

## 1: Induction Stock Photos & Induction Stock Images - Alamy

*Study guide for Exam 2 (ch 16 & 27) - OB The labor would result in hemorrhaging, and fetal station. Induction is more successful if the score is greater than.*

Received Oct 10; Accepted Sep The classified and organized databases as the source of data for this study can be found at the study data registry of this hospital. Abstract Background By increased concerns about the accuracy of the traditional methods to predict outcomes after induction of labor, developing new standards has a great clinical importance. Here, we compared the predictive value of translabial ultrasound measurements with Bishop Score to determine the suitability of induction of labor. Methods A homogenous population of primigravid women was recruited. Induction of labor was performed with low-dose infusion of oxytocin. Translabial ultrasound and assessment of Bishop Score were performed by two different obstetricians. Receiverâ€™operating characteristics curves were obtained to measure area under curve and subsequently, test sensitivity of each method. Results One hundred women entered the investigation. Maternal body mass index was significantly higher among candidates of Cesarean section P: Maternal age and fetus weight, gender and occiput position were not determinants of outcomes of induction of labor. Conclusion This study demonstrates that translabial measurements can be a suitable alternative method to monitor labor progress with an admissible predictive value compared with Bishop Score. It is a non-invasive method which provides valuable objective measurements and can be better accepted by women when considering the painful process which is required in evaluating Bishop Score. Therefore, many investigations have tried to determine factors which are related to a successful vaginal delivery after IOL [ 3 ]. Fetal distress is the most common reason for necessity of an operative delivery when IOL fails [ 4 ]. Identifying factors that can predict the success of IOL is clinically essential. Bishop Score is measured by assessment of dilatation, effacement, consistency and position of the cervix and fetal station [ 5 ]. Since Bishop Score is a subjective measure, it can be accompanied with high intra- and inter-observer variability [ 6 â€™ 11 ]. Moreover, the procedure of calculating Bishop Score is painful. By considering the limitations of Bishop Score the necessity of identification alternative measures to predict suitability of IOL is clear. Previously, Newman et al. Furthermore, some studies have shown that transvaginal ultrasound measurements perform better than Bishop Score [ 13 â€™ 16 ]. However, conflicting results exist when addressing the comparison between Bishop Score and Ultrasound measurements [ 17 , 18 ]. Existence of these conflicting results emphasize on more research in this field especially with adjustment for other confounders to come to a proper comparison. However, since other factors such as parity and body mass index BMI are known to affect prediction of vaginal delivery after IOL [ 3 ], investigations on homogenous populations with considering the confounders were required to compare the predictive value of Bishop Score and ultrasound measurements. In this study, only primigravid women were included and the predictive values of Bishop Score and translabial ultrasound measurements in determining suitability of IOL have been evaluated. Translabial ultrasound has been shown to be a suitable technique to assess labor [ 19 ]. Methods Study design and participants Participants were admitted women with term pregnancies in Tehran University Hospital. Exclusion criteria were pre-term pregnancies, previous Cesarean section or other uterine surgeries, twin fetuses multiple pregnancy , any suspicious finding of fetal distress at the time of admission. Women with gestational diabetes or suspicious findings indicating fetus macrosomia were excluded and only women with relatively similar range of fetus weight according to previous ultrasound examinations were recruited. Women with cephalopelvic disproportion detected in previously performed examinations were excluded as well. Total of women were recruited in this prospective study. Written consent was obtained from each individual. Participation in the study was voluntary and those women with unwillingness to participate were considered as not eligible. Data was collected between and Induction of labor IOL Labor was induced with low-dose oxytocin. Successful IOL was defined as vaginal delivery regardless of the required time for its occurrence. Similar dosage and method were applied for all women to induce labor. Translabial ultrasound measurement Translabial Ultrasound was performed by using a Siemens ultrasound system with a five megahertz curved array transducer. The probe was positioned translabially along with the following anatomical

structures [ 23 ]: The transducer was placed in a way so that the symphysis was in horizontal position. All Ultrasound measurements were performed immediately after emptying the bladder and in supine position. The fetal headâ€™perineum distance was defined as the shortest distance between a line through the inferior posterior symphyseal margin parallel to the main transducer axis and the leading edge of the fetal skull. This measure is the distance from the outer bony limit of the fetal skull to the skin surface of the perineum [ 24 ]. Negative values were given when the presenting part was found cranial to the line of reference. Positive values imply that the head was seen beyond this line. Fetal head-pubis symphysis distance was measured according to the method described by Dietz et al. Fetus entry angle and occiput position anterior, transverse and posterior were determined as well.

### 2: Railway Recruitment Board Chennai :: Results

*the physical examinations at the local board, if any, at the induction station and at the Army reception center or Navy recruiting station. In addition, induction stations have maintained records of their.*

The Physical Standards Division determines the standards and supervises their administration. The maintenance of these standards was not a function of the Preventive Medicine Service during World War II, but the effectiveness of physical and psychiatric screening had a highly important bearing upon preventive medicine and materially influenced the measures and procedures necessary to plan and carry out the prevention and control of the acute and chronic infections which condition the health of the Army and the loss of manpower and man-days in military operations. The experience of the Army in World War I made The Surgeon General particularly aware of the necessity for strict screening against tuberculosis. The incidence of tuberculosis during World War I averaged 11 per thousand per year and before World War I was over, about 3, soldiers had died of tuberculosis. Throughout that war, tuberculosis had been a leading cause of disability discharges, accounting for World War I also pointed up the desirability for adequate psychiatric screening. About , men were hospitalized as neuropsychiatric patients during that war. It has been estimated that around 34 percent of these men had to be discharged. XV, pt 2, Tables 46, 48, 54, and New York, The Macmillan Company, , p. This would provide an Army most likely to withstand the physical strain and other exigencies of service and would also avoid inducting men who might shortly be discharged and thereafter be eligible for disability payments and hospital expenses by the Government. The Available Manpower Pool Both the needs of the service and the available manpower pool fluctuated from time to time. The Selective Service System made the initial classification of registrants, complying with current requirements set by Congress as to age, occupation, dependents, and education. The Army determined the number of men needed each month, specified the minimum physical and mental standards required for military service, and conducted the physical examinations. This was a relatively small number to take out of the manpower pool of registrants available at that time, which totaled about 17,, It was, therefore, possible to select only those who would be able to enter immediately upon a period of intensive training and who could reasonably be expected to remain fit for a period of years thereafter. Consequently no reparative or therapeutic work was considered; standards were set high; and psychiatric screening was designed so as to exclude anyone who might not respond well to Army life. After the United States entered the war, the picture changed radically. A large Army was needed immediately. About 3,, men entered the Army during , through inductions and enlistments. Physical standards had to be lowered to get the number of men needed, and limited service personnel were accepted at a fixed percentage of the quota. Industry and agriculture also expanded to keep pace with the enlarged Army. A great effort was made to increase the available manpower pool. Women formed the greatest labor reserve in the United States and hundreds of thousands became industrial workers. Labor was also drawn from the previously unemployed group and from the older age brackets. There was a decrease in civilian activities and in self-employment. To make the best possible use of the labor available, the work week was lengthened to 48 hours. After that date, however, the whole medical processing was taken over by the Army, and the function of the local boards was limited to elimination of the obviously disqualifying defects. Since the physical and mental standards for enlistment in the Navy and Army Air Forces were higher than the general requirements for induction, the result was that they were able to obtain men of better physical and mental caliber than were the Ground and Service Forces. President Roosevelt<sup>6</sup> therefore, in December , stopped all voluntary enlistments of men between 18 and Registrants were thereafter processed through Selective Service and allotted to Army and Navy according to established quotas. The manpower shortage seemed so acute by the end of that Congress directed the appointment of a commission to study requirements for the Armed Forces. The commission reported that existing physical requirements could not be reduced further without impairment of efficiency. The chief need, the report concluded, was for men for general duty. By the middle of , the Army had attained the bulk of its procurement objective. With offensives on all fighting fronts, it urgently needed young men as replacements. Exemptions for those under 26 were rigidly screened; deferments in older age

groups were liberalized. Men becoming of age for registration were the chief source of replacements for the Armed Forces. Concurrently many were being discharged, primarily for physical reasons, and became available as civilian labor. Throughout the period of mobilization and war Selective Service maintained a continuous program of registering, classifying, and reclassifying. Registrants were not considered frozen in one category, but were constantly screened and reevaluated. Evaluation of the physical fitness of present-day inductees. Washington, Government Printing Office, , p. The President declared them part of Selective Service regulations<sup>9</sup> and they were used both by examining physicians of the local boards and by Army induction examiners. Mobilization Regulations went through several major revisions during the war and were also amended from time to time by War Department directive with respect to specific items. Although for some conditions very sharp lines of demarcation were drawn, the introduction to each of the published regulations stated that they were to constitute a guide to the medical examiner. It was expected that he would exercise his professional judgment. In many instances it was the degree of incapacity which led to classification for general or limited service, or for rejection. An analysis for rejection for cardiovascular disorders showed a particularly wide range of professional difference of opinion upon what would be disqualifying. The most drastic changes in the regulations themselves were those relating to visual acuity and dental requirements. The first MR in August set the minimum dental requirements at a total of 6 masticating teeth and 6 incisor teeth properly opposed. As soon as the first statistics were available, it was discovered that failure to meet these requirements had resulted in rejection of approximately 9 percent of those examined. If that standard had been maintained, it has been estimated that by the end of nearly 1,, men who were inducted under the liberalized dental standards would have been lost to the service. This was the second most important cause for rejection, and these requirements were progressively lowered. The registrant did not have to supply the corrective glasses himself; the Army furnished more than 2 million pairs of glasses. In general, no registrant with an acute infectious disease, with the exception of venereal diseases which are considered separately, was to be inducted until he had recovered without disqualifying sequelae. Although intestinal parasites were not considered cause for rejection, such findings were to be noted on the record so that medication could be undertaken. Other parasitic infections such as filariasis, trypanosomiasis, amebiasis, and schistosomiasis were cause for rejection. The Subcommittee on Tuberculosis of the National Research Council, at the request of The Surgeon General, made recommendations regarding screening standards for tuberculosis. The aim was to exclude all men with active tuberculosis or tuberculosis of doubtful stability that might break down and lead to active disease during military service. At the same time it was recognized that tuberculous infiltrations of minor extent not infrequently heal completely, and it would be a waste of manpower to reject all persons showing any traces of healed tuberculous lesions. The standards included detailed instructions on the physical examination of lungs by palpation, percussion, and auscultation although it was recognized that these methods were of less value than X-ray. The Subcommittee on Tuberculosis pointed out that at least 75 percent of early active tuberculosis can be discovered only by X-ray examination, and that about 1 percent of the male population of military age has active tuberculosis. Approximately 1 million men were inducted without X-ray. In March chest X-ray on all inductees became mandatory. The average rejection rate for tuberculosis for the years was approximately 1 percent. The incidence rate of tuberculosis in the Army during those years was 1. A roentgenogram of the chest was made a routine part of the separation physical examination as well. Cases of active tuberculosis discovered averaged 1 per thousand. Tuberculosis in the Armed Forces. A considerable number of men with small active tuberculous lesions escaped detection. Registrants with acute or chronic syphilis, including latent syphilis, were classified as limited service. No limited service registrants were called for induction, however, until July Gonorrhea was considered a remedial defect, and registrants with this disease were temporarily deferred until a cure had been effected. Several things happened to change this attitude. One was pressure of public opinion which produced a flood of letters of protest against a policy which seemed to penalize good conduct. It was soon obvious, also, that a number of men, otherwise qualified, were being lost to the services. Some draft boards, particularly in the South, were hard pressed to meet their quotas because a high percentage of the Negroes in their districts were infected. The treatment of uncomplicated venereal diseases was very much simplified by new therapeutic discoveries. In the summer of the Medical Department conducted an

## RESULTS OF INDUCTION STATION EXAMINATIONS 27 pdf

experimental program of inducing men with venereal diseases and curing them before they reported for active duty. Since successful results were achieved, induction boards were directed to accept infected men within the limits of facilities for their treatment. By March , about 7, venereally infected men were inducted into the Army. About 4, of these inductees were infected with syphilis. The induction of men with venereal disease reached its peak in the last quarter of that year, when about 12, men with venereal disease were inducted each month. By the end of the first half of , the backlog of all registrants previously rejected for venereal disease was completely rescreened and inducted. It has been estimated that with the liberalization of the standards regarding venereal disease the Army absorbed 17Myers, J. A review of induction and discharge examination for tuberculosis in the Army. During the first 2 years of the war great effort was made to screen out all men with actual mental disorders, also those with psychoneurotic traits which might make it difficult for them to adjust to Army life. But the speed of induction, lack of adequate social histories of the registrants, and shortage of trained psychiatrists made it very difficult to make a definitive appraisal. The Army emphasized that men with psychoneurotic traits were a detriment to the morale of a unit, were likely to take up needed hospital beds, and would be a great expense to the Government if they had to be discharged as psychiatric patients. One War Department directive stated: If the candidate gave any suggestive evidence of emotional instability, such as nervousness at the time of examination, sweaty hands, or expressed fears, he was usually rejected. It was noted that, on the basis of previous directives, many such men were being rejected at induction stations. The acute need for manpower made it necessary to admit all individuals who had a reasonable chance of adjusting to military service. This question test was adopted in October and used in all induction stations. The borderline cases posed the real problem. The psychiatrist at the induction center had no possible way of evaluating the four most important factors of influence on the adjustment of a soldier: Venereal disease among inductees. It was also shown that many men at first rejected by psychiatric examiners were able to perform for long periods in a satisfactory manner.

### 3: It's Induction Day at the US Naval Academy - Washington Times

*trance station (AFEES). 3. Form identification. with the induction examination results. Part III each column on line 27 should equal the corre-*

### 4: Office of Medical History

*6 It cannot be claimed that the examination for tuberculosis as conducted was perfect. A considerable number of men with small active tuberculous lesions escaped detection. 17 But the general view of responsible authorities was that the screening process was a highly creditable one, that it eliminated the overwhelming majority of active cases sent to induction stations, and provided a body of.*

### 5: Examination Information

*Incoming freshmen, which are known as plebes at the school, are processed through various stations. They include uniform issue, medical examinations, hair-cuts and learning to salute.*

### 6: Bimanual Vaginal (PV) Examination Â· Obstetrics and Gynaecology Â· OSCE Skills Â· Medistudents

*US Naval Academy incoming freshmen known as Plebes study from Reef Points during Induction Day June 27, in Annapolis, MD. Induction Day begins when the incoming plebes are issued uniforms, given medical examinations, complete registration, receive hair cuts and learn to salute.*

### 7: Induction of Labour - Indications - Risks - Procedure - TeachMeObGyn

## RESULTS OF INDUCTION STATION EXAMINATIONS 27 pdf

*Induction of labour (IOL) is the process of starting labour artificially. Whilst most women will go into labour spontaneously by week 42 of gestation, roughly 1 in 5 pregnancies will require an induction.*

*The operas of Giacomo Meyerbeer The thought culture of the English Renaissance 9. Entry Deterrence and Predation The monster of Aurora, by A. Hynd. Part 2 : The wi-fi journey in perspective. The Jewish Derrida (The Library of Jewish Philosophy) 100 American Women Who Shaped American History The songs of Bilitis. Liturgy of the Holy Apostles Adai and Mari The big store in the twentieth century After the Trojan War: Women of Troy, Hecuba, Helen Interface design for learning design strategies for learning experiences Drywall sheets caculator from Old mutual bursary application form 2018 From kitchen-maid to actress Recent discoveries in the Forum, 1898-1904 Cooking with Christian Kids Music therapy trauma bridging theory and clinical practice V. 1. The disciplines, current movements, and instructional methodology. Beale Street, where the blues began The Home-School Connection Applied functional analysis aubin The poetical works of Henry Kirke White and James Grahame Education and credentialing of the forensic nurse The Welfare of Horses (Animal Welfare) Spatial and Visual Components in Mental Reasoning About Space The initiation, by A. Crowley. Presidents Commission on Bioethics Maple leaves and hemlock branches Mayo Clinic internal medicine Letters from Switzerland, translated by A. J. W. Morrison. Vienna conference on human rights 1993 Cross reference guide index The charter and by-laws of the New York historical society. Kingship, Law and Society Fluid motion factor book The Regulatory Flexibility Act: Are Federal agencies using / The cause of Christian education 2014 yamaha bolt service manual Problem in Greek ethics*