

## Sinclitismo y asinclitismo

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First: it is done to determine the fetal situation (this is the connection between the longitudinal axis of the fetus with the longitudinal axis of the mother; it can be longitudinal, transverse or oblique) Second: it is done to determine the position of the fetus (it is a relationship that has a presentation repair point with the left or right half of the mother's pelvis; it may be right or left) Third : performed to create a fetal presentation (refers to the foetal which is in contact with the upper pelvic strait, follows a certain delivery mechanism and takes it in full, can be cephalic, and pelvis, where they, in turn, are divided into the head: the top, the bregma, the forehead and face, and the conditions of the pelvis representation are full pelvis and incomplete pelvis) Fourth : is done to determine the fit of the fruit (which occurs when the suitable diameter of the representation exceeded the upper strait of the pelvis and the point of repair is at the level of the pelvis A: This occurs when the sagittal seam of the fetus is at the same distance from the pubis as the sacrum. ASINCLITISM: Occurs when the sagittal seam is not equal to the pubic and maternal sacrum. This may be earlier when this seam approaches the sacrum and then when approaching the pubic. They are determined based on the point of repair. Vertex: The repair point is located in the small fontanelle Bregma: the repair point is located at the previous angle of the front fontanelle front: the repair point is located in the face of the nation: the repair point is located in the middle of the front seam and that in the face mode chin They are reference levels ranging from one point to another in the mother's pelvis to divide it imaginably with the find of the fetal presentation position. First, it coincides with the upper pelvic strait; it is drawn between the cape and the upper edge of the second pubic: it is parallel to the first and passes from the lower edge of the pubic symphysis ass to the second sacral vertebra of the Third: it runs parallel to the second; joins two spines of sciatica. Fourth: parallel to the third; is at the height of the tip of the tailbone. HOW MUCH TIP TAZA A TAS GinecolD: this is a typical female pelvis predominance of cross-diameters. The narrow upper is rounded, with a cross diameter larger than the anteroposterior and is positioned well in front of the cape, giving it ample rear space. Side walls are parallel and straight, with not prominent spikes of sciatica. The cross bent backwards. Суболиическая дуга широка, образуя 90-градусный угол. P. ANDROIDE: This is a typical male pelvis, the diameters of which are the largest. The upper strait is triangular in shape, the side walls converge, the prominent spikes of sciatica, the curvature of the unpronounceable sacrum. The angle that forms the branches of the pubic sharply, its narrow upper part is wide and has the shape of a funnel on descent. It can appear in 20-30% of women. P. ANTROPOIDE: its antero-poster diameter is the largest. Upper Strait Oval. Its sidewalls are parallel to the spines of sciatica, which are not noticeable, although their interspic diameter is small. The sacrum of the straight and sub-abc arch is usually narrow. P. PLATPELOIDE: This is a crushed gynecological pelvis from front to back (flat pelvis). The cross-sectional diameter of the upper strait is much larger than the anthero-ostor, which gives an oval shape. Subsequently, his sacrum is tilted and has a wide sub-pabical angle, forming an angle over 90 degrees. UPPER CLOSE OF THE PELVIS Its borders are the upper edges of horizontal branches of pubic symphyse, or orphatetin or non-luminated lines, the upper edge of sacral spoolers and capes. DIAMETERS Diagonal or promonto-sub-pubic conjugated diameter: distance in tre of the lower edge of pubic and cape synphuse (approximate length: 12 to 12.5 cm). This is the only upper-strait antero-posturine diameter that can be obtained during a clinical examination of the Anatomical Conjugated Diameter or Promonto-Supraubic: it goes from the cape to the upper edge of the pubic symphysis (approximate longj tud: 11 cm). True obstetric or promonto-retropubic conjugated diameter of the minimum: from the cape to the nearest point, closer to the back of the symphyse (approximate length: 10.5 cm). It is obtained clinically by subtracting 1.5 cm from the diagonal of conjugated diameter. Transverse diameter: this is the longest distance between innosis lines (approximate length: 13.5 cm). In gynecological, android and platypeloid pelvis is closer to the cape than pubic symphysis. Useful (or medium) transverse diameter: it is a transverse diameter, localized evenly between the pubic symphysis and the cape of the sacrum (approximate length: 12.5 to 13 cm), it uses the pressure of the fetus to descend it. Oblique diameters: from ileopectin arrogance on one side to the sacrum joint on the opposite side (approximate length gives: 12 cm). They are called right or left in accordance with the ileopectin line, where MIDDLE CLOSE OF THE PELVIS Its limits: the lower edge of pubic symphyses, sciatica and sacral spikes at the level of the third-fourth vertebrae. DIAMETER Transverse diameter: goes from the sciatica of the spine on one side to the spine with trawlateral (interspal diameter): (approximate length: 10 cm), is the most obsessed from the obstetric point of view, because it is the longest. The diameter of the antero-ostor: goes from the lower edge of the pubic symphysis ass to the point located between the third and fourth sacral vertebra (approximate length: 11.5 cm). LOWER STRAIT OF THE PELVIS Its limits: subpbic arch, ishiatic tubularity, lower edges of the cruciepi ligaments and the tip of the sacrum. DIAMETERS Anteroposterior diameter: goes from the lower edge of the pubis to the tip of the sacrum (approximate length: 11 cm) Transverse or Biasian diameter: it connects the inner faces of the tubero ishiatic suesty (approximate length: 10.5 cm) This is an inequality or mismatch that exists between the diameters of the mother's pelvis and the diameters of the fetus' head. This can be given: Maternal order: low size, polio, cymocoliosis. Fetal order: macromical, transverse situation. Combined: maternal fetuses. 1. WHICH IS THE DIVERSITY OF THE POSITION AND HOW MUCH. It is a relationship that has a point of repair presentation with ex-tremos of all diameters of the mother's pelvis. In the top mode, the possible position of the varieties is: 1. Pubic occia or anterior occia (OA): the top is located behind the mother's pubic relative to the anterior diameter of the pelvis. 2. Ant and left zozopy (OIA): The top is located in the front extre mo oblique diameter, in the left half of the pelvis. 3. Left transverse occipite (OTI): The top is at the left end of the transverse diameter of the mother's pelvis. 4. Rear left occipite (OIP): The top is in contact with the ex tremo oblique diameter in the left half of the mother's pelvis. 5. Sacral ocypt (OS) or posterior: the top is located on the back of the antero-posterior diameter of the pelvis. 6. Rear Right Cicipit (ODP): The top is relative to the posterior ex tremo oblique diameter in the right half of the pelvis. 7. The right of transverse will cordon off (OTD): the top is in contact with the right end of the transverse diameter of the mother's pelvis, and 2. WHICH IS POINT OF REPAIR. This is the most advanced point of the presentation, and allows you to diagnose the presentation mode. It should be at the center and be the most declining presentation. 3. WHAT THIS REFERENCE POINT This presentation point chosen arbitrarily, which arises for diagnosis with its location in the pelvis, position and variety of distribution position birth is the one that take the caso needs maneuvers or surgical interventions. 4. THERE ARE TYPES OF DYSTOCIA. (DESCRIBE THEM). Types of dystocia: Bones dystocia: they are due to structural malformations of the pelvic, due to changes in the diameters of the upper or/ and lower narrow straits and/or excavations. They are abnormalities in the size or characteristics of the birth canal that have difficulty reducing the fetus. They may be congenital or acquired. -Upper strait stenosis: When the diameter of the anteroposterior is 10 centimeters or less, and the transverse diameter is less than 12 centimeters. The main reason is children's rickterianism. It can also be congenital stenosis or medium narrow: when the interspan diameter falls below 9.5 centimeters or when the amount of posterior biosquitic and sagittal diameters, usually 15.5 centimeters, below 13.5 centimeters. The main cause is ricktering Lower Strait stenosis: When the convex diameter decreases to 8 centimeters or less. Narrow pelvises can be qualified in symmetrical and asymmetrical Symmetric In these pelvis modifications of one hemipelvis is accompanied by modification of another simultaneously. Simple flat pelvis, etiology rickets. Also called ringing (only affected in the upper strait) Taz usually narrows, in women of very low stature. Also called android pelvis (affected by three narrow) cross-narrow pelvis, or congenital non-fundibuliform pelvis. Also called anthropoid. Flat and generally narrow pelvis, characteristic of achondroplase dwarfs. Also called the channeled pelvis asymmetric is also called the oblique pelvis because they have a difference of more than 1 centimeter between one oblique diameter and another, making them have a long oblique and a short oblique. They are etiologically caused by scoliosis, leg defects such as shorter leg than others, polio and birth defects such as absence or sacropy. Soft dystocia: due to malformations of the uterus, tumors that prevent the release of the fetus or changes in the physiology of cervical fibroids in the lower third of the uterus or the previous rupture of the uterus Sinequias and cervical stenosis Conglutination of the outer opening Atrisia vul Vaginalvar Atrisia Large vaginal bruising and vaginal vulva swelling of the uterus malformations of the fetus so that it can not be ruled out by the birch canal of abnormal presentations; shoulder, face, forehead and to a lesser extent bregma complex presentations when one or more members simultaneously enter the pelvic canal next to the head or buttocks. Fetal macrosomy malformations such as hydrocephalus ovular distociates: due to abnormalities of membranes, placenta, umbilical cord and to a lesser extent amniotic, which make it impossible or difficult to expel the fetus procodile and procubus cord without the complete expansion of the placenta to the complete occlusion of Baudelocke Oligoamnios accident and polyhydramnios (relatively) From the uterus contractability Dynamic dystocia: caused by abnormal contractions of the uterus, which do not have enough strength to overcome the resistance that soft tissues and bone canal is present at birth or which appear to over-achieve thanatization of the muscular fibers of the uterus or the failure of the Triple Descending Gradient, with anarchization of frequency, tone and intensity. This word refers to normal childbirth and is considered to start spontaneously in a pregnant batch with the fetus in time in a bent cephalia presentation, the position of the top, and ends spontaneously, without complications in its evolution. This is a state in which the basal tone exceeds 12 mmHg. This is the result of polysystole (more than 5 contractions in 10 minutes) that conditions the impossibility of relaxing the uterus between 2 contractions. If hypertension is constant, it is called uterine tetanus. 5. POLISISTOLIA polysistoly is defined as uterine activity, which reports more than 5 contractions within 10 minutes 6. THIS CORDON PROLAPSO is the glide of the umbilical cord along the free space, outside the space that forms the concaveness of the abdomen. Depending on the degree of descent they are classified on: Cord fallout: when it appears before the presentation and the membrane is already broken. Procubito: The cord came down before the presentation, but the membranes laterocidence are not broken: the cord is located next to the presentation, but without overwork. It is a condition that is established during childbirth, and puts the life of the fetus at risk, and can be caused: metabolic changes caused by reduced exchanges, which usually occur between mother and child, are relatively sharp in setting and that alters the normal metabolism of the fetus, can cause irreparable changes in tissues or even the death of the child. Placental respiratory failure that causes abnormalities in the fetus. Its mild or moderate form produces hypoxia and its severe forms are capable of producing acidosis, cerebral palsy and fetal and/or neonatal death. Polyhydramnios say In the vertical measurement of a bag or space occupied only by amniotic fluid, measurements of more than 8 cm indicate the presence of polyhydramnio, being between 8 and 11 cm, soft polyhydramnio, 12 to 15 cm of moderate polyhydramnio, and more than 16 s, heavy polyhydro. Oligohydramnios occurs when there is an amniotic fluid volume of less than 200 ml, and the bag measuring vertically, less than 2 cm, in tecnicaecographic in ILA's assessment with perniulis below 5 or below 8 cm. Maternal face: it looks at the uterus in which it is inserted, bleeds and has intercotile grooves that divide the placenta into reddish and elevated mammons, called cotyledons. Fetal Face: Looks in the amniotic cavity and padding loquios are secretions originating from uterine varnishes containing more or less necrotic decisive cells, blood and often bacteria. They have a reddish color (red loquios) in the first 2-3 days after delivery, despues lose their red color and by reducing blood loss and increasing exudation (serous loqui), and from about the last day, the secretion becomes mbanlanquecin (white lok) due to the high content of white blood cells; the duration of loquios is 33 days after delivery and in 13% of patients, they persist for 60 days. It is the central organ of pregnancy responsible for fetal nutrition and regulation of embryonic growth and metabolism. It is also an endocrine gland, which, when reaching maturity, forms a disk with a diameter of 18 to 20 cm, weighing from 450 to 60 grams and a rounded contour. In normal childbirth, 500 and 1500 are lost in C-section 11. WHICH IS IMMEDIATE POSTPARTUM, INTERMEDIATE AND LATE, p. immediate: occurs in the first 24 hours between them: this occurs in the first 10 days after late delivery; from 10 days after delivery, to 6 months later. 12. WHAT IS NORMAL VALUE OF AMNIOTIC LIQUID The volume of amniotic fluid increases as she progresses and reaches the maximum volume in weeks 37 and 38, in which the fluid ranges from 700 to 1000 ml; subsequently and as weeks 41 - 42 approach, there is a physiological decline, which after a week 40 to 8% less each week to reach about 400 ml in week 42. 13. WHAT IS PRETERMINO PART This is the one that occurs up to 35 weeks and 6 days. This is the exit of the fetus less than 20 weeks of pregnancy, and less than 500 grams. Weight. 15. THIS IS CALLED A LONG-TERM PREGNANCY. A long pregnancy lasts more than 41 weeks and 6 days. 16. NORMAL VALUE OF AMNIOTIC FLUID. The volume of amniotic fluid increases as she progresses, reaching a maximum volume in weeks 37 and 38, where fluid ranges from 700 to 1000 ml; subsequently and as weeks 41 - 42 approach, there is a physiological decline, which after a week 40 to 8% less each week to reach about 400 ml in week 42. 17. WHAT ARE THE FUNCTIONS OF AMNIOTIC FLUID. Amniotic fluid is present in amnio, a membranous sac surrounding the fetus. The main functions of the liquid are the provision of depreciation, which acts as a protection for the fetus to stabilize the temperature to protect the fetus from extreme temperature changes and promote proper lung growth, as well as the exchange of water and chemicals between the fetus and the mother's circulation. 18. WHAT IS THE COMPOSITION OF AMNIOTIC FLUID. It has a composition similar to the mother's plasma and contains a small number of cells separated from the skin, digestive system and urinary tract of the fetus. It also contains biochemicals produced by the fetus, such as bilirubin, lipids, enzymes, electrolytes, nitrogen compounds and proteins. When fetal urine production begins, creatinine concentrations (between 1.5 and 2 mg/dL up to 36 weeks and more than 2 mg/dL after 36 weeks), uria and uric acid increase, while glucose and protein concentrations decrease. Concentrations of electrolytes, enzymes, hormones and metabolic end products also vary, but have little clinical value of 19. WHICH IS THE TRIPLE GRADIENT DESCENDING There are three gradients that were described during uterine contraction: 1. Reducing gradient spread, is the first component of a tapering wave. It starts in the area of the horn of the uterus with the predominance of the right. The wave invades from top to bottom in all parts of the uterus and it is believed that after about 15 seconds the reproduction is complete, after which the contracting wave begins to disappear and the uterus relaxes. 2. Gradient downward duration, when there is normal coordination, all waves reach and ame at the same time; this means that the waves that started first were on top, so they have a longer duration. 3. As the gradient of intensity decreases, the intensity of the contraction is greater in the background than in the lower parts of the body of the uterus; this can be caused by a decrease in the thickness of myometrial and actin-myosine reduction. 20. WHAT IS PINAR BELL Also called pinard stethoscope; is a tool used to listen to fetal heart tones. 21. WHICH IS SIGNO OF THE FISHERMAN refers to the transfer of small movements in the cord to the bottom of the uterus. 22. WHICH IS TENCA SNOUT This is the vaginal opening of the cervix 23. THIS BOBLE BUDIN SIGN in the vaginal snooker, flattening the bottom of the vaginal sac is perceived by taking a globulous form of acute pain for pressure on the lower part of the uterus; after 6 months, it brings on itself a pelvic presentation. This is an asymmetrical enlargement of the uterus. It's a sign of pregnancy. It refers to vaginal pulsation. This is an early sign of pregnancy It is a purple coloration of the vaginal mucosa, under the urethra hole; observed in the fourth week of pregnancy. This change in consistency and color in the cervix the size of the uterus increases mainly from the diameter of the antero-ostor, becoming then globulous or spherical SIGNS PRESUTION: Common: Asthenia, Abnormal Sensations, Sense of Abdominal Movements, Digestive: Taste-olfactory sensitivity disorders, nausea and vomiting, xialorrhea. Urinary tract: Polaquiuria, Tenesmus, Nicturia, Rarely dysuria. Mamarios: Mastalgia. Psychological: Antojos PROBABILITY SIGNS: Common: Except for all late amenorrhea: Amenorrhea, bloating (from 16 weeks), Pigmentation of the dawn line, the appearance of stretch marks in the abdomen and/or breasts, spontaneous changes in the shape of the abdomen. Mammals: Breast Hypertrophy, Nipple Building, Areola Pigmentation, Double Areola, Haller's Venous Network Increase, Montgomery Tuber Hypertrophy (Morgañial), Colosseven Appearance, Vulvovaginals: Jaquemier Sign, Chadwick Sign, Kluge Sign, Wombs: Increase in Shape Change: Piskacek Sign, Pinard-Budin Sign, Noble-Budin Sign, Oslander Sign, Dickinson Sign, Loenne Probe Sign, Changes in Sequence and Coloring: Body: Landu-Bonner Sign, Holzapfel Sign, Hegar Sign II, Neck: Sign of Goodall, Sign of Pshirembel SIGNS OF CERTAINTY: The desecration of the fetal heartbeat from 20 weeks of pregnancy. With the discovery of Doppler at 12 weeks. Detect fetal movements: from 16 weeks. Palpation of fetal parts and/or movements: Internal or external platoon. Colic-type pain in the case of menstruation is treated in primary dysmenorrhea as physiological (in the absence of organic pelvic trauma) and in secondary dysmenorrhea as caused by underlying pathology. IDENTIFY AMENORRHEA. This is the absence of menstruation, and is divided into: AMENORREA PRIMARY: No menarchy. No menstruation at the age of 14 without the growth or development of secondary sexual characteristics. Lack of menstruation at the age of 16, despite the frequency of growth and development of secondary sexual characteristics. SECONDARY AMENORREA: Stopping menstruation in women who have had menstruation with regular cycles or six months of menarch. Excessive hemorrhage in the uterus both in quantity (more than 80 ml) and in duration at regular intervals. Frequent but regular episodes of hemorrhage during uterine periods at intervals of 21 days or less. It is a slow-growing tumor that forms with trophoblast cells after the sperm fertilizes the egg. Hydatidiform mall contains many cysts. It is usually benign, but can spread to nearby tissues (invasive cool). Ectopic pregnancy is abnormal implantation of embryo outside the mother's uterus sincitismo y asincitismo definicion. sincitismo y asincitismo pdf. que es sincitismo y asincitismo. diferencia entre asincitismo y sincitismo

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