Gyn Rotation

Daily schedule:

Monday
Round
8:30 a.m. OR cases begin. Every other week there are cases in both the North and South OR. The minor cases are done in the North and will be covered by the R1. The majors are simultaneously covered in the South OR by the R4. On alternating Mondays, only majors take place in South OR and both R1 and R4 operate together.

Tuesday
Round
7:00 am or thereabouts :Round on resident patients with Staff of the Month. Be prepared to present your patients.
7:30 am: Path conference with Dr. Bill Rodgers – 5th floor Dillehunt Hall
8:15 am: Chart review for Pre-Op clinic with possible didactics - Physician's Pavillion
9:00 – noon :Pre-Op clinic – Physician's Pavillion
noon-1:00: possible didactics/Leon lunch
1:00 -?: Gyn clinic – Outpatient Clinic

Wednesday
Round
7:30 am: OR cases begin – both North and South OR

Thursday
Round
7:30 am: Urogyn cases – South OR – R4 usually

Friday
Round
7:30 am: Grand rounds
10:45 am : possible R1/R4 meeting with Dr. Gregory for ICU/Op talks? In the works
1:00 pm: R1 and R4 in conti clinics

Other
Each student has a half-day of clinic with a preceptor. We will not expect Your presence during that half day, but please remind us you will be gone.

Rounding

You are expected to round on those patients in whose cases you scrubbed. You may also be asked to see non-surgical gyn patients that are admitted from clinic or the ER. All patients should have a post op note (unless they are the last case of a long day, in

which case the resident on call will see them) and a daily morning note and pm check. These patients will be seen each morning on the weekends and no pm checks are required. Rounds will begin at a time to be determined on a daily basis, as it's dependent on the day's plans and the patient census. If you ever leave the hospital unsure of the time we will round, page one of the residents on your team. If it is Monday or Thursday the R1 will be on call at OHSU. What you should be sure of is to have your rounding and notes DONE before the time agreed upon to meet for rounds. Be ready to present your patients to the residents and the Staff, who will round with the team Tues and Thurs, although this may change with each new staff on a month to month basis.

Rounding Pearls

-Always give yourself more time than you think you need to see a patient. Things happen overnight that you may have to check on.

-Before you even see the patient, read the notes since your last entry. Again, things happen overnight. Read the orders that were written. Look at the vitals and lab results. Check pathology reports/radiology reports. (path reports often take 3 days though so some patients are discharged without final path back).

-If a patient is to be discharged, complete the discharge summary sheet as best as you can. It goes more quickly if this sheet is filled out as you go along. Procedures performed should be added as you go along.

-Fill out prescriptions without quantities and refills. Be sure to stamp the patient's name. The resident will complete these.

-Feel free to write for any orders you think are appropriate. We will co-sign them if we agree.

The Progress Notes/Post Op Note

These notes are in the SOAP format. They are often shorter than a medicine note, and may be longer than the average Gen Surg note.

The post op note

S: Comment on patient's subjective assessment of pain, nausea, vomiting, Chest pain, and shortness of breath.
O: List vitals. A range is often helpful (i.e. Pulse 60s-70s, BPs 110s-120s/70s) and always list the Tmax. List the Is and Os and give the range of time over which it was collected (1000/800 over last shift/8 hrs)
PE should include Lungs, Heart, Ab (including soft/hard, distended/not distended, and bowel sounds), Dressing status (clean and dry), and LE (SCDs –{compression hose} cycling, no edema or cords, NT)
Labs: note any results (often don't have any immediately post op)
A: POD0 from a *[procedure name]*

Assess pain (i.e. “Pain controlled on Morphine PCA)
Comment on patient med problem status, if any (HTN – pt bps stable, DM – CBGs)
Comment on other appropriate issues --- nausea, etc
P: Write new plans (increase pain meds, give antiemetics, etc) and “continue routine post op care”

Rountine Progress note

S: Always comment on pain/lack thereof, nausea/emesis, what patient is tolerating by mouth (clears, regular diet, sips), passage or absence of flatus, activity status (patient sat up in chair, pt. Walked X2), and voiding status (voiding without difficulty/catheter in place)
O Same as Post op note
Except add Incision: clean dry and intact (c/d/i) unless it isn't. Note any bruising, etc. Draw a diagram if it helps. You may remove a dressing if it has been 24 hours or more since the surgery.
Labs: Often post op day 1 HCT or CBC
A: POD___ from a *[procedure]*
Comment on pain control
Comment on other med problem status
Patient tolerating *[kind of diet]*
Foley in/out
P: See summary below. Plan usually addresses what you would like to do with diet, IV fluids, ambulation, and foley catheter and med changes (including d/c PCA and start po meds) Plan may include thoughts on disposition (often the day before you anticipate patient discharge)

PM check notes

This is more of a social rounding thing. Do not get hung up on repeating most of the exam. Just get a feel for what happened during the day and how much of the plan has been achieved. I think these rounds are nice for social reasons for the patient, and they keep nursing/floor staff honest with the plans we made. If we ordered for a PCA to be stopped and a patient isn't off it, find out why. Sometimes plans are sluggishly carried out and a friendly reminder needs to be given to the floor staff (let the residents do this). The PE should include really just the AB, incision, and LE. Any labs/path results should be included. The other purpose for doing a pm check is to get a good sense of the patient's status before we tell the on-call team at night what their deal is. We like to give them the real story.

Typical Post-Operative Course

Patients that have a transverse (Pfannenstiel) or midline abdomenal incision that does not involve the bowel act very similarly post-operatively. We often use a PCA and possibly Toradol or a PCEA (epidural), which anesthesia follows. Once a patient is tolerating a fair amount of clears without GI upset, they can be switched to po meds, often a po narcotic such as Vicodin or Percocet every 3-6 hours and Ibuprofen 600 mg every 6 hrs. or 800 mg every 8 hrs. Also, as they are tolerating greater amounts of clears,

their IVF rate may be decreased from 125 mL/hr or so to 75 mL/hr to nothing (saline lock or SL). On some services, the physicians like to wait until a patient has passed flatus before advancing to a regular or a soft diet. Ask your resident what they like. Nurses often like to wait for flatus, but studies have shown this doesn't make a difference. Patients are often on po meds by POD1 or 2 and on a regular diet by POD2-3. Flatus may not pass until POD3 or so. Patients rarely have a bowel movement prior to their discharge, and often worry about this. Offer reassurance when appropriate.

We often wait at least 24 hours before removing dressings from the incision. After it is removed, a patient may shower once stable and ambulatory (usually POD2-3). There is no need to redress the incision unless the patient desires. We usually use staples to close just the skin. These may be removed in an average-built patient on POD3-5 if it is a transverse incision or POD5-7 if it is a midline incision. Smokers, obese, diabetic and immunocompromised (including on steriods) patients have a higher rate of poor wound healing and their staples should remain longer. Never remove staples without discussing it with your resident. If you are worried about how the incision looks as you remove staples, STOP, and get one of your team residents to look with you.

The Foley catheter remains in place until a patient can ambulate well enough to get to the bathroom on her own. This is usually POD1-2. We record the Is and Os until they are voiding well without the catheter. The patient is often able to walk down the hall by POD3. Patients are usually discharged by POD3-4.

Before a patient can be discharged, she must meet several criteria: eating regular food, pain controlled on meds she can take at home, voiding without problems, and ambulating without problems. Some do this by POD2 and some linger past POD4.

Discharging patients

We review discharge instructions with all our patients and don't expect you to take care of this. FYI, we counsel them to avoid heavy lifting and undergo pelvic rest for 4-6 weeks. Patients shouldn't be driving for several weeks and need to be off narcotic analgesics before even considering it. We review warning signs with them for which to return or call including fevers, increased pain, bleeding, or incision problems. Most patients will need Ibuprofen and the narcotic analgesic they have been on. Stool softers and iron may also be necessary. An order "Discharge to home" needs to be written in the order section.

Clinic

The two GYN clinics are on Tuesdays. The morning clinic involves patients who have a surgery scheduled in the following 1-2 weeks and are here to meet their surgeons and to be counseled. We take a full history and do a physical exam pertinent to the problem. A PARQ session is held with the patient to discuss the surgery, what to expect, the possible complications, and to have them sign a consent form. As a student, we would expect you to be able to take a detailed history and perform a physical exam of the Heart, lungs, Ab, and extremities. Any Pelvic or speculum exam will be done with the residents. The residents will also take care of discussing the surgery. A lot of paperwork

is completed during these visits, and you will be introduced to some of it once you start the clinic.

The afternoon clinic is a GYN clinic. Patients are scheduled here for Gyn-only problems or possibly an annual. Again, you should be able to take a good history and do an exam as appropriate.

The OR

We divide our cases into two rooms on many days. We have "majors" which are major abdominal or pelvic cases that require one or more nights in the hospital post-operatively. These will most commonly be hysterectomies or major urogynocological cases. We also have "minor" cases which are Day Surgery cases. These are mainly laparoscopic and hysteroscopic cases. You are more likley to scrub in on the major Gyn cases. Laparoscopy and hysteroscopy cases are often better observed on the camera monitor in the OR. Your resident will direct you as to whether you will scrub in or not. Urogyn cases often involved several staff members in a small space (especially with vaginal reconstructive surgery) and you may be offered the chance to read during those cases.

Regardless of whether you are scrubbing or not, you should try to read the patient's history and try to understand why the surgery is being done. Ask questions if you have them. We try to go as a team to the Pre-Op area to meet the patient prior to her case. We often get some of the paperwork done here beforehand. Help move the patient. Usually we have one MS3 scrub into a case. They will be able to do a pelvic exam under anesthesia. Get your glove ready for this after the patient has been intubated. Also, upon entering the room, any student should write their names on the wipeboard as the circulating RN needs to record all those present in the OR. If you are scrubbing, pull your gloves and give them to/introduce yourself to the scrub tech. We will let you know where to stand during a case. We will try to involve you. We will let you know when to hold or move or cut things. Otherwise keep your hands at rest and out of the operative field to avoid accidents to yourself and others.

Once the case is finished, you should complete your op note the best you can. We will help you finish this in the Recovery Room, but appreciate and applaud any efforts made to do an operative note. Part of this note can be skeletonized before the surgery. Some orders can too. We'll all work as a team to finish all those little pieces of paperwork.

Please remember to bring a pen to the OR. It is also helpful to have a *Pharmocopia* or drug reference book if you have one. Wear your nametag. Be sure to eat breakfast that morning and use the restroom before the case. If you do not feel well during the case, let us know and step back from the operating table. All of us have experienced this at some time or another. Your residents could probably tell you a story or two.

The Pre-Op Note

This is a note that some residents like in the chart before a case. If serves as an abbreviated history of the patient and summary of labs. It's very useful if something

happens overnight and a cross-covering physician is called to see the patient. He/She can get a quick picture of this patient. Ask your resident if they like to have op notes written. Some may just for major cases. This is a brief note, in the format below:

HPI: Patient is a ____ y.o. G__P__ with *{problem which led to surgery i.e. persisitent vaginal bleeding, symptomatic fibroids, pelvic mass) }*
PMHx: Include if patient is a smoker or nonsmoker
PSHx:
Meds:
Allergies:
Labs: Many patients will have a CBC. Tubals will have a urine pregnancy test. Older patients often have metabolic panels
EGK/CXR: often on in patients over 40 or 50 or a h/o CV or pulm problems.
Plan: The patient has been consented for *[procedure name]*

The Op Note

(write this on an index card to make it easier. By the end of the rotation, you'll probably know it without the card)
***Pre Op Dx:**
Post Op Dx:
***Procedure:**
***Staff Surgeon:** ***Residents/Student:**
***Anesthesia:** (spinal, epidural, local, GETA [general endotracheal anesthesia])
Findings: Leave this area blank for about 5 lines or so.
Specimens:
IVF:
EBL:
UOP:
Complications: Usually/hopefully none. Be sure to ask your resident before writing anything else.
Condition: Usually stable to PACU.

All starred (*)items should be known before the case and can be filled in while in the Pre-Op area. For findings, think about everything you saw and felt in a systematic way. What did your exam under anesthesia (EUA) feel like? What did you observe about the uterus, tubes, ovaries, appendix, and other organs? Where there adhesions/scar tissue? This is the hardest part of the note, but this is where we want you to start thinking like a physician. Draw a diagram in the chart if you feel it helps. For IVF, EBL (est. blood loss) and UOP (urine output), ask the anesthesiologist at the end of the case for the numbers to fill in. Again, we will help you finish up things in the Recovery area.

Orders

You may use this information, or you may not. Some residents may want to write their orders. Often, our patients are medically uncomplicated and the following orders usually hold true.

Typical Post-Laparoscopy/Hysteroscopy cases

Admit to Day Surgery
Dx: s/p *{procedure}*
Condition : Stable
Vitals: per post op routine
Activity: ad lib
Allergies:
Nursing: May straight cath one time for inability to void
Diet: clears when alert. Advance as tolerated.
IVF: D51/2NS at 125 mL/hr. SL when tolerating full clears. D/C when tolerating regulars.
Meds: MS (morphine) 2-4 mg IV q _-2 hrs prn
Toradol 15-30 mg IV for 1 dose prn (ask your resident if they want this or not)
Vicodin or Percocet 1-2 po q3-6 hrs prn
Ibuprofen 600 mg po q 6 hrs prn
Benadryl 25-50 mg iv/po q 4-6 hrs. prn
Inapsine _-1/2 cc iv q 6 hrs prn / OR Phenergan 12.5-25 mg iv/im/po q4-6 hrs prn

Patient may be discharged to home when tolerating pos, ambulating, voiding, and pain controlled by po meds.

Discharge info

Patients should have prescriptions for Ibuprofen and a small amount of po narcotics. (10-25 depending on patient and the case). Warning signs are bleeding a pad an hour for 3 hrs, fever, increased pain. Pts should undergo pelvic rest and avoid heavy lifting for 2 weeks until they return for their post-op check and talk with their MD.

Typical Post-Abdominal Cases

Admit to Gyn Service
S/P *{procedure}*
Condition: Stable
Vitals: per post op routine including strict Is and Os
Activity: Bedrest. May dangle in afternoon (if it's an a.m. case. Otherwise dangle in AM)
Nursing: Foley to gravity. (also include any drains and where they are), Turn, cough, and deep breath every 1-2 hrs while awake. {Order IS/incentive spirometer for high risk respiratory pts/smokers)
Diet: sips when alert. Then advance to clears as tolerated.
IVF: D51/2 NS with 20 Meq of KCL/Liter at 125cc an hour
Meds: See PCA or PCEA orders (these are filled out on a separate sheet)
(If patient has a PCEA then anesthesia writes for pain med/anti-emetics/and sleeping pills)
Benedryl 25-50 mg IV/po q 4-6 hrs prn

Inapsine _-1/2 cc IV q 6hrs prn or Phenergan 12.5-25 mg IV/po/IM q 4-6 hrs prn
Ativan 1-2 mg IV/po q 6 hrs prn anxiety or insomnia
Toradol (ask your resident) 15 mg IV q6 hrs prn breakthrough pain.

Labs: If there has been significant blood loss, the team may order a HCT or ABC.

Call HO for T>38.3, P<50 or >115, SBP <80 or >160, DBP <40 or > 110 or UOP <30 cc/hr for 3 consecutive hours. (Note your team may want different parameters --- this is just one possibility)

Didactics

In addition to your Friday sessions with your rotation group, each Gyn service will have their own plan for team didactics related to General Gynecology. During your time on the service, you will be expected to give a 15-20 minute talk on a gyn topic of your choice. You should discuss your ideas with your residents, as they may be able to help you focus on a managable and clinically useful topic. Talks may occur during Attending Rounds or time before Pre-Op clinic on Tuesdays.

Expectations

Learn how to take a complete Gynecological history

Learn how to do and feel more comfortable with a pelvic and speculum exam.

Become more efficient at rounding and writing Progress notes, showing progressively more confidence in contributing to a patient's post-op care plan.

Become more comfortable in an OR setting, including scrubbing, OR demeanor and writing Operative Notes/Findings.

Learn about the most common Gyn complaints seen at a Gyn outpatient practice.

Work as a team unit with members at the same level as you, as well as with those with increasingly more experience.

Be on time.

Learn that paperwork is not usually fun (definitely not NEARLY as fun as surgery), but we all do it --- students, interns, chiefs, staff. Please refrain from referring to paperwork you are asked to do as scut……..you'll be doing infinately more of it when you become a resident.