentials including hyperthyroidism and explain the hypothalamic-pituitary-gonadal (HPG) axis.

Investigations

- Describe tests to investigate a patient with menopausal symptoms including oestrogen, FSH, LH, TFT, including their interpretation.

Management

- Explain the principles of management of menopausal symptoms, the indications for different types of HRT and the advantages and disadvantages of hormone replacement therapy.
- Communicate the concept of disease prevention to the patient with special reference to cardiovascular disease and osteoporosis

22. Menstrual problems

By the end of the block students should be able to:

History

- Take a history of the onset of symptoms, duration and progression including pain, heaviness of bleeding, IMB, PCB, pattern of cycle, effect on social / occupational life.

Examination

- Perform an appropriate abdominal and pelvic examination for menstrual problems.

Differential diagnoses

- Describe appropriate differential diagnoses including amenorrhoea, menorrhagia, metrorrhagia, dysfunctional uterine bleeding and postmenopausal bleeding.
- Explain the physiology of normal menstruation and common causes of abnormal menstruation

Investigations

- Describe bedside, clinical, laboratory and radiological investigations to investigate a patient with abnormal menstruation including pelvic USS, endometrial biopsy, hormonal profile – TFTs, prolactin, FSH/LH

Management

- Explain the principles of management of common causes and the concerns which a patient might have.

Women's health: Obstetrics

23. Antenatal care, screening and risk assessment

By the end of the block students should be able to:

History

- Take an obstetric history including past obstetric history and mode of delivery

Examination

- Examine the pregnant abdomen and auscultate the foetal heart beat

Investigations

- Describe routine antenatal screening tests including urine (urinalysis), blood tests (FBC, Blood Group / Rhesus type, thalassaemia), infection screen (HIV, Hepatitis B, Syphilis) and dating scan/mid-trimester anomaly scan.
- Understand when additional screening tests are needed e.g. sickle cell disease screening in at risk group and eye screening in women with diabetes.

Management

- Outline pre-conceptual care, the use of folic acid preconception and the nutritional requirements / lifestyle changes in pregnancy
- Explain the importance of 1st and 2nd trimester screening tests for congenital abnormalities and the markers used.
- Explain genetic modes of inheritance and common structural abnormalities in the foetus resulting from abnormal development.
- Describe routine vaccination in pregnancy (e.g. influenza vaccine, combined diphtheria/tetanus/polio/pertussis vaccine) and when additional vaccination is required e.g. Hepatitis B in those at risk
- Outline schedules of routine antenatal care, midwifery care for low-risk women and the use of Anti-D.
- Explain the principles of risk assessment in pregnancy, the risks of drug treatment and the risks of substance abuse in pregnancy.
- Demonstrate an awareness of the patient's autonomy (e.g. informed maternal choice) and be aware of the legal rights of pregnant women.

24. Labour

By the end of the block students should be able to:

History

- Take a good history of the key features of labour including characterisation of pain and other symptoms.

Examination

- Demonstrate the key features in the examination of the pregnant abdomen, pelvis and perineum including episiotomy cuts.

Differential diagnoses

- Describe the various stages of normal labour including anatomy of the pelvis and mechanism of normal labour.

Investigations

- Describe the clinical and laboratory investigations that would be appropriate to investigate a patient in labour.

Management

- Explain maternal and foetal wellbeing monitoring including use of the partogram and awareness of multi-professional working.
- Fully participate, assist, or conduct a normal vaginal delivery under supervision.
- Outline the principles for the choice of mode of delivery by the mother in partnership with healthcare professionals and the legal status of the foetus and the mother.
- Explain the various types of pain relief in labour, their use, limitations and / or side effects.

25. Normal pregnancy and physiology of pregnancy

By the end of the block students should be able to:

History

- Take an obstetric history including past obstetric history and mode of delivery.

Examination

- Examine the pregnant abdomen and auscultate the foetal heart beat.

Differential diagnoses

- Describe the physiological changes that happen during pregnancy including homeostatic changes, prothrombotic changes (coagulation factors, Protein C, S, etc).

- Describe the changes in body systems / organs that accompany pregnancy including cardiovascular, renal, GI and immune systems.

Investigations

- Describe relevant investigations including health checks during pregnancy, ultrasound and CTG

Management

- Explain the hormonal changes during pregnancy, sources of the hormones, their effects and the developmental processes including the feto-placental unit.
- Explain the principles of management of common conditions during pregnancy including hypertension and diabetes mellitus.

26. Puerperium and difficulty in breast feeding

By the end of the block students should be able to:

History

- Take a history during puerperium and understand the definition of puerperium as the time from the delivery of the placenta to the end of the 6th postnatal week.

Examination

- Carry out relevant examination (general, breast, abdominal, pelvic) during the puerperium.

Differential diagnoses

- Describe the physiological changes during the puerperium including uterine involution, changes in lochia, changes in plasma volume / red cell mass and lactation.

Investigations

- Describe bedside, laboratory and imaging tests which may be appropriate during puerperium.

Management

- Explain the importance of breastfeeding / awareness of breastfeeding initiatives difficulty establishing breastfeeding and common breast problems such as nipple pain, nipple cracking, breast engorgement, mastitis.
- Be able to advise on postpartum contraception.
- Demonstrate an awareness of the roles of other healthcare professionals (e.g. midwives, health visitors, physiotherapists) during puerperium.