Ministry of Health of the Russian Federation

Federal State Budgetary Educational Institution of Higher Education "North-Western State Medical University named after I.I. Mechnikov" of the Ministry of Health of the Russian Federation

(FSBEI HE NWSMU named after I.I. Mechnikov of the Ministry of Health of the Russian Federation)

Course Work Program

«Obstetrics and Gynecology»

Specialty: 30.05.01 General Medicine (English Medium Instruction — EMI)

Specialization: Organization and provision of primary healthcare to the adult population in medical organizations.

Language of instruction: English

2021

The Work Program of the "Anatomy" course is compiled on the basis of the Federal State Educational Standard of Higher Education - Specialist's program in specialty 31.05.01 General Medicine, approved by Order No. 988 of the Ministry of Science and Higher Education of the Russian Federation dated August 12, 2020 "On the approval of the federal state educational standard of higher education - specialist's program in specialty 31.05.01 General Medicine".

The working program of the discipline was compiled by:
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The working program of the discipline was discussed at the meeting of the Department of Obstetrics and Gynecology on April 00, 2021, Protocol No. 0

Head of the Department _____ / Berlev I.V./

Approved by the Methodological Commission for the Specialty 31.05.01 General Medicine on May 11, 2021.

Chairman _____ / Bakulin I.G./

Reviewed by the Methodological Council and recommended for approval by the Academic Council on May 20, 2021

Chairman _____ / Artyushkin S.A. //

Update date:

Content

1. Aim of the discipline

The objective of mastering the discipline "Obstetrics and Gynecology" is to develop the learner's competencies and train a qualified medical specialist equipped with a system of general professional and professional competencies, capable of and prepared for independent professional practice in the field of healthcare organization.

2. Place of the discipline in the structure of the educational program

The discipline "Obstetrics and Gynecology" belongs to the mandatory part of Block 1 "Disciplines (Modules)" of the main professional educational program for specialty 31.05.01 General Medicine (specialty level: MD / MBBS), specialization: Organization and provision of primary healthcare to the adult population in medical organizations. The course is obligatory for this specialty level.

3. List of planned learning outcomes for the discipline, aligned with the planned outcomes of the educational program

Code and name of the Competencies	Code and name of the competency achievement indicator
GPC-4. Able to use medical devices, as stipulated by the standard of medical care, and conduct patient examinations for the purpose of establishing a diagnosis.	AI-1 GPC-4.1. ПApplies medical devices for diagnostic examinations, as stipulated by the standards of medical care
	AI-2 GPC-4.2. Applies diagnostic methods, including instrumental methods, during patient examinations for the purpose of establishing a diagnosis
	AI-3 GPC-4.3. Performs diagnosis verification using laboratory, instrumental, specialized examination methods, and consultative opinions from relevant specialist physicians
	AI-4 GPC-4.4. Applies medical devices justifiably in solving diagnostic problems
GPC-5. Is capable of assessing morphological and functional states, physiological conditions, and pathological processes in the human body to solve professional tasks	AI-1 GPC-5.1. Assesses the patient's degree of functional activity and independence in self-care, mobility, and communication
	AI-2 GPC-5.2. Determines and interprets patient vital signs during dynamic monitoring
	AI-3 GPC-5.3. Determines the main indicators of physical development and functional status of the patient, taking into account the anatomical and physiological characteristics of the patient's age
GPC-7. Is capable of prescribing treatment and monitoring its effectiveness and safety	AI-1 GPC-7.1. Prescribes a therapeutic and protective regimen, selects the location and type of treatment considering the severity of the patient's condition
	AI-2 GPC-7.2. Selects medicinal products, determines specific dosage forms, routes of administration, and provides rational substitution of drugs based on the patient's condition
	AI-3 GPC-7.3. Predicts adverse effects of medicinal products and implements their prevention
	AI-4 GPC-7.4. Monitors the effectiveness and safety of prescribed treatment at all stages of its implementation
PC- 2 Is capable of conducting patient	AI-1 PC-2.1. Conducts patient interview and examination (collecting complaints, medical and life

examinations to identify primary pathological conditions, symptoms, syndromes of diseases, and nosological forms	history, inspection, palpation, percussion, auscultation). AI-2 PC-2.2. Formulates a preliminary diagnosis, develops a plan, and refers the patient for laboratory and/or instrumental examination when medically indicated, in accordance with current standards of medical care, clinical guidelines for healthcare provision, and considering medical care standards AI-3 PC-2.3. Refers the patient for consultation with specialist physicians and/or for specialized medical care in inpatient settings or day hospital settings when medically indicated, in accordance with current standards of medical care, clinical guidelines for healthcare provision, and considering medical care standards AI-4 PC-2.4. Performs differential diagnosis with other diseases/conditions AI-5 PC-2.5. Establishes a diagnosis considering clinical classifications and the current International Statistical Classification of Diseases and Related Health Problems (ICD).
PC-3 Is capable of managing and treating patients requiring medical care	AI-1 PC-3.1. Develops a plan and prescribes non-pharmacological and pharmacological treatment for patients, considering the diagnosis, age, and clinical presentation, in accordance with current standards of medical care, clinical guidelines for healthcare provision, and medical care standards within the context of primary healthcare AI-2 PC-3.2. Evaluates the effectiveness and safety of using medicinal products, medical devices, therapeutic nutrition, and other treatment methods within the context of primary healthcare AI-3 PC-3.3. Provides palliative medical care in collaboration with specialist physicians, specialized medical institutions, and social services within the context of primary healthcare AI-4 PC-3.4. Provides personalized general therapeutic care to patients, including pregnant women and elderly/geriatric patients, within the context of primary healthcare
PC-4 Is capable of carrying out a set of measures to prepare for and conduct various types of examinations	AI-1 PC-4.1. Conducts examinations for temporary incapacity for work AI-2 PC-4.2. Determines indications for referral to a medical and social examination within the context of primary healthcare
PC-5 Is capable of determining the need to apply natural therapeutic factors, pharmacological and non-pharmacological therapy, and other methods in patients requiring medical rehabilitation and spa treatment.	AI-1 PC-5.1. Identifies and refers patients requiring medical rehabilitation to a specialist physician for the prescription and implementation of medical rehabilitation measures and/or spa treatment, including in the context of executing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with current standards of medical care, clinical guidelines (treatment protocols) for healthcare provision, and considering medical care standards

Code of the competency's achievement indicator	Learning outcomes (Assessment Indicators)	Assessment methods
AI-1 GPC-4.1.	**Knows** General issues in organizing healthcare for the population.	Cases Tests Control questions
	Able to Use medical devices during diagnostic tests as provided for by healthcare delivery procedures.	Cases Tests Control questions
	Has the skill to verify a diagnosis using laboratory, instrumental, and specialized examination methods.	Cases Tests Control questions Birth history Case history
AI-2 GPC-4.2.	**Knows** Methods of laboratory and instrumental tests for assessing health status, medical indications for conducting tests, and rules for interpreting their results.	Cases Tests Control questions
	Able to Apply diagnostic methods, including those using instrumental techniques, during patient examinations to establish a diagnosis.	Cases Tests Control questions Birth history Case history
	Has the skill to perform diagnosis verification using laboratory, instrumental, and specialized examination methods.	Cases Practical skill
AI-3 GPC-4.3.	**Knows** Methodologies for conducting a complete physical examination of a patient (inspection, palpation, percussion, auscultation).	Cases Tests Control questions
	Able to Perform diagnosis verification using laboratory, instrumental, and specialized examination methods, as well as advisory conclusions from specialized medical doctors.	Cases Tests Control questions Birth history Case history
	Has the skill to Perform diagnosis verification using laboratory, instrumental, and specialized examination methods, as well as advisory conclusions from specialized medical doctors.	Cases Practical skill
AI-4 GPC-4.4.	**Knows** Methodologies for conducting a complete physical examination of a patient (inspection, palpation, percussion, auscultation).	Cases Tests Control questions
	Able to Use medical devices in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards	Cases Tests Control questions Birth history Case history
	Has the skill to use medical devices for solving diagnostic problems.	Cases Practical skill
AI-1 GPC-5.1.	**Knows** The specifics of medical rehabilitation for elderly and senile patients.	Cases Tests Control questions

	Able to develop a treatment plan for a patient's disease or condition, taking into account the diagnosis, the patient's age, and the clinical presentation of the disease, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Tests Control questions Case history
	Has the skill to assess the degree of a patient's functional activity and independence in self-care, mobility, and communication. Refer patients for specialized inpatient or day hospital care when medically indicated, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Knows the patterns of functioning of a healthy human body and the mechanisms of health maintenance from the perspective of functional systems theory; the specifics of regulating the body's functional systems during pathological processes. Methods of laboratory and instrumental tests for assessing health status, medical indications for conducting tests, and rules for interpreting their results. The etiology, pathogenesis, and pathomorphology; clinical presentation; differential diagnosis; specifics of progression; complications; and outcomes of internal organ diseases. Methodology for collecting patient complaints, life history, and medical history. Able to develop a treatment plan for a disease or condition, taking into account the diagnosis, the patient's age, and the clinical presentation, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Practical skill
AI-2 GPC-5.2.	**Knows** The patterns of functioning of a healthy human body and the mechanisms of health maintenance from the perspective of functional systems theory; the specifics of regulating the body's functional systems during pathological processes.	Cases Tests Control questions
	Able to Conduct medical examinations taking into account age, health status, and profession in accordance with current regulatory legal acts and other documents.	Cases Tests Control questions
	Has the skill to Determine and interpret patient vital signs during follow-up monitoring.	Cases
AI-3 GPC-5.3.	**Knows** The procedures for providing palliative medical care.	Cases Tests Control questions
	Able to Provide palliative medical care in collaboration with medical specialists and other healthcare professionals. Organize personalized treatment for patients, including pregnant women and elderly/senile patients, and assess	Cases Tests Control questions Birth history Case history

	the effectiveness and safety of the treatment.	
	Has the skill to Determine key indicators of physical development and functional status of a patient, taking into account the anatomical and physiological characteristics of the patient's age.	Cases
AI-1 GPC-7.1.	**Knows** The mechanism of action of non-pharmacological treatments; medical indications and contraindications for their prescription; side effects and complications caused by their use. Modern methods of non-pharmacological treatment for patient diseases and conditions in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Tests Control questions
	Able to Develop a treatment plan for a patient's disease or condition, taking into account the diagnosis, the patient's age, and the clinical presentation of the disease, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Tests Control questions Birth history Case history
	Has the skill to prescribe a therapeutic and protective regimen, select the location and type of treatment based on the severity of the patient's condition. Can prescribe non-pharmacological treatment considering the diagnosis, age, and clinical presentation of the disease in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Practical skill
AI-2 GPC-7.2.	**Knows** Modern methods of using medications, medical devices, and therapeutic nutrition for patient diseases and conditions in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Tests Control questions
	Able to Prescribe medications, medical devices, and therapeutic nutrition taking into account the diagnosis, age, and clinical presentation of the disease, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Tests Control questions Case history
	Has the skill to select medications, choose specific dosage forms, routes of administration, and make rational substitutions based on the patient's condition. Can prescribe medications, medical devices, and therapeutic nutrition taking into account the diagnosis, age, and clinical presentation of the disease, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of	Cases Practical skill

	medical care, and in compliance with healthcare standards.	
AI-3 GPC-7.3.	**Knows** The mechanism of action of medications, medical devices, and therapeutic nutrition; medical indications and contraindications for their use; complications caused by their application.	Cases Tests Control questions
	Able to Develop a treatment plan for a disease or condition, taking into account the diagnosis, age, and clinical presentation, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Case history
	Has the skill to Predict the side effects of medications and implement their prevention. Assess the effectiveness and safety of using medications, medical devices, therapeutic nutrition, and other treatment methods.	Cases
AI-4 GPC-7.4.	**Knows the** algorithm for non-pharmacological treatment, taking into account the diagnosis, age, and clinical picture of the disease, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Tests Control questions
	Able to Assess the effectiveness and safety of using medications, medical devices, and therapeutic nutrition.	Cases Tests Control questions
	Has the skill to Provide palliative medical care in collaboration with medical specialists and other healthcare professionals. Organize personalized treatment for patients, including pregnant women and elderly/senile patients, assess the effectiveness and safety of treatment, and monitor the efficacy and safety of prescribed treatment at all stages of its implementation.	Cases
AI-1 PC-2.1.	**Knows** The legislation of the Russian Federation in the field of healthcare, regulatory legal acts and other documents governing the activities of medical organizations and medical professionals. The methodology for collecting patient complaints, life history, and medical history. The methodology for conducting a complete physical examination of a patient (inspection, palpation, percussion, auscultation).	Cases Tests Control questions
	Able to conduct patient examinations to identify primary pathological conditions, symptoms, syndromes of diseases, and nosological forms. Perform the collection of patient complaints, life history, and medical history, and analyze the obtained information. Conduct a complete physical examination of the patient (inspection, palpation, percussion, auscultation) and interpret its results.	Case history Birth history
	Has the skill to collect patient complaints, life history, and medical	Practical skill

	history. Perform a complete physical examination of the patient (inspection, palpation, percussion, auscultation).	
AI-2 PC-2.2.	**Knows** The procedures for providing medical care, clinical guidelines (treatment protocols) for the provision of medical care, and healthcare standards	Cases Tests Control questions
	Able to Justify the necessity and scope of laboratory examination for a patient. Justify the necessity and scope of instrumental examination for a patient.	Birth history Case history
	Has the skill to Formulate a preliminary diagnosis and develop a plan for laboratory and instrumental examinations of the patient.	Cases Practical skill
AI-3 PC-2.3.	**Knows how to** Justify the need to refer a patient for consultations with medical specialists. Analyze the obtained results of a patient's examination, and when necessary, justify and plan the scope of additional investigations. Interpret the results of gathering information about a patient's illness. Interpret data obtained from a patient's laboratory examination. Interpret data obtained from a patient's instrumental examination. Interpret data obtained from consultations of the patient with medical specialists. Conduct early diagnosis of internal organ diseases.	Cases Tests Control questions
	Able to Determine the priority, scope, content, and sequence of diagnostic procedures. Determine medical indications for providing emergency, including specialized emergency, medical care. Use medical devices in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Birth history Case history
	Has the skill to Refer a patient for laboratory examination when medically indicated, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Refer a patient for instrumental examination when medically indicated, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Refer a patient for consultation with medical specialists when medically indicated, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Refer a patient for specialized inpatient or day hospital care when medically indicated, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Practical skill

AI-4 PC-2.4.	**Knows** The patterns of functioning of a healthy human body and the mechanisms of health maintenance from the perspective of functional systems theory; the specifics of regulating the body's functional systems during pathological processes.	Tests Control questions
	Able to Conduct differential diagnosis of internal organ diseases from other diseases.	Birth history Case history
	Has the skill to Conduct differential diagnosis with other diseases/conditions, including urgent ones.	Cases Practical skill
AI-5 PC-2.5.	**Knows** Issues related to the organization of sanitary and anti-epidemic (preventive) measures aimed at preventing the occurrence and spread of infectious diseases.	Tests Control questions
	Able to Use laboratory and instrumental test methods to assess health status, understand medical indications for conducting tests, and follow the rules for interpreting their results.	Cases Tests Control questions Birth history Case history
	Has the skill to Establish a diagnosis in accordance with the current International Statistical Classification of Diseases and Related Health Problems (ICD).	Practical skill
AI-1 PC-3.1.	**Knows** Modern methods of using medications, medical devices, and therapeutic nutrition for patient diseases and conditions in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Modern methods of non-pharmacological treatment for patient diseases and conditions in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	Cases Tests Control questions
	Able to Prescribe medications, medical devices, and therapeutic nutrition taking into account the diagnosis, age, and clinical presentation of the disease, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Prescribe non-pharmacological treatment taking into account the diagnosis, age, and clinical presentation of the disease, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Knows the mechanism of action of non-pharmacological treatments; medical indications and contraindications for their prescription; side effects and complications caused by their use.	Cases Case history
	Has the skill to prescribe medications, medical devices, and	Cases Practical skill

	therapeutic nutrition taking into account the diagnosis, age, and clinical presentation of the disease, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. prescribe non-pharmacological treatment taking into account the diagnosis, age, and clinical presentation of the disease, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards.	
AI-2 PC-3.2.	**Knows** The mechanism of action of medications, medical devices, and therapeutic nutrition; medical indications and contraindications for their use; complications caused by their application.	Cases Tests Control questions
	Able to Assess the effectiveness and safety of using medications, medical devices, and therapeutic nutrition.	Cases Tests Control questions
	Has the skill to Assess the effectiveness and safety of using medications, medical devices, therapeutic nutrition, and other treatment methods.	Cases
AI-3 PC-3.3.	**Knows** The procedures for providing palliative medical care.	Tests Control questions
	Able to Assess the need for involving required specialists and the scope of palliative medical care to be provided.	Cases Tests Control questions
	Has the skill to Organize the provision of palliative medical care and consult individuals involved in its delivery, both from medical staff and those without professional skills.	Cases
AI-4 PC-3.4.	**Knows** Managing patients in need of medical care, taking into account their socio-physiological characteristics.	Tests Control questions
	Able to Develop a treatment plan for a disease or condition, taking into account the diagnosis, age, and clinical presentation, in accordance with current healthcare procedures and clinical guidelines.	Cases Birth history Case history
	Has the skill to Organize personalized treatment for patients, including pregnant women and elderly/senile patients, and assess the effectiveness and safety of the treatment.	Cases Practical skill
AI-1 PC-4.1.	**Knows** The signs of persistent impairment of body functions due to diseases, consequences of injuries, or defects.	Tests Control questions
	Able to Identify signs of temporary disability and signs of persistent impairment of body functions due to diseases, consequences of injuries, or defects.	Cases Tests Control questions
	Has the skill to Apply the algorithm for conducting temporary disability examinations and work as part of a medical commission that performs temporary disability	Cases Practical skill

	examinations.	
AI-2 PC-4.2.	**Knows** The procedure for referring a patient to a medical and social examination.	Cases Tests Control questions
	Able to Identify signs of temporary disability and signs of persistent impairment of body functions due to diseases, consequences of injuries, or defects.	Cases Tests Control questions
	Has the skill to Prepare the necessary medical documentation for conducting a medical and social examination in federal state institutions of medical and social examination.	Practical skill
AI-1 PC-5.1.	**Knows** Measures for the medical rehabilitation of a patient, medical indications and contraindications for their implementation considering the diagnosis, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Medical indications and contraindications for prescribing spa treatment as a stage of the patient's medical rehabilitation. Specifics of medical rehabilitation for elderly and senile patients.	Tests Control questions
	Able to Determine medical indications for conducting medical rehabilitation measures, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Perform medical rehabilitation measures for a patient in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Determine specialized physicians to carry out rehabilitation measures for a patient in need of medical rehabilitation, considering the diagnosis and in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Prescribe spa treatment for a patient in need of medical rehabilitation, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with current clinical guidelines (treatment protocols) for the provision of medical care, healthcare procedures, and in compliance with healthcare standards. Monitor the implementation and assess the effectiveness and safety of rehabilitation measures, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, considering the diagnosis and in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of	Cases

	medical care, and in compliance with healthcare standards.	
	Has the skill to apply the algorithm for medical rehabilitation measures for a patient, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Can refer a patient in need of medical rehabilitation to a specialized physician for the prescription and implementation of medical rehabilitation measures, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Can refer a patient in need of medical rehabilitation to a specialized physician for the prescription and implementation of spa treatment, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Can assess the effectiveness and safety of a patient's medical rehabilitation measures in accordance with current healthcare procedures, clinical guidelines (treatment protocols) for the provision of medical care, and in compliance with healthcare standards. Can refer a patient with a persistent impairment of body functions due to diseases, consequences of injuries, or defects to a medical and social examination.	Cases

4. Scope of the discipline and types of academic work

Type of educational work	Course workload	Semesters			
		7	8	9	10
Contact hours of students with the professor	**196**	**60**	**60**	**36**	**40**
Classroom work:	192	60	60	36	36
Lectures (L)	48	12	12	12	12
Practical Classes (PC)	144	36	36	36	36
Independent work:	**128**	**24**	**24**	**24**	**56**
During the period of theoretical training	96	24	24	24	24
Exam preparation	32				32
Interim assessment: Exam, including passing, and group consultations	4				4
Total course workload: Academic hours	**324**				
Credit units	**9**				

5. Content of the discipline, structured by sections (topics) indicating the number of academic hours and types of instructional sessions

5.1. Content of the discipline sections.

Serial No.	Name of the discipline section	Annotated content of the discipline section	List of competencies developed during the mastery of the section
1	Introduction to Obstetrics	The objective is to review key historical information on the development of obstetrics and perinatology, and the organization of obstetric and perinatal care systems. Anatomy of the female reproductive organs, the menstrual cycle and its regulation. Physiological processes in a woman's body during various life stages.	GPC-4, GPC-5
2	Physiological Obstetrics	The objective is to examine the physiology of pregnancy, methods of special obstetric examination of women, the physiology of childbirth, the physiology of the postpartum period and the neonatal period, as well as methods for assessing the condition of the fetus and newborn.	GPC-4, GPC-5, GPC-7, PC-2, PC-3
3	Pathological Obstetrics	The objective is to examine the main pathologies of pregnancy, childbirth, and the postpartum period, as well as the most common forms of perinatal pathology, along with the principles of their diagnosis, treatment, and prevention.	GPC-4, GPC-5, GPC-7, PC-2, PC-3, PC-4, PC-5
4	Operative Obstetrics	The objective is to examine the main obstetric operations: procedures to maintain pregnancy, delivery procedures, and operations performed during the postpartum period. Anesthesia for obstetric procedures. Anesthesia for cesarean section.	GPC-4, GPC-5, GPC-7, PC-3, PC-4, PC-5
5	Methods for Examining Gynecological Patients	The objective is to examine modern methods for examining gynecological patients, both clinical and specialized.	GPC-4, PC-2
6	Pathology of the Female Reproductive Organs	The objective is to examine the issues of etiology, pathogenesis, clinical presentation, diagnosis, and treatment of the main types of gynecological pathology: disorders of ovarian hormonal and reproductive function, inflammatory diseases, benign, precancerous, and malignant lesions of the uterus and ovaries, as well as conditions presenting with an "acute abdomen." The discussion also covers issues related to the problem of infertile marriage.	GPC-4, GPC-5, GPC-7, PC-3, PC-4

Serial No.	Name of the discipline section	Annotated content of the discipline section	List of competencies developed during the mastery of the section
7	Surgical Treatment Methods in Gynecology	The objective is to examine the main types of gynecological operations and the management of patients in the postoperative period.	GPC-5, GPC-7, PC-3, PC-4, PC-5
8	Family Planning and Modern Contraceptive Methods	The objective is to examine issues related to family planning and modern contraceptive methods, and the role of family planning in protecting women's reproductive health.	GPC-5, GPC-7, PC-2, PC-3

5.2. Lecture syllabus

Serial No.	Name of the discipline section	Lecture Topics	Active learning methods	Workload (academic hours)
1.	Introduction to Obstetrics	L.1 Main stages in the development of obstetrics. Current problems in obstetric science and practice. Organization of obstetric care in the country. Key performance indicators of the women's consultation office and maternity hospital	LC	2
2.	Physiological Obstetrics	L.2 The normal menstrual cycle and its regulation. Placenta formation and its functions	LC	2
3.	Physiological Obstetrics	L.3 Changes in the female body during pregnancy	LC	2
4.	Physiological Obstetrics	L.4 Childbirth. The concept of the body's readiness for labor. Causes of the onset of labor. Clinical course and management of childbirth. Modern methods of monitoring labor. Assessment of the condition of the intrauterine fetus and the newborn. Pain relief during childbirth	LC	2
5.	Pathological Obstetrics	L.5 Miscarriage (Pregnancy loss). Etiopathogenesis, clinical presentation, diagnosis, treatment. Preterm birth. Risk groups. Features of the course and management of preterm labor	LC	2
6.	Pathological Obstetrics	L.6 Intrauterine infections. The impact of harmful factors on the fetus. Fetal hypoxia and neonatal asphyxia	LC	2

Serial No.	Name of the discipline section	Lecture Topics	Active learning methods	Workload (academic hours)
7.	Pathology of the Female Reproductive Organs	L.7 Regulation of the menstrual cycle. Amenorrhea and hypomenstrual syndrome. Dysfunctional uterine bleeding	LC	2
8.	Pathology of the Female Reproductive Organs	L.8 Inflammatory diseases of the female reproductive organs. Diseases of the lower and upper parts of the genital tract. Sexually transmitted infections. Tuberculosis of the female reproductive organs	LD	2
9.	Pathology of the Female Reproductive Organs	L.9 Uterine fibroids. Hyperplastic processes of the endometrium. Endometrial cancer	LC	2
10.	Pathology of the Female Reproductive Organs	L. 10 Benign changes of the cervix. Precancerous conditions and cervical cancer	LD	2
1.	Pathology of the Female Reproductive Organs	L. 11 Ovarian tumors	LC	2
12.	Pathology of the Female Reproductive Organs	L. 12 "Acute abdomen" in gynecology	LC	2
13.	Pathology of the Female Reproductive Organs	L. 13 Endometriosis	LC	2
14.	Pathology of the Female Reproductive Organs	L. 14 Trophoblastic disease	LC	2
15.	Pathology of the Female Reproductive Organs	L. 15 Tubo-ovarian inflammatory formations. Diagnosis. Treatment principles	LC	2
16.	Pathology of the Female Reproductive Organs	L. 16 Infected abortion	LC	2
17.	Pathology of the Female Reproductive Organs	L. 17 Infertile marriage	LD	2
18.	Family planning. Modern contraceptive methods	L. 18 Family planning. Modern contraceptive methods	LD	2

Serial No.	Name of the discipline section	Lecture Topics	Active learning methods	Workload (academic hours)
19.	Pathological Obstetrics	L. 19 Narrow pelvis. Classification, peculiarities of the course and management of labor with a narrow pelvis	LC	2
20.	Pathological Obstetrics	L.20 Postpartum purulent-septic diseases..	LC	2
21.	Pathological Obstetrics	L.21 Preeclampsia. Classification, etiopathogenesis. Clinical presentation of late gestosis. Treatment principles. Emergency care for an eclamptic seizure.	LC	2
22.	Pathological Obstetrics	L.22 Bleeding during pregnancy. Placenta previa. Premature detachment of a normally situated placenta.	LC	2
23.	Pathological Obstetrics	L.23 Bleeding in the placental and early postpartum periods.	LC	2
24.	Operative Obstetrics	L.24 Obstetric delivery operations.	LD	2
		TOTAL: 24		48

LC – lecture-conversation
LD – lecture-discussion

5.3. Practical session syllabus

Serial No.	Name of the discipline section	Themes of the practical session	Active learning methods	Forms of Ongoing assessment	Workload (academic hours)
1.	Introduction to Obstetrics	PS.1 Structure and organization of a maternity hospital and women's clinic. Anatomy and physiology of the female reproductive organs. Birth canal.	GD	Tests Control questions	4
2.	Physiological Obstetrics	PS.2 Diagnosis of early pregnancy. Early toxemia. Classification, diagnosis, therapy.	ST	Tests Control questions Case Practical skill	4
3.	Physiological Obstetrics	PS.3 Pelvis from an obstetric point of view. The fetus as the object of childbirth.	ST	Tests Control questions Practical skill	4
4.	Physiological	PS.4	ST	Tests	4

	Obstetrics	Methods for examining a pregnant woman at different stages of pregnancy.		Control questions Practical skill	
5.	Physiological Obstetrics	PS.5 The concept of the body's readiness for childbirth. Clinical course and management of the first stage of labor. Modern methods of recording labor activity. Prescriptions of medications used in the first stage of labor.	RP	Tests Control questions Case Practical skill	4
6.	Physiological Obstetrics	PS.6 Clinical course and management of the second stage of labor. Biomechanism of labor in anterior and posterior occipital presentations. Manual assistance during delivery. Primary care of the newborn.	RP	Tests Control questions Case Practical skill	4
7.	Physiological Obstetrics	PS.7 Clinical course and management of the third stage of labor. Methods for the prevention of hemorrhage. Prescriptions of medications.	RP	Tests Control questions Case Practical skill	4
8.	Physiological Obstetrics	PS.8 The physiological postpartum period. Prescriptions of medications used in the postpartum period.	GD	Tests Control questions Case	4
9.	Pathological Obstetrics	PS.9 Breech presentation of the fetus. Classification, diagnosis, course, and management	ST	Tests Control questions Case Practical skill	4

		of labor.			
10.	Pathological Obstetrics	PS.10 Deflexion (extended) presentations of the fetal head. Classification, diagnosis, course, and management of labor.	ST	Tests Control questions Case	4
11.	Pathological Obstetrics	PS.11 Abnormalities of labor.	GD	Tests Control questions Case	4
12.	Pathological Obstetrics	PS.12 Abnormal fetal positions. Multiple pregnancy. Diagnosis, course, and management of labor.	GD	Tests Control questions Case	4
13.	Methods for examining gynecological patients	PS.13 Methodology of examination for gynecological patients. Specific functions of the female body. Primary patient complaints.	ST	Tests Control questions Assessment of the demonstration of practical skills	8
14.	Pathology of the Female Reproductive Organs	PS.14 Inflammatory diseases of the female genital organs. Etiology, pathogenesis. Inflammatory diseases of the lower genital tract. Diagnosis, treatment.	GD	Tests Control questions Case	4
15.	Pathology of the Female Reproductive Organs	PS.15 Inflammatory diseases of the upper genital tract. Sexually transmitted infections (trichomoniasis, gonorrhea, chlamydia, genital herpes, HPV and HIV infection). Tuberculosis of the female genital organs.	GD	Tests Control questions Case	4
16.	Pathology of the	PS.16	GD	Tests	4

	Female Reproductive Organs	Regulation of the menstrual cycle. Amenorrhea and hypomenstrual syndrome.		Control questions Case	
17.	Pathology of the Female Reproductive Organs	PS.17 Dysfunctional uterine bleeding. Diagnosis, treatment.	GD	Tests Control questions Case	4
18.	Pathology of the Female Reproductive Organs	PS.18 Hyperplastic processes of the endometrium.	GD	Tests Control questions Case	4
19.	Pathology of the Female Reproductive Organs	PS.19 Malignant diseases of the uterine body. Endometrial cancer.	GD	Tests Control questions Case	4
20.	Pathology of the Female Reproductive Organs	PS.20 Uterine fibroids (leiomyoma). Classification. Etiology, pathogenesis. Clinical manifestations, diagnosis, treatment.	GD	Tests Control questions Case	4
21.	Pathology of the Female Reproductive Organs	PS.21 Benign cervical changes. Precancerous diseases and cervical cancer. Diagnosis, clinical features, treatment, and prevention.	GD	Tests Control questions Case	4
22.	Pathology of the Female Reproductive Organs	PS.22 Опухоли яичников.	GD	Tests Control questions Case	4
23.	Pathology of the Female Reproductive Organs	PS.23 «Острый живот» в гинекологии (внематочная беременность, апоплексия яичника, перекрут кисты яичника, разрыв кисты яичника и нарушение кровоснабжения узла миомы).	CA	Tests Control questions Case	4

24.	Pathology of the Female Reproductive Organs	PS.24 Trophoblastic disease.	GD	Tests Control questions Case	4
25.	Pathology of the Female Reproductive Organs	PS.25 Spontaneous abortion (miscarriage). Etiology, stages of abortion. Classification, diagnosis, medical management. Induced (artificial) abortion.	BG	Tests Control questions Case	4
26.	Pathology of the Female Reproductive Organs	PS.26 Infected abortions, classification, medical management. Sepsis, septic shock. Causes, diagnosis, principles of treatment.	GD	Tests Control questions Case	4
27.	Family Planning. Modern Methods of Contraception.	PS.27 Family planning. Modern methods of contraception.	BG	Tests Control questions Case	4
28.	Pathology of the Female Reproductive Organs	PS.28 Abnormal positions and prolapse of the female genital organs.	ASM	Tests Control questions Case	4
29.	Surgical treatment methods in gynecology.	PS.29 Typical gynecological operations.	ASM	Tests Control questions Case	4
30.	Pathological obstetrics.	PS.30 Narrow pelvis.	ST	Tests Control questions Case	4
31.	Pathological obstetrics.	PS.31 Maternal birth trauma.	CA	Tests Control questions Case	4
32.	Pathological obstetrics.	PS.32 Purulent-septic diseases in the postpartum period.	GD	Tests Control questions Case	4
33.	Pathological obstetrics.	PS.33 Preeclampsia. Eclampsia.	GP	Tests Control questions Case	4
34.	Pathological obstetrics.	PS.34 Bleeding in the	CA	Tests Control	4

		second half of pregnancy. Placenta previa. Premature detachment of a normally situated placenta.		questions Case	
35.	Pathological obstetrics.	PS.35 Bleeding in the third stage of labor and early postpartum period. Hemorrhagic shock.	CA	Tests Control questions Case	4
				TOTAL:	144

RP - Role-play
BG - Business game
GD - Group discussion
ST- Simulation-based training
GP - Game-based project
CA - Case analysis
ASM - Analysis of simulation models

5.4. Self-Study

Serial No.	Name of the discipline section	Types of Self-Study Activities	Forms of ongoing assessment	Workload (academic hours)
1	Introduction to Obstetrics	Working with lecture material.	Tests Control questions	10
2	Physiological Obstetrics	Working with academic literature.	Tests Control questions case	10
3	Pathological Obstetrics	Writing the birth history	Assessment of the birth history.	18
4	Operative obstetrics	Working with academic literature	Tests Control questions case	10
5	Methods for examining gynecological patients	Working with academic literature	Tests Control questions case	10
6	Pathology of the Female Reproductive Organs	Writing the case history	Assessment of the case history	18
7	Surgical treatment methods in gynecology.	Working with academic literature	Tests Control questions case	10
8	Family Planning. Modern Methods of Contraception.	Working with academic literature	Tests Control questions case	10
9	Exam preparation:			32
			TOTAL:	128

6. Guidelines for students on mastering the discipline

While mastering the discipline, the student should strive to acquire and consolidate the necessary knowledge and skills, to form professional competencies, preparing themselves for independent and individual work and for making responsible decisions within their professional competence. For the effective study of the course sections, it is necessary to independently study the teaching and methodological materials posted in the MOODLE system, complete the testing on all proposed topics; actively participate in discussions on the development of the discipline during practical classes, and, if necessary, seek the instructor's advisory help. To successfully pass the interim assessment in the form of an exam, it is necessary to study and work through all assessment tools: interview questions, situational tasks, and the demonstration of practical skills. Studying additional educational and methodological literature, utilizing online resources, as well as the material and technical base, will help the student develop a readiness to scientifically analyze medical and socially significant problems, to logically analyze various kinds of reasoning, and to master skills in communication, argumentation, polemics, and discussion on the discipline's topics.

Planning and organizing the time required to study the discipline.

An important condition for successfully mastering the discipline is establishing a system for proper work organization, which allows distributing the academic workload evenly in accordance with the educational process schedule. Creating a work plan for the semester, month, week, and day can be of great assistance in this regard. Having such a plan will help allocate free time toward academic goals, enabling more successful and efficient work. It is advisable to plan the next day's tasks each evening.

At the end of each day, it is useful to summarize the work completed: thoroughly check whether everything scheduled in the plan has been accomplished, note any deviations, and if there were any, identify the reasons for them. Self-monitoring should be practiced, as it is a necessary condition for successful study. If any tasks remain unfinished, time should be found to complete them without reducing the scope of the weekly plan. It is recommended to complete all assignments for practical sessions, as well as tasks designated for independent work, immediately after the corresponding lecture topic. This approach promotes better assimilation of the material, allows for timely identification and correction of knowledge gaps, helps systematize previously covered material, and facilitates the acquisition of new knowledge and skills based on it.

The university education system is based on a rational combination of several types of academic activities (primarily lectures and practical sessions), each of which has its own specific requirements and approaches to work.

Preparation for lectures.

Acquaintance with the discipline begins at the very first lecture, where you are required not only to pay attention but also to independently take notes. When working with lecture notes, it is important to consider that some lectures provide answers to specific questions on the topic, while others reveal the relationships between phenomena, helping to understand the underlying processes of the subject's development, both historically and in the present.

Taking lecture notes is a complex type of university classroom work that requires intense mental engagement from the student. Notes are useful only when they capture the most essential points and are written by the student themselves. There is no need to try to write down the entire lecture word-for-word. Such "note-taking" does more harm than good. It is advisable to first understand the main idea presented by the lecturer and then write it down. It is recommended to write on one side of the page or leave margins where additional notes can be added later during independent work with the notes, marking unclear points.

It is better to structure lecture notes into sections, using indented paragraphs. The lecture outline provided by the instructor can greatly assist with this. Pay attention to the emphasis and conclusions made by the lecturer, marking the most important points in the lecture material with notes such as "important," "remember well," etc. This can also be done using colored highlighters or pens to underline terms and definitions.

It is advisable to develop your own system of abbreviations, acronyms, and symbols. However, when later working with the notes, it is better to replace symbols with ordinary words for faster visual comprehension of the text.

When working on lecture notes, always use not only the textbook but also the additional literature recommended by the lecturer. It is precisely this serious, meticulous work with lecture material that will allow you to deeply master the theoretical content.

Preparation for practical classes.

Thorough consideration and study of the plan's questions are based on working through the current lecture material, followed by studying the mandatory and additional literature recommended for the topic. All new concepts related to the topic must be memorized and added to a glossary, which is advisable to maintain from the very beginning of the course.

The result of such work should be reflected in the ability to freely answer the theoretical questions of the practical session, to present and participate in collective discussions on the topic being studied, and to correctly complete practical tasks and tests.

During preparation for practical classes, special attention must be paid to the independent study of recommended literature. No matter how comprehensive the lecture notes are, it is impossible to cover all the material within the limited classroom hours. Therefore, independent work with textbooks, study guides, scientific and reference literature, periodicals, and internet materials is the most effective method for acquiring additional knowledge. It significantly enhances the process of mastering information, promotes a deeper understanding of the material, and fosters a correct attitude toward specific problems.

Recommendations for working with literature

It is advisable to begin working with literature by studying general works on the topic, as well as textbooks and study guides. Next, it is recommended to proceed to the analysis of monographs and articles that examine specific aspects of the issues studied within the course, along with official materials and unpublished documents (research papers, dissertations), which may contain key questions related to the topic under study.

Work with sources should begin with skimming, i.e., reviewing the text while highlighting its structural units. During skimming, use bookmarks to mark pages that require closer study.

Depending on the results of the skimming, choose the next method for working with the source. If resolving the task at hand requires studying certain fragments of the text, the method of selective reading is used. If the book lacks a detailed table of contents, the student should be directed to pay attention to subject and name indexes.

The selected fragments or the entire text (if it is entirely relevant to the topic) require thoughtful, unhurried reading with "mental processing" of the material. Such reading involves identifying: 1) the main points in the text; 2) the key arguments; 3) the conclusions. Particular attention should be paid to whether the thesis logically follows from the arguments.

It is also necessary to analyze which of the author's statements are problematic or hypothetical in nature and to discern any underlying questions.

It is clear that the ability to work with text in this manner does not come immediately. The best way to learn how to identify the main points in a text, recognize the problematic nature of statements, and evaluate the author's position is through comparative reading. This involves familiarizing yourself with various opinions on the same issue, comparing the weight and persuasiveness of the arguments presented by different sides, and drawing conclusions about which position is most convincing.

If the literature presents different viewpoints on a particular issue due to the complexity of past events and legal phenomena, they should not be dismissed without proper examination. In cases of discrepancies between authors, it is important to find the rational kernel in each of their positions, as this will lead to a deeper mastery of the subject and a more critical evaluation of the issues being studied. When encountering authors' unique perspectives, identify their similar judgments, arguments, and conclusions, then compare them and adopt the one that is more persuasive.

The next stage in working with literary sources is creating notes that record the main theses and arguments. You can make notes on separate sheets of paper, which can later be easily systematized according to specific topics of the course. Another method is maintaining thematic notebooks summarizing a single topic. For extensive specialized monographic works, it is advisable to take notes in separate notebooks. Here, it is important to remember that notes should be written on one side of the sheet, with margins and sufficient line spacing for corrections and remarks (these rules are followed for ease of editing). If quotes are included in the notes, the source must always be indicated (author, title, publication details, page number).

7. Assessment methods

Assessment methods for the discipline, used for conducting ongoing monitoring of academic progress and interim certification of students, include examples of assessment tools (Appendix A to the discipline's syllabus), as well as the procedure and criteria for evaluation.

8. List of educational literature and Internet resources required for mastering the discipline

8.1. Educational literature:

Obstetrics: textbook for medical university students / E.K. Ailamazyan. - 4th ed., доп. - St. Petersburg: SpetsLit, 2003. - 527p.
Obstetrics: textbook for medical universities / E.K. Ailamazyan. - 2nd ed., испр. - St. Petersburg: SpetsLit, 2000. – 493p.
Obstetrics. National Guideline + CD / under the editorship of E.K. Ailamazyan , V.I. Kulakov , V.E. Radzinsky , G.M. Saveleva . – M., 2013. – 1200 p.*Gynecology: textbook for medical university students / B. I. Baisova, D. A. Bizhanova, L. N. and others Boginskaya; editors G. M. Saveleva, V. G. Breusenko. - 3rd ed., испр. и доп. - M.: GEOTAR-Media, 2006. – 430p.
Gynecology: textbook for medical university students / B. I. Baisova, D. A. Bizhanova, L. N. and others Boginskaya ; editors G. M. Saveleva, V. G. Breusenko. - M.: GEOTAR-MED, 2004. – 472p.
Methodological recommendations for the preparation of an academic medical history in gynecology/E.V.Komlichenko, E.L.Nezhentseva, I.G.Nadzharyan;under the editorship of E.V.Komlichenko. - St. Petersburg: publishing house of the North-Western State Medical University named after I.I.Mechnikov, 2013. - 48 p.
Ailamazyan, E. K. Obstetrics : textbook / E. K. Ailamazyan [et al.]. - 10th ed. , перераб. и доп. - Moscow : GEOTAR-Media, 2022. - 768 p. - ISBN 978-5-9704-6698-8. - Electronic text // EBS "Student Consultant" : [website]. - URL : https://www.studentlibrary.ru/book/ISBN9785970466988.html
Saveleva, G. M. Obstetrics : textbook / Saveleva G. M. , Shalina R. I. , Sichinava L. G. , Panina O. B. , Kurtzer M. A. - Moscow : GEOTAR-Media, 2020. - 576 p. - ISBN 978-5-9704-5324-7. - Electronic text // EBS "Student Consultant" : [website]. - URL : https://www.studentlibrary.ru/book/ISBN9785970453247.html
Gynecology : textbook / editors V. E. Radzinsky, A M. Fuchs- M. : GEOTAR–Media, 2022 –1091 p.
Gynecology / under the editorship of V. E. Radzinsky, A. M. Fuchs - Moscow : GEOTAR-Media, 2016. - 1000 p. - ISBN 978-5-9704-4249-4. - Electronic text // EBS "Student Consultant" : [website]. - URL : https://www.studentlibrary.ru/book/ISBN9785970442494.html
Gynecology : textbook** / under the editorship of G. M. Saveleva, V. G. Breusenko. - 4th ed. , перераб. и доп. - Moscow : GEOTAR-Media, 2022. - 432 p. - ISBN 978-5-9704-7188-3. - Electronic text // EBS "Student Consultant" : [website]. - URL : https://www.studentlibrary.ru/book/ISBN9785970471883.html
Radzinsky, V. E. Gynecology. Guide to practical classes : textbook / Under the editorship of V. E. Radzinsky. 3rd ed. , перераб. и доп. 2020. - 552 p. : ил. - 552 p. - ISBN 978-5-9704-5459-6. - Electronic text // EBS "Student Consultant" : [website]. - URL : https://www.studentlibrary.ru/book/ISBN9785970454596.html.
Baisova, B. I. Gynecology : textbook / Under the editorship of G. M. Saveleva, V. G. Breusenko. - 4th ed. , перераб. и доп. - Moscow : GEOTAR-Media, 2012. - 432 p. - ISBN 978-5-9704-2254-0. - Electronic text // EBS "Student Consultant" : [website]. - URL : https://www.studentlibrary.ru/book/ISBN9785970422540.html
Obstetrics and gynecology. Practical skills and abilities with a phantom course : textbook / V. A. Kaptilny, M. V. Berishvili, A. V. Murashko ; under the editorship of A. I. Ishchenko. - Moscow : GEOTAR-Media, 2024. - 392 p. - ISBN 978-5-9704-8639-9, DOI: 10.33029/9704-8639-9-OAG-2024-1-392. - Electronic version available on the EBS "Student Consultant" website : [website]. URL: https://www.studentlibrary.ru/book/ISBN9785970486399.html
Ailamazyan, E. K. Obstetrics. National Guideline. Brief edition / under the editorship of E. K. Ailamazyan, V. N. Serov, V. E. Radzinsky, G. M. Saveleva. - Moscow : GEOTAR-Media, 2021. - 608 p. - 608 p. // access mode: https://mbasegeotar.ru/book/ISBN9785970461044/call_reader.html?SSr=07E9020F97152

8.2. Resources of the information and telecommunication network "Internet":

Name of the Internet resource	Resource's electronic address (URL)
Cambridge University Press – journals	https://www.cambridge.org/core
EastView Medicine and Healthcare in Russia -	https://dlib.eastview.com/
MEDLINE Complete EBSCOhost Web -	http://web.b.ebscohost.com/ehost/
Scopus – the world's largest unified abstract and citation database -	https://www.scopus.com/search/form.uri?display=basic
ScienceDirect - journals from 2014 г., books according to the list -	https://www.sciencedirect.com/
Web of Science - abstract and scientometric electronic databases -	https://apps.webofknowledge.com/
Database Nano –	https://nano.nature.com/
Database zbMath -	https://zbmath.org/
Database Springer Materials -	https://materials.springer.com/
Database Springer Protocols -	https://experiments.springernature.com/springer-protocols-closure
NEICON search across scientific journal archives.	http://archive.neicon.ru/xmlui/
PlatformNature	https://www.nature.com/
PlatformSpringer Link (journals and books 2005-2017)-	https://rd.springer.com/
Scientific electronic library eLIBRARY.RU -	https://elibrary.ru/project_orgs.asp

9. List of information technologies used for mastering the discipline, including a list of software, professional databases, and information reference systems.

9.1. List of information technologies used in the implementation of the educational process:

Serial No.	Name of the discipline section	Information technologies
1.	Introduction to Obstetrics	Placement of educational materials in the Electronic Information and Educational Environment (EIEE) of the North-Western State Medical University named after I.I. Mechnikov of the Ministry of Health of Russia, https://moodle.szgmu.ru/course/view.php?id=150&section=1
2.	Physiological Obstetrics	
3.	Pathological Obstetrics	
4.	Operative obstetrics	
5.	Methods for examining gynecological patients	
6.	Pathology of the Female Reproductive Organs	
7.	Surgical treatment methods in gynecology	
8.	Family Planning. Modern Methods of Contraception.	

9.2. List of software used in the implementation of the educational process (licensed and freely distributed software, including domestically produced software):

Serial No.	Name of the software product	License validity period	Documents confirming the right to use software products
лицензионное программное обеспечение			

1.	ESET NOD 32	1 year	State contract № 07/2020
2.	MS Windows 8 MS Windows 8.1 MS Windows 10 MS Windows Server 2012 Datacenter - 2 Proc MS Windows Server 2012 R2 Datacenter - 2 Proc MS Windows Server 2016 Datacenter Core	Unlimited	State contract № 30/2013-О; State contract № 399/2013-ОА; State contract № 07/2017-ЭА.
3.	MS Office 2010 MS Office 2013	Unlimited	State contract № 30/2013-ОА; State contract № 399/2013-ОА.
4.	Academic LabVIEW Premium Suite (1 User)	Unlimited	State contract № 02/2015
licensed domestically produced software			
1.	Anti-plagiarism	1 year	State contract № 2409
2.	«WEBINAR » VERSION 3.0	1 year	Contract № 347/2020-М
3.	«Electronic learning environment 3KL»	1 year	Contract № 348/2020-М
4.	TrueConf Enterprise	1 year	Contract № 396/2020-ЭА
freely distributed software (open-source/free software)			
1.	Google Chrome	Unlimited	Open License Agreement GNU GeneralPublicLicense
2.	NVDA	Unlimited	Open License Agreement GNU GeneralPublicLicense
freely distributed domestically produced software			
1.	Moodle	Unlimited	Open License Agreement GNU GeneralPublicLicense

9.3. List of professional databases and information reference systems:

Serial No.	Name of the software product	License validity period	Documents confirming the right to use software products	Access mode for students with disabilities and persons with special needs
1.	Consultant Plus	1 year	Contract № 655/2020-ЕА	-
2.	EBS "Student Consultant"	1 year	Contract № 307/2020-ЕА	http://www.studmedlib.ru/
3.	EMB "Doctor Consultant"	1 year	Contract № 281/2020-ЕА	http://www.rosmedlib.ru/
4.	EBS "Aibooks.ru/ibooks.ru"	1 year	Contract № 06/2020	https://ibooks.ru
5.	EBS «IPRBooks»	1 year	Contract № 08/2020-ЗК	http://www.iprbookshop.ru/special
6.	Electronic library system "Bukap"	1 year	Contract № 05/2020	https://www.books-up.ru/
7.	EBS "Publishing House Lan"	1 year	Contract № 395/2020-ЕА	https://e.lanbook.com/

10. Material and technical support of the discipline

Classrooms for conducting lecture-type classes, group and individual consultations, current academic performance monitoring, and interim certification of students, Saint Petersburg, Piskarevsky Ave., 47, building H, pavilion 21/H: 1st floor

classroom№6, №23 for PIB

classroom№ 5, №22 for PIB

classroom№4, №15 for PIB

classroom№3, №16 for PIB

classroom№2, №17 for PIB

classroom№1, №18 for PIB

Equipped with educational equipment and technical training aids:

tables, benches, computers, projector, screen, board

Special technical training aids: Roger Pen (Individual wireless transmitter Roger in pen form), Roger MyLink (receiver for the Roger Pen system) (for students with hearing impairments); IntelliKeys (wired keyboard with Russian Braille font and matte black finish), (St. Petersburg, Piskarevsky Prospekt, 47, building R (corp. 9), rooms No. 18, 19, North-Western State Medical University named after I.I. Mechnikov of the Ministry of Health of Russia).

Training aids: 1 screen, 1 multimedia projector, 1 laptop, childbirth training manikins, gynecological examination manikin for speculum and bimanual exams, manikin for smear collection, instruments for culdocentesis, uterine aspiration, and uterine curettage.

Classrooms for conducting seminar-type classes, group and individual consultations, current academic performance monitoring, and interim certification of students, equipped with educational equipment and technical training aids: Anatomical models – female pelvis models, dolls, available at the university's simulation center:

Equipment used in the educational program:

Title	Amount	Configuration	Description	Purpose
VIRTUGIN vaginal examination phantom LF01235U	2	Includes: pelvis, labia, vagina and rectum without pathologies, abdominal gel lubricant, abdominal tissue overlay imitation, overlay skin simulating the abdominal cavity, seven uteri (normal, and uteri with various options: uterus with cervicitis, uterine cancer, transparent uterus with IUD, postmenopause/herpes, fibroid/polyp, early pregnancy), five removable ovaries (normal, with polycystic ovary syndrome, with small cysts, enlarged adnexa), stand with urinary bladder, baby powder, trauma simulation palette (contains six colors: flesh, burgundy, dark	Advanced gynecology and gynecological examination simulator. Model of female genital organs in the lower part of a female torso.	Designed for teaching, conducting training sessions, and testing gynecological examination skills: bimanual examination with palpation of the uterus and ovaries, rectal examination, speculum examination, cervical smear technique, HPV testing, collection of cytological samples, fetal fibronectin testing. The simulator allows practicing: - insertion of a Foley catheter up to size 16. - simulation of a full bladder. - performance of pelvic organ prolapse simulation. - simulation of discharge by preparing and administering simulation mixtures based on methylcellulose or simulated blood.

		purple, yellow, green, blue-gray), basic makeup application palette (includes five colors: white, black, red, yellow, and blue), concentrate for preparing simulated blood, thickener with methylcellulose, training syringe, lubricant, user manual, and a hard carrying case.		
Cesarean section simulation trainer.	1	Configuration: - abdominal overlay – 1 pc. - replaceable surgical insert – 2 pcs. - fetus – 1 pc.	Comes with two replaceable surgical inserts and a fetus. Represents an abdominal overlay, an anatomically correct abdomen of a pregnant adult woman.	Module for simulating cesarean section. Compatible with the Noelle childbirth simulation manikin produced by Gaumard.
Trainer for practicing perineal repair skills after episiotomy LT60450	2	Set of 6 perineal models for episiotomy incision - 1 set.• Fetal head model - 1 pc.• Set of 2 pads for episiotomy and perineal repair - 1 set.• Plastic base for pads - 1 pc.• Block for restoring perineal integrity after episiotomy and second-degree tear - 1 pc.• Base for securing the block for restoring perineal integrity after episiotomy and second-degree tear - 1 pc.• Plastic base for securing the trainer - 1 pc.• Clamping device for securing to the work table surface - 2 pcs.• Carrying and storage case• User manual in Russian.	The trainer is a set of three trainers, teaching the three stages of the episiotomy and episiorrhaphy procedure. The first-stage trainer includes a fetal head model and a perineal tissue model. The second-stage trainer includes a model for suturing inside the vaginal canal and for restoring perineal integrity.	Stage 1: - identification of fontanelles before episiotomy- performing an incision on perineal tissues under tension- reducing the risk of maternal trauma and fetal injury- infiltration of the perineum before episiotomy- performing mediolateral and median episiotomy- use of instruments. Stage 2: The trainer provides the ability to place sutures in two planes. - continuous suture placement- subcutaneous suture placement- knot tying.

Model for practicing suprapubic catheterization technique, AR341	1	trainer (manikin) - 1 pc.- vacuum system - 1 pc.- plastic container with lid - 1 pc.- Foley catheter No. 16 - 1 pc.- storage bag - 1 pc.- user manual in Russian	The trainer is an anatomical model of the pelvis and lumbar region of the human torso.	The trainer allows practicing the skill of suprapubic catheterization. The trainer is equipped with a vacuum system to ensure the presence of fluid in the simulated bladder. The trainer allows monitoring the pressure applied to the abdominal wall during suprapubic catheterization. The trainer allows monitoring the correct insertion of the urinary catheter for bladder emptying. There is a sensation of resistance from the anterior abdominal wall during suprapubic catheterization.
Trainer for gynecological examination and procedures (transvaginal ultrasound), CH.BPP-** Virtumed	1	Configuration: Assembled pelvic phantom – 1 pc. Instructions in Russian.	The trainer is a realistically executed female pelvis with anatomical landmarks.	Combined pelvic phantom for practicing transvaginal ultrasound skills. Designed for practicing transvaginal ultrasound examination skills, as well as scanning with an ultrasound probe to recognize normal and pathological structures of pelvic organs in patients during the first trimester of pregnancy. Works with a standard ultrasound machine with a transvaginal linear high-frequency probe. Diagnosis of intrauterine, ectopic pregnancy, and pathologies. Skills practiced: - Operating the ultrasound machine - Orienting and maneuvering the probe - Visualizing pelvic organs - Diagnosing pathologies - Applying obstetric ultrasound measurement

				methods to determine cyst size, fetal crown-rump length, and gestational sac size - Two-dimensional, three-dimensional, and four-dimensional ultrasonography techniques

Surgical trainer of the female pelvis, LT60251	1	Configuration: Abdominal frame - 1 pc. Uterus - 1 pc. Abdominal skin - 1 pc. Perineum - 1 pc. Intestine - 1 pc. Venous blood Bleeding simulation kit – 1 set. Blunt-tip needle and syringe - 1 pc. User manual in Russian.	The trainer is a model of the pelvic cavity with anatomical structures, the anterior abdominal wall, and the perineum, made from highly realistic materials that visually and tactilely resemble human tissue.	The trainer allows practicing the following skills: - Salpingectomy - Salpingostomy - Myomectomy - Cystectomy - Hysterectomy - Oophorectomy - Identifying anatomical structures - Surgical access to the ureters and determining their location - Insertion and use of a uterine manipulator - Working with various laparoscopic instruments used in gynecological surgeries The trainer enables the following procedures: - Performing abdominal insufflation - Practicing basic gynecological surgical skills - Insertion and use of a uterine manipulator - Using an ultrasonic scalpel Simulating realistic bleeding when arteries are damaged.
Gynecological simulator NS.SB23542U	2	Configuration: - Phantom - 1 pc. - Replaceable uteri (normal and with various pathologies) - 7 pcs. - Normal uterus - 1 pc. - Replaceable cervixes in a normal uterus - 6 pcs. - Uterus for intrauterine device insertion - 2 pcs. - Lubricant - 1 pc. - Instructions. - Storage bag.	A realistically executed, life-size lower part of a female torso with realistic external features and internal anatomical structures. The set includes a normal uterus and uteri with pathologies.	Performing a vaginal examination. Bimanual examination of the pelvic organs. Insertion and removal of an intrauterine device. Cervical examination. Diagnosis of pathological conditions.

Trainer for vaginal examination.	2	Configuration: - Phantom without pathologies - 1 pc. Phantom with pathologies - 1 pc. - Lubricant - 25 pcs. - Instructions - Storage bag.	A set of two phantoms (models) of the lower part of a woman's torso with anatomical landmarks and internal differences.	For practicing pelvic organ examination skills. Pathological changes: ovarian cyst, tumor formation, uterine leiomyoma.
Pelvic phantom for diagnostic examination. KN.LM-050	2	Configuration: Assembled pelvic phantom – 1 pc. Instructions in Russian.	A realistically executed female pelvis with anatomical landmarks. Includes: - Model of a normal uterus, - Model of a uterus in early pregnancy, - Model of a uterus with a fibroid in the muscular layer, - Model of a uterus with a fibroid in the mucosal layer, - Model with an ovarian cyst, - Model with hydrosalpinx. The replaceable uterine models are easily installed in the phantom.	For diagnosing pathological conditions. Skills: Abdominal palpation, Vaginoscopy, Bimanual vaginal examination, Rectal examination, Insertion and removal of a speculum, Bimanual rectovaginal examination, Sounding, Smear collection. The size of the tumors can be adjusted by inflating with air using a rubber bulb.
Childbirth simulation system with manikin, monitor, and bed, Noelle.	1	Configuration: Full-size birthing manikin – 1 pc. Fetal manikin – 1 pc. Newborn manikin – 1 pc. Premature newborn manikin – 1 pc. CPR controller – 1 pc. Laptop – 1 pc. Tablet computer – 3 pcs. User manual – 1 pc. Obstetric bed – 1 pc.	The childbirth simulation system includes: - A full-sized electronic birthing manikin. - A full-term newborn manikin with simulated cyanosis development. - A fetal manikin with articulating limbs. - A premature newborn manikin with simulated cyanosis. - Obstetric bed - Virtual simulator of bedside and fetal monitors with rapid physiological states.	Practicing actions in obstetric emergencies during normal and pathological childbirth, including shoulder dystocia, postpartum hemorrhage, umbilical cord prolapse, ruptures, operative interventions during childbirth, and cardiopulmonary resuscitation of the mother and newborn.

			- Additional software for practicing clinical reasoning elements in obstetric practice.	
Robot-simulator for practicing childbirth assistance skills "Lucina"	1	Configuration - The delivery set includes: - a wireless robot-simulator of a woman in labor with an automatic delivery system, - a fetus, - software with an integrated physiological model of the mother and fetus, - a portable control computer, a bedside monitor simulator with a touch screen for the mother and fetus - an all-in-one unit, 10 scenarios, - 4 licenses for developing your own scenarios. - Training external defibrillator – 2 pcs. - ECG machine – 1 pc. - Functional obstetric bed – 1 pc. - Instructions in Russian, paper and electronic version on a digital medium. – 1 set.	Wireless, automatic, highly realistic robot-simulator of a woman in labor and fetus for training in childbirth assistance techniques (including monitoring the woman in labor, delivery, postpartum care), includes an anatomically realistic robot-simulator of the mother and fetus.	The robot-simulator of a woman in labor is used for training in a set of childbirth assistance measures – before, during, and after delivery, including practicing normal childbirth as well as pathological deliveries, for example, birth in cephalic presentation, birth in breech presentation, shoulder dystocia, intact/fragmented placenta, inverted uterus, postpartum hemorrhage, preeclampsia.

Ultrasound diagnostic machine Landwind Mirror 2				This system is used for ultrasound diagnosis of tissue organs and is suitable for use in hospitals, clinics, and healthcare facilities. The system is used in the following areas: abdominal diagnosis, urology, gynecology, obstetrics, cardiac, vascular, and small organ studies, transcranial diagnosis, musculoskeletal system studies, ophthalmology, emergency care, pediatric diagnosis, etc.
Premature, manikin of a premature newborn (28 weeks).				for practicing advanced CPR skills, child care, and emergency treatment in neonatology.

Saint Petersburg, Piskarevsky pr., 47, building A, pav. 26, 1st floor, right wing, room No. 18, accreditation and simulation center.

Special technical training aids: Roger Pen (Individual wireless transmitter Roger in pen form), Roger MyLink (receiver for the Roger Pen system) (for students with hearing impairments); IntelliKeys (wired keyboard with Russian Braille font and matte black finish), (St. Petersburg, Piskarevsky Prospekt, 47, building R (corp. 9), rooms No. 18, 19, North-Western State Medical University named after I.I. Mechnikov of the Ministry of Health of Russia).

Contract № 107/2016 – TPA dated April 25, 2016 "City Alexandrovskaya Hospital". St. Petersburg, Solidarnosti Ave., 4. Classroom in the gynecology department. Specialized furniture: chairs, desks (property of the hospital).

Contract № 249/2018-TPA dated 03.12.2018 "D.O. Ott Research Institute of Obstetrics, Gynecology and Reproductology". St. Petersburg, Mendeleevskaya line, house 3. Classrooms No. 2,3,4. Specialized furniture: chairs, desks, boards (property of the D.O. Ott Research Institute of Obstetrics, Gynecology and Reproductology). Pathological anatomical museum with specimens (property of the D.O. Ott Research Institute of Obstetrics, Gynecology and Reproductology). Premises of the admission ward, maternity ward, antenatal wards, postpartum ward, gynecological departments, operating block: diagnostic and treatment equipment (property of the D.O. Ott Research Institute of Obstetrics, Gynecology and Reproductology).

Contract №210/2018-TPA dated 14.05.2018 "City Hospital No. 40 of the Kurortny District". St. Petersburg, Sestroretsk, Borisova st., 9, lit. B. Classroom in the gynecology department. Specialized furniture: chairs, desks (property of the hospital).

Contract №147/2017-FPA dated 28.08.2017 "Maternity Hospital No. 13". St. Petersburg, Kostromskaya st., 4. Classroom. Specialized furniture: chairs, desks (property of the maternity hospital).

Contract 190/2018-TPA dated 28.03.2018. "Maternity Hospital No. 1". St. Petersburg, V.O., Bolshoy pr., 49-51. Classroom. Specialized furniture: chairs, desks (property of the maternity hospital).

Contract 220/2018-TPA dated 18.05.2018. "Maternity Hospital No. 10". St. Petersburg, Tambasova st., 21. Classroom. Specialized furniture: chairs, desks (property of the maternity hospital).

Premises for independent student work, equipped with computer technology with internet connectivity and providing access to the University's electronic information and educational environment: Saint Petersburg, Piskarevsky Prospekt, 47, building AE (corp. 32), room No. 1, building R (corp. 9), rooms No. 18, 19, North-Western State Medical University named after I.I. Mechnikov of the Ministry of Health of Russia.

Appendix A

Ministry of Health of the Russian Federation

Federal State Budgetary Educational Institution of Higher Education "North-Western State Medical University named after I.I. Mechnikov" of the Ministry of Health of the Russian Federation

(FSBEI HE NWSMU named after I.I. Mechnikov of the Ministry of Health of the Russian Federation)

Assessment methods
(for conducting current academic performance monitoring and interim certification of students.)

Specialty	30.05.01 General Medicine (English Medium Instruction — EMI)
Specialization	Organization and provision of primary healthcare to the adult population in medical organizations
Name of the discipline:	Obstetrics and gynecology.
Language of instruction:	English

Saint Petersburg – 2021

1. List of planned learning outcomes for the discipline

Code of the competence achievement indicator	Learning outcomes (assessment indicators)	Assessment tools
AI-1 GPC-4.1.	**Knows** General issues of organizing medical care for the population.	Case Tests Control questions
	Able to Use medical devices in diagnostic investigations as stipulated by the procedures for providing medical care.	Case Tests Control questions
	Has the skill of verifying a diagnosis using laboratory, instrumental, and specialized examination methods.	Case Tests Control questions Birth history Case history
AI-2 GPC-4.2.	**Knows** Methods of laboratory and instrumental investigations for health assessment, medical indications for performing investigations, and the rules for interpreting their results.	Case Tests Control questions
	Is able to Apply diagnostic methods, including instrumental methods, during patient examination to establish a diagnosis.	Case Tests Control questions Birth history Case history
	Has the skill of performing diagnosis verification using laboratory, instrumental, and specialized examination methods.	Case Practical skill
AI-3 GPC-4.3.	**Knows.** Methodologies for a complete physical examination of a patient (inspection, palpation, percussion, auscultation).	Case Tests Control questions
	Is able to Perform diagnosis verification using laboratory, instrumental, specialized examination methods, and consultative opinions from relevant specialist physicians.	Case Tests Control questions Birth history Case history
	Has the skill of Performing diagnosis verification using laboratory, instrumental, specialized examination methods, and consultative opinions from relevant specialist physicians.	Case Practical skill
AI-4 GPC-4.4.	**Knows** Methodologies for a complete physical examination of a patient (inspection, palpation, percussion, auscultation).	Case Tests Control questions
	Is able to Use medical devices in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, taking into account medical care standards.	Case Tests Control questions Birth history Case history
	Has the skill of	Case

	using medical devices for solving diagnostic tasks.	Practical skill
AI-1 GPC-5.1.	**Knows** The specifics of medical rehabilitation for elderly and senile patients.	Case Tests Control questions
	Is able to develop a treatment plan for the patient's disease and condition, taking into account the diagnosis, the patient's age, and the clinical picture of the disease, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Tests Control questions Case history
	Has the skill of assessing the level of functional activity and patient independence in self-care, mobility, and communication. Referring the patient for specialized inpatient or day hospital care when medically indicated, in accordance with current medical care procedures, clinical guidelines (treatment protocols) regarding medical care provision, and considering medical care standards. The patterns of functioning of a healthy human body and the mechanisms of health maintenance from the perspective of functional systems theory; the specifics of regulation of the human body's functional systems during pathological processes. Methods of laboratory and instrumental investigations for health assessment, medical indications for performing investigations, and the rules for interpreting their results. Etiology, pathogenesis, and pathomorphology, clinical presentation, differential diagnosis, specific course, complications, and outcomes of internal organ diseases. Methodology for collecting patient complaints, life history, and medical history. Developing a treatment plan for a disease or condition, taking into account the diagnosis, age, and clinical picture, in accordance with current medical care procedures, clinical guidelines (treatment protocols) regarding medical care provision, and considering medical care standards.	Case Practical skill
AI-2 GPC-5.2.	**Knows.** The patterns of functioning of a healthy human body and the mechanisms of health maintenance from the perspective of functional systems theory; the specifics of regulation of the human body's functional systems during pathological processes.	Case Tests Control questions
	Is able to Conduct medical examinations, taking into account age, health status, and profession, in accordance with current regulatory legal acts and other documents.	Case Tests Control questions
	Has the skill of Determining and interpreting patient vital signs indicators during dynamic observation.	Case
AI-3 GPC-5.3.	**Knows** The procedure for providing palliative medical care.	Case Tests Control questions
	Is able to Provide palliative medical care in collaboration with	Case Tests

	specialist physicians and other medical professionals. Organize personalized patient treatment, including for pregnant women, elderly, and senile patients, and assess the effectiveness and safety of treatment.	Control questions Birth history Case history
	Has the skill of Determining the main indicators of physical development and functional status of the patient, taking into account the anatomical and physiological characteristics of the patient's age.	Case
AI-1 GPC-7.1.	**Knows** The mechanism of action of non-pharmacological treatment; medical indications and contraindications for its prescription; side effects and complications caused by its use. Modern methods of non-pharmacological treatment of diseases and conditions in a patient in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Tests Control questions
	Is able to Develop a treatment plan for the patient's disease and condition, taking into account the diagnosis, the patient's age, and the clinical picture of the disease, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Tests Control questions Birth history Case history
	Has the skill of prescribing a therapeutic and protective regimen, selecting the location and type of treatment based on the severity of the patient's condition. Prescribing non-pharmacological treatment, taking into account the diagnosis, age, and clinical picture of the disease, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Practical skill
AI-2 GPC-7.2.	**Knows** Modern methods of using medications, medical devices, and therapeutic nutrition for diseases and conditions in a patient in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Tests Control questions
	Is able to Prescribe medications, medical devices, and therapeutic nutrition, taking into account the diagnosis, age, and clinical picture of the disease, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Tests Control questions Case history
	Has the skill of selecting medications, choosing specific dosage forms, routes of administration, and rationally substituting drugs based on the patient's condition. Prescribing medications, medical devices, and therapeutic nutrition, taking into account the diagnosis, age, and	Case Practical skill

	clinical picture of the disease, and in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	
AI-3 GPC-7.3.	**Knows** The mechanism of action of medications, medical devices, and therapeutic nutrition, medical indications and contraindications for their use; complications caused by their application.	Case Tests Control questions
	Is able to Develop a treatment plan for a disease or condition, taking into account the diagnosis, age, and clinical picture, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Case history
	Has the skill of Predicting side effects of medications and implementing their prevention. Assessing the effectiveness and safety of using medications, medical devices, therapeutic nutrition, and other treatment methods.	Case
AI-4 GPC-7.4.	**Knows the** algorithm for non-pharmacological treatment, taking into account the diagnosis, age, and clinical picture of the disease, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Tests Control questions
	Is able to Evaluate the effectiveness and safety of using medications, medical devices, and therapeutic nutrition.	Case Tests Control questions
	Has the skill of Providing palliative medical care in collaboration with specialist physicians and other medical professionals. Organizing personalized patient treatment, including for pregnant women, elderly, and senile patients, and assessing the effectiveness and safety of treatment. Monitoring the effectiveness and safety of prescribed treatment at all stages of its implementation.	Case
AI-1 PC-2.1.	**Knows** The legislation of the Russian Federation in the field of healthcare, regulatory legal acts, and other documents governing the activities of medical organizations and medical professionals. Methodology for collecting patient complaints, life history, and medical history. Methodology for a complete physical examination of a patient (inspection, palpation, percussion, auscultation).	Case Tests Control questions
	Is able to conduct patient examinations to identify main pathological conditions, symptoms, syndromes of diseases, and nosological forms. Collect patient	Birth history Case history

	complaints, life history, and medical history and analyze the obtained information. Perform a complete physical examination of a patient (inspection, palpation, percussion, auscultation) and interpret its results.	
	Has the skill of Collecting patient complaints, life history, and medical history. Performing a complete physical examination of a patient (inspection, palpation, percussion, auscultation).	Practical skill
AI-2 PC-2.2.	**Knows** The procedure for providing medical care, clinical guidelines (treatment protocols) regarding medical care provision, and medical care standards.	Case Tests Control questions
	Is able to Justify the necessity and scope of laboratory examination of a patient. Justify the necessity and scope of instrumental examination of a patient.	Birth history Case history
	Has the skill of Formulating a preliminary diagnosis and developing a plan for laboratory and instrumental examinations of a patient.	Case Practical skill
AI-3 PC-2.3.	**Knows** Justifying the need to refer a patient for consultations with specialist physicians. Analyze the obtained results of patient examination, and if necessary, justify and plan the scope of additional investigations. Interpret the results of collecting information about the patient's disease. Interpret data obtained from laboratory examination of a patient. Interpret data obtained from instrumental examination of a patient. Interpret data obtained from patient consultations with specialist physicians. Perform early diagnosis of internal organ diseases.	Case Tests Control questions
	Is able to Determine the priority, scope, content, and sequence of diagnostic measures. Determine medical indications for providing emergency, including specialized emergency, medical care. Use medical devices in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, taking into account medical care standards.	Case Birth history Case history
	Has the skill of Referring a patient for laboratory examination when medically indicated, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Referring a patient for instrumental examination when medically indicated, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Referring a patient for consultation with specialist physicians when medically indicated, in accordance	Case Practical skill

	with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Referring a patient for specialized medical care in an inpatient setting or in a day hospital when medically indicated, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	
AI-4 PC-2.4.	**Knows** The patterns of functioning of a healthy human body and the mechanisms of health maintenance from the perspective of functional systems theory; the specifics of regulation of the human body's functional systems during pathological processes.	Tests Control questions
	Is able to Perform differential diagnosis of internal organ diseases from other diseases.	Birth history Case history
	Has the skill of Performing differential diagnosis with other diseases/conditions, including emergency ones.	Case Practical skill
AI-5 PC-2.5.	**Knows** Issues of organizing sanitary and anti-epidemic (preventive) measures to prevent the emergence and spread of infectious diseases.	Tests Control questions
	Is able to Use laboratory and instrumental investigation methods to assess health status, medical indications for conducting investigations, and the rules for interpreting their results.	Case Tests Control questions Birth history Case history
	Has the skill of Establishing a diagnosis in accordance with the current International Statistical Classification of Diseases and Related Health Problems (ICD).	Practical skill
AI-1 PC-3.1.	**Knows** Modern methods of using medications, medical devices, and therapeutic nutrition for diseases and conditions in a patient in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Modern methods of non-pharmacological treatment of diseases and conditions in a patient in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Tests Control questions
	Is able to Prescribe medications, medical devices, and therapeutic nutrition, taking into account the diagnosis, age, and clinical picture of the disease, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Prescribe non-pharmacological treatment, taking into account the diagnosis, age, and clinical picture of the disease, in accordance with the current procedures for providing medical care, clinical	Case Birth history

	guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. The mechanism of action of non-pharmacological treatment; medical indications and contraindications for its prescription; side effects, complications caused by its application.	
	Has the skill of Prescribing medications, medical devices, and therapeutic nutrition, taking into account the diagnosis, age, and clinical picture of the disease, and in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Prescribing non-pharmacological treatment, taking into account the diagnosis, age, and clinical picture of the disease, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	Case Practical skill
AI-2 PC-3.2.	**Knows** The mechanism of action of medications, medical devices, and therapeutic nutrition, medical indications and contraindications for their use; complications caused by their application.	Case Tests Control questions
	Is able to Evaluate the effectiveness and safety of using medications, medical devices, and therapeutic nutrition.	Case Tests Control questions
	Has the skill of Assessing the effectiveness and safety of using medications, medical devices, therapeutic nutrition, and other treatment methods.	Case
AI-3 PC-3.3.	**Knows** The procedure for providing palliative medical care.	Tests Control questions
	Is able to Assess the need for involving necessary specialists and the scope of palliative medical care provision.	Case Tests Control questions
	Has the skill of Organizing the provision of palliative medical care and consulting individuals involved in its delivery, both from among medical personnel and individuals without professional skills.	Case
AI-4 PC-3.4.	**Knows** Managing patients requiring medical care, taking into account their socio-physiological characteristics.	Tests Control questions
	Is able to Develop a treatment plan for a disease or condition, taking into account the diagnosis, age, and clinical picture, in accordance with the current procedures for providing medical care and clinical guidelines.	Case Birth history Case history
	Has the skill of Organizing personalized patient treatment, including for pregnant women, elderly, and senile patients, and assessing the effectiveness and safety of treatment.	Case Practical skill
AI-1 PC-4.1.	**Knows** Signs of persistent impairment of body functions	Tests Control questions

	caused by diseases, consequences of injuries, or defects.	
	Is able to Identify signs of temporary disability and signs of persistent impairment of body functions caused by diseases, consequences of injuries, or defects.	Case Tests Control questions
	Has the skill of The algorithm for conducting temporary disability assessment and working as part of a medical commission performing temporary disability assessment.	Case Practical skill
AI-2 PC-4.2.	**Knows** The procedure for referring a patient for a medical and social examination.	Case Tests Control questions
	Is able to Identify signs of temporary disability and signs of persistent impairment of body functions caused by diseases, consequences of injuries, or defects.	Case Tests Control questions
	Has the skill of Preparing the necessary medical documentation for conducting a medical and social examination in federal state institutions of medical and social examination.	Practical skill
AI-1 PC-5.1.	**Knows** Measures for medical rehabilitation of a patient, medical indications and contraindications for their implementation, taking into account the diagnosis, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Medical indications and contraindications for prescribing spa treatment as a stage of medical rehabilitation of a patient. Specifics of medical rehabilitation for elderly and senile patients.	Tests Control questions
	Is able to Determine medical indications for conducting medical rehabilitation measures, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Perform medical rehabilitation measures for a patient in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Determine specialist physicians for conducting rehabilitation measures for a patient in need of medical rehabilitation, taking into account the diagnosis and in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Prescribe spa treatment for a patient in need of medical rehabilitation, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with the current clinical guidelines	Case

	(treatment protocols) on issues of medical care provision, procedures for providing medical care, and considering medical care standards. Monitor the implementation and evaluate the effectiveness and safety of rehabilitation measures, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, taking into account the diagnosis and in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards.	
	Has the skill of the algorithm for medical rehabilitation measures for a patient, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Referring a patient in need of medical rehabilitation to a specialist physician for the prescription and implementation of medical rehabilitation measures, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Referring a patient in need of medical rehabilitation to a specialist physician for the prescription and implementation of spa treatment, including when implementing an individual rehabilitation or habilitation program for persons with disabilities, in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Assessing the effectiveness and safety of medical rehabilitation measures for a patient in accordance with the current procedures for providing medical care, clinical guidelines (treatment protocols) on issues of medical care provision, and considering medical care standards. Referring a patient with persistent impairment of body functions caused by diseases, consequences of injuries, or defects for a medical and social examination.	Case

2. Examples of assessment tools and evaluation criteria for conducting current progress monitoring.

2.1. Examples of entrance assessment.

1. What constitutes the lower genital tract?
2. Where is the boundary between the lower and upper genital tract?
3. Where is the cervix located, what is its length, and what does it consist of?
4. What are the "external os," "internal os," and the cervical canal?
5. What type of epithelium covers the vaginal portion of the cervix?

6. List the layers of this epithelium?

Assessment criteria, pass/fail grading scale

Grade	Description
«pass»	Demonstrates a complete understanding of the issue.
«fail»	Demonstrates a lack of understanding of the issue. No response.

2.2. Examples of test questions.

AI-1 GPC-4.1, AI-2 GPC-4.2, AI-3 GPC-4.3, AI-4 GPC-4.4.
1. Clinical course of labor?
AI-1 GPC-5.1, AI-2 GPC-5.2, AI-3 GPC-5.3.
2. Modern methods of labor analgesia (pain relief)?
AI-1 GPC-7.1, AI-2 GPC-7.2, AI-3 GPC-7.3, AI-4 GPC-7.4.
3. Methods for assessing fetal condition during pregnancy and labor?
AI-1 PC-2.1, AI-2 PC-2.2, AI-3 PC-2.3, AI-4 PC-2.4, AI-5 PC-2.5.
4. Course and management of the postpartum period?
AI-1 PC-3.1, AI-2 PC-3.2, AI-3 PC-3.3, AI-4 PC-3.4.
5. Fetal hypoxia. Causes. Diagnosis. Obstetric management.
AI-1 PC-4.1, AI-2 PC-4.2, AI-1 PC-5.1.
6. Assessment of the newborn's condition.

Assessment criteria, pass/fail grading scale

Grade		Description
«Excellent»	5	Knows all the educational material, understands it excellently and has mastered it solidly. Answers questions (within the curriculum) correctly, consciously, and confidently. In oral responses, uses a literally correct language and does not make mistakes
«Good»	4	Knows all the required educational material, understands it well, and has mastered it solidly. Answers questions (within the curriculum) without difficulty. In oral responses, uses a literary language and does not make serious errors
«Satisfactory»	3	Knows the main educational material. Answers questions (within the curriculum) with difficulty. In oral responses, makes errors when presenting material and in speech construction.
«Unsatisfactory»	2	Does not know most of the educational material, typically answers only leading questions from the instructor, and does so uncertainly. Makes frequent and serious errors in oral responses.

2.3. Examples of test tasks:

AI-1 GPC-4.1.
Question Title: Question № 1
Smears for hormonal studies are taken from:
1) posterior fornix
2) anterior fornix
3) cervical canal
4) ectocervix

Question Title: Question № 2
Basal body temperature during an anovulatory menstrual cycle is:
1) biphasic
2) monophasic
3) with a shortened luteal phase
4) with a shortened follicular phase

Question Title: Question № 3
The method for endoscopic examination of the uterine cavity is:
1) Hysteroscopy
2) Laparoscopy
3) Colposcopy
4) Colpomicroscopy

AI-2 GPC-4.2.
Question Title: Question № 4
The method for cytological examination of the ovaries is taking:
1) smears from the cervical canal
2) aspirate from the uterine cavity
3) washings from the pouch of Douglas
4) smears from the vagina

Question Title: Question № 5
The cause of bleeding in postmenopause is:
1) Submucous myomatous node
2) Adenomyosis
3) Endometrial atrophy
4) Endometrial cancer

Question Title: Question № 6
The main sign of a biphasic menstrual cycle is:
1) Regular menstrual rhythm
2) Cycle length
3) Ovulation
4) Time of menarche onset

AI-3 GPC-4.3.
Question Title: Question № 7
Gonadotropic hormones are:
1) ACTH and STH
2) TSH and STH
3) FSH, LH, prolactin
4) ACTH, TSH

Question Title: Question № 8
In the hypothalamus, secretion occurs of:
1) Gonadotropins
2) Estrogens
3) Releasing factors
4) Progesterone

Question Title: Question № 9
Estrogens include:
1) Testosterone, prolactin, estriol
2) Estrone, estriol, estradiol
3) Prolactin, androstenediol, estrone
4) Androstenediol, estradiol, estriol

AI-4 GPC-4.4.
Question Title: Question № 10
The state of the endometrium during anovulatory uterine bleeding is characterized by:
1) Glandular hyperplasia of the endometrium
2) Secretory phase
3) Decidual changes
4) Atrophy

Question Title: Question № 11
To stop bleeding in the climacteric period, the following are used:
1) Uterine contracting agents
2) Estrogens
3) Curettage of the uterine cavity
4) Synthetic progestins

Question Title: Question № 12
Hypothalamic amenorrhea includes:
1) Prolactinoma
2) Testicular feminization syndrome
3) Sheehan's syndrome
4) False pregnancy

AI-1 GPC-5.1.
Question Title: Question № 13
In Chiari–Frommel syndrome, an increased level in the blood is noted of:
1) FSH and LH
2) Estrogens
3) Testosterone
4) Prolactin

Question Title: Question № 14
The cause of false amenorrhea is:
1) Atresia of the vagina
2) Hysterectomy
3) Postmenopause
4) Occlusion of the cervical canal

Question Title: Question № 15
FSH stimulates:
1) Follicle maturation
2) Development of the corpus luteum
3) Endometrial proliferation
4) Endometrial secretion

AI-2 GPC-5.2.
Question Title: Question № 16
Smears for diagnosing gonorrhea are taken from:
1) Vagina and urethra
2) Ectocervix and endocervix
3) Endocervix and urethra
4) Vaginal vestibule

Question Title: Question № 17
Tests for functional diagnosis in gynecology include:
1) Measuring basal temperature
2) Determining the "pupil" sign

3) The crystallization (ferning) symptom of cervical mucus
4) All of the above are correct

Question Title: Question № 18
Under the influence of FSH and LH, the following occurs:
1) Follicle development
2) Corpus luteum development
3) Ovulation
4) Endometrial proliferation

AI-3 GPC-5.3.
Question Title: Question № 19
The corpus luteum produces:
1) Estradiol
2) Prolactin
3) Folliculin
4) Progesterone

Question Title: Question № 20
The precursor of steroid hormones is:
1) Gonadotropins
2) β-lipoproteins
3) Cholesterol
4) LH and FSHГ

Question Title: Question № 21
In the presence of acyclic bloody discharge, it is necessary to perform:
1) Hysterosalpingography
2) Determination of LH level in blood
3) Ultrasound examination
4) Diagnostic curettage of the uterine cavity

AI-1 GPC-7.1.
Question Title: Question № 22
The main method of treatment for climacteric syndrome is:
1) Physiotherapy
2) Administration of sedatives
3) Hormone therapy
4) Vitamin therapy

Question Title: Question № 23
Pathogenetic signs of algomenorrhea (dysmenorrhea) are:
1) Hyperestrogenism and hyperprostaglandinemia
2) Hypoprogesteronemia and hyperprolactinemia
3) All of the above are correct
4) None of the above are correct

Question Title: Question № 24
Causes of uterine amenorrhea are:
1) Tuberculous endometritis or Asherman's syndrome
2) Stein-Leventhal syndrome or Chiari-Frommel syndrome
3) All of the above are correct
4) None of the above are correct

AI-2 GPC-7.2.
Question Title: Question № 25

Changes in the ovaries during anovulatory uterine bleeding are characterized by:
1) Follicle persistence and follicle atresia
2) Corpus luteum formation
3) Hyperplasia of the ovarian theca tissue
4) Ovarian atrophy

Question Title: Question № 26
To stop bleeding in the juvenile age, the following are prescribed:
1) Estrogens, synthetic progestins
2) Curettage of the uterine cavity
3) All of the above are correct
4) None of the above are correct

Question Title: Question № 27
Under the influence of estrogens, the following occur:
1) Proliferation of the endometrium and vaginal epithelial cells
2) Increase in basal body temperature and endometrial secretion
3) All of the above are correct
4) None of the above are correct

AI-3 GPC-7.3.
Question Title: Question № 28
The biosynthesis of steroid hormones in the ovary occurs in:
1) Granulosa cells and cells of the corpus luteum
2) Sertoli cells and Leydig cells
3) All of the above are correct
4) None of the above are correct

Question Title: Question № 29
Climacteric syndrome is characterized by:
1) Hyperestrogenism
2) Hypoestrogenism
3) Increased level of gonadotropins
4) Increased progesterone

Question Title: Question № 30
As a result of pituitary necrosis, the following syndrome develops:
1) Chiari-Frommel
2) Stein-Leventhal
3) Sheehan's
4) Asherman's

AI-4 GPC-7.4.
Question Title: Question № 31
Premenstrual syndrome is characterized by:
1) Hypoestrogenism
2) Hyperestrogenism and hyperprostaglandinemia
3) Hyperprogesteronemia
4) Hyperandrogenemia

Question Title: Question № 32
The most informative method for diagnosing salpingitis is:
1) Bimanual examination
2) Ultrasound examination
3) Hysteroscopy
4) Bacterioscopy

Question Title: Question № 33
The main method for diagnosing parametritis is:
1) Puncture of the posterior vaginal fornix
2) Bacterioscopy
3) Ultrasound examination
4) Rectovaginal examination

AI-1 PC-2.1.
Question Title: Question № 34
The method of anesthesia for the operation of opening an abscess of the Bartholin's (greater vestibular) gland is:
1) Local anesthesia
2) Intravenous anesthesia
3) Mask anesthesia
4) Endotracheal anesthesia

Question Title: Question № 35
The main route of infection spread in parametritis is:
1) Hematogenous
2) Lymphogenous
3) Canalicular
4) By continuity (direct spread)

Question Title: Question № 36
The most common genital inflammation in girls is:
1) Salpingo-oophoritis
2) Endometritis
3) Colpitis (vaginitis)
4) Vulvitis

AI-2 PC-2.2.
Question Title: Question № 37
The main route of infection spread in acute metroendometritis is:
1) Intracanalicular
2) Hematogenous
3) Lymphogenous
4) By continuity (direct spread)

Question Title: Question № 38
A diagnosis of gonorrhea is established upon detection in smears of:
1) Extracellular diplococci
2) Intracellular diplococci
3) Extracellular diplococci and leukocytes
4) Extracellular diplococci and trichomonads

Question Title: Question № 39
The spread of infection in the genitals is facilitated by:
1) Spermatozoa
2) Hormonal contraceptives
3) Intrauterine interventions
4) Lack of hygiene

AI-3 PC-2.3.
Question Title: Question № 40
For chlamydial infection, the antibiotic used is:
1) Kanamycin
2) Ampicillin

3) Cephalosporin
4) Tetracycline

Question Title: Question № 41
With trichomonas colpitis, the following discharge is observed:
1) Mucous, copious
2) Cheesy
3) "Meat-washing water" color (pinkish, bloody)
4) Yellow-green, frothy

Question Title: Question № 42
The method of treatment for parametritis in the suppuration stage is:
1) Laparotomy (celiotomy)
2) Conservative
3) Colpotomy
4) Laparoscopy

AI-4 PC-2.4.
Question Title: Question № 43
The most common location of trichomonas infection is:
1) Fallopian tubes
2) Vagina
3) Rectum
4) Urethra

Question Title: Question № 44
Indications for surgery in acute salpingo-oophoritis are:
1) Presence of an adnexal mass (adnextumor) and pyosalpinx
2) Intoxication syndrome
3) History of infertility
4) Sepsis

Question Title: Question № 45
Acute adnexitis should be differentiated from:
1) Ovarian tumor and uterine myoma
2) Ectopic pregnancy and appendicitis
3) All of the above are correct
4) None of the above are correct

AI-5 PC-2.5.
Question Title: Question № 46
Factors that prevent the spread of infection in the genital organs are:
1) Acidic vaginal environment and the mucous plug of the cervical canal
2) Alkaline vaginal environment and the canalicular structure of the genitals
3) All of the above are correct
4) None of the above are correct

Question Title: Question № 47
Indications for surgical treatment of metroendometritis are:
1) Intoxication syndrome or combination with parametritis
2) Combination with pyosalpinx or peritonitis
3) All of the above are correct
4) None of the above are correct

Question Title: Question № 48
Methods for determining the etiology of acute adnexitis are:
1) Bacterioscopy and bacteriological examination

2) Speculum examination and bimanual examination
3) All of the above are correct
4) None of the above are correct

AI-1 PC-3.1.
Question Title: Question № 49
Complaints with tuberculous endometritis include:
1) Infertility and hypomenorrhea
2) Hyperpolymenorrhea
3) All of the above are correct
4) None of the above are correct

Question Title: Question № 50
Complaints with tuberculosis of the fallopian tubes include:
1) Primary infertility and aching pain in the lower abdomen
2) Secondary infertility and menstrual cycle disorders
3) All of the above are correct
4) None of the above are correct

Question Title: Question № 51
Clinical signs of trichomoniasis are:
1) Frothy yellow vaginal discharge and itching of the external genitalia
2) Bloody discharge and lower abdominal pain
3) All of the above are correct
4) None of the above are correct

AI-2 PC-3.2.
Question Title: Question № 52
Tuberculous infection is most often localized in the:
1) Uterus and fallopian tubes
2) Vagina and cervix
3) All of the above are correct
4) None of the above are correct

Question Title: Question № 53
Signs of uterine inflammation upon bimanual examination are:
1) Firm, reduced in size
2) Soft, enlarged
3) Painful
4) Correct answers are 2 and 3

Question Title: Question № 54
Indications for surgical treatment of ascending gonorrhea are:
1) Peritonitis and pyosalpinx
2) Acute salpingitis and intoxication syndrome
3) All of the above are correct
4) None of the above are correct

AI-3 PC-3.3.
Question Title: Question № 55
Emergency surgical treatment is performed for:
1) Perforation of a purulent tumor of the uterine appendages or threat of pyosalpinx perforation
2) Acute salpingo-oophoritis
3) Acute metroendometritis
4) All of the above are correct

Question Title: Question № 56
Primary foci of infection in gonorrhea are:
1) Vagina and fallopian tubes
2) Urethra and cervical canal
3) All of the above are correct
4) None of the above are correct

Question Title: Question № 57
Chlamydial infection is often the cause of:
1) Infertility and miscarriage
2) Polymenorrhea and algodysmenorrhea
3) All of the above are correct
4) None of the above are correct

AI-4 PC-3.4.
Question Title: Question № 58
To establish a definitive diagnosis of hydatidiform mole, the following examination is used:
1) Ultrasound
2) Bimanual
3) Rectovaginal
4) Histological

Question Title: Question № 59
Risk factors for endometrial cancer development are:
1) Stein-Leventhal syndrome or recurrent endometrial hyperplasia
2) Endometritis or a high number of pregnancies
3) All of the above are correct
4) None of the above are correct

Question 3
Processes considered background for the cervix are:
1) Ectopy and polyp
2) Dysplasia and carcinoma in situ
3) All of the above are correct
4) None of the above are correct

AI-1 PC-4.1.
Question Title: Question № 60
Cervical cancer spreads to the bladder mucosa at stage:
1) I
2) II
3) IIA
4) IV

Question Title: Question № 61
Endometrial cancer spreads to the cervix at stage:
1) I
2) IB
3) IV
4) II

Question Title: Question № 62
To determine the stage of cervical cancer, the following are used:
1) Laparoscopy
2) Ultrasound examination
3) Lymphography
4) All of the above are correct

AI-2 PC-4.2.
Question Title: Question № 63
A clinical sign of complete placenta previa in a pregnant woman is:
1) Recurrent bleeding
2) Presence of abdominal pain
3) Uterine hypertonus
4) All of the above are correct

Question Title: Question № 64
A reliable sign of placenta previa is:
1) Discrepancy between the fundal height and gestational age
2) Rupture of membranes (amniotic fluid leakage)
3) Vaginal bloody discharge
4) Ultrasound (USG)

Question Title: Question № 65
The clinical picture of premature abruption of a normally situated placenta is characterized by:
1) Development of hemorrhagic shock
2) Change in fetal heart rate
3) Tension and tenderness upon uterine palpation
4) All of the above are correct

AI-1 PC-5.1.
Question Title: Question № 66
For a platypelloid (flat rachitic) pelvis, the following is not characteristic:
1) The sacral promontory protrudes into the pelvic cavity
2) All direct diameters of the pelvic outlet are reduced
3) The sacrum is flattened, shortened, widened, and thinned
4) The upper half of the sacral rhombus (Michaelis rhombus) is smaller than the lower half

Question Title: Question № 67
For a transversely contracted pelvis, the following is not characteristic:
1) Diagonal conjugate is 13 cm
2) Narrow pubic arch
3) Steep inclination of the iliac wings
4) Reduction of the transverse diameters of the pelvis

Question Title: Question № 68
The most important sign of a generally contracted pelvis (pelvis justo minor) is:
1) Reduction of all pelvic dimensions by 2 cm
2) Shortening of the diagonal conjugate
3) Short stature and correct body build of the pregnant woman
4) Reduction in the size of the sacral rhombus (Michaelis rhombus)

Evaluation criteria, grading scale for test tasks

Grade		**Description**
«excellent»	5	Completed in full – 90%-100%
«good»	4	Not completed in full – 80%-89%
«satisfactory»	3	Completed with deviation – 70%-79%
«unsatisfactory»	2	Partially completed – 69% and fewer correct answers

2.4. Examples of algorithms for demonstrating practical skills
Algorithm for demonstrating practical skills

Serial No.	Student's Action
1	Established contact with the patient (greeted, introduced themselves, offered a seat) **-1 PC-2.1**

Serial No.	Student's Action
2	Clarified the patient's well-being **AI-1 PC-2.1**
3	Correctly performed hand hygiene **AI-3 GPC-4.3**
4	Correctly examined the pregnant woman, gynecological patient (Leopold's maneuvers, measurement of external pelvic dimensions, auscultation of fetal heart sounds, speculum examination) **AI-2 GPC-4.4; AI-2 PC-2.2; AI-3 PC-2.3; AI-5 PC-2.5; AI-1 PC-3.1**
5	Correctly performed smear collection (smears for cancer cells from the cervix, smears for bacterioscopy, smears for PCR, smears for bacteriological culture, smears for hormonal studies) **AI-3 GPC-4.3**
6	Performed hand hygiene using the hygienic method after the procedure **AI-1 GPC-5.1**
7	Informed the patient about the progress of the examination **AI-1 GPC-7.1, AI-2 GPC-7.2, AI-1 PC-2.1; AI-4 PC-3.4; AI-2 PC-4.2;**

Evaluation criteria, grading scale for the demonstration of practical skills

Grade		**Description**
«excellent»	5	Knows the methodology for performing practical skills, indications and contraindications, possible complications, standards, etc., independently demonstrates the execution of practical skills without errors
«good»	4	Knows the methodology for performing practical skills, indications and contraindications, possible complications, standards, etc., independently demonstrates the execution of practical skills, allowing some inaccuracies (minor errors), which they independently identify and promptly correct
«satisfactory»	3	Knows the main points of the methodology for performing practical skills, indications and contraindications, possible complications, standards, etc., demonstrates the execution of practical skills, allowing some errors, which they can correct with instructor feedback
«unsatisfactory»	2	Does not know the methodology for performing practical skills, indications and contraindications, possible complications, standards, etc., cannot independently demonstrate practical skills or performs them with critical errors

2.5. Examples of situational tasks:

AI-1 GPC-4.1.

Case 1. A 26-year-old postpartum woman, on the 4th day after her first full-term vaginal delivery, presents with complaints of weakness, chills, and fever up to 39.4°C. The delivery was complicated by a 14-hour period of ruptured membranes and a manual removal of a retained placental lobe.

History: Menarche at age 14, menstruation lasts 3-5 days, cycle 29-31 days, moderate, painless, regular. Past history: 2 induced abortions before 12 weeks, without complications. Registered for prenatal care from 10 weeks of gestation and attended regularly. Weight gain during pregnancy was 12 kg, steady. The current pregnancy was uncomplicated.Objective examination: Condition is satisfactory. Skin and visible mucous membranes are of normal color. Pulse 94 beats per minute, satisfactory volume, rhythmic. BP 110/70 mm Hg. Body temperature 38.6°C. Lactation is sufficient. Milk expression is extremely difficult and painful. Both mammary glands are diffusely hyperemic and tender on palpation. Nipples are clear. Abdomen is soft and non-tender on palpation. Uterus is firm, non-tender on palpation. The uterine fundus is located 3 fingerbreadths below the umbilicus. Vaginal discharge is serosanguineous, moderate.

Questions:

1) Formulate a preliminary diagnosis.
2) Are any additional examination methods necessary?
3) Further management tactics for this postpartum woman.

4) Justify the further management tactics.
5) Justify the diagnosis.

Case 2. A 43-year-old female patient was brought by ambulance to the emergency department of a city hospital with complaints of sharp lower abdominal pain, nausea, vomiting, and abdominal ...distention, which began 3 hours ago after physical exertion.From the medical history: Menarche at age 13. Menstruation occurs every 28 days, lasting 5-7 days, is heavy, painless, and regular. She reports an increase in the duration and heaviness of her periods over the past year. Her last menstrual period started 9 days ago, on schedule.Past medical history: 2 full-term vaginal deliveries and 1 induced abortion at 8 weeks gestation, performed three years ago without complications. During a routine check-up with an obstetrician-gynecologist 2 years ago, uterine fibroids were diagnosed, corresponding in size to an 8-week pregnancy.Objective findings:The patient's condition is moderately severe. Skin and visible mucous membranes are moderately pale. Body temperature is 37.7°C. Pulse is 100 beats per minute, of satisfactory volume and rhythm. Blood pressure is 120/70 mm Hg. The abdomen is moderately distended and tender to palpation in the lower quadrants. Positive peritoneal signs are present there. On speculum examination: The vaginal and cervical mucosa show no pathological changes. There is scant dark bloody discharge from the cervical canal.
Bimanual vaginal examination (P.V.): The cervix is cylindrical in shape, the external os is closed. Cervical motion tenderness is present. The uterine body is anteverted and anteflexed, corresponds in size to a 14-week pregnancy, is nodular, firm in consistency, mobile, and tender on palpation. On the anterior wall, there is a subserosal nodule 4 cm in diameter, which is exquisitely tender. Adnexa on both sides are unremarkable. The vaginal fornices are clear. No infiltrates are noted in the parametrium.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 3. A 40-year-old woman presented to the women's clinic with complaints of copious, purulent, creamy-white vaginal discharge and urinary symptoms that appeared immediately after her period. Last month, she had unprotected sexual intercourse with a casual partner.History: Menarche at age 14. Menstruation occurs every 28 days, lasts 4 days, is regular, moderate, and painless. Her last menstrual period began 6 days ago. Sexually active since age 17, currently married.Obstetric-Gynecologic History: Pregnancies - 3; Deliveries - 2; Abortions - 1.Contraception: Combined oral contraceptives (Yarina).Gynecological History: Chronic salpingo-oophoritis, last exacerbation 1 year ago.Past Medical History: Childhood infections; Acute respiratory viral infections (ARVI).Objective Examination: Patient's condition is satisfactory. Pulse 76 beats per minute. Blood pressure 120/80 mm Hg. Abdomen is not distended, soft and non-tender to palpation in all quadrants. The external urethral meatus is hyperemic, edematous, with mucopurulent discharge.Speculum Examination: The vaginal and cervical mucosa is hyperemic and edematous. On the cervix, there is an epithelial defect in the form of a red spot with sharply defined edges; its base is covered with a purulent coating. Discharge is purulent, grayish, and creamy.Bimanual Examination (PV): The uterus is anteverted and anteflexed, normal in size, firm, mobile, non-tender. Adnexa are not palpable.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

AI-2 GPC-4.2.

Case 1. A 28-year-old postpartum woman, on the 5th day after her first full-term, uncomplicated vaginal delivery, presents with complaints of weakness, chills, fever up to 39.1°C, and bursting pain in the left breast.History: Menarche at age 13. Menstruation lasts 3-5 days, every 29-31 days, moderate, painless, regular.Past Medical History: 3 induced abortions before 12 weeks of gestation, without

complications. Registered for prenatal care from 11 weeks of gestation, attended regularly. Weight gain during pregnancy was 11 kg, steady.
Current Pregnancy: Complicated by threatened miscarriage (hospitalizations at 14 and 24 weeks of gestation) and an upper respiratory tract infection (URTI) at 34 weeks with a fever up to 37.4°C.

Objective Examination: The patient's condition is of moderate severity. The tongue is dry, coated with a white film. Pulse is 102 beats per minute, full, rhythmic. Blood pressure is 120/80 mm Hg. Body temperature is 39.1°C.The left breast is enlarged, edematous, and the skin of the breast is erythematous (reddened). In the lower outer quadrant, an area of fluctuation measuring 4x4x3 cm is noted, which is exquisitely tender to palpation. The right breast is enlarged, with skin of normal color. Milk expression from both breasts is difficult and painful. Both nipples have fissures.
The abdomen is soft and non-tender to palpation. The uterus is firm and non-tender to palpation; the uterine fundus is located midway between the umbilicus and the symphysis pubis. Vaginal discharge is serosanguineous (blood-tinged), scant.
Questions:
1) Formulate a preliminary diagnosis.
2) Are any additional diagnostic tests necessary?
3) What is the further management plan for this postpartum patient?
4) Justify the chosen management plan.
5) Justify the diagnosis.

Case 2. A 26-year-old woman presented to the women's clinic with complaints of copious, mucopurulent vaginal discharge, itching and burning in the vaginal area, and discomfort during urination.History: Menarche at age 13. Menstruation occurs every 28 days, lasts 5 days, is regular, moderate, and painless. Sexually active since age 19.Obstetric History: Pregnancies - 0.
Contraception: Combined oral contraceptives (Lindinet-20), started six months ago; prior contraception was barrier methods.History of Present Illness: One week ago, she had unprotected sexual intercourse with a casual partner. Denies any history of gynecological diseases.
Past Medical History: Childhood infections; Acute respiratory viral infections (ARVI).Objective Examination: Patient's condition is satisfactory. Pulse 76 beats per minute. Blood pressure 120/80 mm Hg. Abdomen is not distended, soft and non-tender to palpation in all quadrants. External genitalia are normally developed, without specific lesions.Speculum Examination: The vaginal and cervical mucosa is hyperemic and edematous. The discharge is mucopurulent.Bimanual Examination (PV): The uterus is anteverted and anteflexed, normal in size, firm, mobile, non-tender. Adnexa are not palpable. The vaginal fornices are deep and clear.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 3. A 36-year-old female patient was admitted to the gynecology department as an emergency with complaints of lower abdominal pain, frequent urination, fever up to 38-38.5°C with chills, and copious creamy discharge from the genital tract.She considers herself ill for two days, when immediately after her menstrual period, she developed discharge and gradually increasing lower abdominal pain, frequent urination, and a body temperature rise to 37.5°C. She did not seek medical attention and took No-shpa and Pentalgin with minimal positive effect. Due to worsening of her condition and an increase in body temperature with chills, she called an ambulance and was hospitalized.From the history, it is known that three weeks ago she had unprotected casual sexual intercourse.Gynecological History: Menarche at age 13. Menstruation lasts 3 days, every 28 days, is regular, moderate, and painful. Her last menstrual period started on time, 5 days ago. Sexually active since age 17, unmarried.Contraception: Condom (not always). Denies gynecological diseases.Obstetric History: Pregnancies - 2; Deliveries - 1 (without complications); Abortions - 1 (without complications).Medical History: Denies chronic diseases. Denies previous surgeries. Denies history of tuberculosis, hepatitis, sexually transmitted diseases, HIV, or blood transfusions.

Objective Examination: Condition: Moderately severe. Skin:Clean, pale.Pulse: 86/min. Blood Pressure: 110/70 mm Hg.Tongue: Dry, coated with a white film. Abdomen: Moderately distended, tender in the lower quadrants. Peritoneal signs are positive in the lower quadrants.Stool: Regular, formed. Urination: Independent, painless.
Gynecological Examination:Speculum Examination: The mucosa of the vagina and cervix is hyperemic. The cervical epithelium...is visually covered with unaltered epithelium. Discharge from the cervical canal is purulent, copious.Bimanual Vaginal Examination (PV):The cervix is cylindrical in shape. Traction on the cervix is painful.The uterine body is of normal size, firm.The adnexa are thickened and cannot be clearly delineated due to severe tension and tenderness of the anterior abdominal wall.The posterior vaginal fornix is bulging and exquisitely tender on palpation.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

AI-3 GPC-4.3.
Case 1. Patient F., 36 years old, second pregnancy, full-term delivery. History of 4 induced abortions. Delivered a full-term infant 30 minutes ago. The placenta has not been delivered, there is no bleeding.
Questions:
1) Most likely diagnosis.
2) What needs to be done in this situation?
3) Sequence of your actions.
4) Formulate the rationale for your chosen management.
5) Provide justification for the diagnosis.

Case 2. A 25-year-old female patient was admitted to the gynecology department on an emergency basis with complaints of lower abdominal pain and a body temperature of up to 38.0°C.

She reports being ill for three days, during which she developed dull, aching lower abdominal pain, weakness, and a fever of up to 38.0°C. She took No-Spa, Spazmalgon, and Paracetamol without significant improvement. Due to worsening pain, she called an ambulance and was hospitalized.Gynecological History:Menstrual History: Menarche at age 13. Menses last 4-5 days, every 28 days, regular, moderate, painless. Her last menstrual period started on time, 7 days ago.Sexual History: Sexually active since age 19, married.Contraception: None.Gynecological History: Denies any gynecological diseases.Obstetric History: Pregnancies - 2; Deliveries - 1 (without complications); Abortions - 1 (without complications) Medical History: Chronic gastritis. Past surgery: Laparoscopic appendectomy (2010). Denies history of tuberculosis, hepatitis, sexually transmitted diseases, HIV, or blood transfusions.Objective Examination:General Condition: Satisfactory.Skin: Clean, normal color.Vitals at Exam: Temperature: 37.7°C; Pulse: 86/min; Blood Pressure: 120/70 mm Hg.Tongue: Clean, moist.Abdomen: Soft, tender to palpation in the lower quadrants. Peritoneal signs negative.Bowel/Bladder: Formed stool. Independent, painless urination.Genital Discharge: Scant, purulent.Gynecological Examination:Speculum Exam (PS): Vaginal and cervical mucosa show no pathological changes.Bimanual Exam (PV): Cervix is cylindrical, external os closed. Uterine body is normal in size, firm, mobile, non-tender. Adnexa on both sides are thickened (indurated), exquisitely tender on palpation. Vaginal fornices are clear.
Questions:
1) Formulate a presumptive (preliminary) diagnosis.
2) What additional examinations are necessary for this patient?
3) Justify the diagnosis.
4) What should be the further management plan?
5) Prescribe treatment.

Case 3. Patient M., 54 years old, was admitted to the gynecology department with complaints of irregular vaginal bleeding for one year.History: She has had two normal vaginal deliveries and three induced (medical) abortions (at 8-10 weeks of gestation). She has been in menopause for 4 years. Two

years ago, a diagnostic curettage of the uterine cavity was performed due to spotting. Histology: Solitary glandular endometrial polyps. Treatment was administered with 17-hydroxyprogesterone caproate (125 mg daily for 6 months). A follow-up diagnostic curettage of the uterine cavity revealed no pathological proliferation. One year later, irregular bleeding recurred, which is the reason for her current admission to the gynecology department. Осмотр при помощи зеркал: The cervix is somewhat edematous. Its mucosa has a cyanotic hue. The external os is closed. From the cervical canal there is a moderate amount of bloody discharge.Vaginal Examination: The cervix is cylindrical in shape and mobile. The uterine body is of normal size, mobile, and non-tender. The adnexal regions are clear and non-tender.Rectal Examination: No tumor formations or infiltrates are detected in the pelvis.A curettage of the uterine cavity was performed, yielding an abundant amount of tissue.Histological Examination: The curettage specimen revealed endometrial hyperplasia. Isolated glandular tissue cells are large, with hyperchromatically stained nuclei. The contours of these nuclei are irregular (cells with signs of atypia).
Questions:
1) What is the most likely diagnosis?
2) What should your further management plan be?
3) Justify your chosen management plan.
4) Formulate a plan for further treatment.
5) Justify your diagnosis.

AI-4 GPC-4.4.
Case 1. Patient I., 20 years old, was brought by ambulance in an unconscious state. First pregnancy, gestational age - 36 weeks. Generalized edema of the body. According to relatives, she had severe headaches for the last two days. She had two seizure episodes at home. A third seizure occurred in the emergency room.
Questions:
1) Make a diagnosis.
2) What needs to be done in this situation?
3) Sequence of actions when providing care.
4) Formulate a plan for further treatment.
5) What should the further management plan be?

Case 2. A 32-year-old patient was admitted to the clinic with complaints of heavy bleeding and cramping lower abdominal pain that began 4 hours ago.This is her second pregnancy. Her first pregnancy ended in a preterm delivery at 30 weeks of gestation. The baby died one day later. Her last menstrual period was 2 months ago.On vaginal examination: The cervix is shortened. The cervical canal is freely passable for one finger past the internal os, where blood clots are detected. The uterus is enlarged to the size of a 6-7 week pregnancy, firm, mobile, and painless. The adnexa are not palpable. The discharge is bloody, heavy, and contains clots.
Questions:
1) What is the most likely diagnosis?
2) What anamnestic (historical) data is necessary to determine the cause of this condition?
3) Justify your diagnosis.
4) What should the further management plan be?
5) What errors were made in the management of this pregnancy at the antenatal clinic?

Case 2. A 23-year-old patient called an ambulance due to cramping lower abdominal pain and heavy vaginal bleeding that began 2 hours ago. She was discharged from the hospital yesterday following an induced abortion procedure. She is afebrile.Vaginal examination revealed: The cervix is cylindrical, the external os is slightly open. The uterus is somewhat enlarged, softish, and non-tender. The adnexa are not palpable. The discharge is bloody and moderate in amount.
Questions:
1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What should your further management plan be?
4) Formulate the rationale for your chosen management plan.
5) What is the sequence of your actions?

AI-1 GPC-5.1.

Case 1. A 22-year-old patient. Admitted on the 3rd day of her menstrual period with complaints of severe abdominal pain and high fever – 39.0°C. She associates the illness with casual sexual intercourse a week before her period. Her condition is of moderate severity. Pulse - 110 beats per minute, rhythmic, satisfactory volume. BP - 110/70 mm Hg. Abdomen is not distended,tender on palpation in the lower quadrants, with a positive Shchetkin-Blumberg sign in the same area. No free fluid is detected in the abdominal cavity.On speculum examination: The cervical mucosa is unchanged. Discharge is bloody, scant.Bimanual examination: The uterus and adnexa cannot be delineated due to extreme tenderness on palpation and abdominal wall guarding.Rectal examination: No pelvic infiltrates are found. Proust's sign (or Promtov's sign) is negative.Laboratory findings: Hemoglobin: 120 g/L, Leukocytes: 22 x 10^9/L, Band neutrophils: 30%, ESR: 40 mm/hr, No toxic granulation in neutrophils.

Questions:

1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) Formulate and justify a plan for additional patient examination.
4) What is your further management plan?
5) Justify your choice of management.

Case 2. A 17-year-old patient was admitted with complaints of fever up to 38°C, chills, mild lower abdominal pain, and slight bloody discharge. She reports being ill for 3 days. Her last menstrual period was 3 months ago.Her general condition on admission is moderately severe. Pulse is 100 beats per minute, rhythmic, satisfactory volume. Blood pressure is 120/80 mm Hg. The abdomen is soft, moderately tender in the lower quadrants. Blood test results: leukocytes - 12 x 10^9/L, hemoglobin - 100 g/L.Vaginal examination: The cervix is shortened. The cervical canal is passable for one finger up to the internal os. The uterus is enlarged to the size of an 8-week pregnancy, somewhat soft, exquisitely tender on examination, and mobile. The adnexa are not palpable. The discharge is bloody with an admixture of pus.

Questions:

1) What is the most likely diagnosis?
2) What information needs to be clarified from the medical history?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Justify your choice of management.

Case 3. A 68-year-old patient. After 18 years of menopause, she began experiencing slight bloody discharge from the genital tract. It was first noted 8 months ago (lasted for 1 day). It recurred 3 months ago. She did not seek medical attention. 3 days ago, due to heavy bleeding, the patient visited the antenatal clinic and was referred to a gynecological hospital.Speculum examination: The ectocervix shows no signs of atrophic changes. There is slight bloody discharge from the cervical canal.Vaginal examination: The cervix is cylindrical, small in size, the external os is closed. Movement of the cervix is painless. The uterine body is slightly larger than normal, of usual consistency, mobile. The adnexal region is clear.Histological examination: The curettage from the cervical canal revealed mucus and small blood clots. The curettage from the uterine cavity showed focal proliferation of endometrial cells with signs of malignancy.

Questions:

1) What is the most likely diagnosis?
2) Formulate the justification for your diagnosis.
3) What should your further management plan be?
4) Formulate the rationale for your chosen management plan.
5) What is the sequence of your actions?

AI-2 GPC-5.2.

Case 1. A 28-year-old patient was admitted with complaints of sudden onset of cramping lower abdominal pain radiating to the sacrum and rectum, and scant bloody discharge from the genital tract. Dizziness and nausea occurred simultaneously.Her menstrual periods are regular, the last one was 6

weeks ago.Obstetric history: Deliveries - 1, abortions - 3. The last abortion was complicated by bilateral adnexitis, for which she was treated in a hospital.On admission: The patient's condition is moderately severe. She is pale. Pulse - 96 beats per minute, rhythmic. Blood pressure - 90/60 mm Hg. Body temperature - 36.8°C. The tongue is somewhat dry, coated with a white film. The abdomen is slightly distended, tender in the lower quadrants, more so on the left, where there are mild signs of peritoneal irritation.On vaginal examination: The cervix is slightly cyanotic. The uterus is larger than normal, somewhat soft, and tender. The adnexa on both sides are adherent; the right side is not enlarged, while on the left, a doughy, poorly defined mass is palpable. The posterior fornix is flattened. The discharge is bloody and scant.
Questions:
1) What is the most likely diagnosis?
2) Provide justification for your diagnosis.
3) What should the further management plan be?
4) Formulate the rationale for your chosen management plan.
5) What is the sequence of your actions?

Case 2. A 30-year-old primigravida (pregnant for the second time, first delivery) was admitted to the maternity unit at 18:00 with regular labor activity for the past 3 hours. At 19:00, clear amniotic fluid was spontaneously released in a moderate amount. The gestational age at admission was 39 weeks. This is her second pregnancy. Her first pregnancy was 3 years ago and ended in a spontaneous miscarriage at 10 weeks of gestation, followed by uterine curettage, which was complicated by endometritis.The first and second stages of labor proceeded without complications. After 8 hours and 40 minutes of labor, a live, full-term baby girl was born, weighing 3650 g, length 53 cm, with an Apgar score of 8/9.Fifteen minutes after delivery, bloody discharge from the genital tract appeared. The estimated blood loss was 500 ml.
Objective Examination: Height: 168 cm, Weight: 70 kg, BMI: 24.8. General condition: Satisfactory. Skin and visible mucous membranes: Pale pink, normal moisture. Pulse: 90 beats/min. BP: 120/80 mm Hg. Abdomen: Soft, non-tender to palpation. Fundal height: At the level of the umbilicus. Uterus: Firm, non-tender. Signs of placental separation (Chukalov-Küstner sign): Positive. Attempted manual placental delivery using the Abduladze technique was ineffective. Attempted manual placental delivery using the Crede-Lazarevich maneuver was ineffective.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3.
From the history:Menarche at age 14. Menstruation lasts 6-7 days, every 28-30 days, moderate, painless, regular. Obstetric history: 1 full-term vaginal delivery and 1 induced abortion before 12 weeks, performed three months prior to the current pregnancy, complicated by repeated uterine curettage and metroendometritis. Registered for prenatal care from 10 weeks of gestation, attended regularly.Total weight gain during pregnancy: 11 kg, steady. Ultrasound findings at 30/31 weeks of gestation. Single fetus in cephalic presentation, estimated fetal weight 1450 g, no visible fetal malformations detected, the placenta completely covers the internal cervical os, normal amount of amniotic fluid.Objective Examination:General: Condition moderately severe. Skin and visible mucous membranes are pale. Vitals: Height: 160 cm, Weight: 85 kg. Pulse: 90 beats/min, satisfactory volume, rhythmic. BP: 100/60 mm Hg.Abdomen: Areas not occupied by the pregnant uterus are soft, non-tender. Uterus: Enlarged corresponding to 34 weeks of gestation, normal tone, non-tender on palpation throughout.Fetus: Position is longitudinal. The fetal head is presenting, mobile above the pelvic inlet. Fetal heart rate: clear, rhythmic, 186 beats per minute.Vaginal discharge: Moderate bloody discharge. The perineal pad is heavily saturated with blood. Total estimated volume of blood loss: 500 ml.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?

4) Justify the chosen management plan.
5) What complications could arise in this situation?

AI-3 GPC-5.3.

Case 1. Больная, 18 лет, поступила с жалобами на повышение температуры до 38-390С, озноб, небольшие боли внизу живота и незначительные кровянистые выделения. Считает себя больной for 7 days. The district physician who was called diagnosed her with: Acute Respiratory Viral Infection (ARVI). She was treated at home. Due to the lack of improvement in her condition, an ambulance was called and transported the patient to the gynecology department. Her last menstrual period was 5 months ago. On admission: The patient's condition is severe. Pallor of the skin is noted. Pulse: 120 beats per minute, rhythmic, satisfactory volume. Tongue: Somewhat dry. Lungs: Harsh breathing sounds, moist rales are heard. Abdomen: Soft, tender in the lower quadrants. Liver: Extends 6 cm below the costal margin. Spleen: Enlarged. Diuresis: Decreased.Vaginal examination: Cervix: Conical, external os is closed. Uterus: Enlarged, corresponding to a 17-18 week pregnancy, soft, exquisitely tender. Adnexa: Enlarged on both sides, tender on examination. Discharge: Purulent, foul-smelling.

Questions:

1) What is the most likely diagnosis?
2) What anamnestic (historical) data needs to be clarified with the patient?
3) Justify your diagnosis.
4) What should the further management plan be?
5) What error did the district physician make?

Case 2. A 36-year-old primigravida was admitted to the maternity hospital at 14:20, reporting the onset of regular contractions since 13:30. At 14:30, clear amniotic fluid was released in a moderate amount. The gestational age at admission was 38/39 weeks.History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless. Sexual: Sexually active since age 23, married.Obstetric: First pregnancy, full-term. Prenatal Care: Registered from 6/7 weeks of gestation. Pregnancy was uncomplicated. Lab: Last blood test showed hemoglobin – 90 g/L. Ultrasound (Doppler): At 37 weeks, fetal-placental blood flow impairment of Grade Ib was detected. Gynecological History: Chronic bilateral salpingo-oophoritis since age 24, last exacerbation over 5 years ago. Medical History: Childhood infections; ARVI; chronic gastritis since age 15, last exacerbation over 3 years ago. Objective Examination on Admission: General: Condition satisfactory. Pulse: 76 bpm, BP: 120/80 mm Hg.External Obstetric Exam: Fetal lie: Longitudinal. Fetal back: On the right. Presenting part: Fetal head, engaged at the pelvic inlet. Fundal height: 38 cm. Uterine circumference: 25 cm. Contractions: Lasting 20 seconds, every 6-8 minutes, weak, regular. Fetal Heart Rate (FHR): Clear, rhythmic, 140 bpm. Pelvic Measurements: 26-29-32-21 cm. Vaginal Exam (PV): Nulliparous vagina. Cervix effaced. Cervical dilation 2 cm. Cervical edges of medium thickness, moderately compliant. No amniotic sac. Presenting part: fetal head, engaged at the pelvic inlet. Sacral promontory not reachable. Clear amniotic fluid leaking.Progress at 18:00: Contractions lasting 30 seconds, every 5 minutes, moderate in strength. Uterus relaxes completely between contractions. Progress at 20:00: Weakening of labor activity noted** – contractions occurring every 6-8 minutes, lasting 15-20 seconds. **FHR deceleration to 90 bpm noted**, heart sounds are muffled and occasionally arrhythmic. Amniotic fluid leaking, slightly meconium-stained. PV: Nulliparous vagina. Cervix effaced. Cervical dilation 5 cm. Cervical edges thin, compliant. No amniotic sac. Presenting part: fetal head, engaged at the pelvic inlet. Sagittal suture in the right oblique diameter. Small fontanelle posterior and to the right. Sacral promontory not reachable. Amniotic fluid leaking, slightly meconium-stained.

Questions:

1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3. A multiparous woman presented to the antenatal clinic (APC). She does not remember the date of her last menstrual period. She knew she was pregnant but did not register for prenatal care and

was not examined. She began feeling fetal movements 15 weeks ago. During the pregnancy, for the last 10 weeks, she has noted periodically recurring spotting from the genital tract but did not seek medical attention.History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless.Sexual: Sexually active since age 16. Obstetric: This is her 7th pregnancy. Previous pregnancies ended in 3 deliveries (without complications) and 3 induced abortions. She is about to have her 4th delivery. Medical History: ARVI. External Obstetric Examination: Fundal height: 34 cm. Abdominal circumference: 89 cm. Fetal lie: Longitudinal. Fetal back: On the left. Presenting part: Fetal head, located high above the pelvic inlet. Fetal Heart Rate (FHR): Clear, rhythmic, 146 bpm. Pelvic measurements: 26-29-32-21 cm. Solovyov's index: 14.5 cm. Vaginal Examination: Cervix: Firm, length 2.5 cm, deviated towards the sacrum, external os closed. Through the lateral vaginal fornices, doughy tissue is palpable. The presenting fetal part cannot be identified. Sacral promontory: Not reachable. Discharge: Clear.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should the doctor's further management plan be?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

AI-1 GPC-7.1.
Case 1. A 35-year-old patient was admitted to the gynecology department with uterine bleeding after a 3-week delay in her menstrual period.History: 2 full-term deliveries, 3 induced abortions. The last abortion was complicated by adnexal inflammation and menstrual dysfunction. Six months ago, due to bleeding, a curettage of the uterine cavity was performed; the histological examination revealed endometrial hyperplasia without atypia. No subsequent treatment was provided.Vaginal examination: The cervix is intact, the external os is closed, there is moderate bloody discharge from the cervical canal. The uterus is unremarkable. The adnexa are adherent (bound by adhesions). The vaginal fornices are clear and deep.
Questions:
1) What is the most likely diagnosis?
2) Justification for the diagnosis.
3) What measures should be taken to stop the bleeding?
4) Sequence of actions when providing care.
5) Formulate the rationale for the chosen management plan.

Case 2. A 30-year-old primigravida (pregnant for the second time, first delivery) was admitted to the maternity unit at 18:00 with regular labor activity for the past 3 hours. At 19:00, clear amniotic fluid was spontaneously released in a moderate amount. The gestational age at admission was 39 weeks. This is her second pregnancy. Her first pregnancy was 3 years ago and ended in a spontaneous miscarriage at 10 weeks of gestation, followed by uterine curettage, which was complicated by endometritis.The first and second stages of labor proceeded without complications. After 8 hours and 40 minutes of labor, a live, full-term baby girl was born, weighing 3650 g, length 53 cm, with an Apgar score of 8/9. Fifteen minutes after delivery, bloody discharge from the genital tract appeared. The estimated blood loss was 500 ml. Objective Examination: Height: 168 cm, Weight: 70 kg, BMI: 24.8. General condition: Satisfactory. Skin and visible mucous membranes: Pale pink, normal moisture. Pulse: 90 beats/min. BP: 120/80 mm Hg. Abdomen: Soft, non-tender to palpation. Fundal height: At the level of the umbilicus. Uterus: Firm, non-tender. Signs of placental separation (Chukalov-Küstner sign): Positive. Attempted manual placental delivery using the Abduladze technique was ineffective. Attempted manual placental delivery using the Crede-Lazarevich maneuver was ineffective.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3.

From the history: Menarche at age 14. Menses last 6-7 days, every 28-30 days, moderate, painless, regular.Obstetric History: 1 full-term vaginal delivery and 1 induced abortion before 12 weeks, performed three months prior to the current pregnancy, complicated by repeated uterine curettage and metroendometritis. Registered for prenatal care from 10 weeks of gestation, attended regularly.Total weight gain during pregnancy: 11 kg, steady. Ultrasound findings at 30/31 weeks gestation: Singleton fetus in cephalic presentation, estimated fetal weight 1450 g, no visible fetal malformations detected, the placenta completely covers the internal cervical os, normal amniotic fluid volume.Objective Examination:General Condition: Moderately severe. Skin and visible mucous membranes are pale. Vitals: Height: 160 cm, Weight: 85 kg. Pulse: 90 beats/min, satisfactory volume, rhythmic. BP: 100/60 mm Hg. Abdomen: Areas free of the pregnant uterus are soft, non-tender. Uterus: Enlarged corresponding to 34 weeks gestation, normotonic, non-tender on palpation throughout. Fetus: Lie is longitudinal. Fetal head is presenting, mobile above the pelvic inlet. Fetal heart rate: clear, rhythmic, 186 beats per minute. Vaginal Discharge: Moderate bloody discharge. The perineal pad is heavily saturated with blood. Total estimated blood loss: 500 ml.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

AI-2 GPC-7.2.
Case 1. A 55-year-old patient was admitted with complaints of pain in the left iliac region, worsening with movement. The pain began suddenly, without apparent cause. Menopause for 1 year. No history of gynecological diseases. Condition is satisfactory. Vital Signs: Pulse - 84 bpm, rhythmic, satisfactory volume. BP - 140/90 mm Hg. Temperature - 37.4°C. Abdomen: Normal shape, somewhat distended. Tender to palpation in the left iliac region, where the **upper pole of a painful mass originating from the pelvis is palpable. Shchetkin-Blumberg sign negative. No free fluid detected in the abdominal cavity. Vaginal Examination: Uterus is retroverted, not enlarged, firm, with limited mobility, non-tender on palpation but sensitive to movement. The right fornix is clear, adnexa not palpable. **To the left and anterior to the uterus, a round, firm, smooth-surfaced mass measuring up to 14 cm in diameter is palpable, with limited mobility and exquisite tenderness.
Questions:
1) What is the most likely diagnosis?
2) Justify your diagnosis.
3) What should the further management plan be?
4) Formulate the rationale for your chosen management plan.
5) Develop a plan for further treatment.

Case 2. A 29-year-old primigravida presented to the maternity hospital emergency room with complaints of regular contractions that began three hours ago. Clear amniotic fluid in a moderate amount was released one hour ago. Gestational age is 39 weeks.History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless. Sexual: Sexually active since age 18, married. Obstetric: This is her first pregnancy. The pregnancy was complicated by threatened miscarriage at 20 weeks, for which she received tocolytic therapy. Gynecological History: Denies gynecological diseases. Medical History: Childhood infections; ARVI; chronic gastritis.Objective Examination: General; Condition satisfactory. Pulse 76 bpm, BP 120/80 mm Hg. Uterine Measurements: Fundal height - 37 cm. Abdominal circumference - 30 cm. External Obstetric Examination:Fetal lie: Longitudinal. Fetal back: On the right. Presenting part: Fetal head, above the pelvic inlet. Contractions: Lasting 20-25 seconds, every 5-7 minutes, weak, regular. Fetal Heart Rate (FHR): Clear, rhythmic, 146 bpm. Pelvic Measurements: External pelvic dimensions: 22-25-27-17 cm. Zangemeister and Vasten signs: Positive. Solovyov's index: 16.0 cm. Vaginal Examination: Cervix: Effaced. Cervical dilation: 2 cm. Amniotic sac: Not present. Clear amniotic fluid leaking. Presenting

part: The lower pole of the head is reached with difficulty. Pelvic cavity: Entirely free. Sacral promontory: Reachable. Diagonal conjugate: 9.5 cm.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What is the further management plan for labor?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3. A 30-year-old pregnant woman with a history of 3 spontaneous abortions came for an appointment with a doctor at the antenatal clinic.
Questions:
1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) Formulate and justify a plan for additional patient examination.
4) What should the doctor's further management plan for this patient be?
5) Justify your choice of management.

AI-3 GPC-7.3.
Case 1. A 22-year-old patient complained of weakness and dizziness 2 hours after an induced abortion at 10 weeks of gestation. The patient is pale. Pulse is 100 beats per minute, rhythmic. Abdominal examination reveals a uterus whose fundus is located at the midpoint between the pubic symphysis and the umbilicus. There is no bloody vaginal discharge.
Questions:
1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What is your further management plan?
4) Justify your choice of management.
5) What is the sequence of your actions?

Case 2. A 30-year-old primigravida (pregnant for the second time, first delivery) was admitted to the maternity unit at 18:00 with regular labor activity for the past 3 hours. At 19:00, clear amniotic fluid was spontaneously released in a moderate amount. The gestational age at admission was 39 weeks. This is her second pregnancy. Her first pregnancy was 3 years ago and ended in a spontaneous miscarriage at 10 weeks of gestation, followed by uterine curettage, which was complicated by endometritis.The first and second stages of labor proceeded without complications. After 8 hours and 40 minutes of labor, a live, full-term baby girl was born, weighing 3650 g, length 53 cm, with an Apgar score of 8/9. Fifteen minutes after delivery, bloody discharge from the genital tract appeared. The estimated blood loss was 500 ml.Objective Examination: Height: 168 cm, Weight: 70 kg, BMI: 24.8. General condition: Satisfactory. Skin and visible mucous membranes: Pale pink, normal moisture. Pulse: 90 beats/min. BP: 120/80 mm Hg. Abdomen: Soft, non-tender to palpation. Fundal height: At the level of the umbilicus. Uterus: Firm, non-tender. Signs of placental separation (Chukalov-Küstner sign): Positive. Attempted manual placental delivery using the Abduladze technique was ineffective. Attempted manual placental delivery using the Crede-Lazarevich maneuver was ineffective.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3. From the history:Menarche at age 14. Menses last 6-7 days, every 28-30 days, moderate, painless, regular.Obstetric History: 1 full-term vaginal delivery and 1 induced abortion before 12 weeks, performed three months prior to the current pregnancy, complicated by repeated uterine curettage and metroendometritis. Registered for prenatal care from 10 weeks of gestation, attended regularly. Total weight gain during pregnancy: 11 kg, steady.Ultrasound findings at 30/31 weeks gestation: Singleton fetus in cephalic presentation,

estimated fetal weight 1450 g, no visible fetal malformations detected, the placenta completely covers the internal cervical os, normal amniotic fluid volume.Objective Examination: General Condition: Moderately severe. Skin and visible mucous membranes are pale. Vitals: Height: 160 cm, Weight: 85 kg. Pulse: 90 beats/min, satisfactory volume, rhythmic. BP: 100/60 mm Hg. Abdomen: Areas free of the pregnant uterus are soft, non-tender.Uterus: Enlarged corresponding to 34 weeks gestation, normotonic, non-tender on palpation throughout.Fetus: Lie is longitudinal. Fetal head is presenting, mobile above the pelvic inlet. Fetal heart rate: clear, rhythmic, 186 beats per minute.mVaginal Discharge: Moderate bloody discharge. The perineal pad is heavily saturated with blood. Total estimated blood loss: 500 ml.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

AI-4 GPC-7.4.
Case 1. Patient M., 40 years old, was admitted to the gynecology department on referral from a doctor at the antenatal clinic. The patient complains of yellow vaginal discharge.History: No significant family medical history. She has had three pregnancies: one ended in a normal vaginal delivery, and the other two ended in induced abortions (at 8 and 10 weeks) without complications.Examination: Speculum Exam: Vaginal mucosa is hyperemic. The posterior lip of the cervix has whitish areas with clear borders. Bimanual Exam: The cervix is cylindrical in shape. The uterine body is of normal size, mobile. The adnexal region is clear and non-tender. Discharge: Yellow, frothy. Microbiological Test: Vaginal smear showed yellow, frothy discharge. Bacterioscopic Exam: Vaginal smear revealed mixed flora and Trichomonas vaginalis. Colposcopy: Revealed two whitish areas measuring 1 x 1.5 cm, located on the anterior and posterior lips, which did not stain with iodine (Lugol's solution negative).
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) Prescribe treatment.

Case 2. Patient K., a 30-year-old multipara (woman who has given birth before), was admitted to the maternity hospital. She has been in labor for 10 hours. Pelvic measurements: 26, 29, 30, 18 cm. Fetal lie: Oblique. The fetal head is on the right side. Fetal Heart Rate (FHR): Clear, rhythmic, 140 beats per minute. Vaginal examination revealed: Cervical dilation: 6 cm. Cervical edges: Thin, compliant. Amniotic sac: Intact. A pulsating loop of umbilical cord is presenting. Sacral promontory: Reachable. Diagonal conjugate: 11 cm.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) Calculate the true conjugate.
4) What should be the further management plan?
5) Formulate the rationale for your chosen management plan.

Case 3. Patient T., 25 years old. Pelvic measurements: 27, 27, 30, 17 cm. This is her second delivery, a preterm birth. Her first delivery ended in a cesarean section. She gave birth to a boy weighing 1300 g 10 minutes ago. Significant bleeding appeared. During manual removal of the placenta, it is impossible to detach a significant portion of the placenta attached to the anterior wall of the uterus. Severe, life-threatening bleeding has developed.
Questions:
1) Most likely diagnosis.
2) What should be the further management plan?

3) Formulate the rationale for your chosen management plan.
4) What is the sequence of your actions?
5) Justify the diagnosis.

AI-1 PC-2.1.

Case 1.A 25-year-old patient was brought to the gynecology department by ambulance with complaints of lower right abdominal pain, nausea, dizziness, and spotting. She fell ill suddenly, 6 hours ago, when she experienced lower abdominal pain radiating to the rectum, and reports a 2-week delay in her menstrual period. History: One pregnancy ended in a full-term vaginal delivery, another in an induced abortion at 10 weeks; the abortion was complicated by an inflammatory process of the uterus and adnexa.Condition on Admission: Condition: Satisfactory. Pulse: 90 bpm. BP: 110/70 mm Hg. Skin and visible mucous membranes: Pale pink. Abdomen: Normal shape, some tension of the abdominal wall muscles noted on the right. Shchetkin-Blumberg sign is weakly positive. Examination: Speculum Exam: Slight cyanosis of the vaginal and cervical mucosa. Cervical mucus sign (pupil sign) negative. Dark bloody discharge, scant. Vaginal Exam (Bimanual): Uterus slightly enlarged, doughy in consistency; movement is exquisitely painful. To the right of the uterus, in the adnexal region, tissue edema (pastosity) and exquisite tenderness are noted. The posterior fornix is bulging and tender on palpation.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What is the sequence of your actions?

Case 2. Patient S., 36 years old, primigravida (first pregnancy). Pelvic measurements: 24, 26, 29, 18 cm. History: infertility for 8 years. She was admitted to the antenatal ward with a full-term pregnancy. The fetus is in a breech presentation. Estimated fetal weight is 4250 g.
Questions:
1) Formulate the diagnosis.
2) Justify your diagnosis.
3) What should the further management plan be?
4) Formulate the rationale for your chosen management plan.
5) Develop a plan for further management.

Case 3. Patient I., 28 years old. Second pregnancy, full-term delivery. It is the third day of the postpartum period. She experienced chills and a temperature of 39.0°C. Breasts are soft, non-tender. The uterine fundus is at the level of the umbilicus, and the uterus is exquisitely tender to palpation. Lochia is moderate in amount and has an unpleasant odor.
Questions:
1) Most likely diagnosis.
2) Justify your diagnosis.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) Prescribe treatment.

AI-2 PC-2.2.

Case 1. Patient V., 36 years old, presented with complaints of heavy menstrual periods lasting 7-10 days over the past year. History: Family history and menstrual function (prior to the last year) are unremarkable. Sexually active since age 30, using contraception to prevent pregnancy. Objective Examination: General: Condition satisfactory. Skin pale. Systems Review: No pathology detected in internal organs. Gynecological Exam: External genitalia: Normally developed, female-pattern pubic hair. Speculum Exam: Vaginal and cervical mucosa unremarkable. Discharge is clear, mucous, moderate. Bimanual Exam: Vagina: Nulliparous. Cervix: Conical, external os closed. Uterus: Enlarged to the size of a 9-week pregnancy, firm, nodular, mobile, non-tender, correctly positioned. Adnexa: Not enlarged on either side. Vaginal fornices are clear.
Questions:

1) What is the most likely diagnosis?
2) Develop an examination plan for the patient.
3) Justify the diagnosis.
4) What should be the further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. Patient Ya., 28 years old. Pelvic measurements: 25, 28, 31, 20 cm. Second delivery, full-term. She gave birth to a boy weighing 3050 g 20 minutes ago. A second fetus in longitudinal lie, cephalic presentation, is found in the uterine cavity. Fetal heart tones are rhythmic, 120 bpm. There are no contractions. The amniotic sac of the second fetus is intact.
Questions:
1) Formulate the diagnosis.
2) What should be the further management plan?
3) Formulate the rationale for your chosen management plan.
4) What is the sequence of your actions?
5) What complications could arise?

Case 3. A multiparous woman was admitted with regular contractions of moderate intensity that began 10 hours ago. The membranes are intact. This is her second pregnancy and delivery. The pregnancy is full-term. Her first delivery was 3 years ago, without complications. Estimated fetal weight is 3200 g. Fetal lie: Longitudinal. At the uterine fundus, a round, firm part is palpated. The presenting part is softer and engaged at the pelvic inlet. Fetal heart rate: Distinct, 128 bpm, rhythmic. Half an hour after admission, clear amniotic fluid was released.Vaginal examination reveals: Cervical dilation: 8 cm. Amniotic sac: Absent. Fetal feet are palpated in the vagina, with the buttocks at the pelvic inlet. Sacral promontory: Not reachable.
Questions:
1) Formulate the diagnosis.
2) What is the further management plan?
3) Formulate the rationale for your chosen management plan.
4) What is the sequence of your actions?
5) What complications could arise in this situation?

AI-3 PC-2.3.
Case 1. A 31-year-old patient was admitted with complaints of sudden onset of cramping lower abdominal pain radiating to the sacrum, scant bloody vaginal discharge, and nausea following the pain. Her last menstrual period was 6 weeks ago. History: 1 full-term delivery and 2 induced abortions; following the second abortion, she developed bilateral adnexitis. Condition: Satisfactory. Pulse 84 bpm, rhythmic, satisfactory volume. BP 110/70 mm Hg. Temperature 36.8°C. Abdomen: Normal shape, moves with respiration, slightly distended, tender over the pubis and in the left iliac region. No signs of peritoneal irritation. Lab Findings: Hemoglobin 119 g/L, leukocytes 8.6 x 10^9/L, ESR 19 mm/hr. Examination:Speculum Exam: Cervix is slightly cyanotic. Discharge is spotting, bloody. Vaginal Exam (Bimanual): Cervical motion tenderness is present. Uterine body is in typical position, somewhat larger than normal, somewhat soft, tender on movement. On the left, in the adnexal region, a tumor-like mass is palpated; it is immobile, with unclear borders, and somewhat soft in consistency. In the left fornix, there is tissue edema (pastosity). Adnexa on the right are not enlarged.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. A 25-year-old patient was admitted to the clinic with complaints of mild, dull, intermittent lower abdominal pain and scant bloody discharge from the genital tract for one week. This is her third pregnancy. The two previous pregnancies ended in spontaneous abortions at 9-10 weeks of gestation. Her last menstrual period was 3 months ago. Vaginal examination revealed: The cervix is intact, the

external os is closed. The uterus is enlarged to the size of an 11-12 week pregnancy, somewhat soft, mobile, and non-tender. The adnexa are not palpable. The discharge is bloody, scant.
Questions:
1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What anamnestic (historical) data is necessary to determine the cause?
4) What errors were made in the management of this pregnancy by the antenatal clinic doctor?
5) What is your further management plan?

Case 3. A multiparous woman was admitted 4 hours after the onset of labor. The pregnancy is full-term. Membranes are intact. Pulse 78 bpm, rhythmic, satisfactory volume. BP - 180/120 mm Hg. Generalized edema. Urine protein: 2 g/L. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate: 134 bpm, rhythmic, clear.
Suddenly, the woman in labor complained of abdominal pain, became pale, and her pulse increased to 100 bpm. On palpation, localized tenderness is noted on the left side near the edge of the uterus. The uterus is tense and does not relax between contractions. The fetal heart rate is irregular, muffled - 90 bpm.Vaginal examination: The cervix is effaced, cervical dilation is 5 cm. The amniotic sac is intact and extremely tense. The presenting part cannot be palpated.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What errors were made by the antenatal clinic doctor?

AI-4 PC-2.4.
Case 1. A 37-year-old multiparous woman was admitted to the maternity hospital at full term, with regular labor activity for the past 4 hours. The membranes are intact. She feels fetal movements clearly. Shortly before arriving at the hospital, scant bloody discharge from the genital tract appeared. History: Menstrual: Menarche at age 13. Menses last 5-7 days, every 28 days, heavy, painless, regular. Obstetric History: 2 full-term vaginal deliveries and 2 induced abortions before 12 weeks, the last of which was performed 1 year ago and complicated by repeated uterine curettage and metroendometritis. Prenatal Care: Registered at the antenatal clinic from 17 weeks of gestation, visited only twice during the entire pregnancy. She categorically refused obstetric ultrasound. Objective Examination: General: Condition satisfactory. Skin and visible mucous membranes of normal color. Height: 170 cm, Weight: 88 kg.Vitals: Pulse: 82 bpm, satisfactory volume, rhythmic. BP: 110/70 mm Hg. Abdomen: Areas free of the pregnant uterus are soft, non-tender. Uterus: Enlarged corresponding to full term, relaxes well between contractions, non-tender on palpation throughout. Labor: Contractions every 3-4 minutes, moderate intensity, lasting 35-40 seconds. Fetus: Lie is longitudinal. Fetal head is presenting, slightly engaged at the pelvic inlet. Fetal heart rate: clear, rhythmic, 140 bpm. Discharge: Scant bloody discharge from the genital tract. CTG: Fetal condition is compensated. Vaginal Examination (PV): Vagina is capacious. Small amount of blood clots in the vagina (up to 30 ml). Cervical dilation: 8 cm, edges thin. Amniotic sac: Intact. To the right and posteriorly, at the edge of the cervical os, a small area of placental edge with a doughy consistency is detected. Presenting part: Fetal head, slightly engaged at the pelvic inlet. Sagittal suture in the left oblique diameter, small fontanelle anterior and to the right. Sacral promontory: Not reachable. No exostoses or deformities in the pelvis.
Questions:
1) Formulate a preliminary diagnosis.
2) Justify the diagnosis.
3) What is the obstetric management plan for labor in this case?
4) Justify the chosen management plan.
5) Possible complications.

Case 2. A 36-year-old primigravida has been in labor for 16 hours. Pelvic measurements: 23-25-29-17. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate is clear, rhythmic, 130 bpm. Contractions are frequent and very painful.

Vaginal examination revealed: Cervical dilation: Complete (full). Amniotic sac: Intact, extremely tense, and was artificially ruptured (amniorrhexis). A moderate amount of meconium-stained amniotic fluid was released. The fetal head is engaged at the pelvic inlet. Sagittal suture in the right oblique diameter. Small fontanelle posterior and to the right. Sacral promontory: Reachable. Diagonal conjugate: 10 cm.
Questions:
1) Most likely diagnosis.
2) Justify your diagnosis.
3) How can the true conjugate be calculated?
4) Calculate the true conjugate for this woman in labor.
5) What should be the further management plan?

Case 3. A 34-year-old multiparous woman was admitted due to bleeding. This is her third delivery, full-term. Contractions are regular, short. Fetal lie is longitudinal. Fetal heart rate is clear, rhythmic, 140 bpm. Vaginal examination revealed: Cervix: Effaced. Cervical edges: Thin. Cervical dilation: 8 cm. To the right and posteriorly, placental tissue is detected. Amniotic sac: Intact. Fetal head: Slightly engaged at the pelvic inlet. Sacral promontory: Not reachable.
Questions:
1) Make a diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) Sequence of your actions.

AI-5 PC-2.5.
Case 1. A 35-year-old primigravida (first pregnancy) was admitted to the emergency department at 12:40 with complaints of spontaneous rupture of clear amniotic fluid at 11:00. The gestational age at admission is 37 weeks. History: Menstrual: Menarche at 14. Menses last 5 days, every 30 days, regular, moderate, painless. Sexual: Sexually active since age 16. Obstetric: First pregnancy. Prenatal Care: Registered at the antenatal clinic from 13 weeks. Attended only three times throughout the pregnancy. Infections: Mycoplasma genitalium was detected during screening for sexually transmitted infections; the patient received no treatment. Ultrasound at 33/34 weeks: Revealed polyhydramnios. Treatment Refusal: She refused both hospital admission and outpatient antibiotic therapy. Gynecological History: Chronic salpingo-oophoritis since age 20 (last exacerbation 3 years ago). Medical History: Childhood infections; ARVI. Objective Examination: General: Condition satisfactory. Pulse: 66 bpm. BP: 120/80 mm Hg. Abdomen: Shape: Transverse-oval. Fundal height: 31 cm. Abdominal circumference: 110 cm. External Obstetric Exam: Above the right iliac crest, the fetal head is palpated. The fetal back is oriented anteriorly. No presenting part is identified in the pelvis. Fetal Heart Rate (FHR): Heard clearly at the level of the umbilicus; clear, rhythmic, 134 bpm. Vaginal Exam: Vagina: Nulliparous. Cervix: Positioned along the pelvic axis, length 2.0 cm, partially softened. The cervical canal admits one fingertip up to the internal os. No presenting tissue is palpated through the lateral vaginal fornices. Clear amniotic fluid is leaking.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the further management plan.
5) What complications could arise in this situation?

Case 2. A multiparous woman was admitted 4 hours after the onset of labor. The pregnancy is full-term. Membranes are intact. Pulse 78 bpm, rhythmic, satisfactory volume. BP - 180/120 mm Hg. Generalized edema. Urine protein: 2 g/L. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate: 134 bpm, rhythmic, clear. Suddenly, the woman in labor complained of abdominal pain, became pale, and her pulse increased to 100 bpm. On palpation, localized tenderness is noted on the left side near the edge of the uterus. The uterus is tense and does not relax between contractions. The fetal heart rate is irregular, muffled - 90 bpm.Vaginal examination:The cervix is

effaced, cervical dilation is 5 cm. The amniotic sac is intact and extremely tense. The presenting part cannot be palpated.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What errors were made by the antenatal clinic doctor?

Case 3. A 37-year-old multiparous woman. During her first delivery, she had severe preeclampsia, and after delivery was diagnosed with Stage I hypertension. Over the past 3 weeks of observation at the antenatal clinic, her blood pressure readings were 140/90, 150/100 mm Hg. She was brought by ambulance in a severe condition. Pulse 118 bpm, weak. Blood pressure 90/50 mm Hg. The uterus is sized to full-term pregnancy, is exquisitely tender and tense on the right side. Fetal heart tones are absent. Discharge is bloody, moderate.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis.
3) What errors were made by the antenatal clinic doctor?
4) What needs to be done in this situation?
5) Formulate the rationale for your chosen management plan..

AI-1 PC-3.1.
Case 1. A 34-year-old multiparous woman was admitted to the maternity unit with regular labor activity for the past 4 hours, and spontaneous rupture of membranes one hour after admission. This is her second pregnancy, gestational age - 40 weeks. First pregnancy - 5 years ago - ended in spontaneous vaginal delivery at 38-39 weeks. Second pregnancy - 2 years ago - ended in an induced abortion at 8-9 weeks, complicated by metroendometritis. The first and second stages of labor proceeded without complications. After 7 hours and 40 minutes of labor, a live, full-term baby boy was born, weighing 3450 g, length 52 cm, with an Apgar score of 8/8. Twenty minutes after delivery, the placenta was delivered, and bloody discharge from the genital tract appeared. Estimated blood loss is 350 ml. On examination, the placenta has a defect measuring 2 x 2.5 cm. Objective Examination: Height: 167 cm, Weight: 60 kg, BMI: 21.5. General condition: Satisfactory. Skin and visible mucous membranes: Pale pink, normal moisture. Pulse: 84 bpm. BP: 110/70 mm Hg. Abdomen: Soft, non-tender on palpation. Fundal height: At the level of the umbilicus. Uterus: Firm, non-tender.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 2. A 28-year-old primigravida (first-time mother) was admitted with regular, intense contractions that began 8 hours ago. This is her second pregnancy, full-term. Her first pregnancy, 3 years ago, ended in a criminal abortion in the third month, followed by repeated uterine curettage. Pelvic measurements: 24–27–30–19 cm. Four hours after admission, she delivered a live, full-term infant. Fifteen minutes after delivery, bleeding began. Blood loss is 300 ml. There are no signs of placental separation.
Questions:
1) Most likely diagnosis.
2) What signs of placental separation do you know?
3) What should be the further management plan in this situation?
4) What is the sequence of actions?
5) Justify the diagnosis.

Case 3. A 20-year-old primigravida (first pregnancy) was admitted to the clinic with a referral from the antenatal clinic with the diagnosis: Pregnancy 8 weeks, early pregnancy toxemia (emesis

gravidarum). Over the past 2 weeks, she has lost 2 kg of weight. In the last 24 hours, she has vomited 16 times (3 times at night). Acetone has been detected in her urine. The patient was a healthy child. Menarche at age 12, regular cycles established within a year, periods were painful, occurring every 30 days, lasting 3 days, with moderate flow. Her last menstrual period was 9 weeks ago. On admission: Temperature 37.4°C, pulse 100 bpm, satisfactory volume. BP - 100/60 mm Hg.
Questions:
1) Make a diagnosis.
2) Order investigations.
3) Prescribe treatment.
4) Justify the prescribed treatment.
5) Does the pregnant woman require hospitalization?

AI-2 PC-3.2.

Case 1. A 25-year-old patient was admitted to the clinic with complaints of mild, dull, intermittent lower abdominal pain and scant bloody discharge from the genital tract for one week. This is her third pregnancy. The two previous pregnancies ended in spontaneous abortions at 9-10 weeks of gestation. Her last menstrual period was 3 months ago. Vaginal examination revealed: The cervix is intact, the external os is closed. The uterus is enlarged to the size of an 11-12 week pregnancy, somewhat soft, mobile, and non-tender. The adnexa are not palpable. The discharge is bloody, scant.
Questions:
1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What anamnestic (historical) data is necessary to determine the cause?
4) What errors were made in the management of this pregnancy by the antenatal clinic doctor?
5) What is your further management plan?

Case 2. A multiparous woman was admitted 4 hours after the onset of labor. The pregnancy is full-term. The membranes are intact. Pulse 78 bpm, rhythmic, satisfactory volume. BP - 180/120 mm Hg. Generalized edema. Urine protein: 2 g/L. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate: 134 bpm, rhythmic, clear. Suddenly, the woman in labor complained of abdominal pain, became pale, and her pulse increased to 100 bpm. On palpation, localized tenderness is noted on the left side near the edge of the uterus. The uterus is tense and does not relax between contractions. The fetal heart rate is irregular, muffled - 90 bpm.Vaginal examination: The cervix is effaced, cervical dilation is 5 cm. The amniotic sac is intact and extremely tense. The presenting part cannot be palpated.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What errors were made by the antenatal clinic doctor?

Case 3. A 20-year-old primigravida (first pregnancy) was admitted to the clinic with a referral from the antenatal clinic with the diagnosis: Pregnancy 8 weeks, early pregnancy toxemia (emesis gravidarum). Over the past 2 weeks, she has lost 2 kg of weight. In the last 24 hours, she has vomited 16 times (3 times at night). Acetone has been detected in her urine. The patient grew up as a healthy child. Menarche at age 12, regular cycles established within a year, periods were painful, occurring every 30 days, lasting 3 days, with moderate flow. Her last menstrual period was 9 weeks ago. On admission: Temperature 37.4°C, pulse 100 bpm, satisfactory volume. BP - 100/60 mm Hg.
Questions:
1) Make a diagnosis.
2) Order investigations.
3) Prescribe treatment.
4) Justify the prescribed treatment.
5) Does the pregnant woman require hospitalization?

AI-3 PC-3.3.

Case 1. A 38-year-old patient was admitted to the gynecology department of a city hospital with complaints of heavy bloody discharge from the genital tract for two weeks, weakness, fatigue, and dizziness. History: Menstrual: Menarche at age 12. Menstruation lasts 4-5 days, every 28-30 days, heavy, painful, regular. She reports an increase in the duration and volume of her periods over the last six months. Her last menstrual period began two weeks ago, on schedule. Heavy bloody discharge has continued since then. Obstetric: One full-term vaginal delivery and two induced abortions at 8 and 10 weeks, without complications. Gynecological: During a preventive examination by an obstetrician-gynecologist a year ago, uterine fibroids were diagnosed. Contraception: None. Objective Examination: General:Condition moderately severe. Skin and visible mucous membranes are moderately pale. Vitals:Body temperature 36.7°C. Pulse 86 beats per minute, satisfactory volume, rhythmic. BP 100/70 mm Hg. Abdomen: Soft, non-tender to palpation. Peritoneal signs negative. Stool and diuresis are normal. Speculum Examination: Vaginal and cervical mucosa show no pathological changes. There is heavy bloody discharge from the cervical canal. Bimanual Examination (P.V.): Cervix: Cylindrical in shape, external os closed. Movement of the cervix is painless. Uterus: Anteverted and anteflexed, corresponds in size to an 8-week pregnancy, nodular, firm in consistency, mobile, non-tender on palpation. On the anterior wall, intramural-subserosal nodules approximately 2 cm and 6 cm in diameter are detected, non-tender on palpation. Adnexa: Unremarkable on both sides. Vaginal fornices: Clear. No infiltrates in the parametrium.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. A 36-year-old primigravida has been in labor for 16 hours. Pelvic measurements: 23-25-29-17. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate is clear, rhythmic, 130 bpm. Contractions are frequent and very painful. Vaginal examination revealed: Cervical dilation: Complete (full). Amniotic sac: Intact, extremely tense, and was artificially ruptured (amniorrhexis). A moderate amount of meconium-stained amniotic fluid was released. The fetal head is engaged at the pelvic inlet. Sagittal suture in the right oblique diameter. Small fontanelle posterior and to the right. Sacral promontory: Reachable. Diagonal conjugate: 10 cm.
Questions:
1) Most likely diagnosis.
2) Justify your diagnosis.
3) How can the true conjugate be calculated?
4) Calculate the true conjugate for this woman in labor.
5) What should be the further management plan?

Case 3. A 34-year-old multiparous woman was admitted due to bleeding. This is her third delivery, full-term. Contractions are regular, short. Fetal lie is longitudinal. Fetal heart rate is clear, rhythmic, 140 bpm. Vaginal examination revealed: Cervix: Effaced. Cervical edges: Thin. Cervical dilation: 8 cm. To the right and posteriorly, placental tissue is detected. Amniotic sac: Intact. Fetal head: Slightly engaged at the pelvic inlet. Sacral promontory: Not reachable.
Questions:
1) Make a diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) Sequence of your actions.

AI-4 PC-3.4.
Case 1. A 38-year-old woman presented to the antenatal clinic regarding discharge. Last year, two cervical cytology (Pap) smears were performed: no cellular atypia was detected. HPV test was positive; high-risk HPV was detected twice. She has not received any treatment for cervical conditions. History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless. Sexual: Sexually active since age 22, unmarried. Obstetric History: Pregnancies - 7; Deliveries - 1;

Abortions - 6. Contraception: Barrier method - condom. Gynecological History: Previously treated for gonorrhea, follow-up tests negative. Medical History: Childhood infections; ARVI. Smoker. Objective Examination: General: Condition satisfactory. Pulse 76 bpm, BP 120/80 mm Hg. Abdomen: Not distended, soft, non-tender in all quadrants. External Genitalia: Unremarkable. Speculum Exam: Vaginal mucosa pink. On the cervix, a localized epithelial change is noted on the posterior lip, measuring 1.5 cm in diameter. Discharge is mucous, moderate. Bimanual Exam (PV): Uterus is anteverted and anteflexed, normal size, firm, mobile, non-tender. Adnexa are not palpable. Fornices are clear.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. A 25-year-old patient was admitted to the clinic with complaints of mild, dull, intermittent lower abdominal pain and scant bloody discharge from the genital tract for one week. This is her third pregnancy. The two previous pregnancies ended in spontaneous abortions at 9-10 weeks of gestation. Her last menstrual period was 3 months ago. Vaginal examination revealed: The cervix is intact, the external os is closed. The uterus is enlarged to the size of an 11-12 week pregnancy, somewhat soft, mobile, and non-tender. The adnexa are not palpable. The discharge is bloody, scant. Questions:
1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What anamnestic (historical) data is necessary to determine the cause?
4) What errors were made in the management of this pregnancy by the antenatal clinic doctor?
5) What is your further management plan?

Case 3. A multiparous woman was admitted 4 hours after the onset of labor. The pregnancy is full-term. The membranes are intact. Pulse 78 bpm, rhythmic, satisfactory volume. BP - 180/120 mm Hg. Generalized edema. Urine protein: 2 g/L. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate: 134 bpm, rhythmic, clear. Suddenly, the woman in labor complained of abdominal pain, became pale, and her pulse increased to 100 bpm. On palpation, localized tenderness is noted on the left side near the edge of the uterus. The uterus is tense and does not relax between contractions. The fetal heart rate is irregular, muffled - 90 bpm. Vaginal examination: The cervix is effaced, cervical dilation is 5 cm. The amniotic sac is intact and extremely tense. The presenting part cannot be palpated.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What errors were made by the antenatal clinic doctor?

AI-1 PC-4.1.
Case 1. A 35-year-old woman presented to the antenatal clinic with complaints of itching in the external genital area, and copious, whitish vaginal discharge with a strong, unpleasant "fishy" odor. History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless. Sexual: Sexually active since age 18, married. Obstetric History: Pregnancies - 2; Deliveries - 1 (2 years ago, without complications); Abortions - 1 (medical termination of pregnancy 3 months ago, without complications). Gynecological History: Denies gynecological diseases. Medical History: Childhood infections; ARVI; chronic gastritis. Objective Examination: General: Condition satisfactory. Pulse 76 bpm, BP 120/80 mm Hg. Abdomen: Not distended, soft, non-tender in all quadrants. External Genitalia: Normally developed, without specific lesions or signs of inflammation. Speculum Examination: Vaginal and cervical mucosa are pink. Discharge is copious, homogeneous, whitish-gray, with a strong, unpleasant "fishy" odor. Bimanual Examination (PV): Uterus is anteverted and anteflexed, normal size, firm, mobile, non-tender. Adnexa are not palpable. Fornices are clear.
Questions:

1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. Patient: A 25-year-old female, brought to the gynecology department by ambulance with complaints of pain in the lower abdomen on the right, nausea, dizziness, and spotting. The illness began suddenly 6 hours ago with the onset of lower abdominal pain radiating to the rectum; she reports a 2-week delay in her menstrual period. History: One pregnancy ended in full-term delivery, another in an induced abortion at 10 weeks; the abortion was complicated by an inflammatory process of the uterus and adnexa. Condition on admission: Satisfactory; pulse 90 bpm, BP 110/70 mm Hg; skin and visible mucous membranes are pale pink. The abdomen is of normal shape, with some tension of the abdominal wall muscles on the right. The Shchetkin-Blumberg sign is weakly positive. Speculum examination: Slight cyanosis of the vaginal and cervical mucosa; pupil sign (-); dark bloody, scanty discharge. Vaginal examination: The uterus is slightly enlarged, of doughy consistency; displacement is sharply painful. To the right of the uterus, in the adnexal region, tissue pastiness and sharp tenderness are noted. The posterior fornix is bulging and tender on palpation.
Questions:
1. Most likely diagnosis.
2. Justify the diagnosis you have made.
3. What should be the further management?
4. Formulate the rationale for your chosen management strategy.
5. What is the sequence of your actions?

Case 3. Patient S., 36 years old, primigravida. Pelvic dimensions: 24, 26, 29, 18 cm. History: infertility for 8 years. Admitted to the antenatal department at full term. The fetus is in a breech presentation. Estimated fetal weight 4250 g.
Questions:
1) Formulate the diagnosis.
2) Justify your diagnosis.
3) What should be the further management?
4) Formulate the rationale for choosing this management.
5) Outline a plan for further management.

AI-2 PC-4.2.
Case 1. Patient, 48 years old, admitted to the gynecology department as an emergency with complaints of lower abdominal pain, fever up to 38-38.9°C with chills, and purulent discharge from the genital tract. Considers herself ill for the last three weeks, when she experienced nagging lower abdominal pain and periodic rises in body temperature to 37.2-37.5°C; she did not consult a doctor and took No-Spa and Pentalgin with slight positive effect. Due to increased pain, fever up to 39.0°C, and the onset of chills, she called an ambulance and was hospitalized. Her last gynecological examination was 15 years ago. Gynecological history: Menarche at age 12, menstruation for 5 days every 28 days, regular, moderate, painless. Last menstruation was 3 weeks ago. Pregnancies - III, Deliveries - I (without complications), Abortions - II (without complications). Sexually active since age 18, married. Has had 2 sexual partners. Contraception: IUD for the last 15 years. Denies gynecological diseases. Chronic diseases: denies. Past surgeries: denies. History of tuberculosis, hepatitis, venereal diseases, HIV, or blood transfusion is denied. Objective examination: Condition is moderate. Skin is clear, pulse 96/min, BP 110/70 mm Hg. RR - 19. Tongue is dry, coated with white coating. The abdomen is distended, tender in the lower quadrants. Peritoneal signs are weakly positive in the lower abdomen. Bowel sounds are audible. Had one episode of loose stool 12 hours ago. Urination is free and painless. Gynecological examination: Speculum: Vaginal walls are hyperemic, cervical epithelium appears visually unchanged. IUD strings are visible protruding from the cervical canal. Discharge is purulent, copious. Bimanual: The cervix is cylindrical in shape. The uterus is of normal size and shape, firm, mobile, non-tender. Right adnexa are not enlarged, stringy, moderately tender on palpation. To the left of the uterus, a mass measuring 8 x 7 x 7 cm is palpated, with limited mobility, tender on palpation. Movement of the cervix is painful.

Questions:
1) Provisional/most likely diagnosis.
2) What additional tests are needed to clarify the diagnosis?
3) Justify the diagnosis you have made.
4) What is your further therapeutic management?
5) Formulate the rationale for your chosen management.

Case 2. Patient M., 40 years old, admitted to the gynecology department with a referral from a women's consultation doctor. The patient complains of yellow vaginal discharge. History: Family history is non-contributory. She has had three pregnancies, one of which ended in normal childbirth, and the other two in induced abortions (at 8 and 10 weeks) without complications. Speculum examination: The vaginal mucosa is hyperemic. Whitish areas with clear borders are present on the posterior lip of the cervix. Bimanual examination: The cervix is cylindrical in shape. The uterine body is of normal size, mobile. The adnexal region is clear, non-tender. Vaginal discharge is yellow, frothy. Microbiological examination: Frothy yellow discharge in the vaginal smear. Bacterioscopic examination: Mixed flora and Trichomonas vaginalis in the vaginal smear. Colposcopy: Revealed two whitish areas measuring 1*1.5 cm, located on the anterior and posterior lips, which gave a negative iodine reaction when treated with Lugol's solution.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have made.
3) What should be the further management?
4) Formulate the rationale for your chosen management.
5) Prescribe treatment.

Case 3. Citizen K., a 30-year-old multiparous woman, was admitted to the maternity hospital. She has been in labor for 10 hours. Pelvic measurements: 26, 29, 30, 18 cm. The fetal position is oblique, the head is on the right, fetal heart sounds are clear, rhythmic, 140 beats per minute. Vaginal examination revealed: Cervical dilation 6 cm, cervical edges thin and pliable. Amniotic sac is intact. A pulsating loop of the umbilical cord is presenting. The sacral promontory is reachable. Diagonal conjugate is 11 cm.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) Calculate the true conjugate.
4) What should be the further management?
5) Formulate the rationale for your chosen management.

AI-1 PC-5.1.
Case 1. A 26-year-old primiparous woman on the 4th day after her first full-term spontaneous vaginal delivery. The delivery was complicated by a 14-hour rupture of membranes interval and a manual removal of retained placental fragments. She presents with complaints of weakness, chills, and fever up to 39.4°C. History: Menarche at 14, menses lasting 3-5 days every 29-31 days, moderate, painless, regular. History includes 2 induced abortions up to 12 weeks without complications. Registered at the antenatal clinic from 10 weeks of pregnancy, attended regularly. Weight gain during pregnancy was 12 kg, steady. The current pregnancy was uncomplicated. Objective examination: Condition satisfactory. Skin and visible mucous membranes are of normal color. Pulse 94 beats per minute, satisfactory volume, rhythmic. BP 110/70 mm Hg. Body temperature 38.6°C. Lactation is sufficient. Milk expression is extremely difficult and painful. Both mammary glands are diffusely hyperemic, tender on palpation. Nipples are clean. Abdomen is soft on palpation, non-tender. The uterus is firm, non-tender on palpation. The fundal height is 3 fingerbreadths below the umbilicus. Lochia is serosanguineous, moderate.
Questions:
1) Formulate a preliminary diagnosis.
2) Are any additional diagnostic tests necessary?
3) Further management of the puerperal woman in this case.
4) Justify the further management plan.

5) Justify the diagnosis.

Case 2. A 28-year-old primiparous woman on the 5th day after her first full-term spontaneous vaginal delivery, which proceeded without complications, presents with complaints of weakness, chills, fever up to 39.1°C, and a bursting pain in the left breast. History: Menarche at 13, menses lasting 3-5 days every 29-31 days, moderate, painless, regular. History includes 3 induced abortions up to 12 weeks without complications. Registered at the antenatal clinic from 11 weeks of pregnancy, attended regularly. Weight gain during pregnancy was 11 kg, steady. The current pregnancy was complicated by threatened miscarriage (hospitalizations at 14 and 24 weeks of gestation) and an upper respiratory viral infection at 34 weeks with fever up to 37.4°C. Objective examination: Condition is moderate. Tongue is dry, coated with white fur. Pulse 102 beats per minute, tense, rhythmic. BP 120/80 mm Hg. Body temperature 39.1°C. The left breast is enlarged, edematous, with erythema of the skin. In the lower-outer quadrant, a fluctuant area measuring 4x4x3 cm is palpated, sharply tender on palpation. The right breast is enlarged, skin color is normal. Milk expression from both breasts is difficult and painful. Both nipples have fissures. Abdomen is soft on palpation, non-tender. The uterus is firm, non-tender on palpation; the fundal height is midway between the umbilicus and the symphysis pubis. Lochia is serosanguineous, scant.
Questions:
1) Formulate a preliminary diagnosis.
2) Are any additional diagnostic tests necessary?
3) Further management of the puerperal woman in this case.
4) Justify the further management plan.
5) Justify the diagnosis.

Case 3. Citizen F., 36 years old, second full-term delivery. History of 4 induced abortions. Gave birth to a full-term infant 30 minutes ago. The placenta has not been delivered, and there is no bleeding.
Questions:
1) Most likely diagnosis.
2) What needs to be done in this situation?
3) The sequence of your actions.
4) Formulate the rationale for your chosen management.
5) Justify the diagnosis.

Evaluation criteria, grading scale for situational tasks

Grade		**Description**
«excellent»	5	Explanation of the solution to the situational task is detailed, sequential, competent, with theoretical justifications, necessary schematic diagrams and visual demonstrations, with correct and fluent use of terminology; answers to additional questions are correct and clear
«good»	4	Explanation of the solution to the situational task is detailed but insufficiently logical, with isolated errors in details, some difficulties in theoretical justification, schematic diagrams, and visual demonstrations; answers to additional questions are correct but insufficiently clear
«satisfactory»	3	Explanation of the solution to the situational task is insufficiently complete, inconsistent, with errors, weak theoretical justification, with significant difficulties and errors in schematic diagrams and visual demonstrations; answers to additional questions are insufficiently clear, with errors in details
«unsatisfactory»	2	Explanation of the solution to the situational task is incomplete, inconsistent, with critical errors, lacking theoretical justification, without the ability to create schematic diagrams and visual demonstrations or with a large number of errors; answers to additional questions are

		incorrect or absent

2.6. Academic Medical History (Case History) - 9 semester

1. Formatting the title page of the academic medical history
2. Content of the academic medical history in accordance with the requirements of the methodological guidelines.
3. Description of the labor management process and management of patients.

Grade		Description
«excellenet»	5	All requirements for writing and defending the medical history have been fulfilled: the medical history has been collected in full, the course of the disease is reflected, information on the results of previously conducted examinations and treatment effectiveness is provided, all necessary laboratory and instrumental research methods for this disease are presented, the dynamics of indicators are reflected, the interpretation of results is correct, the justification of the diagnosis includes all necessary anamnestic (including complaints), objective, and laboratory data, the diagnosis of the main disease, its complications, and concomitant pathology is justified in accordance with the classification. The required volume is maintained, and requirements for external formatting are met
«good»	4	The main requirements for the medical history and its defense have been fulfilled, but there are shortcomings; in particular, there are inaccuracies in the presentation of the material: the medical history is not collected in full, the course of the disease is not reflected, results of some research methods essential for diagnosing this disease are missing, there are remarks regarding the interpretation of results, and incomplete answers were given during the defense
«satisfactory»	3	There are significant deviations from the requirements for formatting the medical history, in particular, the medical history is not neatly formatted, there are corrections, stylistic and grammatical errors, results of some research methods essential for diagnosing this disease are missing, and there are remarks regarding the interpretation of the results
«unsatisfactory»	2	The medical history has not been submitted. The medical history is collected superficially and does not allow for an assessment of the course of the disease or the effectiveness of previously administered treatment. The medical history is carelessly formatted, containing incomplete sentences and significant stylistic and grammatical errors.

2.7. Academic birth history - 10 semester

1. Formatting the title page of the academic medical history.
2. Content of the academic medical history in accordance with the requirements of the methodological guidelines.
3. Description of the patient management process.

Grade		Description
«excellent»	5	The work fully meets the requirements and format of the labor and delivery history. It is written competently, in literary

		language, using modern medical terminology. The student is able to consciously and promptly transform acquired knowledge when characterizing theoretical, clinical-diagnostic, and therapeutic aspects of the discipline "Obstetrics and Gynecology."
«good»	4	In the Labor and Delivery History, the student makes some inaccuracies in formulating the detailed clinical diagnosis, examination, and treatment.
«satisfactory»	3	The Labor and Delivery History is formatted with errors, written in illegible handwriting, contains inaccuracies in formulating the detailed clinical diagnosis and treatment, and the pathogenesis of the disease is not fully covered.
«unsatisfactory»	2	The Labor and Delivery History is written in illegible handwriting, contains critical errors (the detailed clinical diagnosis is not established or justified, treatment is incorrectly prescribed, the pathogenesis of the disease is not covered). The Labor and Delivery History has not been submitted.

3. Procedure for conducting current (ongoing) control

Current progress monitoring in the discipline is conducted in the form of: answering control questions, solving test tasks, situational tasks, writing a medical history and a labor and delivery history, and demonstrating practical skills.

4. Examples of assessment tools and evaluation criteria for conducting intermediate certification.

4.1. Sample list of control questions for exam preparation:

AI-1 GPC-4.1.
1. Dysfunctional uterine bleeding. Clinical forms. Principles of therapy.
2. Inflammatory diseases of the female genital organs in the lower genital tract. Clinical presentation. Diagnosis. Treatment.
3. Inflammatory diseases of the female genital organs in the upper genital tract. Clinical presentation. Diagnosis. Treatment.
AI-2 GPC-4.2.
1. Pregnancy with cardiovascular diseases. Features of the course and management of pregnancy. Indications for antenatal hospitalization.
2. Features of the course and management of pregnancy in kidney diseases.
3. "Acute abdomen" in pregnant women. Causes, clinical presentation, diagnosis, treatment.
AI-3 GPC-4.3.
1. Infected and septic abortion. Bacterial-toxic shock. Etiology. Pathogenesis. Clinical presentation. Diagnosis. Treatment.
2. Modern methods of contraception. Family planning.
3. Endometriosis. Etiology, pathogenesis, classification, clinical presentation, diagnosis. Principles of endometriosis treatment.
AI-4 GPC-4.4.
1. Pregnancy termination procedures. Indications and requirements. Contraindications. Methods of pregnancy termination. Complications.
2. Uterine fibroids (leiomyoma). Etiology, classification, clinical presentation, diagnosis. Indications for surgical treatment methods. Surgical technique. Conservative treatment of uterine fibroids: indications, treatment regimens.
3. Benign diseases and conditions of the cervix. Diagnosis. Treatment methods.
AI-1 GPC-5.1.

1. Intrauterine infections. Etiology and pathogenesis. Risk groups. Clinical presentation. Diagnosis, treatment, prevention.
2. Causes, risk groups, and management of preterm labor. Concept of fetal maturity and term. Prevention of respiratory distress syndrome.
3. Preeclampsia. Etiology and pathogenesis. Classification. Clinical picture of severe preeclampsia. Obstetric management and therapy. General principles of intensive care, management of labor in severe preeclampsia.

AI-2 GPC-5.2.

1. Eclampsia. Factors contributing to the development of eclampsia. Clinical forms, differential diagnosis, complications of eclampsia. Emergency care for eclampsia.
2. Immunological relationship between mother and fetus. Principles of managing pregnancy and childbirth in Rh immunization.
3. Placenta previa. Classification, differential diagnosis. Possible complications. Obstetric management.

AI-3 GPC-5.3.

1. Definition of an anatomically narrow pelvis. Classification. Features of labor management.
2. Definition of a clinically narrow pelvis. Causes, clinical presentation, timely diagnosis, obstetric management. Complications.
3. Birth trauma in the mother. Uterine rupture. Etiology and pathogenesis. Classification. Clinical presentation, diagnosis and treatment of uterine rupture.

AI-1 GPC-7.1.

1. Hyperplastic processes of the endometrium. Endometrial precancer. Pathogenesis, clinical presentation, diagnosis, treatment.
2. Endometrial cancer. Etiology, pathogenesis, classification, clinical presentation, diagnosis. Treatment.
3. Ovarian tumors. Classification. Diagnosis, differential diagnosis, treatment.

AI-2 GPC-7.2.

1. "Acute abdomen" in gynecology. Causes, clinical presentation, diagnosis, treatment.
2. Prolapse of female genital organs. Causes. Treatment. Prevention.
3. Neuroendocrine syndromes in gynecology.

AI-3 GPC-7.3.

1. Trophoblastic disease: hydatidiform mole, choriocarcinoma. Clinical presentation, diagnosis. Treatment. Prognosis.
2. Infertile marriage. Causes of female infertility. Examination methods.
3. Ectopic pregnancy. Etiology, pathogenesis, clinical presentation, differential diagnosis. Treatment. Prevention.

AI-4 GPC-7.4.

1. Precancerous conditions of the cervix. Etiology. Diagnosis. Treatment methods.
2. Cervical cancer. Diagnosis. Clinical presentation. Stages of the disease. Treatment methods for patients with cervical cancer.
3. Malignant ovarian tumors. Etiology, pathogenesis, classification, clinical presentation, diagnosis. Treatment methods.

AI-1 PC-2.1.

1. Pathogenesis, clinical presentation, diagnosis, treatment of hyperemesis gravidarum (vomiting of pregnancy).
2. Clinical course of labor. Modern methods of labor analgesia. Methods for assessing fetal status during pregnancy and labor.
3. Course and management of the postpartum period.

AI-2 PC-2.2.

1. Classification of postpartum diseases according to Sazonov-Bartels. Features of the course of septic postpartum infection in modern conditions. Postpartum metroendometritis. Clinical presentation, diagnosis, treatment. Lactational mastitis. Etiology, clinical presentation, diagnosis, treatment, prevention.
2. Extension presentations of the fetal head. Classification. Diagnosis. Course and management of labor.
3. Breech presentations of the fetus. Features of antenatal care in the women's consultation and management of labor. Modern methods of delivery.

AI-3 PC-2.3.
1. Multiple pregnancy. Diagnosis. Features of the course of pregnancy and labor. Physician's management.
2. Fetal hypoxia. Causes. Diagnosis. Obstetric management. Assessment of the newborn's condition.
3. Premature abruption of a normally situated placenta. Causes. Clinical presentation and diagnosis. Treatment. Complications.
AI-4 PC-2.4.
1. Bleeding in the third stage of labor and postpartum period. Etiology. Diagnosis. Physician's management.
2. Bleeding in the postpartum period. Etiology. Diagnosis. Physician's management.
3. Delivery operations in modern practice. Indications. Technique. Complications.
AI-5 PC-2.5.
1. Management of pregnancy and childbirth in the presence of a uterine scar. Concept of an "incompetent" uterine scar.
2. Amenorrhea and hypomenstrual syndrome. Etiology, clinical forms, principles of therapy.
3. Tuberculosis of the female genital organs. Clinical presentation. Diagnosis. Treatment.
AI-1 PC-3.1.
1. Infections transmitted sexually (trichomoniasis, gonorrhea, chlamydia, genital herpes. HPV infection. HIV infection).
2. Miscarriage. Causes. Spontaneous abortion. Stages of abortion. Physician's management depending on the stage of abortion.
3. Extension presentations of the fetal head. Classification. Diagnosis. Course and management of labor.
AI-2 PC-3.2.
1. Precancerous conditions of the cervix. Etiology. Diagnosis. Treatment methods.
2. Cervical cancer. Diagnosis. Clinical presentation. Stages of the disease. Treatment methods for patients with cervical cancer.
3. Malignant ovarian tumors. Etiology, pathogenesis, classification, clinical presentation, diagnosis. Treatment methods.
AI-3 PC-3.3.
1. Eclampsia. Factors contributing to the development of eclampsia. Clinical forms, differential diagnosis, complications of eclampsia. Emergency care for eclampsia.
2. Immunological relationship between mother and fetus. Principles of managing pregnancy and childbirth in Rh immunization.
3. Placenta previa. Classification, differential diagnosis. Possible complications. Obstetric management.
AI-4 PC-3.4.
1. Dysfunctional uterine bleeding. Clinical forms. Principles of therapy.
2. Inflammatory diseases of the female genital organs in the lower genital tract. Clinical presentation. Diagnosis. Treatment.
3. Inflammatory diseases of the female genital organs in the upper genital tract. Clinical presentation. Diagnosis. Treatment.
AI-1 PC-4.1.
1. Management of pregnancy and childbirth in the presence of a uterine scar. Concept of an "incompetent" uterine scar.
2. Amenorrhea and hypomenstrual syndrome. Etiology, clinical forms, principles of therapy.
3. Tuberculosis of the female genital organs. Clinical presentation. Diagnosis. Treatment.
AI-2 PC-4.2.
1. Classification of postpartum diseases according to Sazonov-Bartels. Features of the course of septic postpartum infection in modern conditions. Postpartum metroendometritis. Clinical presentation, diagnosis, treatment. Lactational mastitis. Etiology, clinical presentation, diagnosis, treatment, prevention.
2. Extension presentations of the fetal head. Classification. Diagnosis. Course and management of labor.
3. Intrauterine infections. Etiology and pathogenesis. Risk groups. Clinical presentation. Diagnosis, treatment, prevention.
AI-1 PC-5.1.

1. Pathogenesis, clinical presentation, diagnosis, treatment of hyperemesis gravidarum (vomiting of pregnancy).
2. Clinical course of labor. Modern methods of labor analgesia. Methods for assessing fetal status during pregnancy and labor.
3. Course and management of the postpartum period.

Evaluation criteria, grading scale for control questions

Grade		Description
«excellent»	5	Knows the entire educational material, has an excellent understanding and has firmly mastered it. Gives correct, conscious, and confident answers to questions (within the curriculum). Uses literary correct language in oral answers and does not make errors
«good»	4	Knows all the required educational material, understands it well, and has firmly mastered it. Answers questions (within the curriculum) without difficulty. Uses literary language in oral answers and does not make critical errors
«satisfactory»	3	Knows the main educational material. Answers questions (within the curriculum) with difficulty. In oral answers, makes errors in presenting the material and in speech construction
«unsatisfactory»	2	Does not know most of the educational material, usually only answers leading questions from the instructor, with uncertainty. Makes frequent and critical errors in oral answers.

4.2. Examples of cases

AI-1 GPC-4.1.
Case 1. A 26-year-old postpartum woman, on the 4th day after her first full-term vaginal delivery, presents with complaints of weakness, chills, and fever up to 39.4°C. The delivery was complicated by a 14-hour period of ruptured membranes and a manual removal of a retained placental lobe.
History: Menarche at age 14, menstruation lasts 3-5 days, cycle 29-31 days, moderate, painless, regular. Past history: 2 induced abortions before 12 weeks, without complications. Registered for prenatal care from 10 weeks of gestation and attended regularly. Weight gain during pregnancy was 12 kg, steady. The current pregnancy was uncomplicated.Objective examination: Condition is satisfactory. Skin and visible mucous membranes are of normal color. Pulse 94 beats per minute, satisfactory volume, rhythmic. BP 110/70 mm Hg. Body temperature 38.6°C. Lactation is sufficient. Milk expression is extremely difficult and painful. Both mammary glands are diffusely hyperemic and tender on palpation. Nipples are clear. Abdomen is soft and non-tender on palpation. Uterus is firm, non-tender on palpation. The uterine fundus is located 3 fingerbreadths below the umbilicus. Vaginal discharge is serosanguineous, moderate.
Questions:
1) Formulate a preliminary diagnosis.
2) Are any additional examination methods necessary?
3) Further management tactics for this postpartum woman.
4) Justify the further management tactics.
5) Justify the diagnosis.

Case 2. A 43-year-old female patient was brought by ambulance to the emergency department of a city hospital with complaints of sharp lower abdominal pain, nausea, vomiting, and abdominal ...distention, which began 3 hours ago after physical exertion.From the medical history: Menarche at age 13. Menstruation occurs every 28 days, lasting 5-7 days, is heavy, painless, and regular. She reports an increase in the duration and heaviness of her periods over the past year. Her last menstrual period started 9 days ago, on schedule.Past medical history: 2 full-term vaginal deliveries and 1 induced abortion at 8 weeks gestation, performed three years ago without complications. During a routine check-up with an obstetrician-gynecologist 2 years ago, uterine fibroids were diagnosed, corresponding in size to an 8-week pregnancy.Objective findings:The patient's condition is moderately severe. Skin and visible mucous membranes are moderately pale. Body temperature is 37.7°C. Pulse is

100 beats per minute, of satisfactory volume and rhythm. Blood pressure is 120/70 mm Hg. The abdomen is moderately distended and tender to palpation in the lower quadrants. Positive peritoneal signs are present there. On speculum examination: The vaginal and cervical mucosa show no pathological changes. There is scant dark bloody discharge from the cervical canal.
Bimanual vaginal examination (P.V.): The cervix is cylindrical in shape, the external os is closed. Cervical motion tenderness is present. The uterine body is anteverted and anteflexed, corresponds in size to a 14-week pregnancy, is nodular, firm in consistency, mobile, and tender on palpation. On the anterior wall, there is a subserosal nodule 4 cm in diameter, which is exquisitely tender. Adnexa on both sides are unremarkable. The vaginal fornices are clear. No infiltrates are noted in the parametrium.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 3. A 40-year-old woman presented to the women's clinic with complaints of copious, purulent, creamy-white vaginal discharge and urinary symptoms that appeared immediately after her period. Last month, she had unprotected sexual intercourse with a casual partner.History: Menarche at age 14. Menstruation occurs every 28 days, lasts 4 days, is regular, moderate, and painless. Her last menstrual period began 6 days ago. Sexually active since age 17, currently married.Obstetric-Gynecologic History: Pregnancies - 3; Deliveries - 2; Abortions - 1.Contraception: Combined oral contraceptives (Yarina).Gynecological History: Chronic salpingo-oophoritis, last exacerbation 1 year ago.Past Medical History: Childhood infections; Acute respiratory viral infections (ARVI).Objective Examination: Patient's condition is satisfactory. Pulse 76 beats per minute. Blood pressure 120/80 mm Hg. Abdomen is not distended, soft and non-tender to palpation in all quadrants. The external urethral meatus is hyperemic, edematous, with mucopurulent discharge.Speculum Examination: The vaginal and cervical mucosa is hyperemic and edematous. On the cervix, there is an epithelial defect in the form of a red spot with sharply defined edges; its base is covered with a purulent coating. Discharge is purulent, grayish, and creamy.Bimanual Examination (PV): The uterus is anteverted and anteflexed, normal in size, firm, mobile, non-tender. Adnexa are not palpable.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

AI-2 GPC-4.2.
Case 1. A 28-year-old postpartum woman, on the 5th day after her first full-term, uncomplicated vaginal delivery, presents with complaints of weakness, chills, fever up to 39.1°C, and bursting pain in the left breast.History: Menarche at age 13. Menstruation lasts 3-5 days, every 29-31 days, moderate, painless, regular.Past Medical History: 3 induced abortions before 12 weeks of gestation, without complications. Registered for prenatal care from 11 weeks of gestation, attended regularly. Weight gain during pregnancy was 11 kg, steady.
Current Pregnancy: Complicated by threatened miscarriage (hospitalizations at 14 and 24 weeks of gestation) and an upper respiratory tract infection (URTI) at 34 weeks with a fever up to 37.4°C.

Objective Examination: The patient's condition is of moderate severity. The tongue is dry, coated with a white film. Pulse is 102 beats per minute, full, rhythmic. Blood pressure is 120/80 mm Hg. Body temperature is 39.1°C.The left breast is enlarged, edematous, and the skin of the breast is erythematous (reddened). In the lower outer quadrant, an area of fluctuation measuring 4x4x3 cm is noted, which is exquisitely tender to palpation. The right breast is enlarged, with skin of normal color. Milk expression from both breasts is difficult and painful. Both nipples have fissures.
The abdomen is soft and non-tender to palpation. The uterus is firm and non-tender to palpation; the uterine fundus is located midway between the umbilicus and the symphysis pubis. Vaginal discharge is serosanguineous (blood-tinged), scant.

Questions:
1) Formulate a preliminary diagnosis.
2) Are any additional diagnostic tests necessary?
3) What is the further management plan for this postpartum patient?
4) Justify the chosen management plan.
5) Justify the diagnosis.

Case 2. A 26-year-old woman presented to the women's clinic with complaints of copious, mucopurulent vaginal discharge, itching and burning in the vaginal area, and discomfort during urination.History: Menarche at age 13. Menstruation occurs every 28 days, lasts 5 days, is regular, moderate, and painless. Sexually active since age 19.Obstetric History: Pregnancies - 0.
Contraception: Combined oral contraceptives (Lindinet-20), started six months ago; prior contraception was barrier methods.History of Present Illness: One week ago, she had unprotected sexual intercourse with a casual partner. Denies any history of gynecological diseases.
Past Medical History: Childhood infections; Acute respiratory viral infections (ARVI).Objective Examination: Patient's condition is satisfactory. Pulse 76 beats per minute. Blood pressure 120/80 mm Hg. Abdomen is not distended, soft and non-tender to palpation in all quadrants. External genitalia are normally developed, without specific lesions.Speculum Examination: The vaginal and cervical mucosa is hyperemic and edematous. The discharge is mucopurulent.Bimanual Examination (PV): The uterus is anteverted and anteflexed, normal in size, firm, mobile, non-tender. Adnexa are not palpable. The vaginal fornices are deep and clear.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 3. A 36-year-old female patient was admitted to the gynecology department as an emergency with complaints of lower abdominal pain, frequent urination, fever up to 38-38.5°C with chills, and copious creamy discharge from the genital tract.She considers herself ill for two days, when immediately after her menstrual period, she developed discharge and gradually increasing lower abdominal pain, frequent urination, and a body temperature rise to 37.5°C. She did not seek medical attention and took No-shpa and Pentalgin with minimal positive effect. Due to worsening of her condition and an increase in body temperature with chills, she called an ambulance and was hospitalized.From the history, it is known that three weeks ago she had unprotected casual sexual intercourse.Gynecological History: Menarche at age 13. Menstruation lasts 3 days, every 28 days, is regular, moderate, and painful. Her last menstrual period started on time, 5 days ago. Sexually active since age 17, unmarried.Contraception: Condom (not always). Denies gynecological diseases.Obstetric History: Pregnancies - 2; Deliveries - 1 (without complications); Abortions - 1 (without complications).Medical History: Denies chronic diseases. Denies previous surgeries. Denies history of tuberculosis, hepatitis, sexually transmitted diseases, HIV, or blood transfusions.
Objective Examination: Condition: Moderately severe. Skin:Clean, pale.Pulse: 86/min. Blood Pressure: 110/70 mm Hg.Tongue: Dry, coated with a white film. Abdomen: Moderately distended, tender in the lower quadrants. Peritoneal signs are positive in the lower quadrants.Stool: Regular, formed. Urination: Independent, painless.
Gynecological Examination:Speculum Examination: The mucosa of the vagina and cervix is hyperemic. The cervical epithelium...is visually covered with unaltered epithelium. Discharge from the cervical canal is purulent, copious.Bimanual Vaginal Examination (PV):The cervix is cylindrical in shape. Traction on the cervix is painful.The uterine body is of normal size, firm.The adnexa are thickened and cannot be clearly delineated due to severe tension and tenderness of the anterior abdominal wall.The posterior vaginal fornix is bulging and exquisitely tender on palpation.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?

5) Formulate the rationale for your chosen management plan.

AI-3 GPC-4.3.

Case 1. Patient F., 36 years old, second pregnancy, full-term delivery. History of 4 induced abortions. Delivered a full-term infant 30 minutes ago. The placenta has not been delivered, there is no bleeding.
Questions:
1) Most likely diagnosis.
2) What needs to be done in this situation?
3) Sequence of your actions.
4) Formulate the rationale for your chosen management.
5) Provide justification for the diagnosis.

Case 2. A 25-year-old female patient was admitted to the gynecology department on an emergency basis with complaints of lower abdominal pain and a body temperature of up to 38.0°C.

She reports being ill for three days, during which she developed dull, aching lower abdominal pain, weakness, and a fever of up to 38.0°C. She took No-Spa, Spazmalgon, and Paracetamol without significant improvement. Due to worsening pain, she called an ambulance and was hospitalized.Gynecological History:Menstrual History: Menarche at age 13. Menses last 4-5 days, every 28 days, regular, moderate, painless. Her last menstrual period started on time, 7 days ago.Sexual History: Sexually active since age 19, married.Contraception: None.Gynecological History: Denies any gynecological diseases.Obstetric History: Pregnancies - 2; Deliveries - 1 (without complications); Abortions - 1 (without complications) Medical History: Chronic gastritis. Past surgery: Laparoscopic appendectomy (2010). Denies history of tuberculosis, hepatitis, sexually transmitted diseases, HIV, or blood transfusions.Objective Examination:General Condition: Satisfactory.Skin: Clean, normal color.Vitals at Exam: Temperature: 37.7°C; Pulse: 86/min; Blood Pressure: 120/70 mm Hg.Tongue: Clean, moist.Abdomen: Soft, tender to palpation in the lower quadrants. Peritoneal signs negative.Bowel/Bladder: Formed stool. Independent, painless urination.Genital Discharge: Scant, purulent.Gynecological Examination:Speculum Exam (PS): Vaginal and cervical mucosa show no pathological changes.Bimanual Exam (PV): Cervix is cylindrical, external os closed. Uterine body is normal in size, firm, mobile, non-tender. Adnexa on both sides are thickened (indurated), exquisitely tender on palpation. Vaginal fornices are clear.
Questions:
1) Formulate a presumptive (preliminary) diagnosis.
2) What additional examinations are necessary for this patient?
3) Justify the diagnosis.
4) What should be the further management plan?
5) Prescribe treatment.

Case 3. Patient M., 54 years old, was admitted to the gynecology department with complaints of irregular vaginal bleeding for one year.History: She has had two normal vaginal deliveries and three induced (medical) abortions (at 8-10 weeks of gestation). She has been in menopause for 4 years. Two years ago, a diagnostic curettage of the uterine cavity was performed due to spotting. Histology: Solitary glandular endometrial polyps. Treatment was administered with 17-hydroxyprogesterone caproate (125 mg daily for 6 months). A follow-up diagnostic curettage of the uterine cavity revealed no pathological proliferation. One year later, irregular bleeding recurred, which is the reason for her current admission to the gynecology department. Осмотр при помощи зеркал: The cervix is somewhat edematous. Its mucosa has a cyanotic hue. The external os is closed. From the cervical canal there is a moderate amount of bloody discharge.Vaginal Examination: The cervix is cylindrical in shape and mobile. The uterine body is of normal size, mobile, and non-tender. The adnexal regions are clear and non-tender.Rectal Examination: No tumor formations or infiltrates are detected in the pelvis.A curettage of the uterine cavity was performed, yielding an abundant amount of tissue.Histological Examination: The curettage specimen revealed endometrial hyperplasia. Isolated glandular tissue cells are large, with hyperchromatically stained nuclei. The contours of these nuclei are irregular (cells with signs of atypia).
Questions:
1) What is the most likely diagnosis?

2) What should your further management plan be?
3) Justify your chosen management plan.
4) Formulate a plan for further treatment.
5) Justify your diagnosis.

AI-4 GPC-4.4.

Case 1. Patient I., 20 years old, was brought by ambulance in an unconscious state. First pregnancy, gestational age - 36 weeks. Generalized edema of the body. According to relatives, she had severe headaches for the last two days. She had two seizure episodes at home. A third seizure occurred in the emergency room.

Questions:

1) Make a diagnosis.
2) What needs to be done in this situation?
3) Sequence of actions when providing care.
4) Formulate a plan for further treatment.
5) What should the further management plan be?

Case 2. A 32-year-old patient was admitted to the clinic with complaints of heavy bleeding and cramping lower abdominal pain that began 4 hours ago.This is her second pregnancy. Her first pregnancy ended in a preterm delivery at 30 weeks of gestation. The baby died one day later. Her last menstrual period was 2 months ago.On vaginal examination: The cervix is shortened. The cervical canal is freely passable for one finger past the internal os, where blood clots are detected. The uterus is enlarged to the size of a 6-7 week pregnancy, firm, mobile, and painless. The adnexa are not palpable. The discharge is bloody, heavy, and contains clots.

Questions:

1) What is the most likely diagnosis?
2) What anamnestic (historical) data is necessary to determine the cause of this condition?
3) Justify your diagnosis.
4) What should the further management plan be?
5) What errors were made in the management of this pregnancy at the antenatal clinic?

Case 2. A 23-year-old patient called an ambulance due to cramping lower abdominal pain and heavy vaginal bleeding that began 2 hours ago. She was discharged from the hospital yesterday following an induced abortion procedure. She is afebrile.Vaginal examination revealed: The cervix is cylindrical, the external os is slightly open. The uterus is somewhat enlarged, softish, and non-tender. The adnexa are not palpable. The discharge is bloody and moderate in amount.

Questions:

1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What should your further management plan be?
4) Formulate the rationale for your chosen management plan.
5) What is the sequence of your actions?

AI-1 GPC-5.1.

Case 1. A 22-year-old patient. Admitted on the 3rd day of her menstrual period with complaints of severe abdominal pain and high fever – 39.0°C. She associates the illness with casual sexual intercourse a week before her period. Her condition is of moderate severity. Pulse - 110 beats per minute, rhythmic, satisfactory volume. BP - 110/70 mm Hg. Abdomen is not distended,tender on palpation in the lower quadrants, with a positive Shchetkin-Blumberg sign in the same area. No free fluid is detected in the abdominal cavity.On speculum examination: The cervical mucosa is unchanged. Discharge is bloody, scant.Bimanual examination: The uterus and adnexa cannot be delineated due to extreme tenderness on palpation and abdominal wall guarding.Rectal examination: No pelvic infiltrates are found. Proust's sign (or Promtov's sign) is negative.Laboratory findings: Hemoglobin: 120 g/L, Leukocytes: 22 x 10^9/L, Band neutrophils: 30%, ESR: 40 mm/hr, No toxic granulation in neutrophils.

Questions:

1) What is the most likely diagnosis?

2) Justify the diagnosis you have proposed.
3) Formulate and justify a plan for additional patient examination.
4) What is your further management plan?
5) Justify your choice of management.

Case 2. A 17-year-old patient was admitted with complaints of fever up to 38°C, chills, mild lower abdominal pain, and slight bloody discharge. She reports being ill for 3 days. Her last menstrual period was 3 months ago.Her general condition on admission is moderately severe. Pulse is 100 beats per minute, rhythmic, satisfactory volume. Blood pressure is 120/80 mm Hg. The abdomen is soft, moderately tender in the lower quadrants. Blood test results: leukocytes - 12 x 10^9/L, hemoglobin - 100 g/L.Vaginal examination: The cervix is shortened. The cervical canal is passable for one finger up to the internal os. The uterus is enlarged to the size of an 8-week pregnancy, somewhat soft, exquisitely tender on examination, and mobile. The adnexa are not palpable. The discharge is bloody with an admixture of pus.
Questions:
1) What is the most likely diagnosis?
2) What information needs to be clarified from the medical history?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Justify your choice of management.

Case 3. A 68-year-old patient. After 18 years of menopause, she began experiencing slight bloody discharge from the genital tract. It was first noted 8 months ago (lasted for 1 day). It recurred 3 months ago. She did not seek medical attention. 3 days ago, due to heavy bleeding, the patient visited the antenatal clinic and was referred to a gynecological hospital.Speculum examination: The ectocervix shows no signs of atrophic changes. There is slight bloody discharge from the cervical canal.Vaginal examination: The cervix is cylindrical, small in size, the external os is closed. Movement of the cervix is painless. The uterine body is slightly larger than normal, of usual consistency, mobile. The adnexal region is clear.Histological examination: The curettage from the cervical canal revealed mucus and small blood clots. The curettage from the uterine cavity showed focal proliferation of endometrial cells with signs of malignancy.
Questions:
1) What is the most likely diagnosis?
2) Formulate the justification for your diagnosis.
3) What should your further management plan be?
4) Formulate the rationale for your chosen management plan.
5) What is the sequence of your actions?

AI-2 GPC-5.2.
Case 1. A 28-year-old patient was admitted with complaints of sudden onset of cramping lower abdominal pain radiating to the sacrum and rectum, and scant bloody discharge from the genital tract. Dizziness and nausea occurred simultaneously.Her menstrual periods are regular, the last one was 6 weeks ago.Obstetric history: Deliveries - 1, abortions - 3. The last abortion was complicated by bilateral adnexitis, for which she was treated in a hospital.On admission: The patient's condition is moderately severe. She is pale. Pulse - 96 beats per minute, rhythmic. Blood pressure - 90/60 mm Hg. Body temperature - 36.8°C. The tongue is somewhat dry, coated with a white film. The abdomen is slightly distended, tender in the lower quadrants, more so on the left, where there are mild signs of peritoneal irritation.On vaginal examination: The cervix is slightly cyanotic. The uterus is larger than normal, somewhat soft, and tender. The adnexa on both sides are adherent; the right side is not enlarged, while on the left, a doughy, poorly defined mass is palpable. The posterior fornix is flattened. The discharge is bloody and scant.
Questions:
1) What is the most likely diagnosis?
2) Provide justification for your diagnosis.
3) What should the further management plan be?
4) Formulate the rationale for your chosen management plan.
5) What is the sequence of your actions?

Case 2. A 30-year-old primigravida (pregnant for the second time, first delivery) was admitted to the maternity unit at 18:00 with regular labor activity for the past 3 hours. At 19:00, clear amniotic fluid was spontaneously released in a moderate amount. The gestational age at admission was 39 weeks. This is her second pregnancy. Her first pregnancy was 3 years ago and ended in a spontaneous miscarriage at 10 weeks of gestation, followed by uterine curettage, which was complicated by endometritis.The first and second stages of labor proceeded without complications. After 8 hours and 40 minutes of labor, a live, full-term baby girl was born, weighing 3650 g, length 53 cm, with an Apgar score of 8/9.Fifteen minutes after delivery, bloody discharge from the genital tract appeared. The estimated blood loss was 500 ml.
Objective Examination: Height: 168 cm, Weight: 70 kg, BMI: 24.8. General condition: Satisfactory. Skin and visible mucous membranes: Pale pink, normal moisture. Pulse: 90 beats/min. BP: 120/80 mm Hg. Abdomen: Soft, non-tender to palpation. Fundal height: At the level of the umbilicus. Uterus: Firm, non-tender. Signs of placental separation (Chukalov-Küstner sign): Positive. Attempted manual placental delivery using the Abduladze technique was ineffective. Attempted manual placental delivery using the Crede-Lazarevich maneuver was ineffective.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3.
From the history:Menarche at age 14. Menstruation lasts 6-7 days, every 28-30 days, moderate, painless, regular. Obstetric history: 1 full-term vaginal delivery and 1 induced abortion before 12 weeks, performed three months prior to the current pregnancy, complicated by repeated uterine curettage and metroendometritis. Registered for prenatal care from 10 weeks of gestation, attended regularly.Total weight gain during pregnancy: 11 kg, steady. Ultrasound findings at 30/31 weeks of gestation. Single fetus in cephalic presentation, estimated fetal weight 1450 g, no visible fetal malformations detected, the placenta completely covers the internal cervical os, normal amount of amniotic fluid.Objective Examination:General: Condition moderately severe. Skin and visible mucous membranes are pale. Vitals: Height: 160 cm, Weight: 85 kg. Pulse: 90 beats/min, satisfactory volume, rhythmic. BP: 100/60 mm Hg.Abdomen: Areas not occupied by the pregnant uterus are soft, non-tender. Uterus: Enlarged corresponding to 34 weeks of gestation, normal tone, non-tender on palpation throughout.Fetus: Position is longitudinal. The fetal head is presenting, mobile above the pelvic inlet. Fetal heart rate: clear, rhythmic, 186 beats per minute.Vaginal discharge: Moderate bloody discharge. The perineal pad is heavily saturated with blood. Total estimated volume of blood loss: 500 ml.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

AI-3 GPC-5.3.
Case 1. Больная, 18 лет, поступила с жалобами на повышение температуры до 38-390С, озноб, небольшие боли внизу живота и незначительные кровянистые выделения. Считает себя больной for 7 days. The district physician who was called diagnosed her with: Acute Respiratory Viral Infection (ARVI). She was treated at home. Due to the lack of improvement in her condition, an ambulance was called and transported the patient to the gynecology department. Her last menstrual period was 5 months ago. On admission: The patient's condition is severe. Pallor of the skin is noted. Pulse: 120 beats per minute, rhythmic, satisfactory volume. Tongue: Somewhat dry. Lungs: Harsh breathing sounds, moist rales are heard. Abdomen: Soft, tender in the lower quadrants. Liver: Extends 6 cm below the costal margin. Spleen: Enlarged. Diuresis: Decreased.Vaginal examination: Cervix: Conical, external os is closed. Uterus: Enlarged, corresponding to a 17-18 week pregnancy, soft,

exquisitely tender. Adnexa: Enlarged on both sides, tender on examination. Discharge: Purulent, foul-smelling.
Questions:
1) What is the most likely diagnosis?
2) What anamnestic (historical) data needs to be clarified with the patient?
3) Justify your diagnosis.
4) What should the further management plan be?
5) What error did the district physician make?

Case 2. A 36-year-old primigravida was admitted to the maternity hospital at 14:20, reporting the onset of regular contractions since 13:30. At 14:30, clear amniotic fluid was released in a moderate amount. The gestational age at admission was 38/39 weeks.History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless. Sexual: Sexually active since age 23, married.Obstetric: First pregnancy, full-term. Prenatal Care: Registered from 6/7 weeks of gestation. Pregnancy was uncomplicated. Lab: Last blood test showed hemoglobin – 90 g/L. Ultrasound (Doppler): At 37 weeks, fetal-placental blood flow impairment of Grade Ib was detected. Gynecological History: Chronic bilateral salpingo-oophoritis since age 24, last exacerbation over 5 years ago. Medical History: Childhood infections; ARVI; chronic gastritis since age 15, last exacerbation over 3 years ago. Objective Examination on Admission: General: Condition satisfactory. Pulse: 76 bpm, BP: 120/80 mm Hg.External Obstetric Exam: Fetal lie: Longitudinal. Fetal back: On the right. Presenting part: Fetal head, engaged at the pelvic inlet. Fundal height: 38 cm. Uterine circumference: 25 cm. Contractions: Lasting 20 seconds, every 6-8 minutes, weak, regular. Fetal Heart Rate (FHR): Clear, rhythmic, 140 bpm. Pelvic Measurements: 26-29-32-21 cm. Vaginal Exam (PV): Nulliparous vagina. Cervix effaced. Cervical dilation 2 cm. Cervical edges of medium thickness, moderately compliant. No amniotic sac. Presenting part: fetal head, engaged at the pelvic inlet. Sacral promontory not reachable. Clear amniotic fluid leaking.Progress at 18:00: Contractions lasting 30 seconds, every 5 minutes, moderate in strength. Uterus relaxes completely between contractions. Progress at 20:00: Weakening of labor activity noted** – contractions occurring every 6-8 minutes, lasting 15-20 seconds. **FHR deceleration to 90 bpm noted**, heart sounds are muffled and occasionally arrhythmic. Amniotic fluid leaking, slightly meconium-stained. PV: Nulliparous vagina. Cervix effaced. Cervical dilation 5 cm. Cervical edges thin, compliant. No amniotic sac. Presenting part: fetal head, engaged at the pelvic inlet. Sagittal suture in the right oblique diameter. Small fontanelle posterior and to the right. Sacral promontory not reachable. Amniotic fluid leaking, slightly meconium-stained.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3. A multiparous woman presented to the antenatal clinic (APC). She does not remember the date of her last menstrual period. She knew she was pregnant but did not register for prenatal care and was not examined. She began feeling fetal movements 15 weeks ago. During the pregnancy, for the last 10 weeks, she has noted periodically recurring spotting from the genital tract but did not seek medical attention.History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless.Sexual: Sexually active since age 16. Obstetric: This is her 7th pregnancy. Previous pregnancies ended in 3 deliveries (without complications) and 3 induced abortions. She is about to have her 4th delivery. Medical History: ARVI. External Obstetric Examination: Fundal height: 34 cm. Abdominal circumference: 89 cm. Fetal lie: Longitudinal. Fetal back: On the left. Presenting part: Fetal head, located high above the pelvic inlet. Fetal Heart Rate (FHR): Clear, rhythmic, 146 bpm. Pelvic measurements: 26-29-32-21 cm. Solovyov's index: 14.5 cm. Vaginal Examination: Cervix: Firm, length 2.5 cm, deviated towards the sacrum, external os closed. Through the lateral vaginal fornices, doughy tissue is palpable. The presenting fetal part cannot be identified. Sacral promontory: Not reachable. Discharge: Clear.
Questions:
1) Formulate the diagnosis.

2) Justify the diagnosis.
3) What should the doctor's further management plan be?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

AI-1 GPC-7.1.

Case 1. A 35-year-old patient was admitted to the gynecology department with uterine bleeding after a 3-week delay in her menstrual period.History: 2 full-term deliveries, 3 induced abortions. The last abortion was complicated by adnexal inflammation and menstrual dysfunction. Six months ago, due to bleeding, a curettage of the uterine cavity was performed; the histological examination revealed endometrial hyperplasia without atypia. No subsequent treatment was provided.Vaginal examination: The cervix is intact, the external os is closed, there is moderate bloody discharge from the cervical canal. The uterus is unremarkable. The adnexa are adherent (bound by adhesions). The vaginal fornices are clear and deep.
Questions:
1) What is the most likely diagnosis?
2) Justification for the diagnosis.
3) What measures should be taken to stop the bleeding?
4) Sequence of actions when providing care.
5) Formulate the rationale for the chosen management plan.

Case 2. A 30-year-old primigravida (pregnant for the second time, first delivery) was admitted to the maternity unit at 18:00 with regular labor activity for the past 3 hours. At 19:00, clear amniotic fluid was spontaneously released in a moderate amount. The gestational age at admission was 39 weeks. This is her second pregnancy. Her first pregnancy was 3 years ago and ended in a spontaneous miscarriage at 10 weeks of gestation, followed by uterine curettage, which was complicated by endometritis.The first and second stages of labor proceeded without complications. After 8 hours and 40 minutes of labor, a live, full-term baby girl was born, weighing 3650 g, length 53 cm, with an Apgar score of 8/9. Fifteen minutes after delivery, bloody discharge from the genital tract appeared. The estimated blood loss was 500 ml. Objective Examination: Height: 168 cm, Weight: 70 kg, BMI: 24.8. General condition: Satisfactory. Skin and visible mucous membranes: Pale pink, normal moisture. Pulse: 90 beats/min. BP: 120/80 mm Hg. Abdomen: Soft, non-tender to palpation. Fundal height: At the level of the umbilicus. Uterus: Firm, non-tender. Signs of placental separation (Chukalov-Küstner sign): Positive. Attempted manual placental delivery using the Abduladze technique was ineffective. Attempted manual placental delivery using the Crede-Lazarevich maneuver was ineffective.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3.

From the history: Menarche at age 14. Menses last 6-7 days, every 28-30 days, moderate, painless, regular.Obstetric History: 1 full-term vaginal delivery and 1 induced abortion before 12 weeks, performed three months prior to the current pregnancy, complicated by repeated uterine curettage and metroendometritis. Registered for prenatal care from 10 weeks of gestation, attended regularly.Total weight gain during pregnancy: 11 kg, steady. Ultrasound findings at 30/31 weeks gestation: Singleton fetus in cephalic presentation, estimated fetal weight 1450 g, no visible fetal malformations detected, the placenta completely covers the internal cervical os, normal amniotic fluid volume.Objective Examination:General Condition: Moderately severe. Skin and visible mucous membranes are pale. Vitals: Height: 160 cm, Weight: 85 kg. Pulse: 90 beats/min, satisfactory volume, rhythmic. BP: 100/60 mm Hg. Abdomen: Areas free of the pregnant uterus are soft, non-tender. Uterus: Enlarged corresponding to 34 weeks gestation, normotonic, non-tender on palpation throughout. Fetus: Lie is longitudinal. Fetal head is presenting, mobile above the pelvic inlet. Fetal heart rate:

clear, rhythmic, 186 beats per minute. Vaginal Discharge: Moderate bloody discharge. The perineal pad is heavily saturated with blood. Total estimated blood loss: 500 ml.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

AI-2 GPC-7.2.
Case 1. A 55-year-old patient was admitted with complaints of pain in the left iliac region, worsening with movement. The pain began suddenly, without apparent cause. Menopause for 1 year. No history of gynecological diseases. Condition is satisfactory. Vital Signs: Pulse - 84 bpm, rhythmic, satisfactory volume. BP - 140/90 mm Hg. Temperature - 37.4°C. Abdomen: Normal shape, somewhat distended. Tender to palpation in the left iliac region, where the **upper pole of a painful mass originating from the pelvis is palpable. Shchetkin-Blumberg sign negative. No free fluid detected in the abdominal cavity. Vaginal Examination: Uterus is retroverted, not enlarged, firm, with limited mobility, non-tender on palpation but sensitive to movement. The right fornix is clear, adnexa not palpable. **To the left and anterior to the uterus, a round, firm, smooth-surfaced mass measuring up to 14 cm in diameter is palpable, with limited mobility and exquisite tenderness.
Questions:
1) What is the most likely diagnosis?
2) Justify your diagnosis.
3) What should the further management plan be?
4) Formulate the rationale for your chosen management plan.
5) Develop a plan for further treatment.

Case 2. A 29-year-old primigravida presented to the maternity hospital emergency room with complaints of regular contractions that began three hours ago. Clear amniotic fluid in a moderate amount was released one hour ago. Gestational age is 39 weeks.History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless. Sexual: Sexually active since age 18, married. Obstetric: This is her first pregnancy. The pregnancy was complicated by threatened miscarriage at 20 weeks, for which she received tocolytic therapy. Gynecological History: Denies gynecological diseases. Medical History: Childhood infections; ARVI; chronic gastritis.Objective Examination: General; Condition satisfactory. Pulse 76 bpm, BP 120/80 mm Hg. Uterine Measurements: Fundal height - 37 cm. Abdominal circumference - 30 cm. External Obstetric Examination:Fetal lie: Longitudinal. Fetal back: On the right. Presenting part: Fetal head, above the pelvic inlet. Contractions: Lasting 20-25 seconds, every 5-7 minutes, weak, regular. Fetal Heart Rate (FHR): Clear, rhythmic, 146 bpm. Pelvic Measurements: External pelvic dimensions: 22-25-27-17 cm. Zangemeister and Vasten signs: Positive. Solovyov's index: 16.0 cm. Vaginal Examination: Cervix: Effaced. Cervical dilation: 2 cm. Amniotic sac: Not present. Clear amniotic fluid leaking. Presenting part: The lower pole of the head is reached with difficulty. Pelvic cavity: Entirely free. Sacral promontory: Reachable. Diagonal conjugate: 9.5 cm.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What is the further management plan for labor?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3. A 30-year-old pregnant woman with a history of 3 spontaneous abortions came for an appointment with a doctor at the antenatal clinic.
Questions:
1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) Formulate and justify a plan for additional patient examination.

4) What should the doctor's further management plan for this patient be?
5) Justify your choice of management.

AI-3 GPC-7.3.

Case 1. A 22-year-old patient complained of weakness and dizziness 2 hours after an induced abortion at 10 weeks of gestation. The patient is pale. Pulse is 100 beats per minute, rhythmic. Abdominal examination reveals a uterus whose fundus is located at the midpoint between the pubic symphysis and the umbilicus. There is no bloody vaginal discharge.

Questions:

1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What is your further management plan?
4) Justify your choice of management.
5) What is the sequence of your actions?

Case 2. A 30-year-old primigravida (pregnant for the second time, first delivery) was admitted to the maternity unit at 18:00 with regular labor activity for the past 3 hours. At 19:00, clear amniotic fluid was spontaneously released in a moderate amount. The gestational age at admission was 39 weeks. This is her second pregnancy. Her first pregnancy was 3 years ago and ended in a spontaneous miscarriage at 10 weeks of gestation, followed by uterine curettage, which was complicated by endometritis.The first and second stages of labor proceeded without complications. After 8 hours and 40 minutes of labor, a live, full-term baby girl was born, weighing 3650 g, length 53 cm, with an Apgar score of 8/9. Fifteen minutes after delivery, bloody discharge from the genital tract appeared. The estimated blood loss was 500 ml.Objective Examination: Height: 168 cm, Weight: 70 kg, BMI: 24.8. General condition: Satisfactory. Skin and visible mucous membranes: Pale pink, normal moisture. Pulse: 90 beats/min. BP: 120/80 mm Hg. Abdomen: Soft, non-tender to palpation. Fundal height: At the level of the umbilicus. Uterus: Firm, non-tender. Signs of placental separation (Chukalov-Küstner sign): Positive. Attempted manual placental delivery using the Abduladze technique was ineffective. Attempted manual placental delivery using the Crede-Lazarevich maneuver was ineffective.

Questions:

1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 3. From the history:Menarche at age 14. Menses last 6-7 days, every 28-30 days, moderate, painless, regular.Obstetric History: 1 full-term vaginal delivery and 1 induced abortion before 12 weeks, performed three months prior to the current pregnancy, complicated by repeated uterine curettage and metroendometritis. Registered for prenatal care from 10 weeks of gestation, attended regularly. Total weight gain during pregnancy: 11 kg, steady.Ultrasound findings at 30/31 weeks gestation: Singleton fetus in cephalic presentation, estimated fetal weight 1450 g, no visible fetal malformations detected, the placenta completely covers the internal cervical os, normal amniotic fluid volume.Objective Examination: General Condition: Moderately severe. Skin and visible mucous membranes are pale. Vitals: Height: 160 cm, Weight: 85 kg. Pulse: 90 beats/min, satisfactory volume, rhythmic. BP: 100/60 mm Hg. Abdomen: Areas free of the pregnant uterus are soft, non-tender.Uterus: Enlarged corresponding to 34 weeks gestation, normotonic, non-tender on palpation throughout.Fetus: Lie is longitudinal. Fetal head is presenting, mobile above the pelvic inlet. Fetal heart rate: clear, rhythmic, 186 beats per minute.mVaginal Discharge: Moderate bloody discharge. The perineal pad is heavily saturated with blood. Total estimated blood loss: 500 ml.

Questions:

1) Formulate the diagnosis.
2) Justify the diagnosis.

3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

AI-4 GPC-7.4.

Case 1. Patient M., 40 years old, was admitted to the gynecology department on referral from a doctor at the antenatal clinic. The patient complains of yellow vaginal discharge.History: No significant family medical history. She has had three pregnancies: one ended in a normal vaginal delivery, and the other two ended in induced abortions (at 8 and 10 weeks) without complications.Examination: Speculum Exam: Vaginal mucosa is hyperemic. The posterior lip of the cervix has whitish areas with clear borders. Bimanual Exam: The cervix is cylindrical in shape. The uterine body is of normal size, mobile. The adnexal region is clear and non-tender. Discharge: Yellow, frothy. Microbiological Test: Vaginal smear showed yellow, frothy discharge. Bacterioscopic Exam: Vaginal smear revealed mixed flora and Trichomonas vaginalis. Colposcopy: Revealed two whitish areas measuring 1 x 1.5 cm, located on the anterior and posterior lips, which did not stain with iodine (Lugol's solution negative).
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) Prescribe treatment.

Case 2. Patient K., a 30-year-old multipara (woman who has given birth before), was admitted to the maternity hospital. She has been in labor for 10 hours. Pelvic measurements: 26, 29, 30, 18 cm. Fetal lie: Oblique. The fetal head is on the right side. Fetal Heart Rate (FHR): Clear, rhythmic, 140 beats per minute. Vaginal examination revealed: Cervical dilation: 6 cm. Cervical edges: Thin, compliant. Amniotic sac: Intact. A pulsating loop of umbilical cord is presenting. Sacral promontory: Reachable. Diagonal conjugate: 11 cm.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) Calculate the true conjugate.
4) What should be the further management plan?
5) Formulate the rationale for your chosen management plan.

Case 3. Patient T., 25 years old. Pelvic measurements: 27, 27, 30, 17 cm. This is her second delivery, a preterm birth. Her first delivery ended in a cesarean section. She gave birth to a boy weighing 1300 g 10 minutes ago. Significant bleeding appeared. During manual removal of the placenta, it is impossible to detach a significant portion of the placenta attached to the anterior wall of the uterus. Severe, life-threatening bleeding has developed.
Questions:
1) Most likely diagnosis.
2) What should be the further management plan?
3) Formulate the rationale for your chosen management plan.
4) What is the sequence of your actions?
5) Justify the diagnosis.

AI-1 PC-2.1.

Case 1.A 25-year-old patient was brought to the gynecology department by ambulance with complaints of lower right abdominal pain, nausea, dizziness, and spotting. She fell ill suddenly, 6 hours ago, when she experienced lower abdominal pain radiating to the rectum, and reports a 2-week delay in her menstrual period. History: One pregnancy ended in a full-term vaginal delivery, another in an induced abortion at 10 weeks; the abortion was complicated by an inflammatory process of the uterus and adnexa.Condition on Admission: Condition: Satisfactory. Pulse: 90 bpm. BP: 110/70 mm Hg. Skin and visible mucous membranes: Pale pink. Abdomen: Normal shape, some tension of the abdominal wall muscles noted on the right. Shchetkin-Blumberg sign is weakly positive. Examination: Speculum Exam: Slight cyanosis of the vaginal and cervical mucosa. Cervical mucus sign (pupil sign)

negative. Dark bloody discharge, scant. Vaginal Exam (Bimanual): Uterus slightly enlarged, doughy in consistency; movement is exquisitely painful. To the right of the uterus, in the adnexal region, tissue edema (pastosity) and exquisite tenderness are noted. The posterior fornix is bulging and tender on palpation.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What is the sequence of your actions?

Case 2. Patient S., 36 years old, primigravida (first pregnancy). Pelvic measurements: 24, 26, 29, 18 cm. History: infertility for 8 years. She was admitted to the antenatal ward with a full-term pregnancy. The fetus is in a breech presentation. Estimated fetal weight is 4250 g.
Questions:
1) Formulate the diagnosis.
2) Justify your diagnosis.
3) What should the further management plan be?
4) Formulate the rationale for your chosen management plan.
5) Develop a plan for further management.

Case 3. Patient I., 28 years old. Second pregnancy, full-term delivery. It is the third day of the postpartum period. She experienced chills and a temperature of 39.0°C. Breasts are soft, non-tender. The uterine fundus is at the level of the umbilicus, and the uterus is exquisitely tender to palpation. Lochia is moderate in amount and has an unpleasant odor.
Questions:
1) Most likely diagnosis.
2) Justify your diagnosis.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) Prescribe treatment.

AI-2 PC-2.2.
Case 1. Patient V., 36 years old, presented with complaints of heavy menstrual periods lasting 7-10 days over the past year. History: Family history and menstrual function (prior to the last year) are unremarkable. Sexually active since age 30, using contraception to prevent pregnancy. Objective Examination: General: Condition satisfactory. Skin pale. Systems Review: No pathology detected in internal organs. Gynecological Exam: External genitalia: Normally developed, female-pattern pubic hair. Speculum Exam: Vaginal and cervical mucosa unremarkable. Discharge is clear, mucous, moderate. Bimanual Exam: Vagina: Nulliparous. Cervix: Conical, external os closed. Uterus: Enlarged to the size of a 9-week pregnancy, firm, nodular, mobile, non-tender, correctly positioned. Adnexa: Not enlarged on either side. Vaginal fornices are clear.
Questions:
1) What is the most likely diagnosis?
2) Develop an examination plan for the patient.
3) Justify the diagnosis.
4) What should be the further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. Patient Ya., 28 years old. Pelvic measurements: 25, 28, 31, 20 cm. Second delivery, full-term. She gave birth to a boy weighing 3050 g 20 minutes ago. A second fetus in longitudinal lie, cephalic presentation, is found in the uterine cavity. Fetal heart tones are rhythmic, 120 bpm. There are no contractions. The amniotic sac of the second fetus is intact.
Questions:
1) Formulate the diagnosis.
2) What should be the further management plan?
3) Formulate the rationale for your chosen management plan.

4) What is the sequence of your actions?
5) What complications could arise?

Case 3. A multiparous woman was admitted with regular contractions of moderate intensity that began 10 hours ago. The membranes are intact. This is her second pregnancy and delivery. The pregnancy is full-term. Her first delivery was 3 years ago, without complications. Estimated fetal weight is 3200 g. Fetal lie: Longitudinal. At the uterine fundus, a round, firm part is palpated. The presenting part is softer and engaged at the pelvic inlet. Fetal heart rate: Distinct, 128 bpm, rhythmic. Half an hour after admission, clear amniotic fluid was released.Vaginal examination reveals: Cervical dilation: 8 cm. Amniotic sac: Absent. Fetal feet are palpated in the vagina, with the buttocks at the pelvic inlet. Sacral promontory: Not reachable.
Questions:
1) Formulate the diagnosis.
2) What is the further management plan?
3) Formulate the rationale for your chosen management plan.
4) What is the sequence of your actions?
5) What complications could arise in this situation?

AI-3 PC-2.3.
Case 1. A 31-year-old patient was admitted with complaints of sudden onset of cramping lower abdominal pain radiating to the sacrum, scant bloody vaginal discharge, and nausea following the pain. Her last menstrual period was 6 weeks ago. History: 1 full-term delivery and 2 induced abortions; following the second abortion, she developed bilateral adnexitis. Condition: Satisfactory. Pulse 84 bpm, rhythmic, satisfactory volume. BP 110/70 mm Hg. Temperature 36.8°C. Abdomen: Normal shape, moves with respiration, slightly distended, tender over the pubis and in the left iliac region. No signs of peritoneal irritation. Lab Findings: Hemoglobin 119 g/L, leukocytes 8.6 x 10^9/L, ESR 19 mm/hr. Examination:Speculum Exam: Cervix is slightly cyanotic. Discharge is spotting, bloody. Vaginal Exam (Bimanual): Cervical motion tenderness is present. Uterine body is in typical position, somewhat larger than normal, somewhat soft, tender on movement. On the left, in the adnexal region, a tumor-like mass is palpated; it is immobile, with unclear borders, and somewhat soft in consistency. In the left fornix, there is tissue edema (pastosity). Adnexa on the right are not enlarged.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. A 25-year-old patient was admitted to the clinic with complaints of mild, dull, intermittent lower abdominal pain and scant bloody discharge from the genital tract for one week. This is her third pregnancy. The two previous pregnancies ended in spontaneous abortions at 9-10 weeks of gestation. Her last menstrual period was 3 months ago. Vaginal examination revealed: The cervix is intact, the external os is closed. The uterus is enlarged to the size of an 11-12 week pregnancy, somewhat soft, mobile, and non-tender. The adnexa are not palpable. The discharge is bloody, scant.
Questions:
1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What anamnestic (historical) data is necessary to determine the cause?
4) What errors were made in the management of this pregnancy by the antenatal clinic doctor?
5) What is your further management plan?

Case 3. A multiparous woman was admitted 4 hours after the onset of labor. The pregnancy is full-term. Membranes are intact. Pulse 78 bpm, rhythmic, satisfactory volume. BP - 180/120 mm Hg. Generalized edema. Urine protein: 2 g/L. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate: 134 bpm, rhythmic, clear.
Suddenly, the woman in labor complained of abdominal pain, became pale, and her pulse increased to 100 bpm. On palpation, localized tenderness is noted on the left side near the edge of the uterus. The

uterus is tense and does not relax between contractions. The fetal heart rate is irregular, muffled - 90 bpm.Vaginal examination: The cervix is effaced, cervical dilation is 5 cm. The amniotic sac is intact and extremely tense. The presenting part cannot be palpated.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What errors were made by the antenatal clinic doctor?

AI-4 PC-2.4.
Case 1. A 37-year-old multiparous woman was admitted to the maternity hospital at full term, with regular labor activity for the past 4 hours. The membranes are intact. She feels fetal movements clearly. Shortly before arriving at the hospital, scant bloody discharge from the genital tract appeared. History: Menstrual: Menarche at age 13. Menses last 5-7 days, every 28 days, heavy, painless, regular. Obstetric History: 2 full-term vaginal deliveries and 2 induced abortions before 12 weeks, the last of which was performed 1 year ago and complicated by repeated uterine curettage and metroendometritis. Prenatal Care: Registered at the antenatal clinic from 17 weeks of gestation, visited only twice during the entire pregnancy. She categorically refused obstetric ultrasound. Objective Examination: General: Condition satisfactory. Skin and visible mucous membranes of normal color. Height: 170 cm, Weight: 88 kg.Vitals: Pulse: 82 bpm, satisfactory volume, rhythmic. BP: 110/70 mm Hg. Abdomen: Areas free of the pregnant uterus are soft, non-tender. Uterus: Enlarged corresponding to full term, relaxes well between contractions, non-tender on palpation throughout. Labor: Contractions every 3-4 minutes, moderate intensity, lasting 35-40 seconds. Fetus: Lie is longitudinal. Fetal head is presenting, slightly engaged at the pelvic inlet. Fetal heart rate: clear, rhythmic, 140 bpm. Discharge: Scant bloody discharge from the genital tract. CTG: Fetal condition is compensated. Vaginal Examination (PV): Vagina is capacious. Small amount of blood clots in the vagina (up to 30 ml). Cervical dilation: 8 cm, edges thin. Amniotic sac: Intact. To the right and posteriorly, at the edge of the cervical os, a small area of placental edge with a doughy consistency is detected. Presenting part: Fetal head, slightly engaged at the pelvic inlet. Sagittal suture in the left oblique diameter, small fontanelle anterior and to the right. Sacral promontory: Not reachable. No exostoses or deformities in the pelvis.
Questions:
1) Formulate a preliminary diagnosis.
2) Justify the diagnosis.
3) What is the obstetric management plan for labor in this case?
4) Justify the chosen management plan.
5) Possible complications.

Case 2. A 36-year-old primigravida has been in labor for 16 hours. Pelvic measurements: 23-25-29-17. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate is clear, rhythmic, 130 bpm. Contractions are frequent and very painful.
Vaginal examination revealed: Cervical dilation: Complete (full). Amniotic sac: Intact, extremely tense, and was artificially ruptured (amniorrhexis). A moderate amount of meconium-stained amniotic fluid was released. The fetal head is engaged at the pelvic inlet. Sagittal suture in the right oblique diameter. Small fontanelle posterior and to the right. Sacral promontory: Reachable. Diagonal conjugate: 10 cm.
Questions:
1) Most likely diagnosis.
2) Justify your diagnosis.
3) How can the true conjugate be calculated?
4) Calculate the true conjugate for this woman in labor.
5) What should be the further management plan?

Case 3. A 34-year-old multiparous woman was admitted due to bleeding. This is her third delivery, full-term. Contractions are regular, short. Fetal lie is longitudinal. Fetal heart rate is clear, rhythmic, 140 bpm. Vaginal examination revealed: Cervix: Effaced. Cervical edges: Thin. Cervical dilation: 8

cm. To the right and posteriorly, placental tissue is detected. Amniotic sac: Intact. Fetal head: Slightly engaged at the pelvic inlet. Sacral promontory: Not reachable.
Questions:
1) Make a diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) Sequence of your actions.

AI-5 PC-2.5.
Case 1. A 35-year-old primigravida (first pregnancy) was admitted to the emergency department at 12:40 with complaints of spontaneous rupture of clear amniotic fluid at 11:00. The gestational age at admission is 37 weeks. History: Menstrual: Menarche at 14. Menses last 5 days, every 30 days, regular, moderate, painless. Sexual: Sexually active since age 16. Obstetric: First pregnancy. Prenatal Care: Registered at the antenatal clinic from 13 weeks. Attended only three times throughout the pregnancy. Infections: Mycoplasma genitalium was detected during screening for sexually transmitted infections; the patient received no treatment. Ultrasound at 33/34 weeks: Revealed polyhydramnios. Treatment Refusal: She refused both hospital admission and outpatient antibiotic therapy. Gynecological History: Chronic salpingo-oophoritis since age 20 (last exacerbation 3 years ago). Medical History: Childhood infections; ARVI. Objective Examination: General: Condition satisfactory. Pulse: 66 bpm. BP: 120/80 mm Hg. Abdomen: Shape: Transverse-oval. Fundal height: 31 cm. Abdominal circumference: 110 cm. External Obstetric Exam: Above the right iliac crest, the fetal head is palpated. The fetal back is oriented anteriorly. No presenting part is identified in the pelvis. Fetal Heart Rate (FHR): Heard clearly at the level of the umbilicus; clear, rhythmic, 134 bpm. Vaginal Exam: Vagina: Nulliparous. Cervix: Positioned along the pelvic axis, length 2.0 cm, partially softened. The cervical canal admits one fingertip up to the internal os. No presenting tissue is palpated through the lateral vaginal fornices. Clear amniotic fluid is leaking.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the further management plan.
5) What complications could arise in this situation?

Case 2. A multiparous woman was admitted 4 hours after the onset of labor. The pregnancy is full-term. Membranes are intact. Pulse 78 bpm, rhythmic, satisfactory volume. BP - 180/120 mm Hg. Generalized edema. Urine protein: 2 g/L. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate: 134 bpm, rhythmic, clear. Suddenly, the woman in labor complained of abdominal pain, became pale, and her pulse increased to 100 bpm. On palpation, localized tenderness is noted on the left side near the edge of the uterus. The uterus is tense and does not relax between contractions. The fetal heart rate is irregular, muffled - 90 bpm.Vaginal examination:The cervix is effaced, cervical dilation is 5 cm. The amniotic sac is intact and extremely tense. The presenting part cannot be palpated.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What errors were made by the antenatal clinic doctor?

Case 3. A 37-year-old multiparous woman. During her first delivery, she had severe preeclampsia, and after delivery was diagnosed with Stage I hypertension. Over the past 3 weeks of observation at the antenatal clinic, her blood pressure readings were 140/90, 150/100 mm Hg. She was brought by ambulance in a severe condition. Pulse 118 bpm, weak. Blood pressure 90/50 mm Hg. The uterus is sized to full-term pregnancy, is exquisitely tender and tense on the right side. Fetal heart tones are absent. Discharge is bloody, moderate.
Questions:

1) Most likely diagnosis.
2) Justify the diagnosis.
3) What errors were made by the antenatal clinic doctor?
4) What needs to be done in this situation?
5) Formulate the rationale for your chosen management plan..

AI-1 PC-3.1.

Case 1. A 34-year-old multiparous woman was admitted to the maternity unit with regular labor activity for the past 4 hours, and spontaneous rupture of membranes one hour after admission. This is her second pregnancy, gestational age - 40 weeks. First pregnancy - 5 years ago - ended in spontaneous vaginal delivery at 38-39 weeks. Second pregnancy - 2 years ago - ended in an induced abortion at 8-9 weeks, complicated by metroendometritis. The first and second stages of labor proceeded without complications. After 7 hours and 40 minutes of labor, a live, full-term baby boy was born, weighing 3450 g, length 52 cm, with an Apgar score of 8/8. Twenty minutes after delivery, the placenta was delivered, and bloody discharge from the genital tract appeared. Estimated blood loss is 350 ml. On examination, the placenta has a defect measuring 2 x 2.5 cm. Objective Examination: Height: 167 cm, Weight: 60 kg, BMI: 21.5. General condition: Satisfactory. Skin and visible mucous membranes: Pale pink, normal moisture. Pulse: 84 bpm. BP: 110/70 mm Hg. Abdomen: Soft, non-tender on palpation. Fundal height: At the level of the umbilicus. Uterus: Firm, non-tender.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Justify the chosen management plan.
5) What complications could arise in this situation?

Case 2. A 28-year-old primigravida (first-time mother) was admitted with regular, intense contractions that began 8 hours ago. This is her second pregnancy, full-term. Her first pregnancy, 3 years ago, ended in a criminal abortion in the third month, followed by repeated uterine curettage. Pelvic measurements: 24–27–30–19 cm. Four hours after admission, she delivered a live, full-term infant. Fifteen minutes after delivery, bleeding began. Blood loss is 300 ml. There are no signs of placental separation.
Questions:
1) Most likely diagnosis.
2) What signs of placental separation do you know?
3) What should be the further management plan in this situation?
4) What is the sequence of actions?
5) Justify the diagnosis.

Case 3. A 20-year-old primigravida (first pregnancy) was admitted to the clinic with a referral from the antenatal clinic with the diagnosis: Pregnancy 8 weeks, early pregnancy toxemia (emesis gravidarum). Over the past 2 weeks, she has lost 2 kg of weight. In the last 24 hours, she has vomited 16 times (3 times at night). Acetone has been detected in her urine. The patient was a healthy child. Menarche at age 12, regular cycles established within a year, periods were painful, occurring every 30 days, lasting 3 days, with moderate flow. Her last menstrual period was 9 weeks ago. On admission: Temperature 37.4°C, pulse 100 bpm, satisfactory volume. BP - 100/60 mm Hg.
Questions:
1) Make a diagnosis.
2) Order investigations.
3) Prescribe treatment.
4) Justify the prescribed treatment.
5) Does the pregnant woman require hospitalization?

AI-2 PC-3.2.

Case 1. A 25-year-old patient was admitted to the clinic with complaints of mild, dull, intermittent lower abdominal pain and scant bloody discharge from the genital tract for one week. This is her third pregnancy. The two previous pregnancies ended in spontaneous abortions at 9-10 weeks of gestation.

Her last menstrual period was 3 months ago. Vaginal examination revealed: The cervix is intact, the external os is closed. The uterus is enlarged to the size of an 11-12 week pregnancy, somewhat soft, mobile, and non-tender. The adnexa are not palpable. The discharge is bloody, scant.
Questions:
1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What anamnestic (historical) data is necessary to determine the cause?
4) What errors were made in the management of this pregnancy by the antenatal clinic doctor?
5) What is your further management plan?

Case 2. A multiparous woman was admitted 4 hours after the onset of labor. The pregnancy is full-term. The membranes are intact. Pulse 78 bpm, rhythmic, satisfactory volume. BP - 180/120 mm Hg. Generalized edema. Urine protein: 2 g/L. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate: 134 bpm, rhythmic, clear. Suddenly, the woman in labor complained of abdominal pain, became pale, and her pulse increased to 100 bpm. On palpation, localized tenderness is noted on the left side near the edge of the uterus. The uterus is tense and does not relax between contractions. The fetal heart rate is irregular, muffled - 90 bpm.Vaginal examination: The cervix is effaced, cervical dilation is 5 cm. The amniotic sac is intact and extremely tense. The presenting part cannot be palpated.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What errors were made by the antenatal clinic doctor?

Case 3. A 20-year-old primigravida (first pregnancy) was admitted to the clinic with a referral from the antenatal clinic with the diagnosis: Pregnancy 8 weeks, early pregnancy toxemia (emesis gravidarum). Over the past 2 weeks, she has lost 2 kg of weight. In the last 24 hours, she has vomited 16 times (3 times at night). Acetone has been detected in her urine. The patient grew up as a healthy child. Menarche at age 12, regular cycles established within a year, periods were painful, occurring every 30 days, lasting 3 days, with moderate flow. Her last menstrual period was 9 weeks ago. On admission: Temperature 37.4°C, pulse 100 bpm, satisfactory volume. BP - 100/60 mm Hg.
Questions:
1) Make a diagnosis.
2) Order investigations.
3) Prescribe treatment.
4) Justify the prescribed treatment.
5) Does the pregnant woman require hospitalization?

AI-3 PC-3.3.
Case 1. A 38-year-old patient was admitted to the gynecology department of a city hospital with complaints of heavy bloody discharge from the genital tract for two weeks, weakness, fatigue, and dizziness. History: Menstrual: Menarche at age 12. Menstruation lasts 4-5 days, every 28-30 days, heavy, painful, regular. She reports an increase in the duration and volume of her periods over the last six months. Her last menstrual period began two weeks ago, on schedule. Heavy bloody discharge has continued since then. Obstetric: One full-term vaginal delivery and two induced abortions at 8 and 10 weeks, without complications. Gynecological: During a preventive examination by an obstetrician-gynecologist a year ago, uterine fibroids were diagnosed. Contraception: None. Objective Examination: General:Condition moderately severe. Skin and visible mucous membranes are moderately pale. Vitals:Body temperature 36.7°C. Pulse 86 beats per minute, satisfactory volume, rhythmic. BP 100/70 mm Hg. Abdomen: Soft, non-tender to palpation. Peritoneal signs negative. Stool and diuresis are normal. Speculum Examination: Vaginal and cervical mucosa show no pathological changes. There is heavy bloody discharge from the cervical canal. Bimanual Examination (P.V.): Cervix: Cylindrical in shape, external os closed. Movement of the cervix is painless. Uterus: Anteverted and anteflexed, corresponds in size to an 8-week pregnancy, nodular, firm in consistency, mobile, non-tender on palpation. On the anterior wall, intramural-subserosal nodules approximately 2 cm and 6 cm in

diameter are detected, non-tender on palpation. Adnexa: Unremarkable on both sides. Vaginal fornices: Clear. No infiltrates in the parametrium.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. A 36-year-old primigravida has been in labor for 16 hours. Pelvic measurements: 23-25-29-17. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate is clear, rhythmic, 130 bpm. Contractions are frequent and very painful. Vaginal examination revealed: Cervical dilation: Complete (full). Amniotic sac: Intact, extremely tense, and was artificially ruptured (amniorrhexis). A moderate amount of meconium-stained amniotic fluid was released. The fetal head is engaged at the pelvic inlet. Sagittal suture in the right oblique diameter. Small fontanelle posterior and to the right. Sacral promontory: Reachable. Diagonal conjugate: 10 cm.
Questions:
1) Most likely diagnosis.
2) Justify your diagnosis.
3) How can the true conjugate be calculated?
4) Calculate the true conjugate for this woman in labor.
5) What should be the further management plan?

Case 3. A 34-year-old multiparous woman was admitted due to bleeding. This is her third delivery, full-term. Contractions are regular, short. Fetal lie is longitudinal. Fetal heart rate is clear, rhythmic, 140 bpm. Vaginal examination revealed: Cervix: Effaced. Cervical edges: Thin. Cervical dilation: 8 cm. To the right and posteriorly, placental tissue is detected. Amniotic sac: Intact. Fetal head: Slightly engaged at the pelvic inlet. Sacral promontory: Not reachable.
Questions:
1) Make a diagnosis.
2) Justify the diagnosis.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) Sequence of your actions.

AI-4 PC-3.4.
Case 1. A 38-year-old woman presented to the antenatal clinic regarding discharge. Last year, two cervical cytology (Pap) smears were performed: no cellular atypia was detected. HPV test was positive; high-risk HPV was detected twice. She has not received any treatment for cervical conditions. History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless. Sexual: Sexually active since age 22, unmarried. Obstetric History: Pregnancies - 7; Deliveries - 1; Abortions - 6. Contraception: Barrier method - condom. Gynecological History: Previously treated for gonorrhea, follow-up tests negative. Medical History: Childhood infections; ARVI. Smoker. Objective Examination: General: Condition satisfactory. Pulse 76 bpm, BP 120/80 mm Hg. Abdomen: Not distended, soft, non-tender in all quadrants. External Genitalia: Unremarkable. Speculum Exam: Vaginal mucosa pink. On the cervix, a localized epithelial change is noted on the posterior lip, measuring 1.5 cm in diameter. Discharge is mucous, moderate. Bimanual Exam (PV): Uterus is anteverted and anteflexed, normal size, firm, mobile, non-tender. Adnexa are not palpable. Fornices are clear.
Questions:
1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. A 25-year-old patient was admitted to the clinic with complaints of mild, dull, intermittent lower abdominal pain and scant bloody discharge from the genital tract for one week. This is her third pregnancy. The two previous pregnancies ended in spontaneous abortions at 9-10 weeks of gestation. Her last menstrual period was 3 months ago. Vaginal examination revealed: The cervix is intact, the external os is closed. The uterus is enlarged to the size of an 11-12 week pregnancy, somewhat soft, mobile, and non-tender. The adnexa are not palpable. The discharge is bloody, scant. Questions:

1) What is the most likely diagnosis?
2) Justify the diagnosis you have proposed.
3) What anamnestic (historical) data is necessary to determine the cause?
4) What errors were made in the management of this pregnancy by the antenatal clinic doctor?
5) What is your further management plan?

Case 3. A multiparous woman was admitted 4 hours after the onset of labor. The pregnancy is full-term. The membranes are intact. Pulse 78 bpm, rhythmic, satisfactory volume. BP - 180/120 mm Hg. Generalized edema. Urine protein: 2 g/L. Fetal lie is longitudinal. The fetal head is engaged at the pelvic inlet. Fetal heart rate: 134 bpm, rhythmic, clear. Suddenly, the woman in labor complained of abdominal pain, became pale, and her pulse increased to 100 bpm. On palpation, localized tenderness is noted on the left side near the edge of the uterus. The uterus is tense and does not relax between contractions. The fetal heart rate is irregular, muffled - 90 bpm. Vaginal examination: The cervix is effaced, cervical dilation is 5 cm. The amniotic sac is intact and extremely tense. The presenting part cannot be palpated.
Questions:

1) Most likely diagnosis.
2) Justify the diagnosis you have proposed.
3) What should be the further management plan?
4) Formulate the rationale for your chosen management plan.
5) What errors were made by the antenatal clinic doctor?

AI-1 PC-4.1.

Case 1. A 35-year-old woman presented to the antenatal clinic with complaints of itching in the external genital area, and copious, whitish vaginal discharge with a strong, unpleasant "fishy" odor. History: Menstrual: Menarche at 13. Menses last 5 days, every 28 days, regular, moderate, painless. Sexual: Sexually active since age 18, married. Obstetric History: Pregnancies - 2; Deliveries - 1 (2 years ago, without complications); Abortions - 1 (medical termination of pregnancy 3 months ago, without complications). Gynecological History: Denies gynecological diseases. Medical History: Childhood infections; ARVI; chronic gastritis. Objective Examination: General: Condition satisfactory. Pulse 76 bpm, BP 120/80 mm Hg. Abdomen: Not distended, soft, non-tender in all quadrants. External Genitalia: Normally developed, without specific lesions or signs of inflammation. Speculum Examination: Vaginal and cervical mucosa are pink. Discharge is copious, homogeneous, whitish-gray, with a strong, unpleasant "fishy" odor. Bimanual Examination (PV): Uterus is anteverted and anteflexed, normal size, firm, mobile, non-tender. Adnexa are not palpable. Fornices are clear.
Questions:

1) What is the most likely diagnosis?
2) What additional investigations are necessary to clarify the diagnosis?
3) Justify the diagnosis you have proposed.
4) What is your further management plan?
5) Formulate the rationale for your chosen management plan.

Case 2. Patient: A 25-year-old female, brought to the gynecology department by ambulance with complaints of pain in the lower abdomen on the right, nausea, dizziness, and spotting. The illness began suddenly 6 hours ago with the onset of lower abdominal pain radiating to the rectum; she reports a 2-week delay in her menstrual period. History: One pregnancy ended in full-term delivery, another in an induced abortion at 10 weeks; the abortion was complicated by an inflammatory process of the uterus and adnexa. Condition on admission: Satisfactory; pulse 90 bpm, BP 110/70 mm Hg; skin and visible mucous membranes are pale pink. The abdomen is of normal shape, with some tension of the abdominal wall muscles on the right. The Shchetkin-Blumberg sign is weakly positive. Speculum examination: Slight cyanosis of the vaginal and cervical mucosa; pupil sign (-); dark bloody, scanty

discharge. Vaginal examination: The uterus is slightly enlarged, of doughy consistency; displacement is sharply painful. To the right of the uterus, in the adnexal region, tissue pastiness and sharp tenderness are noted. The posterior fornix is bulging and tender on palpation.
Questions:
1. Most likely diagnosis.
2. Justify the diagnosis you have made.
3. What should be the further management?
4. Formulate the rationale for your chosen management strategy.
5. What is the sequence of your actions?

Case 3. Patient S., 36 years old, primigravida. Pelvic dimensions: 24, 26, 29, 18 cm. History: infertility for 8 years. Admitted to the antenatal department at full term. The fetus is in a breech presentation. Estimated fetal weight 4250 g.
Questions:
1) Formulate the diagnosis.
2) Justify your diagnosis.
3) What should be the further management?
4) Formulate the rationale for choosing this management.
5) Outline a plan for further management.

AI-2 PC-4.2.
Case 1. Patient, 48 years old, admitted to the gynecology department as an emergency with complaints of lower abdominal pain, fever up to 38-38.9°C with chills, and purulent discharge from the genital tract. Considers herself ill for the last three weeks, when she experienced nagging lower abdominal pain and periodic rises in body temperature to 37.2-37.5°C; she did not consult a doctor and took No-Spa and Pentalgin with slight positive effect. Due to increased pain, fever up to 39.0°C, and the onset of chills, she called an ambulance and was hospitalized. Her last gynecological examination was 15 years ago. Gynecological history: Menarche at age 12, menstruation for 5 days every 28 days, regular, moderate, painless. Last menstruation was 3 weeks ago. Pregnancies - III, Deliveries - I (without complications), Abortions - II (without complications). Sexually active since age 18, married. Has had 2 sexual partners. Contraception: IUD for the last 15 years. Denies gynecological diseases. Chronic diseases: denies. Past surgeries: denies. History of tuberculosis, hepatitis, venereal diseases, HIV, or blood transfusion is denied. Objective examination: Condition is moderate. Skin is clear, pulse 96/min, BP 110/70 mm Hg. RR - 19. Tongue is dry, coated with white coating. The abdomen is distended, tender in the lower quadrants. Peritoneal signs are weakly positive in the lower abdomen. Bowel sounds are audible. Had one episode of loose stool 12 hours ago. Urination is free and painless. Gynecological examination: Speculum: Vaginal walls are hyperemic, cervical epithelium appears visually unchanged. IUD strings are visible protruding from the cervical canal. Discharge is purulent, copious. Bimanual: The cervix is cylindrical in shape. The uterus is of normal size and shape, firm, mobile, non-tender. Right adnexa are not enlarged, stringy, moderately tender on palpation. To the left of the uterus, a mass measuring 8 x 7 x 7 cm is palpated, with limited mobility, tender on palpation. Movement of the cervix is painful.
Questions:
1) Provisional/most likely diagnosis.
2) What additional tests are needed to clarify the diagnosis?
3) Justify the diagnosis you have made.
4) What is your further therapeutic management?
5) Formulate the rationale for your chosen management.

Case 2. Patient M., 40 years old, admitted to the gynecology department with a referral from a women's consultation doctor. The patient complains of yellow vaginal discharge. History: Family history is non-contributory. She has had three pregnancies, one of which ended in normal childbirth, and the other two in induced abortions (at 8 and 10 weeks) without complications. Speculum examination: The vaginal mucosa is hyperemic. Whitish areas with clear borders are present on the posterior lip of the cervix. Bimanual examination: The cervix is cylindrical in shape. The uterine body is of normal size, mobile. The adnexal region is clear, non-tender. Vaginal discharge is yellow, frothy. Microbiological examination: Frothy yellow discharge in the vaginal smear. Bacterioscopic

examination: Mixed flora and Trichomonas vaginalis in the vaginal smear. Colposcopy: Revealed two whitish areas measuring 1*1.5 cm, located on the anterior and posterior lips, which gave a negative iodine reaction when treated with Lugol's solution.
Questions:
1) Most likely diagnosis.
2) Justify the diagnosis you have made.
3) What should be the further management?
4) Formulate the rationale for your chosen management.
5) Prescribe treatment.

Case 3. Citizen K., a 30-year-old multiparous woman, was admitted to the maternity hospital. She has been in labor for 10 hours. Pelvic measurements: 26, 29, 30, 18 cm. The fetal position is oblique, the head is on the right, fetal heart sounds are clear, rhythmic, 140 beats per minute. Vaginal examination revealed: Cervical dilation 6 cm, cervical edges thin and pliable. Amniotic sac is intact. A pulsating loop of the umbilical cord is presenting. The sacral promontory is reachable. Diagonal conjugate is 11 cm.
Questions:
1) Formulate the diagnosis.
2) Justify the diagnosis.
3) Calculate the true conjugate.
4) What should be the further management?
5) Formulate the rationale for your chosen management.

AI-1 PC-5.1.
Case 1. A 26-year-old primiparous woman on the 4th day after her first full-term spontaneous vaginal delivery. The delivery was complicated by a 14-hour rupture of membranes interval and a manual removal of retained placental fragments. She presents with complaints of weakness, chills, and fever up to 39.4°C. History: Menarche at 14, menses lasting 3-5 days every 29-31 days, moderate, painless, regular. History includes 2 induced abortions up to 12 weeks without complications. Registered at the antenatal clinic from 10 weeks of pregnancy, attended regularly. Weight gain during pregnancy was 12 kg, steady. The current pregnancy was uncomplicated. Objective examination: Condition satisfactory. Skin and visible mucous membranes are of normal color. Pulse 94 beats per minute, satisfactory volume, rhythmic. BP 110/70 mm Hg. Body temperature 38.6°C. Lactation is sufficient. Milk expression is extremely difficult and painful. Both mammary glands are diffusely hyperemic, tender on palpation. Nipples are clean. Abdomen is soft on palpation, non-tender. The uterus is firm, non-tender on palpation. The fundal height is 3 fingerbreadths below the umbilicus. Lochia is serosanguineous, moderate.
Questions:
1) Formulate a preliminary diagnosis.
2) Are any additional diagnostic tests necessary?
3) Further management of the puerperal woman in this case.
4) Justify the further management plan.
5) Justify the diagnosis.

Case 2. A 28-year-old primiparous woman on the 5th day after her first full-term spontaneous vaginal delivery, which proceeded without complications, presents with complaints of weakness, chills, fever up to 39.1°C, and a bursting pain in the left breast. History: Menarche at 13, menses lasting 3-5 days every 29-31 days, moderate, painless, regular. History includes 3 induced abortions up to 12 weeks without complications. Registered at the antenatal clinic from 11 weeks of pregnancy, attended regularly. Weight gain during pregnancy was 11 kg, steady. The current pregnancy was complicated by threatened miscarriage (hospitalizations at 14 and 24 weeks of gestation) and an upper respiratory viral infection at 34 weeks with fever up to 37.4°C. Objective examination: Condition is moderate. Tongue is dry, coated with white fur. Pulse 102 beats per minute, tense, rhythmic. BP 120/80 mm Hg. Body temperature 39.1°C. The left breast is enlarged, edematous, with erythema of the skin. In the lower-outer quadrant, a fluctuant area measuring 4x4x3 cm is palpated, sharply tender on palpation. The right breast is enlarged, skin color is normal. Milk expression from both breasts is difficult and painful. Both nipples have fissures. Abdomen is soft on palpation, non-tender. The uterus is firm, non-

tender on palpation; the fundal height is midway between the umbilicus and the symphysis pubis. Lochia is serosanguineous, scant.
Questions:
1) Formulate a preliminary diagnosis.
2) Are any additional diagnostic tests necessary?
3) Further management of the puerperal woman in this case.
4) Justify the further management plan.
5) Justify the diagnosis.

Case 3. Citizen F., 36 years old, second full-term delivery. History of 4 induced abortions. Gave birth to a full-term infant 30 minutes ago. The placenta has not been delivered, and there is no bleeding.
Questions:
1) Most likely diagnosis.
2) What needs to be done in this situation?
3) The sequence of your actions.
4) Formulate the rationale for your chosen management.
5) Justify the diagnosis.

Evaluation criteria, grading scale for situational tasks

Grade		**Description**
«excellent»	5	Explanation of the solution to the situational task is detailed, sequential, competent, with theoretical justifications, necessary schematic diagrams and visual demonstrations, with correct and fluent use of terminology; answers to additional questions are correct and clear
«good»	4	Explanation of the solution to the situational task is detailed but insufficiently logical, with isolated errors in details, some difficulties in theoretical justification, schematic diagrams and visual demonstrations; answers to additional questions are correct but insufficiently clear
«satisfactory»	3	Explanation of the solution to the situational task is insufficiently complete, inconsistent, with errors, weak theoretical justification, with significant difficulties and errors in schematic diagrams and visual demonstrations; answers to additional questions are insufficiently clear, with errors in details
«unsatisfactory»	2	Explanation of the solution to the situational task is incomplete, inconsistent, with critical errors, lacking theoretical justification, without the ability to create schematic diagrams and visual demonstrations or with a large number of errors; answers to additional questions are incorrect or absent

4.3. Examples of algorithms for demonstrating practical skills
Algorithm for demonstrating practical skills

Serial No.	Student's action
1	Established contact with the patient (greeted, introduced themselves, offered a seat) **AI-1 PC-2.1**
2	Clarified the patient's well-being **AI-1 PC-2.1**
3	Correctly performed hand hygiene **AI-1 GPC-4.1**
4	Correctly examined the pregnant woman, gynecological patient (Leopold's maneuvers, measurement of external pelvic dimensions, auscultation of fetal heart sounds, speculum examination) **AI-2 GPC-4.2; AI-2 GPC-4.4**
5	Correctly performed smear collection (smears for cancer cells from the cervix, smears for bacterioscopy, smears for PCR, smears for bacteriological culture, smears for hormonal studies) **AI-3 GPC-4.3**

Serial No.	Student's action
6	Performed hand hygiene using the hygienic method after the procedure **AI-1 GPC-4.1**
7	Informed the patient about the progress of the examination **AI-1 PC-2.1**

Evaluation criteria, grading scale for the demonstration of practical skills

Grade		**Description**
«excellent»	5	Knows the methodology for performing practical skills, indications and contraindications, possible complications, standards, etc., independently demonstrates the execution of practical skills without errors
«good»	4	Knows the methodology for performing practical skills, indications and contraindications, possible complications, standards, etc., independently demonstrates the execution of practical skills, allowing some inaccuracies (minor errors), which they independently identify and promptly correct
«satisfactory»	3	Knows the main points of the methodology for performing practical skills, indications and contraindications, possible complications, standards, etc., demonstrates the execution of practical skills, allowing some errors, which they can correct with instructor feedback
«unsatisfactory»	2	Does not know the methodology for performing practical skills, indications and contraindications, possible complications, standards, etc., cannot independently demonstrate practical skills or performs them with critical errors

5. Procedure for conducting intermediate certification

Intermediate certification in the discipline is conducted in the form of an exam. The exam includes: assessment of practical skills, answers to theoretical questions, and solving situational tasks.

Grade		**Description**
«excellent»	5	The student correctly answered the theoretical question(s). Demonstrated excellent knowledge within the scope of the educational material. Correctly completed the practical task(s). Demonstrated excellent abilities and proficiency in applying acquired knowledge and skills to solve problems within the scope of the educational material. Answered all additional questions
«good»	4	The student answered the theoretical question(s) with minor inaccuracies. Demonstrated good knowledge within the scope of the educational material. Completed the practical task(s) with minor inaccuracies. Demonstrated good abilities and proficiency in applying acquired knowledge and skills to solve problems within the scope of the educational material. Answered most of the additional questions
«satisfactory»	3	The student answered the theoretical question(s) with significant inaccuracies. Demonstrated satisfactory knowledge within the scope of the educational material. Completed the practical task(s) with significant inaccuracies. Demonstrated satisfactory abilities and proficiency in applying acquired knowledge and skills to solve problems within the scope of the educational material. Made many inaccuracies when answering additional questions
«unsatisfactory»	2	The student demonstrated an insufficient level of knowledge and

		skills in solving problems within the scope of the educational material when answering the theoretical question(s) and performing the practical task(s). Many incorrect answers were given to the additional questions