# **OBSTETRICS/GYNECOLOGY CLERKSHIP -** Entry #702

**Student's full name**

Tiotin Gabriel Panga

**Class**

Level 6

**Ward's Name and Number**

Antenatal

**Patient's Registration number**

380123

**Patient's demographics**

Esta John Namaun. 31yrs Female Iraq Peasant, Christian, from Dongobesh 2days post admission, self informant.
G2P1L1 LMP 27/01/2025 GA 30weeks EDD-03/08/2026

**Chief complaint**

Painless PV bleeding for 1day.

**History of presenting illness (HPI)**

- Mother was doing fine until 1day prior to admission which is gradual onset bright red in nature, no specific periodicity, No associating factor, no relieving factor also no aggravating factor, But pt denied the history of abdominal pain, Nausea vomiting constipation and Burning sensation during urination.On admission pt was given IV fluid and blood sample were taken.

**Review of other systems**

RS

No chest pain, no difficult in breathing, no shortness of breathing no cough.

CVS

No awareness of heartbeat, no chest pain.

CNS

No headache, no fever, no dizziness

MSS

no muscle and joint pain

**Past obstetric history**

Previous pregnancy.

1st child she was delivered a baby Boy through SVD at term and the baby's weight was 3.7kg which was born on 2023 without any complicationsIndex pregnancy.

she was booked at anc clinic at 20weeks of GA and attend any visit until now. Also she was received 1dose of TT, FeFo medication, SP, VDRL was non reactive and HIV was negative. Her last Hb level was 12mmol/L..

**Past gynecological history**

- She attained menarche at 14yrs of age. She has a cycle of 28days and period of 3-4days, she changes 3times a day which is not fully soaked, No pain during menstrual period that could interfere her daily activities. no history of gynaecological surgery no history of using family planning.

**Past medical history**

This is 2nd admission, the first admission was due to labour pain, no history of BT. no history of chronic illness, no history of known food and drug allergy, no history of surgery.

**Family social history**

She is married with 1 child, live with her husband in their house. She is peasant and her husband also is peasant, no history of cigarette smoking in both family members, no history of Alcoholism in both father and mother, no history of chronic illness in the family.

**General examination**

Mother was conscious with normal hair colour texture and well distributed no any discharge per ENT no paleness per conjunctiva, no jaundice per sclera no lymphadenopathy and no LLS, Also all vital signs were normal.

**Systemic examination**

**Per Abdomen** - Gravida abdomen, ovoid in shape moves with respiration no surgical scar, no traditional marks, striae gravidarum was seen and no visible distended abdomen.

No pain in both deep and superficial palpation. Fundal height was 34cm. The fetal heart rate was normal which was 150beat per minute.

**Cardiovascular System.**

On Inspection; the hands were warm with capillary refill within 2 seconds. Pulse rate was 72 beats per minute, regular with strong volume, synchronized in both radical pulse and blood pressure was 110/72 mmHg

taken on the left arm in sitting position. No jugular venous distension. No precordial hyperactivity and no precordial bulging.

On Palpation; the apical beat was palpable at 5th Intercostal space along the left mid – clavicular line.

On Auscultation; sound 1 and sound 2 were heard without added sounds.

**Respiratory system.**

On Inspection; the chest was flat, symmetrical in shape and moves with respiration, with respiratory rate of 18 breaths per minute. No visible swelling, no visible therapeutic marksand no surgical scars.

On Palpation; trachea was centrally located with normal tactile vocal fremitus and symmetrical chest expansion. No palpable tenderness.

On Percussion; resonant note was heard.

On Auscultation; vesicular breathing sounds were heard.

**Central Nervous System**.

1. The patient was conscious with Glasgow Coma Scale of 15/15 oriented to people, place and time. Language, speech, both long and short term memory were all intact. All cranial nerves were intact.

**Summary**

Esta John Naman 31yrs old from Dongobesh G2P1L1 LNMP 27/10/2026 and GA of 30weeks EDD-03/08/2026, come with complaint of painless per vaginal bleeding for 1 day patient has normal vital signs with no more complain

**Provisional diagnosis**

Placenta Praevia

**Differential diagnosis**

1.Abrupture placenta
2.Vassa Praevia

**Investigations**

Hb level estimation

Abdominal ultrasound

Blood grouping

cross matching

Bleeding indices

**Treatment plan**

Dexamethasone 6mg (PO) 12hourly for 48hours

Metronidazole 400mg (PO) 8hourly for 7days

Amoxclav 625mg (PO) 8hourly for 7days

- FeFo 250mg OD for 30days

**Follow up plan**

Monitoring Hb level
Monitoring vitals signs

**Prognosis**

Prognosis of the patient is good because currently patient has no bleeding

**Preventive measures**

Proper antenatal visit
Avoid heavy activities during pregnancy
Early diagnosis and treatment

**Patients summary of management plan based on daily ward rounds.(kindly include investigation results and decisions)**

Counseling on avoiding the risk factors like lifting heavy weight, balance diet, and discharging the patient with PO Antibiotics amoxclav and metronidazole

**Notes**

**GENERAL COMMENT**

### 1. HISTORY OF PRESENTING ILLNESS

Your HPI has doesnt containt a chief complaint to be amplified.

### 2. SYSTEMIC EXAMINATION

CNS examination findings are extremely partial.

### 3. PATIENTS MANAGENENT SUMMARY

- no ward rounds plans
- no investigation results

Added by medischola on May 26, 2026 2:04 pm

Medischola Tanzania