英汉对照

基础妇产科学

杨鹂主编译

天津科技翻译出版公司

ESSENTIALS OF OBSTETRICS AND GYNAECOLOGY

JAMES WILLOCKS

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前　言

中英对照《基础妇产科学》是英文原版同名书之译本。本书由英文水平高，妇产科临床经验丰富的妇产科主任、副主任、主治医师等翻译，经二译三审后定稿。全书分产科、妇科两大部分，包括产前、产时、产后监护，与妊娠有关的疾病，妊娠合并症，妇科检查及病史采集，女性生殖道各种感染（包括性病），不孕症，子宫脱垂和尿失禁，月经紊乱（闭经，功血等），子宫内膜异位症，子宫肌瘤，卵巢囊肿，女性生殖道恶性肿瘤，滋养叶细胞疾患，避孕，绝育，中止妊娠以及妇产科领域里的伦理道德等18个部分，其中第六，第七部分——母体的死亡率，围产期死亡率和发病率因译文较简单，被略去，留给读者阅后自我练习。本书除有丰富的妇产科理论外，涉及的英语语法范围广，且几乎包括了全部妇产科常用词汇。因此，读后可收到英语水平及妇产科临床理论双提高的效果。

本书的内容较新，且条理性强，便于掌握与运用。适于妇产科各级医师（主任医师，副主任医师、主治医师、住院医师），各级助产士及各级护士学习阅读。亦可做为妇产科工作者晋级，英语水平达标考试参考用书。

由于编写时间仓促，水平有限，不妥之处在所难免，敬请各位同仁笺正。

甄国才

1990年8月1日　于天津

《基础妇产科学》编译组

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PART 1

Obstetrics

1

Antenatal care

PRINCIPLES AND PRACTICE OF ANTENATAL CARE

Antenatal care has two main objectives, medical and educational.

1. It is a form of preventive medicine. Regular attendance and treatment during pregnancy helps to maintain the woman's health, prevents anaemia, confirms normal progress, including normal fetal growth, facilitates the diagnosis of complications of pregnancy and prevents some of the difficulties of delivery, thus reducing maternal and fetal mortality and morbidity.
2. It is a form of health education. The doctor and midwife have a duty to allay the pregnant woman's fears, to instruct her in the care of her body, to inform her about the process of birth, the care of the newborn infant and eventually about methods of family planning. Repeated visits offer a unique opportunity for building up a personal relationship and feeling of confidence which are just as valuable as any technical expertise.

Selection of high risk patients

Now that the incidence of hospital confinement is so high, the traditional criteria for delivery in hospital are not so strictly applied. However, wrong selection of cases still occurs and may be associated with risks to mother and child. Not all hospitals have equal facilities: patients who require intensive antenatal supervision may need to attend a hospital which is equipped to offer this service and this may involve them in personal inconvenience. Particular thought should be given to the presence or absence of an adequate anaesthetic service and of a neonatal paediatric department in the place where babies at risk are to be delivered.

A particularly high risk group consists of women who are unwilling to take advantage of the services provided, who book late or not at all and who do not take advice. These are often either

young, ignorant primigravidae or careless elderly multiparae from poor homes. Maternity departments need to devise a suitable form of outreach to contact these patients.

Women who require antenatal supervision and confinement in the best equipped hospitals include:

1. Age over 40.
2. Parity more than 5
3. Bad obstetric history, of recurrent stillbirths, fetal abnormality or abortions.
4. History of repeated premature labour.
5. Major medical disorders such as cardiac disease, diabetes and severe hypertension.
6. Rhesus Iso-immunisation.
7. Intrauterine fetal growth retardation.
8. Multiple pregnancy.
9. Malpresentations.
10. Previous Caesarean section, myomectomy or hysterotomy.
11. Previous gynaecological operations such as repair of prolapse, stress incontinence, fistula or third degree tear.

Examination at the first antenatal visit

The woman should attend an experienced obstetrician as soon as possible after pregnancy is diagnosed. This is particularly important for the estimation of maturity (see below). At the first visit a careful medical and obstetric history should be obtained and a general medical examination should be made as well as a detailed obstetric examination. Blood and urine tests should be taken.

History

1. Previous serious illnesses, e.g. rheumatic fever, jaundice, renal disease, tuberculosis.
2. Previous surgical operations — particularly abdominal operations.
3. Family history of multiple pregnancy, fetal abnormality, diabetes or hypertension.
4. Obstetric history, with details of date and place of birth, maturity of pregnancy, duration of labour, mode of delivery, birth weight and an account of any complications. Consultation of previous hospital records is often of great importance.
5. Menstrual history should pay particular attention to the date of the last period and the date of stopping the contraceptive pill.

General examination

1. Height, weight and general physical appearance.
2. Presence of oedema or varicose veins.
3. Condition of the breasts.
4. State of the teeth.
5. Pulse and blood pressure.
6. Heart sounds and murmurs.
7. Any evidence of respiratory disease.

Obstetric examination

This should be made with woman lying comfortable and the bladder empty so that accurate abdominal findings can be recorded.

1. The height of the fundus uteri, if palpable, should be noted, as should the presence of any other abdominal mass.
2. The size of the uterus should be estimated on bimanual examination if the pregnancy is of less than 20 weeks duration. Any adnexal swelling should be noted.
3. Fetal parts may be felt by ballotement after 14 weeks.
4. The fetal heart can usually be detected by the ultrasonic 'doppler effect' using simple apparatus, from the 14th week and, by the ultrasonic 'real-time' scanner from the 8th week.
5. The cervix can be inspected and a cervical smear can be taken, although opinions differ about the value of routine antenatal cytology.

Blood tests

These require 20–30 ml blood.

1. Haemoglobin.
2. ABO grouping.
3. Rhesus grouping and antibody titre.
4. Rare blood groups (e.g Kell, Lewis).
5. Syphilitic serology (VDRL test).
6. Rubella antibody titre.
7. Serum alphafetoprotein (AFP) estimation if the pregnancy is between 15 and 20 weeks. If the first visit is at an earlier stage blood can be taken later at the correct time.
8. *Guthrie test* for phenylketonuria. A drop of blood placed on a specially prepared paper is later subjected to a *bacterial inhibition assay*.

9. In susceptible patients, tests are done for thalassaemia, sickle-cell trait and Haemoglobin H.

Urine tests

In addition to simple tests, using reagent strips, for protein, sugar and acetone, a bacteriological examination should be made to detect asymptomatic bacteruria. This can easily be done by the 'Dipslide' technique, which allows the examination of large numbers of specimens, only the positive culture-medium slides requiring more detailed examination.

On conclusion of the examination, the obstetrician should outline to the patient the arrangement for further antenatal visits and indicate the facilities available to her. She is given a supply of iron and folic acid tablets (usually a combined tablet containing 150 mg iron and 300 μg folic acid) and may also be instructed to take fluoride tablets to aid the nutrition of her baby's teeth.

More detailed advice from a dietitian or a nursing sister specialising in breast feeding may be available. The patient is usually given some pamphlets on health during pregnancy.

The first antenatal visit is time-consuming for the patient and should not be overloaded with detail. More important, is to instil a feeling of confidence that she will be looked after with kindness and efficiency.

Examination at subsequent antenatal visits

These visits should take place at intervals of 4 weeks until the 28th week, then at intervals of 2 weeks until the 36th week, then weekly until delivery. Not all these visits need to be to a hospital antenatal clinic and it is common practice for alternate consultations to be undertaken by the general practitioner. If possible, the woman should come to hospital often enough to make her feel she is in familiar surroundings when the time of confinement comes.

At each visit to hospital the following observations should be made

1. *Weight in standard clothing.* The normal weight gain in pregnancy is 21 lb (9.5 kg). The gain in the first 20 weeks is 7 lb (3.2 kg). A further 7 lb (3.2 kg) is gained between 20 and 30 weeks and 7 lb (3.2 kg) is gained between 30 weeks and term.

Excessive weight gain may indicate fluid retention and a failure to gain weight may indicate fetal growth retardation but so many exogenous factors (e.g. diet, vomiting, holidays) affect maternal weight that many are sceptical of its value.

2. *Haemoglobin.* It is most important to repeat the haemoglobin estimation at every visit. Fuller blood examinations can be made if low figures are obtained. By this means folic acid deficiency can be detected early. The need for parental iron therapy has been almost eliminated.
3. *Urine tests for protein and sugar (by reagent strips).* If protein is found a midstream specimen of urine is tested by boiling. If sugar is found on more than one occasion, a glucose tolerance test may be indicated.
4. *Oedema.* If present, the cause of the oedema should be elicited. Is it dependent oedema or generalised? Is it associated with varicose veins? Is it a sign of pre-eclampsia?
5. *Blood pressure.* Levels above 140/90 mmHg are usually considered abnormal. A significant rise above the blood pressure reading taken at the booking visit is particularly important.
6. *Abdominal examination* should include: estimation of the fundal height or, better, of fetal size in relation to gestational age; the presenting part and its level above the pelvic brim; any excess or deficiency in the amount of amniotic fluid; auscultation of the fetal heart.
7. In all cases the date of first fetal movement should be recorded.
8. All women with Rhesus negative blood should have tests for antibodies at the 28th and 36th week, or more frequently if indicated.
9. A pelvic assessment may be made at the 36th week although few would now use this to predict the method of delivery. In all cases of malpresentation or high presenting part it is better to avoid pelvic examination until placenta praevia is excluded.
10. Ultrasound and X-ray examination may be used as indicated. There is much to be said for a programme of routine sonar screening to estimate maturity, locate the placenta etc., and facilities have been developed to allow this to be done in many centres.
11. Antenatal care is largely a matter of routine but it should never become a mindless routine. Alert attention to detail and constant sensitivity to the feelings of the patient are essential throughout.

DIAGNOSIS OF PREGNANCY AND ESTIMATION OF FETAL MATURITY

Some of the clinical aspects of these subjects have already been touched on in the section on Principles and Practice of Antenatal Care but they are of such importance that they merit separate consideration. Practically every antenatal test which reflects the fetal condition is related to maturity and no intelligent use can be made of the tests if this basic fact is uncertain.

Diagnosis of early pregnancy

1. Clinical

The development of rapid, easy and almost universally available immunological tests has led to a neglect of the clinical features of early pregnancy which may lead to wrong diagnosis from time to time.

It is well to answer clinically two questions in every woman who attends:

a. Is she pregnant?
b. Is the pregnancy intrauterine or extrauterine?

The symptoms of early pregnancy (amenorrhea, nausea, tingling of the breasts) are too well known to require detailed repetition. Often a woman may merely have a vague feeling of pregnancy which precedes other symptoms. Clinical signs include:

a. *Breast changes*. Fullness and distension of superficial veins; darkening of areolae and turgidity of nipples, enlargement of sebaceous glands surrounding the nipple forming Montgomery's tubercles.
b. *Bluish discolouration of vagina* due to venous engorgement is often present in the early weeks.
c. *Pulsation in the vaginal fornices* due to the increased vascularity of the uterus.
d. *Softening of the cervix* is present early but the excessive softness of the lower uterine segment is not marked until after the 6th week. Because of the softness of the lower uterine segment, it is difficult to follow the continuity of the cervix with the body of the uterus and thus they appear separate on bimanual examination (Hegar's sign). After the 10th week this sign gradually disappears.

e. *Uterine enlargement*. The uterus becomes soft, cystic and globular and enlarges progressively. The fundus uteri is palpable abdominally at the 12th week. In patients previously delivered by Caesarean section, the uterus often seems to be at a higher level than in others. Any adnexal mass or tenderness should be noted on vaginal examination and may raise the suspicion of ectopic pregnancy.
f. *Internal ballotement*. This sign consists of pushing the examining fingers sharply upwards in the anterior vaginal fornix — the fetus is pushed up towards the fundus uteri, but sinking again will be felt impinging on the fingers. The sign can be elicited from the 14th week.
g. *Fetal heart sounds* can be heard with the ordinary stethoscope from 20 weeks onwards. This is an absolute sign of pregnancy. The 'Doptone' or 'Sonicaid' ultrasonic fetal heart detectors, which utilise the Doppler effect are simple to use and give positive results from 14 weeks onwards.

2. Urine tests

The presence of Human Chorionic Gonadotrophin (HCG) in the urine of pregnant women has been used since 1927 as a means of detecting pregnancy.

Modern tests are immunological. Anti-HCG serum is prepared in animals: this serum is neutralised by the chorionic gonadotrophins in the patient's urine. The other reagent is a suspension of red cells or latex particles which are coated or primed with HCG. The latex slide test is very rapidly performed but the more popular technique now is the red cell test. This test ('Pregnosticon') depends on haemagglutination inhibition. It is performed as follows.

a. A fresh suspension of red cells primed with HCG is made up with the suspension fluid.
b. 0.1 ml of urine is added to an ampoule of anti-HCG serum.
c. 0.4 ml of the primed cell suspension is added to the urine anti-serum mixture.
d. The final mixture is shaken, then left to stand for 2 hours.
e. A clear brown ring indicates a positive result — this is because the primed red cells are not agglutinated by the anti-HCG serum which had already been neutralised by the HCG in the urine. The cells then settle in the test tube in the characteristic brown ring.