



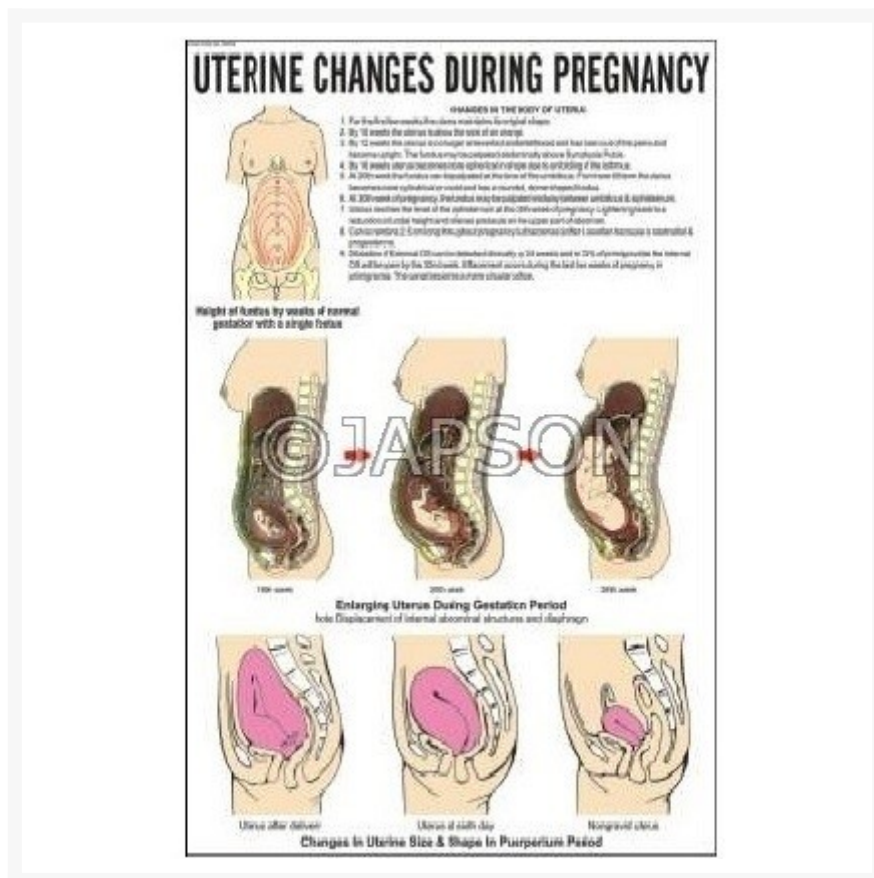
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# Nursing Charts, School Education

## Product Image



## Description

**Standard Size:** 51x66cms, Set of 20 Charts

**Language:** English

Laminated Paper Charts with Plastic Rollers. These Charts have technically accurate and detailed description in vivid colours.

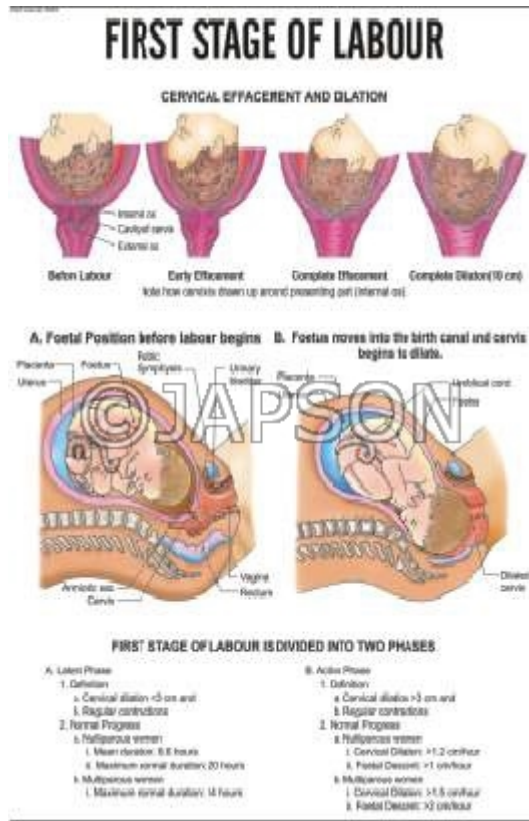
**Note:** Based on minimum order quantity conditions, Charts can be customized to your

requirements in terms of CONTENT, LANGUAGE, SIZE, etc. Please write back to us for discussion.

A. Charts, Foot Presentation



B. Charts, First Stage of labour



C. Charts, Congenital Malformations of New Born

D. Charts, Uterine Changes During Pregnancy

## CONGENITAL MALFORMATIONS OF NEW BORN

**Total Atrial Septal Defect (TASD)**

**Encéphaloceles**

Encéphaloceles are neural tube defects characterized by the protrusion of the brain and meninges from the vertebral canal. These defects are a result of a defect in the neural tube during the development of the embryo.

**Frontal Encephalocele**

**Occipital Encephalocele**

**Lymphatic Malformation (LM)**

**Cervical Lymphatic Malformation**

Birth of an infant with a cervical lymphatic malformation is usually associated with a large swelling in the neck area. This swelling is usually a result of a defect in the lymphatic system during the development of the embryo.

## UTERINE CHANGES DURING PREGNANCY

**CHANGES IN THE BODY OF UTERUS:**

- For the first 12 weeks the uterus maintains its original shape.
- By 12 weeks the uterus begins to enlarge and its position in the pelvis and abdomen changes. The fundus is approximately midway above the pubic symphysis.
- By 16 weeks the fundus is approximately at the level of the umbilicus. The uterus is now approximately midway between the pubic symphysis and the umbilicus.
- At 20 weeks the fundus is approximately at the level of the umbilicus. The uterus is now approximately midway between the pubic symphysis and the umbilicus.
- At 24 weeks of pregnancy the fundus is approximately at the level of the umbilicus. The uterus is now approximately midway between the pubic symphysis and the umbilicus.
- At 28 weeks of pregnancy the fundus is approximately at the level of the umbilicus. The uterus is now approximately midway between the pubic symphysis and the umbilicus.
- At 32 weeks of pregnancy the fundus is approximately at the level of the umbilicus. The uterus is now approximately midway between the pubic symphysis and the umbilicus.
- At 36 weeks of pregnancy the fundus is approximately at the level of the umbilicus. The uterus is now approximately midway between the pubic symphysis and the umbilicus.
- At 40 weeks of pregnancy the fundus is approximately at the level of the umbilicus. The uterus is now approximately midway between the pubic symphysis and the umbilicus.

**Height of fundus by weeks of normal gestation with a single fetus**

**Emerging Uterus During Gestation Period**

Due to Displacement of Internal abdominal structures and diaphragm

**Changes in Uterine Size & Shape in Puerperium Period**

### E. Charts, Shoulder Presentation

## SHOULDER PRESENTATION

- Shoulder Presentation**
  - Occurs when fetus is transverse with back down
  - Shoulder sits over pelvic inlet
- Epidemiology**
  - Incidence: 0.3% of singleton births
- Cause**
  - Prematurity
  - Placenta Praevia
  - Abnormal uterus
  - Contracted pelvis or relaxed abdominal wall
  - Polyploidemia
- Diagnosis**
  - Leopold's 4th maneuver
    - Transverse lie should be easy to identify
  - Digital cervical exam
    - No presenting part
- Management**
  - Cesarean section required in most cases
  - Indications to consider External Cephalic Version
    - Intact membranes and no labour
    - Back-up transverse lie with cervix fully dilated
- Complications**
  - Uterine Rupture

**Dorsoanterior Shoulder Presentation**

**Dorsoanterior Shoulder Presentation**

### G. Charts, Placenta Praevia

### F. Charts, Twin Pregnancy

## TWIN PREGNANCY

**DIZYGOTIC TWINS**

**MONOZYGOTIC TYPE**

(a) ICM splits after day 4

(b) ICM splits between 4-8 days

(c) ICM splits after day 8

### H. Charts, Anencephalus

## PLACENTA PRAEVIA

**Placenta Praevia:** Abnormal implantation of Placenta in lower Uterine Segment. About 85% cases occur in multiparas. Probability increases after the age of 35.

**Risk Factors:**

- Previous Myomectomy
- Scarred Uterine Wall
- Previous Abortus
- Buharskii
- Multiparity
- Erythroblastosis

**Placenta Praevia is a common cause of bleeding in the third trimester. Haemorrhage here it can be fatal to both the fetus & the mother.**

## ANENCEPHALUS

**Clinical Appearance in Anencephaly**

**DEFINITION:** A neural tube defect (NTD) in which the cephalic part of the embryonic axis is missing, resulting in the absence of the brain and skull.

**EPIDEMIOLOGY:** Incidence is 1-2 per 10,000 live births.

**RISK FACTORS:**

1. Maternal age is 45, and increases to 55% if a couple has had 2 previous anencephalic births.
2. Maternal use of certain substances.
3. Folate acid deficiency.

**ASSOCIATED ANOMALIES:**

1. 50% of individuals (usually in males) associated with:
2. 15-20% bilateral club feet, congenital heart disease.

**PATHOPHYSIOLOGY:**

1. Most ventral neuroepithelia die but the lateral and posterior parts are absent.
2. Absence of the cerebellum.
3. Absence of the brainstem usually present.
4. Hypoplastic pituitary gland.
5. The subcutaneous tissue containing masses of primitive connective tissue, "teratomas", and cartilage.

**CLINICAL FEATURES:**

1. Characteristic appearance - a large defect in the skull of the skull (calvarium) containing a firm, gelatinous mass of neural tissue associated with this membrane continuous with the skin.
2. The mass is soft and pulsates strongly in the cranial region, exposing a thin and flattened cranial cap (meningocoele).
3. The skull plates may protrude due to inadequately retracted calvaria.

**DIAGNOSTIC TESTS:**

1. Prenatal Diagnosis
  - a. Elevated maternal serum alpha-fetoprotein (AFP)
  - b. Low HCG
  - c. Sonography - elevated AFP and echodense shadow.

**MANAGEMENT:**

1. No Treatment Most infants are stillborn or die within several days of birth.

**Development of Neural Tube**

I. Charts, Third Stage of Labour

J. Charts, Brow Presentation

## THIRD STAGE OF LABOUR

After the baby is delivered, the new mother enters the third and final stage of labour — delivery of the placenta. This stage usually lasts just a few minutes and involves the passage of the placenta out of the uterus and through the vagina.

**A. EXPULSION OF THE PLACENTA**

**B. CONTRACTION OF UTERUS**

**C. EXPELLED PLACENTA**

K. Charts, Incomplete Breech

## BROW PRESENTATION

Brow Presentation occurring in 8000 consecutive pregnancies	117 or 1.5%
Occurrence	117 or 1.5%
Mortality	38 (32.4%)
Foetus	36 (31.6%)
Perinatal deaths	2 (1.7%)
Fetal malformations	
Anencephaly	-
Hydrocephalus/other neural tube	8 (6.8%)
Abnormalities - total	8 (6.8%)
Bleeding	
Spontaneous	16 (13.7%)
Premature	30 (25.6%)
Cerebral infection	43 (36.7%)

**In Brow Presentations, the head is above the brim and not engaged. The mento-vertical diameter of the head is trying to engage in the transverse diameter at the brim.**

**Vaginal examination with brow presentation.**

**Moulding in a brow presentation (dotted line)**

L. Charts, Second Stage of Labour

# Presentation

## INCOMPLETE BREECH PRESENTATION

The incomplete breech presents with the legs flexed and legs extended as the abdomen. Severely percent of breech presentations are of this type and it is particularly common in paraviviparous whose good uterine muscle tone affords flexion of the legs and feet turning of the trunk.



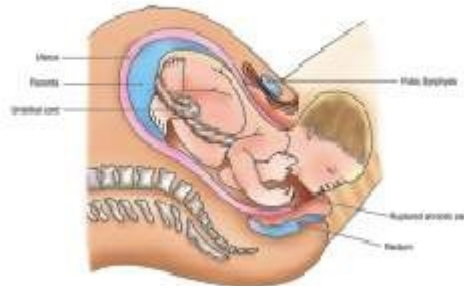
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**Frank Breech**  
(Breech with extended legs)  
Lie: Longitudinal or vertical  
Presenting Part: Occiput  
Attitude: Flexion except for legs at knees

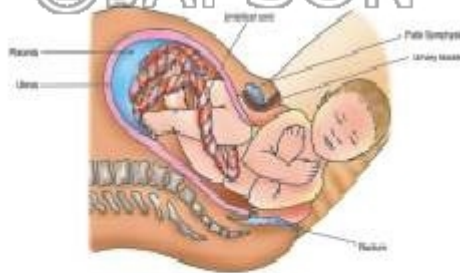


Vaginal Examination of frank breech in LAL position. No feet felt. The legs are extended.

## SECOND STAGE OF LABOUR



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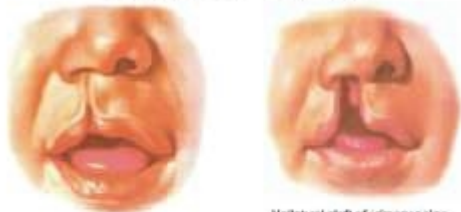


**B. Expulsion of the foetus from uterus.**

The second stage of labour begins when the cervix is completely opened and ends with the delivery of the baby. The second stage is often referred to as the "pushing" stage. During this second stage, the woman becomes actively involved by pushing the baby through the birth canal to the outside world. When the baby's head is visible at the opening of the vagina, it is called "crowning". The second stage is shorter than the first stage, and generally takes between 30 to 60 minutes in a woman's first pregnancy.

## M. Charts, Cleft Lip-Palate

### CLEFT LIP-PALATE



Unilateral cleft lip (partial)

Unilateral cleft of primary palate (complete, involving lip and alveolar ridge)

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Bilateral cleft lip

Partial cleft of palate

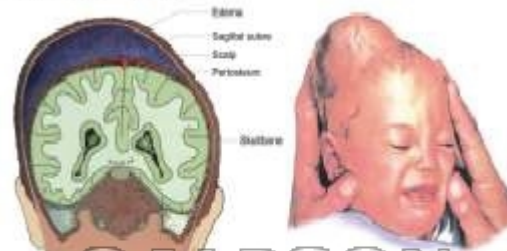
Complete cleft of secondary palate and unilateral cleft of primary palate

Cleft lip and palate are congenital anomalies resulting in structural facial malformation. The lip and palate, fail to close in approximately 1 in every 1,000 neonates. Cleft lip (with or without cleft palate) occurs more frequently in males, and isolated cleft palate is more frequent in females. Combination of cleft lip and palate occurs in approximately 50% of cases; cleft lip alone occurs in about 25% of cases; and cleft palate alone occurs in about 25% of cases.

## N. Charts, Caput Succedaneum

### CAPUT SUCCEDANEUM

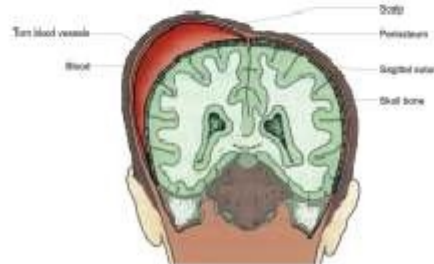
Caput succedaneum is a subcutaneous area of the scalp, most commonly located on the occiput. With severe compression, the maternal passage of the occiput against the cervix results in compression of fetal vessels, particularly the carotid arteries. The above cervical artery isocapsitis is usually a blood clot within the site of the scalp, and an anastomosing swelling develops. The swelling, present at birth, usually resolves spontaneously within 5-10 days.



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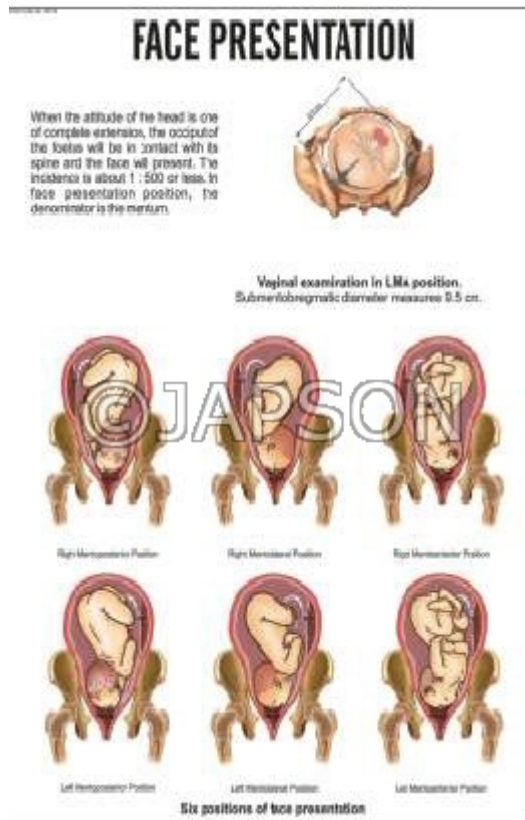
### CEPHALHAEMATOMA

Cephalhaematoma is a collection of blood between the skull bone and its periosteum. Cephalhaematoma does not cross a suture where the sutures resulting in cephalhaematoma may occur with spontaneous laceration from pressure against the maternal bony pelvis. A cephalhaematoma usually disappears after 3-10 days, depending on the underlying stage. The absence of a cephalhaematoma spontaneously resolves in 10-14 days.



## O. Charts, Breast Self Examination

## P. Charts, Face Presentation



Q. Charts, Hydrocephalus

R. Charts, Complete Breech Presentation



S. Charts, Spina Bifida

# SPINA BIFIDA

Spina bifida is a type of birth defect called an neural tube defect. In spina bifida, a baby's spine does not close completely during early pregnancy. Spina bifida continues to develop in a fetus even before the mother knows she is pregnant.



- Occulta**
- The most common form.
  - No symptoms. Clumps in the skin or a growth of hair over malformed vertebrae.
  - Small defect in one or more vertebrae.
  - Spinal cord and nerves are normal.
  - Usually no complications.

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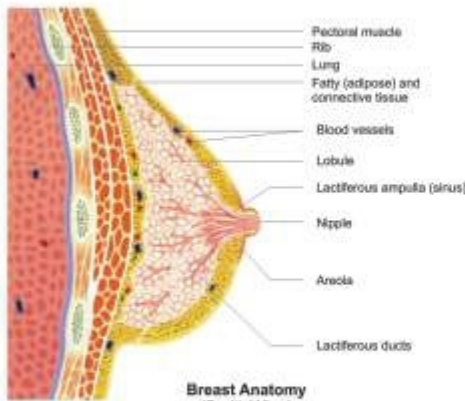


- Myelomeningocele**
- This is the most severe form of spina bifida.
  - A cyst made up of meninges, nerve roots, and sometimes the spinal cord itself comes through the open spine.
  - Substantial problems including paralysis and incontinence of bowel and bladder may occur. These symptoms are frequently not cured by surgery.
  - Myelomeningocele is frequently accompanied by changes in the spinal cord that prevent cerebrospinal fluid from circulating normally around the brain. These changes may require additional surgery to prevent increased pressure in the spinal fluid, which goes into the cerebral cavity, from leading to a serious condition called "hydrocephalus." This causes pressure on the brain itself.

- Menigocele**
- A cyst made up of meninges, which surround the spinal cord, protrudes through the open part of the spine.
  - Spinal fluid can leak out.
  - The cyst can be surgically removed.
  - Development after surgery is usually normal.

T. Charts, Breast Changes In Pregnancy

# BREAST CHANGES IN PREGNANCY



**Breast Anatomy**  
(Sagittal View)

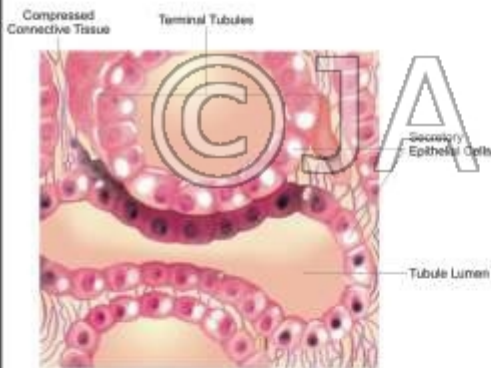
During pregnancy, lobules (milk-producing glands) increase in size and number in preparation for breast-feeding the baby. By the end of the first trimester, they can produce colostrum, the yellow fluid that provides antibodies to protect against allergy and respiratory and gastrointestinal infections in the newborn.



**Milk glands in Non-lactating Breast**



**Milk glands in Engorged Breast**



### Histological changes during Pregnancy

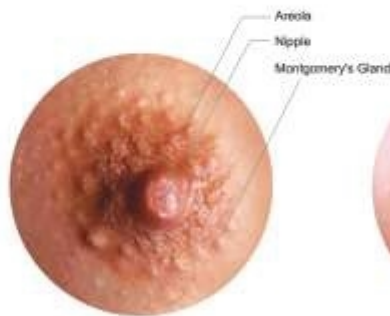
During pregnancy, terminal tubules are converted to acinar structures. The lumens are enlarged and connective tissue is compressed. The secretory epithelial cells are now mature.

### BREAST CHANGES DURING PREGNANCY

1. Hormonal changes in pregnancy can cause improved blood flow and some changes in breast tissues. This causes swelling in breasts, soaring, tingling and abnormally sensitive to touch.
2. Breasts start increasing in size at about eight weeks of pregnancy.
3. Skin start stretching, feel itchiness and develop stretch marks.
4. Nipple and areola become darker and bigger.
5. During third months of pregnancy, the colostrum start producing. In last months of pregnancy, breasts will leak a little amount of thick yellowish liquid.
6. The small glands on the surface of the areola called as Montgomery's tubercles become raised bumps.



**12th week of Pregnancy**  
Breast will feel heavier and tender.



**20th week of Pregnancy**  
Nipple and areola became darker and more prominent.  
Note raised bumps of Montgomery Gland.



**Lactating breast**  
Note bigger areola and somewhat flat nipple due to engorgement.

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