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Cesarean Section Dictation

Preoperative Diagnosis: Arrest of active phase/descent; breech presentation in labor; scheduled RLTCS; NRFHTs, etc.
Postoperative Diagnosis: Same
Procedure: (Scheduled) Primary/Repeat LTCS
Surgeon(s):
Anesthesia:
IVF:
UOP:
EBL:
Indications: Ms. <____> is a <____>yo g<___>p<____> at <__>w <__>d who was admitted for <__________>. Based on <___>, she was taken to the operating room for cesarean section.
Findings: Normal tubes, ovaries, uterus. <____> G infant with Apgars <____> and <____>. UA pH <____>, BE <____>. UV pH <____>, BE <____>. Normal appearing placenta with three vessel cord and central insertion.
Complications:
Drains: Foley to DD
Disposition: stable to recovery
Procedure:
After obtaining and verifying informed consent, the patient was taken to the operating room. A time out was completed to verify correct patient/procedure/site. Spinal/epidural anesthesia was administered and found to be adequate. The patient was then prepared and draped in the usual sterile fashion in a dorsal supine position with a leftward tilt. A pfannenstiel skin incision was made with a scalpel and carried through to the underlying layer of fascia. The fascia was incised in the midline and the incision extended laterally with the mayo scissors. The superior aspect of the facial incision was grasped with the kocher clamps, tented up, and the rectus muscles dissected off bluntly with sharp dissection in the midline. In a similar fashion, the inferior aspect of the facial incision was then grasped with the kocher clamps, tented up, and the rectus muscles dissected off bluntly with sharp dissection in the midline. The rectus muscles were then separated in the midline and the peritoneum entered bluntly. The peritoneal incision was extended bluntly
superiorly and inferiorly with good visualization of the bladder. The bladder blade was then inserted (and the vesicouterine peritoneum identified, grasped with the pickups, and entered sharply with the metzenbaum scissors. The incision was then extended laterally and the bladder flap created digitally. The bladder blade was then reinserted.)

A low transverse incision was made on the uterus with the scalpel and the incision extended bluntly. The bladder blade was then removed and the infant’s head delivered atraumatically. The cord was clamped and cut and the infant was handed off to the awaiting attendants/pediatricians with good cry and tone noted. Cord gases were sent.

The placenta delivered spontaneously. The uterus was then exteriorized and cleared of all clot and debris. The uterine incision was repaired with 0 vicryl in a running locked fashion. A second layer of the same suture was used in an imbricating fashion to obtain excellent hemostasis. The uterus, tubes, and ovaries were then inspected with the findings noted above and then returned to the abdomen. The gutters were irrigated and cleared of all clot and debris. The uterine incision was once again examined and found to be hemostatic. The fascia was examined and found to be hemostatic and without defect. The fascia was reapproximated with 0-PDS in a running fashion. The subcutaneous tissue was irrigated and several areas of bleeding cauterized with the bovie. [The subcutaneous tissue was reapproximated with 3-0 plain suture.] The skin was closed with staples/reapproximated using 4-0 monocryl suture in a subcuticular fashion. The incision was dressed with a sterile dressing and the uterus expressed for clot.

The patient tolerated the procedure well; sponge, lap, instrument and needle counts were correct x 2 at the end of the procedure. Mom and baby were taken in good condition to the recovery room.

For breech deliveries can insert as applies:
The fetus was presenting as a footling/frank/complete/incomplete breech. The feet/hips were grasped and the infant delivered to the level of the hips. Traction was then applied over the iliac crests with delivery to the level of the scapulae. The arms were delivered with two fingers splinted over the humeri to flex the arms medially. The head was then delivered by maintaining flexion with pressure on the maxilla and pressure on the occiput through the lower uterine segment. The cord was clamped and cut....
Vacuum-assisted Vaginal Delivery Dictation

Preoperative Diagnosis: Terminal bradycardia, fetal intolerance of second stage, etc
Postoperative Diagnosis: same
Operation performed: vacuum assisted vaginal delivery. Surgeon(s):
Anesthesia: [Epidural]
Complications: None.
Specimens:
Indication: <___> - year-old gravida <___> para <___> at <___>w <___>d admitted for <___>. The patient received <___> for induction/augmentation, and she progressed to complete. She pushed for <___> minutes and secondary to <___> the soft cup Kiwi vacuum was placed for a vacuum-assisted vaginal delivery. Procedure:
Verbal consent was obtained. The fetus was examined and noted to be in the <___> position, <___> station. The kiwi soft cup vacuum was applied at the vertex without difficulty and with <___> pulls during <___> contractions, with <___> pop-offs the baby's head was delivered without difficulty. The Kiwi suction was disengaged and the body was then delivered without difficulty. The cord was clamped and cut, and the baby was handed to the waiting pediatricians. A <___> gram <___> infant with APGARs <___> and <___> was delivered from the <___> position over a perineum with a <___> degree laceration. Cord gases were sent; UA pH was <___> with a base excess of <___>; UV pH was <___> with a base excess of <___>. The placenta was then spontaneously delivered intact, with central insertion of 3VC. A <___> laceration was repaired [with 10mL of 1% lidocaine for local anesthesia]

The patient tolerated the procedure well; sponge, lap, and instrument counts were correct after the procedure. The patient remained in the room for recovery.
Shoulder Dystocia Dictation

Preoperative Diagnosis: Shoulder dystocia
Postoperative Diagnosis: Shoulder dystocia, resolved with <___>
Procedure: McRoberts maneuver, right medio-lateral episiotomy, Supra-pubic pressure, Woodscrew maneuver, Delivery of posterior arm, etc
Anesthesia:
Attending:
Resident:
EBL:
Specimens: Placenta
Indications for procedure: <___> is a <___> year old G <___> P <___> at <___> w <___> d. Labor course was <___>. Length of second stage was <___>. Fetal heart rate strip was reviewed and assessed as <___>. After delivery of the fetal head we were unable to deliver the anterior shoulder by applying moderate downward motion. The diagnosis of shoulder dystocia was made.
Procedure:
The patient and her family as well as the birth attending staff were informed. The nurse and resident were instructed to proceed with the McRoberts maneuver and suprapubic pressure. By doing so the anterior shoulder delivered underneath the symphysis pubis. The remainder of the infant was delivered, umbilical cord clamped and cut, and the infant handed over to the pediatricians. The perineum revealed a <___> laceration. This was repaired in layers using 3-0 Vicryl suture.
Apgar scores were <____> and <____>. There was no evidence of bruising on the baby's head. Movement of both arms and hands were normal and symmetric.
Cord gasses and cord blood was obtained. The placenta was delivered spontaneously, complete and intact. Sponge and needle counts were correct at the completion of the procedure.
Postpartum Tubal Ligation Dictation

Preoperative Diagnosis: Desire for permanent sterilization.
Postoperative Diagnosis: same
Procedure: Postpartum tubal ligation, Parkland method/modified Pomeroy method
Surgeon(s):
Anesthesia: Spinal
IVF:
UOP:
EBL:
Findings: Normal uterus, tubes, ovaries.
Specimen: Bilateral tube segments
Complications: None
Disposition: to the recovery room in stable condition
Indications: <___> yo G<___> P<___> now s/p NSVD who desires permanent sterilization. The risks and benefits of the procedure were discussed, including failure of 3-5/1000 with increased risk of ectopic pregnancy.
Procedure:
After verifying informed consent, the patient was taken to the operating room where spinal anesthesia was administered and found to be adequate. The patient was then prepped and draped in the usual sterile fashion in a dorsal supine position. A small transverse infraumbilical skin incision was made with a scalpel. The incision was carried down through the underlying layer of fascia until the peritoneum was identified and entered. The peritoneum was noted to be free of any adhesions, and the incision was extended with the Metzenbaum scissors. The patient’s left fallopian tube was then identified, brought through the incision and grasped with a Babcock clamp. The tube was then followed out to the fimbriae. A 1 cm segment of tube was ligated with two free ties and excised. Good hemostasis was noted and the tube returned to the abdomen. The right fallopian tube was then identified, grasped with a Babcock clamp and followed out to the fimbriae. A 1 cm segment of tube was ligated and excised. Good hemostasis was again noted and the tube returned to the abdomen. The fascia was then closed. The skin was closed in a subcuticular fashion. The patient tolerated the procedure well. Sponge, lap, and needle counts were correct times two at the end of the procedure. The patient was taken to the recovery room in good condition.
Laparoscopic Tubal Ligation Dictation

Preoperative Diagnosis: Desire for permanent sterilization.
Postoperative Diagnosis: same
Procedure: Laparoscopic tubal ligation.
Sugeon(s): 
Anesthesia:
EBL:
UOP:
IVF:
Findings: EUA revealed small, mobile, antevered/retroverted uterus w/ no adnexal masses. Laparoscopy revealed normal uterus, tubes, ovaries.
Specimen: Bilateral tube segments
Complications: None
Disposition: to the recovery room in stable condition
Procedure:
After verifying informed consent, the patient was taken to the operating room where general anesthesia was administered and found to be adequate. Exam under anesthesia was performed with the above mentioned findings. The patient was then placed in dorsal lithotomy position and prepared and draped in the usual sterile fashion. A Hulka tenaculum/acorn manipulator was placed on the cervix. A Foley catheter was placed as well. 0.25% Marcaine was then infiltrated into the umbilicus. A 1-cm skin incision was made with the knife. The Veress needle was introduced and the abdomen was insufflated with carbon dioxide gas to a pressure of [14]mmHg after [a saline draw test confirmed appropriate placement/initially verifying an opening pressure of <____> mmHg]. A 5-mm trocar was then passed easily. The camera was passed through the port to confirm proper placement. No injuries were noted. Then 5 mL of 0.25% Marcaine were infiltrated suprapubically, and an 8-mm skin incision was made. An 8-mm port was then placed under direct visualization without difficulty. The uterus was then identified. Both fallopian tubes were identified and followed out to the fimbriae. Filshie clips were placed bilaterally without difficulty. Good hemostasis was noted. The suprapubic port was then removed under direct visualization. The gas was expelled from the abdomen. The 5-mm trocar was then withdrawn over the camera, and the camera withdrawn last. The umbilical and suprapubic port sites were then closed with 4-0 Vicryl and dressed with Steri-Strips and Band- Aids. The Hulka tenaculum was removed. The Foley catheter was removed. The patient tolerated the procedure well and was taken to the recovery room in stable condition.
**Hysteroscopy/D&C Dictation**

Preoperative Diagnosis: Retained products of conception, abnormal uterine bleeding
Postoperative Diagnosis: [same], pending pathology
Procedure: Hysteroscopy, dilation and curettage
Surgeon(s):
Anesthesia:
IVF:
UOP:
EBL:
Specimen: Endometrial curettings/products of conception
Findings: EUA revealed a small, <___> verted, mobile uterus. No adnexal masses detected. Hysteroscopy revealed <_____>
Complications: None.
Disposition: Stable to recovery
Indications: <____>
Procedure:
After verifying informed consent, the patient was taken to the operating room where <___> anesthesia was administered and found to be adequate. The patient was then positioned in the dorsal lithotomy position in the candy-cane stirrups. Examination under anesthesia was performed and revealed the above findings. The patient was then prepared and draped in the usual sterile fashion. A sterile weighted speculum was placed in the vagina, and an anterior Deaver retractor placed anteriorly. A single-tooth tenaculum was used to grasp the cervix. The cervix was dilated using the Pratt dilators to [19]. This was performed without difficulty. The hysteroscope was then introduced with the above findings noted. The hysteroscope was removed (and cervix further dilated to <____>). The uterine cavity was then gently curetted until a gritty texture was noted. The tenaculum was removed, with excellent hemostasis at the tenaculum sites following application of direct pressure (and silver nitrate sticks). The sterile speculum was removed.
The patient tolerated the procedure well. Sponge, lap and instrument counts were correct at the end of the procedure. The patient was taken to the recovery room in good condition.

**Novasure addition**
The hysteroscope was removed and the NovaSure ablation unit was inserted into
the uterus. Cavity length was \(<___>\) cm. Width was \(<___>\) cm. After the unit was deployed, there was no evidence of a leak, and endometrial ablation was then performed at a power of \(<___>\). The ablation time was \(<___>\) seconds. The endometrial ablation unit was then removed and the same was examined with evidence of good char present.

**MVA Dictation**

Preoperative Diagnosis: Retained products of conception, missed abortion, etc
Postoperative Diagnosis: Same, pending pathology
Procedure: Manual Vacuum Aspiration
Anesthesia: Paracerival block with 1% lidocaine
Surgeon(s):
EBL:
Findings:
Complications: None.
Specimens: Products of conception to pathology
Disposition: The patient recovered without difficulty and was discharged home
Indications: \(<___>\) is a \(<___>\) year old G \(<___>\) P \(<___>\) who \(<___>\). She elected to undergo manual vacuum aspiration procedure.
Procedure:
The patient was then placed in the lithotomy position with legs in the footrests. A sterile bivalve speculum was placed in the vagina and the cervix was easily visualized. The cervix was cleansed with betadine swabs x3. The anterior lip of the cervix was infiltrated with [3] cc's of 1% lidocaine, and the anterior lip of the cervix was grasped with the single-tooth tenaculum. The remainder of the paracervical block was the completed with 1% lidocaine. The cervix was then gently dilated using pratt dilators to \(<___>\). A \(<___>\) mm curette was then placed inside the cervix and attached to the manual vacuum aspirator. Multiple passes were made with the cannula until a gritty texture was noted. The tenaculum was removed and good hemostasis was noted at the tenaculum site after \(<___>\). All instruments were removed from the vagina. The patient tolerated the procedure well. Instrument counts were correct at the end of the case.
Laparoscopic BSO Dictation

Pre-operative Diagnosis: <___>
Post-operative Diagnosis:
Procedure: Laparoscopic BSO
Surgeon(s):
Anesthesia:
IVF:
UOP:
EBL:
Indication: <___>
Findings: Exam under anesthesia revealed <__>. Laparoscopic examination revealed (normal-appearing uterus, tubes, and ovaries bilaterally. Normal amount of serous pelvic fluid. Appendix, liver, gallbladder, diaphragmatic surfaces, visible surfaces of bowel and omentum appeared normal.)
Specimens: Bilateral tubes and ovaries
Complications: None
Disposition: Stable to recovery
Procedure:
After verifying informed consent, the patient was taken to the operating room where <___> anesthesia was administered and found to be adequate. The patient was then positioned in the dorsal lithotomy position with the yellow-fin stirrups. Examination under anesthesia was performed and revealed the above findings. The patient was then prepared and draped in the usual sterile fashion. The area within the umbilicus was anesthetized with Marcaine. Following this, a one centimeter skin incision was made with the scalpel. The Veress needle was passed through the skin incision in the umbilicus, and the peritoneum insufflated after [a saline draw test confirmed appropriate placement/initially verifying an opening pressure of <____> mmHg]. The peritoneum was then insufflated to a pressure of <____> mmHg. A 5-mm port was placed without difficulty. The laparoscope was then passed and correct placement was confirmed. Next, two/three additional ports were placed bilaterally, approximately 2 fingerbreadths medial to the anterosuperior iliac spine (and 2 fingerbreadths superior to the pubic symphysis). These were placed in a similar fashion after the skin was anesthetized with Marcaine, and a small skin incision made with a knife. One 10mm port and one/two 5mm ports were then placed under direct visualization. The pelvis was then inspected with the findings noted above.
Meanwhile, an acorn/ZUMI uterine manipulator was placed vaginally. A Foley catheter was also placed. The patient was placed in Trendelenburg and the bowel was readily mobile allowing better visualization of the pelvis. At that point, attention was turned to the left fallopian tube and ovary. The left ureter was identified at a safe distance from the operative field. The [gyrus/harmonic] was used to coagulate and divide the suspensory (IP) ligament of the ovary. Similarly, the utero-ovarian ligament was also divided in a similar fashion with the [gyrus/harmonic]. A series of additional divisions were carried out through the isthmus of the left fallopian tube and through the broad ligament directly inferior to the left fallopian tube. Once the left fallopian tube and left ovary were satisfactorily removed, the ureter was again identified and found to be peristalsing. At that point, attention was turned to the right fallopian tube and ovary. The right ureter was identified and found to be a safe distance from the operative field. In a similar fashion to the left, the [gyrus/harmonic] was used to remove both the right tube and ovary following which the right ureter was also identified and found to be peristalsing. The [gyrus/harmonic] was then used to achieve adequate hemostasis. The EndoCatch was then introduced and the bilateral ovaries and fallopian tubes were (separately) removed. The pressure in the abdomen was taken down to less than 3 millimeters of mercury with no further bleeding identified. At this point, the trocars were removed through each of the port sites under direct visualization. The 10-millimeter port site was closed at the fascial level with 0-Vicryl suture using the EndoClose device, and the 10-millimeter port site and all 5-millimeter port sites were closed at the skin with 4-0 Vicryl. Steri-Strips and sterile dressings were applied. The uterine manipulator was removed. Excellent hemostasis at the tenaculum sites was noted following [application of direct pressure/silver nitrate]. The patient tolerated the procedure well. Sponge, lap, and instrument counts were correct at the end of the procedure. The patient was taken to the recovery room in good condition.
Ectopic – Salpingectomy Dictation

Preoperative Diagnosis: Possible ruptured ectopic pregnancy
Postoperative Diagnosis: Ectopic pregnancy in <____> fallopian tube
Procedure: Laparoscopic [salpingectomy, salpingostomy, etc]
Surgeon(s):
Anesthesia: General
IVF:
UOP:
EBL:
Indications: <____> is a <____> year old G<____> P<____> who was suspected to have an ectopic pregnancy based on <____>. Given <____>, it was recommended that she undergo surgical intervention.
Drains: None.
Specimens: <____>
Complications: <____>
Disposition: Stable, taken to recovery room in good condition.
Procedure:
The patient was taken to the operating room where general anesthesia was administered and found to be adequate. A time out was completed, verifying correct patient, procedure, site, positioning, and special equipment. She was placed in the dorsal lithotomy position with her legs in the Yellowfin stirrups and was prepared and draped in the routine sterile fashion. A foam pad was used on the back along with foam pads on her elbows and wrists to ensure that there was no compression. The patient was positioned properly to make sure that she was not hyper flexed or hyperextended at the hip and knees. The patient's arms were tucked at her sides bilaterally. [An OG tube was placed].
The <____> manipulator was inserted into the uterus and a Foley catheter was placed. [Two] cc's of 0.25% Marcaine was injected in the umbilical port site. The Veress needle was inserted and the peritoneum insufflated after [a saline draw test confirmed appropriate placement/initially verifying an opening pressure of <____> mmHg]. The abdomen was then insufflated to a pressure of <____> mmHg. An incision was made in the superior portion of the umbilicus and the 5-millimeter port was placed. The camera was then inserted and no entry injuries were noted. The patient was placed in steep Trendelenburg. Again, [2] cc's of 0.25% marcaine was injected subcutaneously and a <____> lower quadrant 10-
millimeter port was placed followed by a 5-millimeter lower quadrant port, carefully avoiding any superficial vessels. The [gyrus/harmonic] device was used to perform the salpingectomy. The [gyrus/harmonic] [cutting forceps] were used to cauterize the fallopian tube adjacent to the cornua. Subsequently this was cut using the [cutting forceps]. Further coagulations and cuttings were performed on the mesosalpinx lateral to the tube. This was performed being fully aware that the ovary was away from the site of cautery. The IP was also spared. After successful detachment of the tube, the specimen was placed in the pelvis. The tube was then placed in an Endo Catch bag, which was removed out of the 10-millimeter port. The pelvis was copiously irrigated, a pressure check was performed, and hemostasis was seen at a pressure of mmHg. The instruments were removed under direct visualization. The 10-millimeter lower quadrant fascial incision was closed with an endo-close needle in two interrupted stitches. The skin incisions were all closed with 4-0 Vicryl in a subcuticular fashion. The incisions were covered with steri-strips and tegaderm bandages. The manipulator was removed from the uterus and the foley catheter was removed.

The patient tolerated the procedure well. Sponge, lap, and needle count were correct times 2 at the end of the procedure. The patient was extubated and was taken to the recovery room in stable condition.
LEEP/LASER Dictation

Pre-op diagnosis: Abnormal pap test, demonstrating <____>
Post-op diagnosis: same, pending pathology
Procedure: <____>
Surgeon(s):
Anesthesia: MAPS with paracervical block of 10cc 1% lidocaine with epinephrine
IVF:
UOP:
EBL:
Findings: Exam under anesthesia revealed a small, mobile, anteverted uterus. There were no adnexal masses detected. Application of 5% acetic acid demonstrated acetowhite epithelium at <____>. (Sites of acetowhite epithelium were confirmed with Lugol's stain.)
Specimens:
1. [LEEP excision, anchored with a stitch at 12 o'clock]
2. Endocervical curettings
Complications: None
Disposition: to the recovery room in stable condition
Indications: <____>yo G<____>P<____> with a history of an abnormal pap test on <____>, demonstrating evidence of [high-grade squamous intraepithelial lesion].
She underwent a colposcopic evaluation on <____> and at that time had a cervical biopsy and endocervical curettage. Findings of these biopsies and ECC were consistent with a [high-grade squamous intraepithelial lesion], and the patient was advised to undergo a [LEEP/LASER] procedure. Risks, benefits, indications for and alternatives to the procedure were discussed with the patient and she has opted for [LEEP/LASER].
Procedure:
After verifying informed consent, the patient was taken to the operating room. A time out was completed, verifying correct patient, procedure, site, positioning, and implant(s) or special equipment. MAPS anesthesia was administered and found to be adequate. The patient was then positioned in the dorsal lithotomy position in the candy-cane stirrups. Exam under anesthesia was performed and revealed the above findings. The patient was then prepared and draped in the usual sterile fashion. A sterile weighted speculum was then placed in the vagina. Five percent acetic acid was applied to the cervix with excellent visualization of the lesions. [Lugol's stain was then applied to the cervix for confirmation of the lesions]. The cervix was then infiltrated with approximately <__>cc of 1% lidocaine with epinephrine in a
circumferential fashion. The sterile weighted speculum was removed and a cautery-appropriate speculum was placed in the vagina.

Following adequate blanching of the cervix, a test pass was first made with the <___> cm x <___> cm LEEP electrode without the cautery activated. Then the <___> cm x <___> cm LEEP electrode was used on a first pass and a LEEP specimen was removed. Then, the <___> cm x <___> cm LEEP electrode was used on a second pass in a "top-hat" fashion. Endocervical curettings were then collected.

[IF LASER] At this point, a laser-appropriate speculum was placed in the vagina. The previously defined abnormal areas on colposcopy were then ablated using the carbon dioxide laser operated through the silk touch adapter and the micromanipulator with the power setting at <___> watts and spot size of approximately <___> mm. Depth of ablation was carried down to a level of approximately 3 to 4 mm as the abnormal-appearing areas primarily involve squamous epithelium. All abnormal-appearing areas were ablated as well as a margin of approximately half a centimeter in all directions.

Attention was turned to hemostasis where the Bovie cautery device was used with ball-tip electrode to coagulate bleeding areas of the base judiciously. Monsel's solution was then applied to the cervix. The patient tolerated the procedure well. Sponge, lap and instrument counts were correct at the end of the procedure. The patient was taken to the recovery room in good condition.
Cone Biopsy

Pre-op diagnosis: Abnormal pap test showing, <___>
Post-op diagnosis: same, pending pathology
Procedure: Cone biopsy
Surgeon(s):
Anesthesia:
IVF:
UOP:
EBL:
Findings: Exam under anesthesia revealed a small, mobile, <___>verted uterus. There were no adnexal masses detected. Application of 5% acetic acid demonstrated acetowhite epithelium at <___>. (Sites of acetowhite epithelium were confirmed with Lugol's stain.)
Specimens:
1. Cone biopsy, anchored with a stitch at 12 o'clock
2. Endocervical curettages
Complications: None
Disposition: to the recovery room in stable condition
Indications for Procedure: <___>yo G<___>P<___> with a history of an abnormal pap test on <___>, demonstrating evidence of [high-grade squamous intraepithelial lesion]. She underwent a colposcopic evaluation on <___> and at that time had a cervical biopsy and endocervical curettage. Findings of these biopsies and ECC were consistent with a high-grade squamous intraepithelial lesion, and the patient was advised to undergo a cone biopsy. Risks, benefits, indications for and alternatives to the procedure were discussed with the patient and she has opted for a cone biopsy.
Procedure:
The patient was brought to the OR with an IV in place. Anesthetic was administered and she was placed in the lithotomy position. The patient was prepped and draped in the sterile fashion after which a weighted speculum was placed in the vagina and a tenaculum was placed on the cervix for traction. Anchor stitches of 0 vicryl sutures were placed at 3 o’clock and 9 o’clock in the lateral vagina fornices. The cervix was stained with Lugol’s iodine solution. After the cervix was stained a scalpel was used to excise a cone shaped biopsy circumferentially around the cervical os. The specimen was removed intact after which the uterine cavity was sounded to a depth of <___> cm. A Kevorkian curette was used to obtain endocervical curettages. The cone biopsy site was sutured using a running lock
stitch of 0 vicryl. Upon completion of the suture placement, the endocervical canal was sounded to assure patency. A prophylactic application of Monsel’s solution completed the procedure. The patient was awakened from her anesthetic and taken to the PACU in stable condition. Final sponge, needle, and instrument counts were correct x2 at the end of the procedure.
Dictation Instructions

Dial 188 # (In Hospital) or 734-615-5000 (Outside Hospital)

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<td>Inpatient Progress Note</td>
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<td>Discharge Summary (w/ prompts)</td>
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Function Keys:
2 – Record/Pause  3 – Review  4 – Fast Forward
5 – Disconnect (Job#)  6 – Priority/STAT  7 – Rewind
77 – Back to Beginning  44 – Go to End

** - Correct Work type/patient ID
*0 – Re-enter Incorrect Patient ID or Work type
PAGING INSTRUCTIONS

TO PAGE:

734-936-6266
Enter Page ID #
Enter your Call Back # (a * + your pager # is helpful)

www.med.umich.edu/clinical → Paging

734-936-6267 (operator); ask to have person paged

TO CHANGE YOUR PAGER STATUS:

734-936-6268 (Can Skip Prompts)
Enter Page ID # (0005 (GYN), 33189 (GYO), 37794 (URO), 33333 (L&D-Ante), 34444 (L&D-Labor), or your pager #)

To Change Your Status Dial 1
Status 2 – On Page
Status 3 – Page, Emergency Only
Status 4 – Not available, leave message
Status 5 – Can be reached at #
Status 6 – Not available

To Change Your Covering Dial 2
If you do not have a covering pager:
   Dial 1 to add coverage, then dial covering #
If you do have a covering pager:
   Dial 1 to Change your covering
   Dial 2 to Delete your covering
HOII Contact Info
Meghan Bugosh 20633
989-708-0525

Halley Crissman 20632
989-600-6661

Matt Kucia 20634
734-255-1677

Emma Lawrence 20635
216-409-0899

Aimee Rolston 20636
504-982-8544

Jamie VanArtsdalen 20637
610-393-2284

MCIT 6-8000
Med Path 7-5150
Interpreter Services 6-7021
Risk Mgmt 3-5456
Infection Control 6-6355
Infectious Diseases 6-5205
Outpatient Pharmacy 6-8260
Discharge Pharmacy 6-1041

Tube Stations
8B Tube Station 254
8C Tube Station 248
8E Tube Station 524
Outpatient Pharmacy *Call prior,
changes frequently*

Radiology
Clinical home page:
24/7 reach-a-radiologist

CT, MRI, USN, IR 3-1800
X-rays, NM 3-1700
Portable X-rays 6-4500
Mott Radiology 3-2573
USN Tech Pager 9652
Outpatient Radiology 6-4500
Vascular Tech Pager 3500

Laboratory Numbers
Specimen Processing 6-6777
Biochemistry 6-6702
Coagulation 6-6798
Cytogenetics 3-5802
Cytology 6-6794
Hematology 6-6886
Immunology 6-6749
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| Needle Stick pager            | 5356 |

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<tr>
<td>Onc RN Fax</td>
</tr>
<tr>
<td>Bridget Capo (RN)</td>
</tr>
<tr>
<td>Rhonda Tolbert(RN)</td>
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<tr>
<td>Cathy Christen</td>
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<tr>
<td>Nutrition Pager</td>
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Vascular Access pager  3210  
Wound Care RN Pager  2461  
Wound Care Phone  6-6204  
8A Care Management  3-4821  
D/C Planning Fax  6-1151  
Ellen Higgins (IR bx)  5-3486

**CLINICS**

REI  763-4323  
VV  763-6295  
West AA  998-7380  
East AA  647-5660  
Livonia  248-888-9000  
Canton  844-5400  
Briarwood  998-7207  
Brighton  810-227-9510
L&D Cheat Sheet
Condition (order set): treatment

- Induction.
  - Cervical Ripening
    - Prostaglandins (CI if TOLAC or tachysystole)
      - Cytotec (OB Induction Misoprostol) – q4 hrs, max 6 doses (vaginal or buccal). CAUTION if bad strip, concern for baby, etc (can’t take back)
      - Cervidil (OB Induction Dinoprostone) – q12 hrs
    - Foley bulb (+/- cytotec or Pitocin) – must insert past internal os; great if 1-2cm, will dilate to 3-4cm
    - Low dose Pitocin (OB Induction/Augmentation Oxytocin)
  - Contraction Frequency/Intensity
    - Pitocin (OB Induction/Augmentation Oxytocin)
    - Amniotomy
- GBS prophylaxis (OB Labor/Induction Admission): ampicillin 2 g loading, then 1 g q4h until delivery (PCN allergy: clindamycin 900 mg q8h if sensitive, otherwise cefazolin (2 g loading, 1g q8h) if mild allergy or vancomycin (1g q12h) if severe allergy)
  - Tx: previous baby w/ GBS, GBS bacturia in preg, + cx in preg
  - GBS unknown? Tx if (5 Ps): Preterm (<37 wks); Pyuria; Pyrexia; Prolonged ROM (>18h); Prior affected baby
- Chorioamnionitis (OB postpartum infection): ampicillin 2 g q6h + gentamicin 1.5 mg/kg q8h until delivery
- Endometritis (OB postpartum infection): clindamycin (900mg q8h IV) + gentamicin (5 mg/kg q24h IV) x 48 h afebrile for cesarean (24h for vaginal) +/- ampicillin for broader coverage (especially if GBS +, severe infection based on VS instability, etc)
- Preterm Labor (OB PTL/PPROM/Short cervix): NPO, IVF, continuous monitoring, NICU consult (order + page), GBS prophylaxis (unless neg cx), betamethasone (12 mg IM q24h x2 – may consider q12h), tocolytics if <34 wks (indomethacin [only if <32 wks: 50 mg q6h; CAUTION if cardiac baby] v nifedipine [20 mg q30 min x 3 doses, then 10 mg q6h] until beta complete), neuroprotection if <32 wks (Mg 4 g bolus + 2g/h x 12 h, q4h Mg checks)
- Severe Hypertension (OB preeclampsia): tx >160/110: order PreE labs (urine P/C ratio, creatinine, AST, ALT, CBC)
  - Labetalol: Repeat BP in 15 min > if still elev give 20 mg IV > repeat in 10 min > still elev give 40 mg > repeat in 10 min > still elev give 80 mg > repeat in 10 min > administer hydralazine
  - Hydralazine: Repeat BP in 15 min > if still elev give 5-10 mg IV > repeat in 20 min > still elev give 10 mg IV > repeat in 20 min > administer labetalol
- Preeclampsia w/ Severe Features (OB preeclampsia): Hypertension + 1 severe feature: induction (> 34 wks) + magnesium (4 g bolus + 2g/h until 24 h postpartum, q4h Mg checks)
  - Severe Features: SBP > 160 or DBP > 110 x2 4h apart, PLT <100k, doubling LFTs (or RUQ pain), doubling creatinine or cr >1.1, pulm edema, persistent HA (not resolved with 1g Tylenol), vision changes
- DM in labor (OB Prenatal and Intrapartum Insulin Infusion Protocol): entire order set + AM fasting BG postpartum
- Postpartum Hemorrhage: Bimanual/fundal massage, cytotec 800 mcg PR, pitocin 10-40 units IV gtt, methergine 0.2 mg IM or PO q2-4h (avoid if hypertensive), hemabate 250 mcg IM q15-90 min (avoid in asthmatics)
- Pregnancy Loss Inductions (OB Pregnancy Loss and Termination of Pregnancy): Cytotec, Loss paperwork, SW consult
VH OR Surgical Service/C-section Resident Info

DAY PRIOR
1. Make the next day’s schedule
   - Plan order of cases (talk to the OR Team Leader and/or chief with any questions)
     --D&E/MVAs, patients with diabetes should be first. Typically bad babies (with anomalies, poor prognosis) should be early in the day as well. NICU typically prefers second case (so that they have time for sign out and rounding), but double check with them if they have a preference
     --Check with the listed surgeons to find out if they have any time constraints. Any case with "generic" case provider listed is the C/S attending. Double check with any (other) attending listed on a case to make sure they are planning to actually do that case.

2. Prep the chart and write out checklist to put in email
--History: 1-2 sentence summary of the patient and planned case
--Surgeon/Patient availability: any logistics information that needs to be known, especially for case order planning
--Labs done?: Are they ordered? Have they been completed? Is the patient planning to get them done prior to or will it need to be done in prep? (The TL will make calls the afternoon prior to discuss these details with the patient)
--Consent done?: Is there a scanned consent? For D&Es/MVAs for termination do they have the Michigan 24-hour consent? For tubal ligations, do they have the Medicaid consent (and is it listed on the usual UM consent)? If the surgeon plans salpingectomy, is that on the consent?
--H&P?: Is there an H&P within the last 30 days?
--Orders?: yes or no. If no, go to "Pre-Procedure Navigator" -> open OB C-Section/Major Case Request order set -> put in orders -> assign to the listed case -> sign and hold (make sure the CBCP, T&S are not scheduled for pre-op as they need to be an outpatient order (create a separate "Orders Only" Encounter to put those orders in)
---What's needed: Foley, Fetal Monitoring - Continuous (if C/S), Activate PTS, antibiotics (FYI - for D&Es and MVAs, we are doing doxycycline 200 mg 30-60 minutes pre-op; you'll save yourself a headache if you also order 4mg IV Zofran with that because almost everyone needs it), terbutaline (if ECV), tylenol, bicitra, IVF

3. Send the schedule out using information prepped above (there's a whole list of group emails for the NICU, nurses, anesthesia, etc. that I just pulled forward from the C/S resident on before me). In addition to that list, also add in the anesthesia residents on for the month (can be found here: https://app.qgenda.com/link/view?linkKey=7121941c-45b8-4c8e-b505-df42675f27bc -- scroll down to the CAs on call for OB) and our OB residents on L&D.
   - That's all that is NECESSARY for the email--but sometimes any big important things I NEED people to know, i will write out in the body of the email as well as have it listed in the case list

DAY OF
1. Check in with OR team leader (arrives at 630AM) to discuss any new issues. Also check in to see if you will have 2 or 3 scrub techs (if there are 3 available, then you could potentially run two rooms with the help of a floor resident. There always has to be an available scrub tech for any floor emergencies)
2. Present the case list and order at the beginning of sign out (7 AM) - can be very brief - just the one liner and any concerns that the team and/or anesthesia needs to know about. This is also a good time to talk about any pending floor issues that may hold up the scheduled cases for the day
3. Round on your postpartum patients (before or after sign out depending on how many)
4. Team Huddle (715 AM) - repeat of what you just did at sign out but now with the nurses and anesthesia (again)
5. Do the cases :). And then do all the normal stuff (put in brief op, op note, orders)
   - update the grease board and sign out any issues to the floor residents (ex: mom has T1DM on insulin gtt or pump, EBL 2L s/p 2u pRBCs, etc)
6. Make the next day’s schedule (as discussed above) and send out the email
7. If there’s time - go to Triage (as a 3rd year, go to FDC)
8. List your patients from the day that you will be PP rounding on the next day on the white board
AS THE OFF-GOING RESIDENT WE MAKE THE NEXT DAY’S SCHEDULE (so if my first day is on a Tuesday, the prior C/S resident will have prep'ed my case list, sent out the schedule, put in orders, etc on Monday afternoon)
Pregnancy of Unknown Location
This is a very common consult while you are on Benign GYN/GYN call. A few tips for dealing with these patients:

- Dot phrase for ED consult note (.OBGREGYNPUL)
- Give patients resources: PUL handout and lab draw stations/hours (to be emailed to you)
- Email blurb to clinic chief or chief on call so that patient can be added to Beta book:

  **Template:**
  Name REG#
  HPI: Example: 32yo G1P0 @ 6+1wks by LMP (8/8/2010). Certain LMP with 2 positive home pregnancy tests. Denies vb.
  Exam: Example: Benign vs. minimal R adnexal tenderness; no masses
  Hct: % (date)
  Blood type: ***
  U/S: ***
  BHCG level (with dates): (date) beta
  Phone numbers (include if okay to leave message):
  PLAN:
    ( ) example: repeat beta 10/1
    ( ) example: ultrasound in one week
- Create an “Orders only” encounter and place a standing order for like 10 Beta HCG lab draws. MAKE SURE YOU ORDER THEM AS “STAT” so that they come back faster

GYN Call Cheat Sheet

1. You will be holding three pagers:
   a. 0005 – Benign Gynecology (including MIS and REI); ED and inpatient consults
   b. 37794 – Urogynecology
   c. 33189 – Gynecologic Oncology
2. You are responsible for the care of the inpatients on the following services
   a. Benign Gynecology (UMOG or WH)
   b. Urogynecology
   c. Minimally Invasive Surgery
   d. REI
   e. Gynecologic Oncology
3. There is a fellow on call 24/7 for Urogynecology, MIS, REI and Gyn Onc; you can find out who it is by looking at who is listed as on page on the paging website under OB/GYN.
4. If you get any consults, notify your chief via page prior to going down and seeing them so that they have time to review the patient’s chart.
5. There is always a UMOG and WH staff on L&D in house with whom you can staff consults with on nights and weekends (WH only staffs WH patients). If they are too busy on L&D then you need to call the GYN on-call staff at home. Both of these people are listed on the Outlook Calendar. If you don’t know who to staff with – ask your chief!

Your job on gynecology call is as follows:
1. Take care of the inpatients (orders, evaluating PRN, discharges)
2. See ED consults
3. See inpatient consults
4. Admit patients
5. Patient phone calls – you only should be calling back UMOG patients, Urogyn patients and MIS patients. REI, Gyn Onc, Women’s Health phone calls should be directed towards that provider on call.
6. Post-op checks (during the week)
Urogynecology:
- If you receive a patient phone call from a Urogynecology patient, call the patient back, obtain a history and ALWAYS page the Urogyn fellow on call to discuss the plan for the patient. Always route your phone notes to the clinic nurses/on-call Urogyn fellow so that they can follow up on your phone discussions with the patient.
- If you receive an ED consult about a Urogyn patient that needs to be seen, in addition to paging the chief, page the Urogyn fellow on call.

Gynecologic Oncology:
- You MUST page the fellow to notify them of any ED consults (sometimes they have already been notified by the ED of the consult as they were previously first contact and ED providers are still getting used to new system)
- Page the fellow on call with any questions/concerns/updates as signed out to you by the prior provider.
- As these patients tend to be very sick, it is important to evaluate them in a timely manner if any problems with the patient arise during your shift.

REI:
- If you receive an ED consult on an REI patient, please page the on-call fellow, in addition to the chief, about the consult.

MIS:
- If you receive a patient phone call from an MIS patient, call the patient back, obtain a history and discuss a plan with the patient. If you are unsure of what is an appropriate plan, you can ALWAYS page the MIS fellow on call to discuss. Always route your phone notes to the clinic nurses/on-call MIS fellow so that they can follow up on your phone discussions with the patient.
- If you receive an ED consult on an MIS patient, please page the on-call fellow, in addition to the chief, about the consult.

Random Bits
- You carry a birth center in case there is an “OB chief trauma in ED” as you are the closet to the ED. You must go to the ED immediately with this page. Immediately call the OB chief (23660) to let them know you are en route to ED (remember, it takes at least 10 minutes for the OB team to get to the ED).
- If you see a patient in the ED who has a pregnancy of unknown location, you need to e-mail the chief on call a short signout on the patient, plan and contact information for the patient. You also need to place a standing order bhcq q 2 days for the patient. Make sure you order this STAT so that it will come back in a timely fashion.
- You need to send out the GYN inpatient consult e-mail at the end of your shift -> you must look through the patients chart and update the e-mail as appropriate.
- Any OB patient who is over 20 weeks or less than 6 weeks postpartum will likely need an evaluation in triage. Page OB chief to discuss. All OB patients with chest pain or shortness of breath must be evaluated in ED prior to coming to triage.
- There are green carts located throughout the ED that have pelvic exam supplies (speculum, light cords, culture supplies, lubrication, large q-tips). If you can’t find what you need, find an ED RN to help you.
UNIVERSITY OF MICHIGAN HEALTH—SYSTEM GYNECOLOGY ONCOLOGY
ELECTROLYTE DOSING GUIDELINES

***Use oral electrolyte supplementation whenever possible in patients able to tolerate oral electrolytes due to IV electrolyte products shortage***

WARNINGS AND CAUTIONS

- Patients with renal insufficiency are exempt from these guidelines (serum creatinine ≥ 2 mg/dL)
- These guidelines are for routine electrolyte supplementation, and are not meant for treatment in urgent situations

POTASSIUM: Goal serum potassium concentration 3.5 – 5.0 mEq/L

<table>
<thead>
<tr>
<th>Serum potassium concentration</th>
<th>Oral potassium dose</th>
<th>Intravenous potassium dose †</th>
<th>Recheck serum potassium concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3 – 3.4 mEq/L</td>
<td>20 mEq (1 packet)</td>
<td>20 mEq IVPB</td>
<td>With next AM lab draw</td>
</tr>
<tr>
<td>3.1 – 3.2 mEq/L</td>
<td>40 mEq (2 packets)</td>
<td>40 mEq IVPB</td>
<td>Within 4-6 hours of completing dose</td>
</tr>
<tr>
<td>2.8 – 3.0 mEq/L</td>
<td>60 mEq (3 packets)</td>
<td>60 mEq IVPB</td>
<td>Within 4-6 hours of completing dose</td>
</tr>
</tbody>
</table>

¥ Cardiology Patients

These patients may need higher threshold of potassium to prevent cardiac problems (potassium 4.0 – 5.0 mEq/L), and require additional potassium supplementation.

† Rate of intravenous potassium infusion

10 mEq potassium/hour; can increase to 20 mEq/hour, but continuous cardiac monitoring and infusion via a central venous catheter are recommended for infusion rates > 10 mEq potassium/hour. Maximum of 40 mEq potassium/hour in emergency situations.

**Consider adding scheduled oral potassium chloride as indicated**

CALCIUM: Goal serum ionized calcium concentration 1.12 – 1.3 mmol/L

<table>
<thead>
<tr>
<th>Serum ionized calcium concn</th>
<th>Oral calcium citrate dose</th>
<th>Intravenous calcium gluconate dose †</th>
<th>Recheck serum calcium concentration</th>
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</thead>
<tbody>
<tr>
<td>1.05 – 1.11 mmol/L</td>
<td>2 tablets Ca 315mg---Vit D3 250unit</td>
<td>1 g over 30 – 60 minutes</td>
<td>With next AM lab draw</td>
</tr>
<tr>
<td>0.99 – 1.04 mmol/L</td>
<td>3 tablets Ca 315mg---Vit D3 250unit</td>
<td>2 g over 60 minutes</td>
<td>Within 4 – 6 hours of completing dose</td>
</tr>
<tr>
<td>&lt; 0.99 mmol/L</td>
<td>Not recommended</td>
<td>3 g over 60 minutes</td>
<td>Within 4 – 6 hours of completing dose</td>
</tr>
</tbody>
</table>

* 1 g calcium gluconate = 4.56 mEq calcium; 945mg calcium citrate = 9.9 mEq calcium
† Maximum rate of intravenous infusion = 1.5 mEq calcium/minute

**Consider adding scheduled oral calcium citrate as indicated**

**MAGNESIUM: Goal serum magnesium concentration 1.5 – 2.4 mg/dL**

<table>
<thead>
<tr>
<th>Serum magnesium concentration</th>
<th>Oral magnesium oxide dose</th>
<th>Intravenous magnesium sulfate dose†</th>
<th>Recheck serum magnesium concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3 – 1.4 mg/dL</td>
<td>2 tablets Mag oxide 400mg (800mg)</td>
<td>2 g</td>
<td>With next AM lab draw</td>
</tr>
<tr>
<td>1.0 – 1.2 mg/dL</td>
<td>4 tablets Mag oxide 400mg (1600mg)</td>
<td>3 g</td>
<td>4–6 hours after dose if symptomatic; otherwise with next AM lab draw</td>
</tr>
<tr>
<td>&lt; 1.0 mg/dL</td>
<td>Not recommended</td>
<td>4 g</td>
<td>4–6 hours after dose if symptomatic; otherwise with next AM lab draw</td>
</tr>
</tbody>
</table>

¥ Cardiology Patients
These patients may need higher threshold of magnesium to prevent cardiac problems (magnesium 2.0 – 2.4 mEq/L), and require additional magnesium supplementation.

† Rate of intravenous infusion of magnesium
Recommend infusing 1 g magnesium sulfate/hour (~8 mEq magnesium/hour), up to maximum of 2 g magnesium sulfate/hour

**Consider adding scheduled oral magnesium oxide as indicated**

**PHOSPHORUS/PHOSPHATE: Goal serum phosphorus concentration 2.7 – 4.6 mg/dL**

<table>
<thead>
<tr>
<th>Serum phosphorus concentration</th>
<th>Oral phosphate dose</th>
<th>Intravenous phosphate dose †‡</th>
<th>Recheck serum phosphorus concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0 – 2.6 mg/dL</td>
<td>500 mg (16 mmol, 2 packets)</td>
<td>15 mmol over 2 hours</td>
<td>With next AM lab draw</td>
</tr>
<tr>
<td>1.5 – 2.0 mg/dL</td>
<td>1000 mg (32 mmol, 4 packets)</td>
<td>24 mmol over 4 hours</td>
<td>Within 4 – 6 hours of completing dose</td>
</tr>
<tr>
<td>&lt; 1.5 mg/dL</td>
<td>Not recommended</td>
<td>30 mmol over 6 hours</td>
<td>Within 4 – 6 hours of completing dose</td>
</tr>
</tbody>
</table>

**Consider adding scheduled oral phosphate (Neutra-Phos) as indicated**

- Maximum infusion rate = 7 mmol phosphate/hour.
- † All intravenous doses should be replaced as sodium phosphate. If patient is hypernatremic or hypokalemic, consider replacing as potassium phosphate instead.

1 mMol sodium phosphate = 1.33 mEq sodium; 1 mMol potassium phosphate = 1.47 mEq potassium.
Each packet of oral phosphate replacement contains 8 mmol phos, 7 mEq potassium, 7 mEq sodium.
**GYN ONC SERVICE**  
(Updated 1/29/2016)

**Morning rounds**
- Start early rather than rush! Who would complain about an extra 5 minutes to complete notes or get a coffee?  
  - Chief gets to pick Mon-Thurs start time. Attending/Fellow picks on Fridays and weekends.  
  - Have all vitals and daily fluid balance calculated ready before rounds. If pt getting ISC’d, have ready the voids/PVR #.  
  - Know amount of pain meds used in last 24hrs.  
  - Interview and examine patient during pre-rounding  
  - Chief should pre-round daily on all ICU patients.  
  - PM rounds with review of vitals, labs, i/o’s should be done by at least 1 resident prior to sign-out to night float. Send updates to the fellow.

**Progress notes**
- Short is good. Do not carry info forward if not relevant.  
  - Include interval events, new labs/studies. Preop or imaging from previous admit should NOT be included.  
  - Update the diet every day, explain reasoning.  
  - Update the DISPO every day, ex: “d/c home when tolerating regular diet” or “d/c to SNF when 48 hrs afebrile”  
- **Mon to mix; Tues to KM; Wed to CJ; Thurs SU; Fri to RKR. All weekend notes go to the on-call attending.**

**Postop Check Note**
- Calculating I/Os = In’s: IVF, Blood products (x3), etc; Out’s: Insensible losses = OR time x hours x 1000ml (even if laparoscopic cases, remember the amount of CO2 insufflation and lymph node dissection), EBL(x3), UOP, Ascites, NGT (or any other drain).  
- **”Suppose electrolyte protocol card.”**  
- Send postop notes to surgeon if before 6pm or on call attending if after 6pm.

**Rounding sheets**
- Calculation of maintenance rate (calculate for EVERY patient): 1500cc/24h for first 20kg + 10cc/kg/24h for remainder (ex 70kg: 1500ml + 10cc/kg x 50kg = 2000ml / 24hrs = 83ml/hr).  
  - RKR prefers 20cc/kg in place of the 10cc/kg in the above formula. Document I/Os from OR/PACU.  
  - Example: OR/PACU: IVF 9000, EBL 600 (200x3), Ascites 2000, UOP 300, ISL 3000 (3hrs) = +3100  
  - Preop Hct/Cre = 38.1/0.7, Postop = 32.4/0.8  
  - Running = +1650 (date last updated)  
  - Make sure the procedure is correct in every section of the chart.

**Post op management**
- Always page the RN after entering orders to let her know you put in orders so they get done in a timely fashion.  
- Supplement electrolytes daily per white card.  
- **Home meds:** resume (with sips) on POD0 (except supplements) especially beta blockers and antidepressants/psych meds. Hold bp meds/diuretics/ASA until hemodynamically stable (usually POD 2); diabetic meds, statins, Plavix hold until eating.  
- **GI proph:** Most pts don’t need it unless already on a PPI or have NGT in place. Stress ulcer prophylaxis is indicated for any critically ill patient with >1 of the following: mech ventilated >48 hours, coagulopathy (plts <50, INR >1.5, PTT >2x control), GI ulcer/bleed in the past year, traumatic brain injury, traumatic spinal cord injury, severe burns (>35% of the body surface area) OR 2 or more minor risk factors: sepsis, ICU admission lasting >1 week, occult GI bleeding lasting ≥26 days, high-dose glucocorticoid therapy (>250 mg hydrocortisone or equivalent).  
- **Insulin sliding scale:** at least a moderate insulin sliding scale (never low ISS) on almost every patient if they ‘look’ the part or have diabetes. Most of our patients have DM or undiagnosed DM. If you need to go higher than the high ISS, you can decrease time to q 4 hours, if you need to go higher add 2 units to each level, if you need to go higher than this, order an insulin drip.  
- IVF: POD0 start NS at 125ml/hr unless specifically told to “run dry” (such as significant cardiac hx). POD1 switch fluid to D5½NS with 20meq of KCL but decrease rate to maintenance (see Rounding sheet section for how to calculate). (If serum K is >4.5 do not add KCL to IVF, if serum Na is <130 restrict free water <500ml/day, if diabetic can remove D5 unless type 1 DM.) When tolerating clears, decrease fluids by ½ the current rate. Order Colace and simethicone when ordering clears.  
- SLIV, d/c PCA, start oral pain meds when ordering regular diet.  
- Labs: order CBC, BMP on POD 1, BMP/Mg/Phos on all pts with NGT or those not eating. Supplement electrolytes per electrolyte protocol card.  
- **”Fast Track orders:”** (for ALL da vinic/laparoscopic cases) no PCA!  
- SLIV, d/c PCA, start oral pain meds when ordering regular diet.  
- **”Include code status if DNAR”**  
- labs/imaging/consults being done that night. All overnight studies should get a prelim by am rounds. Fellow should be paged prelims/lab results at night “fyl”.  
- Put NGT or FTG + how many days
Paging the Fellow
- Use the chain of command for questions. Interns ask R2 or Chief, R2 asks your Chief, Chief asks your Fellow, Fellow asks the attending. Keep people in the loop without bouncing everything up that can be handled at the lower level.
- Always page WITH A PLAN for your question. Eg. Not "BP is up. What do I do?" but rather "Vitals are xxx I’d like to give labetalol 10 mg IV x1 now, call at xxx if not ok."
- Always give a name, pager, and call back number.
- Page fellow with important updates and at end of the day to review the list.

OR CASES
- Resident assigned to the case does brief op note and orders.
- Read about the procedure the night before and read the section in blue book.
- Dictations: KM and RKR dictate their cases. Fellow and resident decide who will dictate CJ and SU’s cases.
- Send intern to watch hysterectomies whenever possible.

Duty hours
- Chief makes sure team member are under 80h/week, 10 hours off btw shifts, have 4 days off/month. Chief should have an estimate of everyone’s hours at the beginning of each week; discuss with fellow weekly, esp if over hours. Estimate that you will be in house 13 hours per day Mon-Fri.
- Chief decides at the beginning of the week who goes home early each day based on duty hours.
- If you stay late for an OR case, it is expected that you come in the next day after 10 hours off. Page the team to let everyone know you will not be there for rounds ASAP in case we need to adjust schedules.

Onc Clinic
- Chemo pts – After discussing final plan with attending, let fellow know if dose or chemo is same/changing, any hydration orders, Neupogen/ Neulasta orders (# of days, if self-injecting or getting at infusion center).
- Preops – Need full H&P, consent, orders for abx/ heparin/SCDs, EKG (if >50yo or cardia hx), Chest imaging in last 6 months if >50 yo or pulmonary hx, medical clearance?, preop anesthesia clearance?, on Coumadin? – lovenox bridge and INR day prior to surgery.
- PUT ORDERS IN MiCHART ASAP (for paps, bxs, labs, rads, EKG, referrals).
- FILL OUT CHECKOUT SHEET: with: date of return visit, any labs/ imaging needed and when, date of infusion appt and what chemo, date of neupogen/ neulasta/ IV hydration appts.
- ORDER LABS for next appt.
- Finish preop/ new patient notes 1st, then tackle return visits. Max 72 hours to complete notes is the expectation.
- Use dot phases

Meetings
- M&M: Monday 5:10p-6p
- Core: Wed 3p–5p Forward pager #33189 to Julie. Please take it back ASAP after core and contact Julie to see if tumor board is still going on.
- Tumor Board: Wednesdays 4:00p-5:30p. Come to tumor board AS SOON AS core is over. There are always things to learn.
- Grand Rounds: Thursdays 7:30a-8:30a.
- Fellow Didactics: Wednesdays at noon

Tumor Board Notes
- List comes out usually the Friday prior and includes all OR cancer cases for the week prior + new patients from clinic who are not booked for surgery.
- Use TB template note
- Send write-ups to fellow by Sunday at 5pm.
- Basic outline of brief summary: presenting symptoms, pertinent labs/imaging, procedure performed. Tell a story but be brief.
- Avoid abbreviations! Copy the procedure performed from the op note so that it is correct and comprehensive.
- Check to see if there is RECENT IMAGING and add it to the brief summary (often done after the clinic visit).
- Add path report if complete (only the section called “microscopic diagnosis”, not the gross).
- Come up with a dx/plan (we will correct it if necessary).
- Delete all prompt lines.
- Do NOT delete the words "Brief Summary”.

Learning: ALL THE TIME!
- Fellow will hand out pertinent articles from time to time
- RKR has teaching rounds Fri morning.
- Med studs should give a 5 min talk about a Gyn Onc topic while on service.

Team Member Roles
Chief Roles:
- Oversee notes, orders, signouts and floor activity for all patients (i.e. check everything!)
- Assign patients to junior residents for pre-rounding
- Preround on all ICU patients every day
- Distribute tasks to med students
- Pick Mon-Thurs rounding time and page/email/tell everyone
- Preops – review after Sherrie finishes them, review with fellow, assign residents to cases
- Admit/DC list – send to Sheree weekly
- M&M list – send to Sheree weekly
- Tumor board – Assign team members to notes, confirm all write-ups done, and do write-ups
- Follow up labs/cultures which are pending at the time of discharge
- Supervise TPN notes

Junior Resident Roles:
- Floor responsibilities: Patients divided between HO1 and HO2 (and subl) for rounding – Responsible for the following on that patient:
  - Daily progress note, orders, discharge summary/meds/discharge planning
  - Update signout
- Intern to print signout for each team member.
- Get vitals for all pts including all output of drains, amount of pain meds used last 24hrs, Voids + ISC’s prior to rounding time.

Med Stud Roles:
- Students should see 1-2 pts every morning (especially if they observed the surgery) and present during rounds.
- Attend rounds every day M-F (unless cont clinic is off campus and starts at 7:30, otherwise come to rounds)
- Give a 5 min talk about a Gyn Onc topic while on service
Smartphrase Instructions

Managing SmartPhrases:
-- In MiChart, go to the large EPIC button in the upper left >> select Tools >> SmartTool editors >> SmartPhrase Manager. A box will pop up that automatically with you listed as the User. If you want to edit your SmartPhrases, select yourself and it will take you to a list of all of your SmartPhrases. From there, you can edit, add new ones, etc.
-- To Steal SmartPhrases from others, follow the same steps as above, but when the dialog box pops up with your name, search for the person you want to steal from and open up their list of smartphrases. When you locate the one you want to share, highlight it, click share and then share with yourself (you can also highlight multiple and share them all with yourself at once). If an error box pops up, it is likely that SmartPhrase is already shared with you.

Useful SmartPhrases:
-- You should all have access to the “.obgres**” smartphrases that are very useful. In addition, you may find the list below helpful. **As you rotate through different specialty services and clinics, it is very important to ask the various attendings which Smartphrases/templates they prefer that you use. GYO is very specific and will give you a book with all the smartphrases.

.mdnbgyopostopprog (GYO postoperative progress note)
.mdorio (Postop check I/O calculator)
.mdpreewarnings (pre-eclampsia instructions/warnings for BP check, goals, and when to come back)
.mdsep (“see separate day of discharge progress note” for the DC summaries)
.mdnewobhr
.mdpostpartumrv
.ariol
.arisol
.arppcs
.arppnsvd
.arnewob
.arnewgen
.arpreciob
.arrenatalrv
.arexam
.arpostpartum
.arlabialpostopbandage
.arlaborprogress
.arrensvd
.arphonecounsel
.arpuclinic

A few Urogyn specific ones (again, you should always ask preferences on specialty services)
.mosnewpat – new patient
.mospostopvisitnote – postop visit
.caserequrogyn – preop variables for case requests
.dsauiindex – urinary symptom questionnaires
.mospessary – pessary check note
.cranberry – how to order TheraCran for periop patients
.cwsmhhad – new patient template for Healthy Healing Clinic
.meddisposal – how to dispose properly of leftover pain meds
.mosdrugse – for patients having anticholinergic side effects
.mosexam – basic pelvic exam template for return visits
.mosinconthandout – patient info re: mixed urinary incontinence

POPQ data entered using SmartText – ask where to find this