

INTRODUCTION TO PELVIC

OBSTETRIC AND

GYNAECOLOGICAL

PHYSIOTHERAPY

An Educational Resource

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# Introduction

# Introduction

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# Introduction

It is acknowledged that physiotherapists may become involved in the management of pelvic, obstetric and gynaecological patients. These clinicians will have differing levels of expertise, diverse skills and varying access to learning support. This aim of this handbook is to guide the learning of physiotherapists to extend their knowledge and skills within this speciality.

This manual covers all aspects of the expanding role of the physiotherapist within this specialist area. You can select the areas that are relevant to your current practise.

The handbook is divided into subspecialisms that may be within your scope of practice. Each section: identifies potential learning objectives; provides references to relevant research material and patient information booklets; and contains details of relevant courses.

As an affiliate member of POGP, we hope that you find this resource valuable in validating your continuing professional development, and that you will become a member. There are four ways to achieve membership: pogp.csp.org.uk/content/pogp-membership

# Suggested POGP education routes

# Core skills frameworkSuggested POGP education routes

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POGP educational progression

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  | Service |  |
|  |  |  | development |  |
|  | Clinical |  |  | Assigning a |
|  | supervision |  |  | mentor |
|  | Women’s |  |  |  |
|  | Health/ |  |  |  |
|  | Continence |  |  | Reflection |
|  | module – |  |  |  |
|  | Bradford |  |  |  |
|  |  |  | POGP |  |
|  | Short POGP course |  | membership | Observation |
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|  |  | iCSP |  | POGP |
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Informal learning – 3 years

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# Core skills framework

# ObstetricsCore skills framework

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# ObstetricsCore skills framework

1. Understand normal posture and muscle function.
2. Consider the application of general exercise physiology to the pelvic floor muscles.
3. Consider evidence-based exercise in relation to methods such as: core stability; musculoskeletal techniques; Pilates; and hydrotherapy.
4. Understand the role of the multidisciplinary team in your specific area.
5. Demonstrate an understanding of cultural, social, ethnic and gender identity, sexual orientation, and religious beliefs. Adapt your professional interaction to facilitate care.
6. Demonstrate appropriate skills in communication in a variety of environments, using interpreting services and chaperoning as required. Pay particular attention to gaining informed, valid consent and demonstrating shared decision-making.
7. Demonstrate professional behavioural skills, such as empathy and sensitivity, especially where problems may be related to bereavement, or be of a personal, social or intimate nature. Know whom you should refer patients to if further expertise is required.
8. Apply skills in accurate record-keeping and maintaining confidentiality.
9. Understand the role of the physiotherapist in preventative care.

**Suggested learning resources**

**Websites**

pogp.csp.org.uk

[www.nice.org.uk](http://www.nice.org.uk)

[www.rcog.org.uk](http://www.rcog.org.uk)

**Reading**

*Journal of Pelvic, Obstetric and Gynaecological Physiotherapy*

Royal College of Obstetricians and Gynaecologists (RCOG) guidelines

Chartered Society of Physiotherapy information papers:

*Pelvic Floor Examination – CSP Expectations* (PD092, 2012)

*Chaperoning and Related Issues* (PD104 ERUS-IP 24, 2013)

*Consent and Physiotherapy Practice* (PD078, 2016)

**Academic courses**

University of Bradford Postgraduate Certificates:

Physiotherapy inWomen’s Health

Continence for Physiotherapists

# Obstetrics

# Urology, gynaecology and colorectal servicesObstetrics

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# Urology, gynaecology and colorectal servicesObstetrics

Obstetrics is the field of medicine that deals with pregnancy, delivery of the baby and the first 6 months after delivery. The role of the physiotherapist may vary considerably in obstetrics from face-to-face contact to triage, parentcraft classes, and hydrotherapy in inpatient and outpatient environments.



**Learning objectives:**

1. Understand normal posture and muscle function.
2. Investigate the physiological and physical changes that occur during pregnancy, delivery and the year following childbirth.
3. Investigate the obstetric issues that contribute to musculoskeletal dysfunction.
4. Consider the evidence base for different exercise and treatment methods for obstetrics patients, such as Pilates, acupuncture and hydrotherapy.
5. Be aware of red flags that may affect patient care (e.g. pre-eclampsia and placenta praevia).
6. Select appropriate assessment and examination techniques for the musculoskeletal and continence systems, including outcome measures, and apply your clinical reasoning skills to direct intervention.
7. Develop and adapt therapeutic management skills for use with obstetrics patients, including appropriate musculoskeletal techniques.
8. Develop insight into the effects of obesity in the pregnant woman on her health and that of her unborn child. How can physiotherapists be proactive in the management of pregnancy-related obesity?
9. Develop insight into the psychological needs of the obstetrics patient, including postpartum psychosis, and services that provide appropriate support, such as crisis teams, and support networks, such as Birth Reflections.

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**Antenatal period**

* Consider the health promotion aspect of care for antenatal women, especially those with an elevated body mass index and/or a pre-existing musculoskeletal dysfunction.
* Investigate methods of education during the antenatal period, including face-to-face consultations, patient information leaflets and internet resources.
* Investigate the role of the core muscles in maintaining posture and function during the antenatal period.
* Review the factors that may contribute to pregnancy-related low back pain and pelvic girdle pain.
* Investigate common musculoskeletal conditions that are managed by physiotherapists, including carpal tunnel syndrome and rib flare.
* Explore the differential diagnosis of musculoskeletal pain, such as avascular necrosis and metastatic spinal disease, and the complications of pregnancy that influence care.
* Evaluate the ways in which physiotherapy treatment may be provided, such as telephone triage, classes and hydrotherapy.
* Investigate the role of physiotherapy in preparation for childbirth, including positioning, relaxation techniques and pain management.
* Investigate bladder and bowel management in pregnancy.
* Consider how you may develop services for antenatal people.
* Review the patient information literature available in the antenatal period.

**Available learning resources**

**Booklets available through pogp.csp.org.uk**

*Fit for Pregnancy*

*Fit and Safe: Exercises in the Childbearing Year*

*Fit for Birth*

*Pregnancy Related Pelvic Girdle Pain for Mothers to Be and New Mothers*

*Pregnancy Related Pelvic Girdle Pain for Health Professionals*

*Pilates in Women’s Health Physiotherapy*

*The Mitchell Method of Simple Relaxation*

*Aquanatal Guidelines: Guidance on Antenatal and Postnatal Exercises in Water*

*POGP Guidance on the Safe Use of Transcutaneous Electrical Nerve Stimulation (TENS) for Musculoskeletal Pain During Pregnancy*

*Pelvic Floor Muscle Exercises (for Women)*

**Suggested reading**

Dufour S., Bernard S., Murray-Davis B. & Graham N. (2019) Establishing expert-based recommendations for the conservative management of pregnancy-related diastasis rectus abdominis: a Delphi consensus study. *Journal of Women’s Health Physical Therapy* **43** (2), 73–81.

Hilde G., Gutke A., Slade S. C. & Stuge B. (2016) Physical therapy interventions for pelvic girdle pain (PGP) after pregnancy (Protocol). *Cochrane Database of Systematic Reviews*, Issue 11. Art. No.: CD012441. DOI: 10.1002/14651858.CD012441.

**Delivery**

* Understand the progress of normal labour, and recognise deviations from the normal and how these would need to be managed in the postnatal period.
* Identify the risks associated with delivery and how these can be prevented.

**Postnatal period**

* Consider appropriate advice that would benefit all women in the postnatal period, and how this should be conveyed to those who have experienced the death of a baby.
* How would this information need to be modified for people who have experienced a complicated delivery?
* Recognise pelvic muscle trauma and postpartum bladder and bowel dysfunction, and devise appropriate management plans.
* Review specialist/multidisciplinary team services and practice for managing bladder and bowel dysfunction after delivery, especially for third- and fourth-degree perineal tears.
* Identify the types of musculoskeletal dysfunction that can occur as a result of delivery or during the antenatal period .
* Investigate the methods by which you may manage people with musculoskeletal dysfunction in the postnatal period such as diastasis rectus abdominis and coccydynia.

**Suggested reading (continued)**

National Institute for Health and Care Excellence (NICE) (2015) *Postnatal Care up to 8 Weeks after Birth.* (CG37.) [WWW document.] URL <https://www.nice.org.uk/guidance/cg37>

National Institute for Health and Care Excellence (NICE) (2019) *Antenatal Care for Uncomplicated Pregnancies.* (CG62.) [WWW document.] URL <https://www.nice.org.uk/guidance/cg62>

Royal College of Obstetricians and Gynaecologists (RCOG) (2015) *Pelvic Girdle Pain and Pregnancy.* (Patient information leaflet.) [WWW document.] URL <https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-pelvic-girdle-pain-and-pregnancy.pdf>

Royal College of Obstetricians and Gynaecologists (RCOG) (2015) *Third- and-Fourth degree Perineal Tears Management.* (Green-top Guideline No. 29.) [WWW document.] URL <https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-29.pdf>

POGP good practice statements:

*Digital Examination During Pregnancy*

*The use of Maternity/ Pelvic Support Belts for Perinatal Pelvic Girdle Pain*

*Acupuncture for Pregnancy-Related Low Back Pain and Pelvic Girdle Pain*

*Driving after Gynaecological Surgery and Caesarean-Section Delivery*

**POGP workshops**

Pregnancy-Related Physiotherapy: Assessment and Management of Musculoskeletal Conditions; Lumbar Spine and Pelvis

Pregnancy-Related Physiotherapy: Assessment and Management of Musculoskeletal Conditions; Hip and Trunk



**Methods of enhanced learning: suggested observations**

* Antenatal clinic
* Antenatal ward
* Community midwife
* Ultrasound department
* Midwife classes
* Physiotherapy classes
* Early antenatal session
* Aquanatal class
* Full course in parentcraft
* Partner’s/companion’s session(s)
* Young (teenage) class
* Refresher/multiparae class
* Pre-operative preparation for Caesarean section
* Use of pelvic support belts
* Transcutaneous electrical nerve stimulation (TENS)
* Witness: normal delivery; waterbirth; repair of third-degree tear; forceps delivery; ventouse delivery; multiple delivery; suturing of perineum; and Caesarean section
* Postnatal ward
* Postnatal group
* Assessment and treatment of pregnancy-related problems:

perineal oedema; bruising; haematoma; third- or

fourth-degree tears; haemorrhoids; wound infection; delayed

healing; urinary; defecation problems; carpal tunnel

syndrome; low back and pelvic girdle pain; coccygeal pain;

and diastasis rectus abdominis

# Urology, gynaecology and colorectal services

The fields of paediatric continence, urology, gynaecology, urogynaecology and colorectal physiotherapy are often interlinked.



**Learning objectives:**

1. Understand normal bladder and bowel function, and how this is maintained in the healthy adult.
2. Identify the factors that may contribute to urological, gynaecological and/or

 colorectal dysfunction.

1. Investigate the physiological and physical dysfunctions of the urological, gynaecological and colorectal systems, including incontinence, sexual function, pain and pelvic organ prolapse.
2. Understand the physiology and muscle function of the pelvic floor and associated structures.
3. Assess relevant subjective and objective information.
4. Investigate evidence-based practice of how pelvic floor dysfunction is managed conservatively, including exercise, lifestyle advice, group therapy, devices and electrotherapy/ biofeedback.
5. Investigate medical and surgical management of pelvic floor dysfunction.
6. Investigate the role of the physiotherapist when a patient is admitted for surgical management of urological, gynaecology and colorectal problems.
7. Investigate the role of the physiotherapist following reconstructive surgery.

**Paediatric continence**

* Identify factors that may contribute to childhood incontinence.
* Identify common paediatric bladder and bowel dysfunctions.
* Consider the health promotion aspect of the care of children with long-term conditions that affect bladder dysfunction (e.g. cystic fibrosis).
* Evaluate methods of treating children with pelvic floor dysfunction; for example, dietary advice, defecation dynamics and pelvic floor exercises.
* Consider the role of patient information, and social media that may be appropriate for managing Generation Z.
* Investigate the value of using medication in childhood incontinence.
* Explore the non-conservative management of paediatric incontinence.

**Urinary continence**

* Review the physiology, anatomy and function of the urogenital system.
* Identify factors that may contribute to urinary incontinence and erectile dysfunction.
* Identify the common urinary dysfunctions; for example, stress incontinence, overactive bladder and voiding dysfunction.
* Consider the health promotion aspect of obstetric care, prostatitis and long-term conditions that affect bladder function.
* Investigate the role of the pelvic floor and abdominal muscles in maintaining intra-abdominal pressure, posture and pelvic floor function.
* Demonstrate an understanding of muscle function, and its effect on symptoms.
* Review the evidence-based practice of pelvic floor muscle training, including biofeedback and electrotherapy.

**Suggested reading: paediatric**

National Institute for Health and Care Excellence (NICE) (2014) *Bedwetting in Children and Young People.* (QS70.) [WWW document.] URL <https://www.nice.org.uk/guidance/qs70/resources/bedwetting-in-children-and-young-people-pdf-2098841389765>

National Institute for Health and Care Excellence (NICE) (2014) *Constipation in Children and Young People*. (QS62.) [WWW document.] URL <https://www.nice.org.uk/guidance/qs62/resources/constipation-in-children-and-young-people-pdf-2098784282821>

**Resources**

www.eric.org.uk (children’s bowel and bladder charity)

www.squeezyapp.com (apps supporting women, men and those with cystic fibrosis with pelvic floor muscle exercise programmes)

**Suggested reading: adult**

National Institute for Health and Care Excellence (NICE) documents:

*Urinary Incontinence and Pelvic Organ Prolapse in Women: Management* (NG123, 2019)

*Faecal Incontinence in Adults: Management* (CG49, 2007)

*Constipation* (CKS, 2019)

*Constipation Overview* (NICE Pathway, 2019)

*Menopause: Diagnosis and Management* (NG23, 2015)

Bø K., Berghmans B., Morkved S. & Van Kampen M. (2015) *Evidence-Based Physical Therapy for the Pelvic Floor: Bridging Science and Clinical Practice*, 2nd edn. Churchill Livingstone, Edinburgh.

Bø K., Frawley H. C., Haylen B. T.., *et al.* (2017) An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for the conservative and nonpharmacological management of female pelvic floor dysfunction. *Neurology and Urodynamics* **36** (2), 221–244.

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* Evaluate methods of educating people with bladder dysfunction, including face-to-face interactions, group therapy, patient information leaflets and internet resources.
* Review the patient information literature available to people with incontinence.
* Investigate the value of using medication and devices in urinary incontinence.
* Investigate the surgical management of urinary incontinence.
* Identify appropriate advice and exercises to be given to people in the pre- and postoperative periods.

**Menopause**

* Identify the biochemical and metabolic changes that occur in the perimenopause, menopause and postmenopausal period.
* Identify how health education can assist menopausal women.
* Investigate the beneficial effects of exercise, and the types of exercise recommended for menopausal women.
* Investigate the beneficial effects of acupuncture for menopausal women.
* Investigate the use of medication in managing menopausal symptoms.

**Pelvic organ prolapse**

* Identify factors that may contribute to individuals developing pelvic organ prolapse.
* Identify the types and classifications of pelvic organ prolapse.
* Investigate the symptoms of pelvic organ prolapse that are related to function.
* Consider health promotion and lifestyle advice; for example, with regard to constipation, heavy lifting and a caring role.

**Suggested reading: adult (continued)**

Doggweiler R., Whitmore K. E., Meijlink J. M., *et al.* (2017) A standard for terminology in chronic pelvic pain syndromes: a report from the chronic pelvic pain working group of the International Continence Society. *Neurology and Urodynamics* **36** (4), 984–1008.

Engeler D., Baranowski A. P., Borovicka J., *et al.* (2014) *Guidelines on Chronic Pelvic Pain.* [WWW document.] URL <https://uroweb.org/wp-content/uploads/26-Chronic-Pelvic-Pain_LR.pdf>

Haylen B. T., de Ridder D., Freeman R. M., *et al.* (2010) An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic floor dysfunction. *Neurology and Urodynamics* **29** (1), 4–20.

Haylen B. T., Maher C. F., Barber M. D., *et al.* (2016) An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic organ prolapse (POP). *International Urogynecology Journal* **27** (2), 165–194.

Rana N., Drake M. J., Rinko R., Dawson M. & Whitmore K. E. (2018) The fundamentals of chronic pelvic pain assessment based on International Continence Society recommendations. *Neurology and Urodynamics* **37** (S6), S32–S38.

Sultan A. H., Monga A., Lee J., *et al.* (2017) An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female anorectal dysfunction. *International Urogynecology Journal* **28** (1), 5–31.

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* Investigate the role of the pelvic floor and abdominal muscles in managing the symptoms of pelvic organ prolapse.
* Prescribe pelvic floor muscle exercises relevant to pelvic organ prolapse treatment.
* Evaluate methods of educating people with pelvic organ prolapse, including face-to-face interactions, group therapy, patient information leaflets and internet resources.
* Review the patient information literature available for pelvic organ prolapse.
* Investigate the value of using pessaries and medication in pelvic organ prolapse.
* Review the investigations and surgical management relevant to pelvic organ prolapse.
* Identify appropriate advice and exercises to be given in the pre- and post-operative periods.

**Bowel continence**

* Identify the anatomy and physiology of normal bowel function, including storage and defecation.
* Consider the health promotion of bowel function.
* Identify common forms of bowel dysfunction.
* Investigate the reasons and contributing factors for altered bowel function; for example, urgency, slow transit, constipation and irritable bowel syndrome.
* Evaluate subjective and objective assessments of pelvic floor function, including investigations and the validity of outcome measures.
* Investigate the methods of facilitating pelvic floor muscle function, including techniques such as biofeedback.
* Evaluate methods of educating patients with bowel dysfunction, including face-to-face interactions, group therapy, patient information leaflets and internet resources.

**Resources**

www.imsociety.org/imsimpart\_register.php (IMPACT online training)

thebms.org.uk (British Menopause Society)

**POGP workshops**

Pelvic Health Physiotherapy: Female Urinary Dysfunction

Pelvic Health Physiotherapy: Male Lower Urinary Tract Symptoms – Advancing Your Practice

Pelvic Health Physiotherapy: Pelvic Organ Prolapse – Advancing Your Practice

Pelvic Health Physiotherapy: Pelvic Organ Prolapse – Advancing Your Practice

Pelvic Health Physiotherapy: Lower Bowel Dysfunction

Pelvic Health Physiotherapy: Managing Complex Female Pelvic Pain and Pelvic Floor Muscle Dysfunction – Advancing Your Practice

**Booklets available through pogp.csp.org.uk**

*Fit Following Surgery: Advice and Exercise Following Major Gynaecological Surgery*

*Pilates in Women’s Health Physiotherapy*

*Pelvic Floor Muscle Exercises and Advice for Men*

*Pelvic Floor Muscle Exercises – A Guide for Women*

*Promoting Continence with Physiotherapy*

*Pelvic Organ Prolapse: A Guide for Women*

*Improving Your Bowel Function*

*ACPWH Statement Re: ES for Women with Recent Abnormal Cervical Cytology* (2012)



* Review the patient information literature available to

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@ThePOGP

@JPOGP (POGP journal)

**Facebook**

POGP Members Area (closed group)

patients with bowel incontinence.

* Investigate the use of devices and medication in the treatment of bowel incontinence.
* Investigate the role of surgical management in the treatment of bowel dysfunction.
* Investigate the role of the multidisciplinary team in managing bowel incontinence.

**Chronic pelvic pain**

* Identify factors that may contribute to chronic pelvic pain

(CPP), including endometriosis, irritable bowel syndrome and pudendal nerve neuropathy.

* Define chronic pelvic pain, and common terminologies

associated with this diagnosis (e.g. vaginismus and

vulvodynia).

* Demonstrate effective communication with and identification

of the problems of patients experiencing chronic pain.

* Reflect on approaches to chronic pain management (e.g. cognitive behavioural therapy, mobility and exercise).
* Investigate methods of managing CPP (e.g. neurostimulation,

medication and injection therapy).

* Investigate the surgical management of CPP.

**Methods of enhanced learning: suggested**

**observations**

**Inpatients**

* Observation in theatre: total abdominal hysterectomy; vaginal

hysterectomy; pelvic floor repair; urethral sling procedure;

fistula repair; transurethral resection of the prostate; and laser

vaporesection

* Pre-operative/pre-admission session
* Postoperative care



**Outpatients**

* Urology/gynaecology clinic
* Urodynamics
* Continence adviser
* Nurse specialist
* Vulvodynia clinic
* Specialist paediatric continence services
* Bladder retraining
* Vaginal examination
* Anorectal examination
* Treatment modalities including: lifestyle advice; pelvic floor muscle exercises;posture

re-education; biofeedback; neuromuscular stimulation; manual therapy; and devices (e.g. cones and Contiform vaginal pessaries)

* Group therapy
* Pessary clinic
* Multidisciplinary team meetings (both local and cross-trust)

**AID** artificial insemination with donor’ssemen

## Appendix 1: Obstetric abbreviations

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## Appendix 4: Gynaecology Surgery terminology and abbreviationsAppendix 1: Obstetric abbreviations

## Appendix 1: Obstetric abbreviations

**AIH** artificial insemination with husband’ssemen

**AN** antenatal

**ANC** antenatal clinic

**APH** antepartum haemorrhage

**ARM** artificial rupture of membranes

**BBA** born before arrival (at hospital)

**BKFO** bent knee fall-out

**Ceph** cephalic

**CCT** continuous cord traction

**CPD** cephalopelvic disproportion

**CTG** cardiotocograph

**DRAM/RAD/DRA** divarication rectusabdominis

**EAS** external anal sphincter

**ECV** external cephalic version

**EDD** expected date of delivery

**EL.LSCS** elective lower segment Caesareansection

**EM.LSCS** emergency lower segmentCaesarean section

**ERPC** evacuation of retained products ofconception

**EPAU** early pregnancy assessment unit

**FD** forceps delivery

**FHH(R)** foetal heart heard (regular)

**FM** foetal movement

**GA** general anaesthetic

**GIFT** gamete intrafallopian transfer

**G** gravida (number of pregnancies)

**IAS** internal anal sphincter

**IDDM** insulin-dependent diabetes mellitus

**IOL** induction of labour

**IUCD** intrauterine contraceptive device

**IUD** intrauterine death

**IUGR** intrauterine growth retardation

**IVF** *in vitro* fertilisation

**KRFD** Kielland rotational forcepsdelivery

**LBW** low birth weight

**MROP** manual removal of placenta

**NBFD** Neville–Barnes (Barnes–Neville)forceps delivery

**N(V)D** normal (vaginal) delivery

**NE** not engaged

**NICU** neonatal intensive care unit

**NND** neonatal death

**NNU** neonatal unit

**NICU** neonatal intensive care unit

**OA** occiput anterior

**OASIS** obstetric anal sphincter exercises

**OP** occiput posterior

**P** parity(number of live births over 20–40 weeks)

**PGP** pregnancy-related pelvic girdle pain

**PIH** pregnancy-induced hypertension

**PN** postnatal

**POP** persistent occipiut posterior

1. posterior presentation

**PPH** postpartum haemorrhage

**Primp** primiparous

**PROM** prolonged rupture of membranes

**PAIVM** passive accessory intervertebralmovement

**PAWS** pregnancy and well-being service

**PET** pre-eclamptic toxaemia

**PFME** pelvic floor muscle exercise

**SB** stillbirth/stillborn

**SCBU** special care baby unit

**SIDS** sudden infant death syndrome

**SPD** symphysis pubis dysfunction

**SRM** spontaneous rupture of membranes

**SVD** spontaneous vertex delivery

**UTI** urinary tract infection

**V(V)E** ventouse (vacuum) extraction

**VBAC** vaginal birth after Caesarean

## Appendix 2: Obstetric terminology

## Suggested POGP education routesAppendix 2: Obstetric terminology

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**abortion (miscarriage)** the expulsion from the uterus of the products of conception beforeweek 24 of pregnancy. There are several types:

* *threatened* – the pregnant woman develops vaginal bleeding, possibly with mild uterine contractions, but the cervix remains closed; the pregnancy may continue.
* *inevitable* – uterine contractions become stronger, leading to dilation of the cervix; the pregnancy will not continue.
* *incomplete* – some of the products of conception remain in the uterus.
* *complete* – all the products of conception have been passed; the uterus is empty.
* *missed* – the dead embryo and placenta are not expelled spontaneously.

**after pains** painful uterine contractions occurring during the puerperium.

**amenorrhea** absence of menstrual flow.

**amnion** the tougher inner membrane enclosing the foetus *in utero*.

**android pelvis** a type of pelvis that has features that render it less well adapted for childbearing than the gynaecoid pelvis.

**antenatal** before birth, i.e. during pregnancy.

**antepartum haemorrhage (APH)** bleeding from or into the genital tract between week 24 of pregnancy and the birth of the baby. There are three types:

* *revealed* – bleeding that can be seen per vagina (PV).
* *concealed* – bleeding *in utero* not seen per vagina.
* *mixed* – both.

Causes of APH include:

* *placenta praevia* – part of the placenta lies in front of the foetus (this could berevealed or concealed).
* *placental abruption* – separation of the placenta, or part of the placenta, from the uterine wall (this could be revealed or concealed).
* *cervical/vaginal bleeding* – bleeding from cervix or vagina caused by a polyp or carcinoma, or post-coitus (after intercourse).

**anterior fontanelle** the large “soft spot” at the front of the infant skull.

**antibody** a protein made by the body in response to a foreign substance entering the circulation (e.g. rhesus antibodies).

**anti-D immunoglobulin** medication given to rhesus-negative mothers afterdelivery to prevent rhesus antibody formation; it confers short-term passive immunity.

**Apgar score** a method of evaluating the condition of the newborn infant that considers fivepoints – heartbeat, respiration, colour, muscle tone and response to stimulus – giving a score of 0, 1 or 2 to each point at 1, 5 and 10 minutes after birth.

**areola** the pigmented area of the breast surrounding and including the nipple.

**asphyxia** a condition that occurs when the foetus fails to breathe properly at birth, although there is a heartbeatpresent.

**attitude** the relationship of the foetal limbs and head to the trunk, namely flexed orextended, flexed being normal.

**augmentation** acceleration or re-establishment of labour at any stage when contractionshave weakened or stopped altogether (e.g. by oxytocin).

**biparietal diameter** the widest and, therefore, the most important diameter of the foetal skullbetween the two parietal eminences, usually 9.5 cm.

**breech presentation** a foetus with the buttocks instead of the head in the lower pole of theuterus, which means that these will emerge first at delivery; it may present as an extended or footling breech.

**Caesarean hysterectomy** a hysterectomy performed at the time of a Caesarean section.

**caput succedaneum** oedema of the presenting part formed during labour and after ruptureof the membrane.

**cephalohaematoma** an effusion of blood beneath the periosteum of one of the bones in the skull vault, commonly the parietal bone.

**cephalic** pertaining to the head (e.g. cephalic presentation).

**cephalopelvic disproportion** a discrepancy in size between the foetal head and the mother’s pelvis.

**cervix** the lowest part of the uterus, which inserts into the upper anterior wall of thevagina, is canal-shaped, and connects the uterine cavity and vagina.

**chorion** the outer of the two membranes enclosing the foetus in the uterus; it is continuous with the placenta.

**colostrum** a highly nutritious cloudy fluid secreted by the breasts prior to lactation.

**conception** fusion of the male and female gametes.

**cord, umbilical** the structure connecting foetus and placenta *in utero* that carries the bloodvessels (one vein and two arteries).

**corpus luteum** the yellowish mass of cells in the ovary that proliferates and secretesoestrogen and progesterone.

**crowning** the point during delivery when the biparietal and suboccipitobregmaticdiameters emerge; extension of the head then begins.

**decidua** the specialised endometrium of pregnancy.

**deep transverse arrest** stoppage of the foetal head with the sagittal suture in the transverse diameter of the outlet of the pelvis; this is usually associated with prominent ischial spines.

**denominator** a fixed point on the foetus (e.g. the occiput) that is compared to a fixed point on the maternal pelvis to indicate the position of the foetus *in utero* (e.g. the right occiput anterior).

**descent** the downward movement of the foetus through the birth canal during labour.

**dilation or dilatation** the opening of the external os of the cervix.

**divarication rectus abdominis** separation or diastasis of the two rectus abdominis muscles.

**Döderlein’s bacillus** an organism (also known as lactobacillus) that normally inhabits the vagina and produces lactic acid from the breakdown of glycogen; this creates an acid medium in the vagina that is bactericidal.

**dystocia** difficult or abnormal labour.

**ectopic pregnancy** a pregnancy occurring outside the uterus (e.g. in the fallopian tubes orabdominal cavity).

**effacement or taking up of the cervix** shortening of the cervix as it is drawn up into the lower uterine segment as labour begins; this should not to be confused with dilation of the cervix.

**embryo** the fertilised ovum for the first 8 weeks of intrauterine life; after this time, it is termed a foetus.

**endometrium** the lining mucosa of the uterine cavity.

**engagement of the head** when the widest diameter of the foetal skull (i.e. the biparietaldiameter) has passed through the brim of the pelvis.

**engorgement** a painful condition in which the breasts are overdistended with milk.

**Entonox (“gas and air”)** a mixture of 50% nitrous oxide and 50% oxygen that is used as aninhalational analgesic in labour.

**epidural space** the space outside the dura mater of the spinal cord, and the location for regional analgesia inlabour, especially in the first stage, i.e. epidural block.

**episiotomy** an incision made in the perineum to aid delivery.

**face presentation** the head is presenting, but in a completely extended state insteadof a normal one (e.g. complete flexion).

**flexion** a bending movement, and the normal attitude for the foetus *in utero*.

**foetus** the unborn child *in utero* from 8 weeks of pregnancy until birth.

**forceps** the obstetric forceps that assist delivery of the baby in the second stage of labour; types in common use include Neville–Barnes (Barnes–Neville), Wrigley and Kielland for rotation of the occiput before delivery.

**forewaters** the bag of membranes and liquor lying in front of the presenting part *in utero*.

**gestation** the length of pregnancy; in humans, approximately 9 months, or 280 days.

**gonad** a sex gland; namely, the ovary or testis.

**gonadotrophin** a substance that acts on a gonad (e.g. chorionic gonadotrophin).

**gravid** pregnant; a primigravida is a woman who is pregnant for the first time.

**gravida** the number of times a woman has been pregnant

**Guthrie test** a blood test carried out on days 7–8 of life to detect phenylketonuria.

**gynaecoid pelvis** typical female pelvis that is suitable for childbearing.

**hyperemesis gravidarum** excessive vomiting in pregnancy.

**hypertonic** too much tone (e.g. the uterine muscle during a strong contraction).

**hypotonic** too little tone (e.g. the uterine muscle during a weak contraction).

**implantation** the embedding of the ovum (after fertilisation) in the endometrium of theuterus, now known as decidua.

**infertility** inability to conceive children; there are two types:

* *primary*–in a couple who have never achieved a pregnancy.
* *secondary*–in acouple who have previously achieved at least one pregnancy.

**involution** the return of any organ or system, especially the uterus, to normal afterpregnancy.

**ketonuria** a condition in which fats metabolised as ketones (acetone) are excreted in the urine, indicating acidosis.

**kernicterus** staining of the basal ganglia of the brain with the toxic form of bilirubin (e.g. inrhesus incompatibility).

**labour** the expulsion of the products of conception from the uterus. There are three phases:

* *first stage* – from the outset of true labour to the full dilation of the cervix.
* *second stage* – from full dilation of the cervix to the complete expulsion of the baby.
* *third stage* – separation and expulsion of the placenta and membranes.

**lactation** secretion of milk by the breasts.

**lanugo** the fine downy hair on the body of the foetus *in utero*; this is seen on babies bornprematurely.

**levator ani** the large muscle forming the major part of the pelvic floor.

**lie** the relationship of the long axis of the foetus (i.e. the spine) to the long axis of theuterus, normally longitudinal.

**live birth** an infant that has breathed or had a heartbeat after delivery.

**liquor amnii** the amniotic fluid surrounding the foetus *in utero*.

**lithotomy position** a position in which the woman lies supine with her thighs abducted andflexed to approximately 90° at both the hip and knee; this position is maintained by supports attached to the birthing bed.

**lochia** the discharge from the uterus after childbirth.

**lower segment** the thinner lower part of the uterus at term, which has developed from theisthmus of the non-pregnant uterus; passive in labour.

**malpresentation** an abnormal or unfavourable presentation of the foetus instead of thenormal vertex presentation (e.g. a breech or face presentation).

**malposition** an unfavourable position during the presentation (e.g. an occipitoposteriorposition of the vertex).

**mastitis** inflammation of the breast.

**McRoberts manoeuvre** named after William A. McRobertsJr, this manoeuvre is employed in cases of [shoulder dystocia](http://en.wikipedia.org/wiki/Shoulder_dystocia) during [childbirth,](http://en.wikipedia.org/wiki/Childbirth) and involves hyperflexing the mother’s legs tightly to her abdomen; it is effective because of the increased mobility at the sacroiliac joint during pregnancy, which allows rotation of the pelvis and facilitates the release of the foetal shoulder.

**mechanism of labour** the series of passive movements that the foetus undergoes on its passage through the birth canal.

**meconium** the dark green viscid substance present in the bowel of the new-born infant.

**membranes** the chorion and the amnion.

**mentum** the chin.

**mortality** death; for example:

* *maternal mortality*–deaths of mothers as a result of childbirth.
* *infant mortality* – deaths of babies in the first year of life.
* *neonatal mortality* – deaths of babies in the first month of life.
* *perinatal mortality* – stillbirths and deaths of babies in the first week of life.

**mortality rate** the number of deaths per thousand.

**moulding** alteration of the shape of the foetal skull in labour in order to accommodate it tothe rigid bony pelvis; the presenting diameter becomes shorter, and the one at right angles to it become longer.

**multipara** a woman who has given birth to a live child after each of at least two pregnancies (plural: multiparae).

**multiple pregnancy** more than one foetus (e.g. twins or triplets).

**myometrium** a uterine muscle.

**naevus** a birthmark.

**obstetric cholestasis** a multifactorial condition of pregnancy characterised by pruritus in the absence of a skin rash and abnormal liver function tests, neither of which has an alternative cause and both of which resolve after birth.

**oligohydramnios** less than the normal amount of liquor amnii, i.e. 1.5 litres at term.

**ophthalmia neomatorum** a purulent discharge from the eyes of the new-born baby within21 days of birth; if gonococcal, it may lead to blindness: this is a notifiable disease.

**ovulation** the shedding of the ripe ova from the Graafian follicle into the peritoneal cavity.

**oxytocin** an extract from the posterior pituitary that stimulates uterine muscle and induces a contraction.

**parous** having borne one child or more.

**parity** the condition of having borne children, or the number of children born that are over 20 weeks.

**partogram** a chart for recording the progress of labour.

**parturition** childbirth.

**pelvic girdle pain** the pain experienced between the posterior iliac crest and thegluteal fold, particularly in the vicinity of the sacroiliac joints; it may radiate in the posterior thigh, and can also occur in conjunction with or separately in the symphysis; the endurance capacity for standing, walking and sitting is diminished.

**phenylketonuria** a metabolic disease in which the infant is unable to utilise a specific aminoacid, i.e. phenylalanine; if untreated, it leads to severe intellectual disability.

**placenta praevia** a condition in which the placenta is inserted wholly or in part into the lower segment ofthe uterus; it is classified by ultrasound imaging according to what is relevant clinically (e.g. if the placenta lies over the internal cervical os, it is considered a major praevia; if the leading edge of the placenta is in the lower uterine segment but not covering the cervical os, minor or partial praevia exists).

**placenta accreta, increta and percreta** the placenta penetrates through the decidua basalisinto and then through the myometrium.

**polarity** the neuromuscular harmony between the upper and lower uterine segments inlabour, upon which normal taking up and dilation of the cervix is dependent.

**polyhydramnios** an excessive amount of liquor amnii (e.g. more than 1.5 litres at term).

**posterior fontanelle** a small “soft spot” at back of skull.

**post-maturity** the period when a pregnancy has gone 2 weeks or more past the expected date ofdelivery, i.e. more than 42 weeks.

**postpartum haemorrhage** loss of blood following childbirth:

* *primary*–blood loss from the genital tract up to 24 hours after delivery of 500 millilitres or more; or less, if detrimental to the mother’s condition (usually from the placental site).
* *secondary* – any bleeding from the genital tract during the puerperium, excluding the first 24 hours (usually as a result of an infection).

**pre-eclampsia** a disease peculiar to middle and late pregnancy that is characterised byoedema, elevated blood pressure and proteinuria; if left untreated, it may progress to fulminating eclampsia, which is characterised by the occurrence of major epileptiform convulsions.

**premature birth** a birth that takes place more than 3 weeks before the baby’s estimated due date.

**presentation** the part of the foetus that occupies the lower pole of the uterus, and therefore, lies over the pelvic brim.

**primipara** a woman who has given birth to one live child.

**prolapse of the umbilical cord** a condition in which the cord escapes through the cervix after the ruptureof the membranes and lies in front of the presenting part of the baby.

**puerperium** the period following the delivery of the baby, during which the body returns toits normal pre-pregnant state; this usually takes about 1 month.

**quickening** the perception of foetal movements by the mother; this usually occurs at around 18–20 and 16–18 weeksduring the first pregnancy and a subsequent pregnancy, respectively.

**retraction** a slight permanent shortening of the muscle in the uterus during labour.

**rhesus factor** a blood factor present in 85% of the UK population; the remaining15% are termed rhesus-negative.

**rotation** changing the position of the foetus; in normal labour, the occiput rotates anteriorlyin order to be born; this movement can be assisted by Kielland forceps in the second stage of labour.

**Shirodkar suture** a suture placed around the cervix in week 14 of pregnancy to preventan incompetent cervix dilating.

**show** the expulsion of the mucous plug as a slightly blood-stained mucous discharge inearly labour.

**sickle cell disease** a hereditary haemoglobinopathy that may be exacerbated duringpregnancy.

**sinciput** the brow or forehead; the area between the supraorbital ridges and the bregma.

**small for dates** a baby born at any stage of pregnancy who weighs less than the normal amount.

**sonicaid** high-frequency sound used to detect noises (e.g. that of the foetal heart).

**speculum, vaginal** an instrument designed for the examination of the vagina and cervix (e.g. Sims’s, Cusco’s and Auvard’s).

**stillbirth** the delivery of any child who shows no sign of life after week 24 ofpregnancy.

**striae gravidarum** the so-called “stretch marks” of pregnancy, which are seen on theabdomen and breasts; these may be a sign of pregnancy, or a previous pregnancy.

**surfactant** an agent secreted by the foetal lungs that reduces surface tension and allowsadequate expansion of the alveoli; the absence or lack of surfactant causes respiratory distress syndrome (hyaline membrane disease) in premature babies.

**syntocinon** a synthetic form of oxytocin.

**tears (lacerations)** obstetric anal sphincter injuries; defined by the International Consultation on Incontinence, and the Royal College of Obstetricians and Gynaecologists as follows:

* *first-degree tear* – injury to the perineal skin and/or vaginal mucosa.
* *second-degree tear* – injury to the perineum involving the perineal muscles, but not involving the anal sphincter.
* *third-degree tear* – injury to the perineum involving the anal sphincter complex:
* *grade 3a* *tear* – less than 50% of the external anal sphincter (EAS) thickness torn.
* *grade 3b* *tear* – more than 50% of the EAS thickness torn.
* *grade 3c* *tear* – both the EAS and internal anal sphincter torn.
* *fourth-degree tear* – injury to the perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.

**thrush** a monilial infection that can affect both the mother and baby; in the former,it manifests as vaginitis, and in the latter, it presents as an intestinal tract infection, particularly in the mouth.

**transverse lie** the foetus lies at right angles to the long axis of the uterus.

**trichomonas vaginalis** an organism that commonly infects the vagina.

**ultrasound scan** the use of high-frequency sound waves to locate, define or measure certain structures within the body (e.g. a foetus or the placenta); the conversion of the sound into light allows an image to be displayed on a television screen.

**unstable lie** repeated changes of foetal position.

**upper segment** the very muscular upper part of the uterus at term that has developedfrom the body of the non-pregnant uterus; this is the active part of the uterus in labour.

**vernix** a greasy white substance covering the foetus *in utero* after week 30 ofgestation.

**version** changing the presentation of the foetus (usually external cephalic version), i.e.turning the baby round from a breech or shoulder presentation to a cephalic one, the hands coaxing the baby round through the abdominal wall.

**vertex** the area of the skull between the anterior and posterior fontanelles, and the two parietaleminences.

## Appendix 3: Urology/gynaecology terminology

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**amenorrhoea** the absence of menstruation.

**apareunia** the absence or impossibility of coitus

**cervical carcinoma** cancer of the cervix:

* *Stage 0* – cervical intraepithelial neoplasia (CIN):
* *CIN 1* – mild dysplasia.
* *CIN 2* – moderate dysplasia.
* *CIN 3* – severe dysplasia and carcinoma *in situ*.
* *metaplasia* – normal transformation of cellular tissue.
* *dysplasia* – abnormal development or growth cells.
* *dyskaryosis* – abnormality of the nuclei of cells.

(The terms above denote cellular changes that can be seen in the cervical epithelium when there is no invasion of deeper tissues; these conditions do not invariably progress to malignancy.)

* *Stage I* – lesion invasion, but confined to the cervix, usually the squamocolumnar junction.
* *Stage II* – the lesion extends beyond the cervix to the upper vagina and parametrium, but not the pelvic side walls.
* *Stage III* – the lesion reaches one or both pelvic side walls, and the lower third of the vagina.
* *Stage IV* – the spread of the lesion the involves the bladder and/or rectum; there may be distant metastases.

**debulking** a surgical procedure used for ovarian tumours that may include removal of the ovaries,uterus, cervix and omentum.

**dysfunctional uterine bleeding** blood loss caused by hormone imbalance.

**dyspareunia** difficult or painful intercourse.

**ectopic pregnancy** egg implantation in sites other than the uterus, usually the fallopiantube.

**endometriosis** a disease characterised by growth of the endometrium in places other thanthe lining of the uterus.

**female genital mutilation** female circumcision;any procedure removing part or allof the external female genitalia.

**fibroids (myomata)** benign tumours of the uterus.

**haematometra** trapped blood in the uterus (e.g. as a result of an intact hymen orcervical stenosis).

**haematuria** blood found in the urine on urinalysis

**incontinence** a lack of voluntary control over urination or defecation:

* *urinary incontinence* – involuntary loss of urine.
* *stress urinary incontinence* – involuntary leakage on effort or physical exertion, or on sneezing or coughing.
* *urgency* – involuntary loss of urine associated with urgency.
* *urge urinary incontinence* – involuntary leakage of urine accompanied by or immediately preceded by urgency.
* *mixed urinary incontinence* – involuntary leakage of urine associated with urgency, and also with exertion, effort, sneezing or coughing.
* *nocturnal enuresis* – loss of urine occurring during sleep.
* *overactive bladder* – urgency, with or without urge incontinence, usually with frequency and nocturia.
* *overflow incontinence* – incontinence associated with overdistension of the bladder.
* *detrusor overactivity* – urodynamic observation characterized by involuntary detrusor contractions during the filling phase, which may be spontaneous or provoked.

**inguinal node dissection** removal of lymph nodes near the vulva, usually following avulvectomy (this procedure may be unilateral or bilateral) with drain(s) *in situ* for a few days.

**interstitial cystitis** chronic inflammation of the bladder giving rise to symptoms includingfrequency, urgency and pain in the absence of infection.

**IUCD** intrauterine contraceptive device(not to be confused with IUD, intrauterine death).

**large loop excision of the transformation zone (LLETZ)** outpatient treatment for cervicaldysplasia (i.e. pre-malignant lesions) that aims to totally remove abnormal cells from the cervix; a wire loop with an electric current (diathermy) is used to shave off these cells.

**menorrhagia** abnormally heavy bleeding at menstruation.

**metrorrhagia** irregular bleeding.

**nocturia** the interruption of sleep one or more times because of the need to micturate

**omentectomy** a procedure that involves removal of the fatty tissue overlying the bowel.

**pelvic node dissection** in cases of suspected malignancy, pelvic and para-aortic nodes maybe excised; the extent and type of the dissection depends on the kind of gynaecological malignancy being treated; enlarged nodes are also removed to facilitate sterilization of any micrometastases.

**pelvic organ prolapse** a condition diagnosed with symptoms and clinical examination, assisted by anyrelevant imaging, that involves the descent of one or more parts of the anterior vaginal wall:

* *urethrocele* – prolapse of the urethra (affects the anterior vaginal wall).
* *cystocele* – prolapse of the bladder (affects the anterior vaginal wall).
* *rectocele* – prolapse of the rectum (affects the posterior vaginal wall).
* *enterocele* – prolapse of the pouch of Douglas (affects the posterior vaginal wall).
* *uterine prolapse* – may occur to a variable degree.

**pelvic inflammatory disease** an infection of the female reproductive organs.

**procidentia** third-degree uterine prolapse.

**suprapubic catheter** a long-term catheter surgically inserted above the symphysis pubis.

**uterine adnexa** the fallopian tubes and ovaries.

**uterovaginal prolapse** displacement of one or more of the pelvic organs, causing a bulgeinto the vagina; there are several types.

**urodynamics** a conventional bladder test to diagnose bladder dysfunctions, includingincontinence; it involves artificial bladder filling via urethral catheter, bladder pressure measurement with a second urethral catheter and abdominal pressure measurement using a rectal catheter (subtracting bladder pressure from abdominal pressure gives detrusor pressure).

**vaginal vault** the top of the vagina that remains after surgical removal of the cervix.

## Appendix 4: Gynaecology surgery terminology and abbreviations

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**abdominal hysterectomy** removal of the uterus via an abdominal incision.

**abdominal sacral colpopexy** repair of vaginal vault prolapse by attaching the vault to thepresacral fascia (e.g. with surgical mesh).

**anterior repair/colporrhaphy** repair of the anterior vaginal wall for cystocele and/orurethrocele; performed vaginally.

**Botox** botulinum toxin A injected via cystoscopy for an overactive bladderthat is resistant to other treatments.

**bilateral/left/right salpingo-oophorectomy (BSO/LSO/RSO)** a procedure that may be combined withhysterectomy that can be performed abdominally or laparoscopically.

**colposcopy** the use of a colposcope to examine the upper part of the vagina and cervix.

**colposuspension** a sling suspension operation to restore the urethrovesical angle in cases ofstress incontinence; a sling, usually made of vaginal tissue, is formed to support the bladder neck, and is attached to the ileopectineal ligaments; this procedure may be performed abdominally or laparoscopically.

**cone biopsy** removal of a conical segment from the cervix for diagnostic purposes, or as part of the treatment of cervical cancer.

**cystoscopy** the use of a cystoscope to look inside the bladder.

**D&C** dilation and curettage.

**ERPC** evacuation of retained products of conception.

**EUA** examination under anaesthetic.

**excision of Bartholin’s cyst (marsupialisation)** removal of a cyst from the gland at the base of the labia minora.

**Fenton’s procedure** an operation to enlarge the vaginal introitus.

**hysterectomy** removal of part or all of the uterus:

* *total abdominal* *hysterectomy* – removal of the whole of the uterus through an abdominal incision.
* *subtotal* *hysterectomy* – the cervix is left in place, and only the body of the uterus is removed.
* *vaginal* *hysterectomy* – removal of the uterus through the vagina to treat uterine prolapse; the cardinal and uterosacral ligaments are shortened during the operation, which may be combined with another surgical repair.
* *extended* *hysterectomy* – removal of the uterus, ovaries, fallopian tubes and a vaginal “cuff”.
* *Wertheim’s operation* – removal of the uterus, ovaries, fallopian tubes, broad ligaments, the upper third of the vagina and the adjacent lymph nodes.

**hysteroscopy** the use of a hysteroscope to look inside the uterus.

**laparoscopic sterilisation** by banding the fallopian tubes via two small stabwounds.

**laparoscopy** examination of the pelvic contents by laparoscope via a small subumbilicalincision.

**laparoscopically assisted vaginal hysterectomy (LAVH)** the use of a laparoscope (abdominally) to aid vaginal removal of the uterus.

**myomectomy** removal of fibroids.

**oophorectomy** removal of an ovary.

**ovarian cystectomy** removal of an ovarian cyst.

**pelvic exenteration** removal of the uterus, bladder and/or rectum with transplantation ofthe ureters and colostomy.

**peri-urethral bulking agents** a procedure for stress incontinence: collagen or another agentis injected into the peri-urethral tissues at the urethrovesical junction (i.e. the bladder neck); the aim is to increase resistance to involuntary urine loss by narrowing the lumen of the urethra.

**posterior repair (colpoperineorrhaphy)** repair of an enterocele or rectocele and/ordefective perineum.

**sacrospinous fixation** vaginal repair of vaginal vault prolapse by suturing the vault to themedial portion of the sacrospinous ligament.

**salpingectomy** removal of a fallopian tube.

**salpingolysis** removal of peritubal adhesions.

**salpingo-oophorectomy** the removal of a fallopian tube and ovary.

**salpingostomy** removal of a blocked or damaged portion of a fallopian tube to restorepatency.

**transcervical resection of the endometrium (TCRE)** a procedure performed to treat excessive menstrualbleeding.

**tubal section and ligation** sterilisation by cutting and tying both fallopian tubesthrough a small transverse incision.

**tension-free vaginal tape (TVT)** a procedure performed to treat stress incontinence: a Prolenemesh tape is positioned around the midurethral area, and is drawn upwards within the abdominal cavity on each side to the abdominal skin, the mesh becoming an integral part of the abdominal skin and underlying soft tissues; the aim is to create a solid floor beneath the urethra so that a sudden rise in intra-abdominal pressure (e.g. a cough or a sneeze) will compress the urethra against the tape, occluding the urethra, and thus, preventing involuntary urine loss; unlike other procedures, tension is applied only on episodes of physical stress.

**tension free vaginal tape obturator (TVTO) and transobturator tape (TOT)** a procedure similar to TVT that produces a wider angle of support on the urethra; the tape exits laterally via the obturator foramen.

**VTOP/STOP** vaginal/suction termination of pregnancy.

**vulvectomy, simple or radical** this procedure varies in extent from simple excision of skin in the vulvalarea to excision of the whole of the vulva and the inguinal glands.

Appendix 5: Colorectal terminology

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**ACE** antigrade continence enema.

**adenoma** a glandular lesion; a precursor to colorectal cancer.

**anal abscess** an infected cavity filled with pus found near the anus or rectum.

**anal canal** the short tube at the end of the rectum through which stool leaves the body.

**anal cancer** a form of cancer that develops in the mucosa lining the analcanal.

**anal fissure** a split that occurs within the distal part of the anal lining; this usually causes severeanal pain and fresh bleeding when stools are passed.

**anal fistula** a small, tunnel-like structure (i.e. a tract) that develops between the back passage (i.e. the analcanal) and the skin surrounding the anus.

**anal sphincters** the ring of two muscles (i.e. the internal and external sphincters) surrounding the anus that controls the opening and closing ofthe anus, and plays a major part in maintaining control of faeces.

**anastomosis** the surgical joining of two ducts to allow flow.

**anismus** the failure of the pelvic floor to relax of during defecation.

**anterior resection and total mesorectal resection (TME)** the surgical removal of the rectumand all the fatty tissue around it (i.e. TME) in order to reduce the risk of recurrent local cancer; a join is made between the two ends of the bowel.

**anorectal physiology** tests of the strength of the muscles in the anal canal in order to establishif these are working normally; this procedure also checks the sensitivity of the rectum to small volumes of air and its response to distension.

**anus** the back passage; it is lined with sensitive skin, and surrounded by important musclesthat control the emptying of the bowel.

**banding of haemorrhoids** a procedure that involves using a small instrument to put a very tight elastic bandover a haemorrhoid; this band cuts off the blood supply, and the haemorrhoid should drop off, usually within 3–7 days of the banding.

**barium enema** a contrast medium used to examine the large intestine by X-ray.

**bowel** the name given to the intestines: the term “large bowel” is sometimes used todescribe the colon and rectum; the term “small bowel” is often used to describe the upper part of the intestine, which includes the duodenum, jejunum and ileum.

**celiac disease** a condition in which the body reacts to gluten, causing an inflammatory response.

**colectomy** the surgical removal of all or part of the large intestine.

**colitis** inflammation of the colon; this may have several different causes.

**colon** the part of the intestine or bowel that follows the small intestine; the colon leads to therectum and anus, and its function is to absorb water.

**colonoscopy** an examination of the entire length of the large bowel using a flexiblefibreoptic endoscope.

**colon cancer** a cancer that develops from the mucosa that lines the large bowel (i.e. the colon);this type of cancer usually develops from a non-cancerous polyp, and if this is detected early, the cancer may be prevented by its removal.

**colostomy** a large intestine stoma.

**constipation** the inability to pass stools (i.e. faeces) as often as normal; sufferers may have to strain more than usual, may be unable to completely empty their bowels or pass unusually hard stools.

**Crohn’s disease** a condition that causes inflammation of the gastrointestinal tract (i.e. the gut); itmay affect any part of the gut.

**diarrhoea** liquid stool.

**diverticular disease** small pouches projecting out of the side of the large intestine (i.e. the colon).

**defecating proctogram** the dynamic study of the function of the anorectum and pelvic floor.

**endorectal ultrasound** a procedure in which a probe is inserted into the rectum, and high**-**frequency sound waves are generated; the pattern of echoes made as these sound waves bounce off tissues is converted into a picture (i.e. a sonogram) on a television screen.

**enhanced recovery programme for elective surgery** a plan designed to reducethe length of a hospital stay by shortening the postoperative recovery period.

**faecal incontinence** the inability to control the passage of gas, and liquid or solidstools from the back passage; it is associated with urgency, rushing to a toilet and, at times, accidents.

**fistula** an abnormal connection between two internal organs.

**flexible sigmoidoscopy** a method of viewing the rectum and lower third of the large colon.

**gallbladder disease** acommon condition with a wide variety of symptoms ranging from discomfort to severe pain that mainly begins after consuming food; in severe cases, the patient can suffer from jaundice, nausea and fever (the most common cause of gallbladder disease is gallstones).

**haemorrhoids (piles)** the swelling of the blood vessels within the anus; common symptoms include bright-red bleeding, pain, itching, swelling, and popping out (prolapse) while passing a stool (or at other times).

**hemicolectomy** the removal of part of the colon (i.e. the large bowel or intestine) on either the right orleft side.

**hernia** a piece of tissue or organ that pokes through the muscles that make up the wallof the abdomen, and pushes out under the skin; this appears as a bulge in the abdomen or groin.

**ileostomy** the opening of the ileum (i.e. the final section of the small intestine) to the surface.

**inflammatory bowel disease** a group of disorders that cause the intestines tobecome inflamed (i.e. red and swollen).

**intussusception** the intervagination (i.e. telescoping) of the bowel in on itself.

**laparoscopic ventral rectopexy** an operation to treat internal rectal prolapse in which the rectum is fixed in its original anatomical position.

**perianal abscess** an acute painful swelling containing pus that occurs next to the anus

**peristalsis** the propulsion of food through the intestines.

**piles** see “haemorrhoids” above.

**pilonidal disease** a chronic infection of the skin in the region of the buttock crease; thecondition results from a reaction to hairs embedded in the skin, commonly occurring in the cleft between the buttocks.

**polyp** a benign (i.e. non-cancerous) growth in the lining of the bowel.

**proctectomy** the surgical removal of the rectum; where there is a very low rectal or analcancer, this may involve removal of the anus as well.

**proctoscopy** an examination of the lowest part of the rectum and anal canal using a veryshort telescope; this is usually done in the outpatient clinic.

**pruritus ani** itching and/or soreness around the anus; this is a common symptom thatmay be have a number of different causes.

**rectum** the last part of the large intestine; the main function of the rectum is to act as areservoir for stools.

**rectal cancer** a cancer that develops in the mucosa lining the rectum.

**rectal prolapse** a problem that occurs when part or all of the wall of the rectum slides out of place; sometimes this protrudes out of the anus.

**restorative proctocolectomy with ileoanal pouch–anal anastomosis** the surgical removal of all of thecolon and rectum, and the formation of a new reservoir with the small bowel, which is reattached to the anus.

**rigid sigmoidoscopy** a procedure in which a short and rigid tube is inserted intothe rectum in order to examine the lower portion of the large intestine (or bowel).

**sphincteroplasty** the repair of the anal sphincter muscles.

**stoma** the artificial opening of the intestine to the surface.

**ulcerative colitis** a condition that causes inflammation in the rectum and colon; part or all of thelarge bowel may be involved.