**Topic 1**

**1.** To determine the estimated date of labor (EDL), which day of the menstrual period will you ask?

+1. first

–2. last

–3. third

–4. second

2. According to patient, her last menstrual period is November 15, 2017. What is her estimated date of labor?

+1. August 22, 2018

–2. August 18, 2018

–3. July 22, 2018

–4. February 22, 2018

3. An obstetric history should include:

+1. Current pregnancy details

+2. past obstetric history

+3. past gynaecological history

+4. Drug history and allergies

4. The uterus changes normally become palpable at \_\_\_weeks gestation

+1. 5

–2. 8

–3. 12

–4. 15

5. The uterus normally reaches the level of the umbilicus at \_\_\_weeks gestation

–1. 15

–2. 18

–3. 22

+4. 24

6. Auscultation of the fetal heart by a fetal stethoscope from \_\_\_\_weeks

–1. 15

–2. 28

+3. 20

–4. 25

7. Symphysis – fundal height (SFH) palpated from \_\_\_\_weeks

+1. 12

–2. 18

–3. 22

–4. 25

8. Fetal lie can be:

+1. longitudinal

+2. oblique

–3. horizontal

+4. transverse

9. Body mass index calculated

+1. weight (kg)/ height (m²)

–2. height (m²)/ weight (kg)

–3. weight (kg)+ height (m²)

–4. weight (kg)– height (m²)

10. Which hormone is necessary for a positive pregnancy test?

–1. Progesterone

+2. HCG

–3. Estrogen

–4. Placental Lactogen

11. Fetal Lie refers to:

–1. Longitudinal Axis of the fetus in relation to the oblique axis of the maternal uterus

–2. Longitudinal Axis of the fetus in relation to the transverse axis of the maternal uterus

+3. Longitudinal Axis of the fetus in relation to the long axis of the maternal uterus.

–4. Longitudinal Axis of the fetus in relation to the long axis of the maternal pelvis.

12. The following are presumptive skin signs of pregnancy EXCEPT:

1. Chloasma.

+ 2. Maculo–papular rash.

3. Linea Nigra.

1. Stretch marks.
2. Spider Telangiectases.

13. Normally, pregnancy in 2nd trimester is characterized by all of the following EXCEPT:

1. +Elevated fasting plasma glucose.
2. Decreased fasting plasma glucose.
3. Elevated postprandial plasma glucose.
4. Elevated plasma triglycerides.

14.All are correct, EXCEPT, pregnancy is associated with:

1. Increased cardiac output.
2. Increase venous return.
3. +Increased peripheral resistance.
4. Increase pulse rate.
5. Increase stroke volume.

15. In normal pregnancy, levels of all the following hormones increases EXCEPT:

1. Total Thyroxine (T4).
2. +Parathyroid hormone in the 2nd &3rd trimesters of pregnancy.
3. Cortisol.
4. Prolactin.
5. Estradiol.

16.Changes in the urinary tract system in pregnancy include:

1. +Increase glomerular filtration rate (GFR).
2. Decrease in renal plasma flow.
3. Increase in BUN & Creatinine.
4. Marked increase in both GFR & renal plasma flow when patient is supine.

17.Lowered hemoglobin during normal pregnancy is a physiological finding. It’s mainly due to:

1. Low iron stores in all women.
2. Blood lost to the placenta.
3. +Increase plasma volume.
4. Increased cardiac output as a result greater red cell destruction.
5. Decreased reticulocytosis.

18.Which lung volume is decreased in pregnancy?

1. Peak flow rate.
2. Tidal volume.
3. Vital capacity.
4. +Functional residual capacity.
5. Forced expiratory volume.

19.During normal pregnancy, the renal glomerular filtration rate (GFR) can increase as much as:

1. 10%
2. 25%
3. + 50%
4. 75%
5. 100%

20. The resting pulse in pregnancy is:

1. Decreased by 20bpm.
2. Decreased by 10–15bpm.
3. Unchanged.

4.+ Increased by 10–15bpm

21. A healthy 20 year old primi presents for her booking visit at 10 weeks of gestational age. She denies any significant medical history both personally, and in her family. Which of the following tests is NOT recommended 1st trimester testing in SL?

 -1. Hb concentration

-2. Screening for HIV

-3. Blood group

+4. OGTT

22. Presentation is the part of the fetus that is:

-1. Relates to the right or left side of the maternal pelvis

+2. Presenting or is the closest in proximity to the birthing canal.

-3. Relates to the long axis of the maternal Pelvis

-4. First entering the pelvis

**Topic 2**

**PHYSIOLOGICAL PREGNANCY. PHYSIOLOGICAL LABOR.**

1. What is the most sensitive phase of development in the period organogenesis:

–1. The first 2 weeks.

+2. The first 3 to 6 weeks.

–3. The first 8 weeks.

–4. The first 9 weeks.

2. When is the period of organogenesis and placentation?

–1. The 2nd month of intrauterine fetal development.

+2. The 3rd –4th month intrauterine fetal development.

3. Specify the sequence in which the elements of the membranes eggs are included in the pathological process in the period of organogenesis and placentation:

+1. First chorion, significantly later embryo.

–2. First embryo, significantly later chorion.

4. Please specify which medication is classified as a universal teratogen:

–1. All these products.

–2. Streptomycin.

–3. Monomitsin.

+4. Thalidomide.

–5. Dietilestilbestrol.

5. Which of the following system's fetal bodies lastly forms:

–1. The endocrine.

–2. The respiratory organs.

+ 3. The outer genital organs.

6. Please specify what time of pregnancy the embryo is most sensitive to the impact of radiation exposure:

–1. During the first 2 weeks of pregnancy.

+ 2. During the first 2 to 7 weeks of pregnancy.

–3. During the first 8 weeks of pregnancy.

7. In what period does hypoxia of the mother affects the development of a fertilized embryos:

–1. In preimplantation period.

+2. In the period of organogenesis.

8. Embryonic period continues from the moment of fertilization up to:

–1. 2 weeks

–2. 3 to 6 weeks

–3. 7–8 weeks

–4. 9–11 weeks

+5. 12 weeks

9. The normal volume of Amniotic fluid is:

–1. 200–500 ml.

+2. 1,500 ml.

–3. 1,500 ml.

–4. 2500 ml.

–5. 10000–12000 ml.

10. Which does not refer to the transverse diameter of the pelvic outlet?

–1. Bi–ischial diameter

+2. Bi–spinous diameter

–3. Bi–tuberous diameter

–4. Intertuberous diameter.

11. The Antero–posterior diameter of the pelvic inlet where the fetus will likely mostdifficulty during labor is the:

–1. Diagonal conjugate

–2. True conjugate

–3. conjugate Vera

+4. obstetric conjugate

12. The true conjugate can be measured by subtracting \_\_\_ from the diagonal conjugate?

–1. 2.5 – 3 cm

–2. 3.5 – 4 cm

–3. 3 – 4 cm

+4. 1.5 – 2 cm

13. The most important muscle of the pelvic floor is the:

+1. levator ani muscle

–2. ischiocavernous

–3. bulbocavernous

–4. Pubococcygeous

14. Which pelvic shape has the poorest prognosis for vaginal delivery?

–1. platypelloid

–2. anthropoid

+3. android

–4. gynecoid

15. The two pubic bones meet anteriorly at the:

+1. symphysis pubis

–2. coccyx

–3. sacrococcygeal

–4. sacro–illiac joint

16. The average length of the umbilical cord in human is:

–1. 35 cm

+2. 55 cm

–3. 65 cm

–4. 45 cm

17. Urinary excretion of HCG is maximal between which days of gestation?

–1. 50–60

–2. 40–50

+3. 60–70

–4. 30–40

18. The cardinal function of deciduas is:

–1. Immune resonse

–2. Production of hormones

+3. Maintenance of pregnancy

–4. None of the above

19. The diagonal conjugate is 11 cm. The obstetric conjugate is:

−1. 7 cm

+2. 9 cm

−3. 11 cm

−4. 13 cm

−5. 15 cm

20. The narrowest diameter of the true pelvis is:

−1. the anterior–posterior diameter of the inlet

−2. the transverse diameter of the inlet

−3. the anterior–posterior diameter of the mid–pelvis

+4. the transverse diameter of the mid–pelvis

−5. none of the above

21. An ultrasound dating examination is most accurate during which trimester?

+1. first

−2. second

−3. third

22. All of the following are indications for an obstetrical ultrasound EXCEPT:

−1. size–dates discrepancy

−2. vaginal bleeding

+3. gender identification

−4. history of previous congenital anomaly

23. Fetal cardiac activity can be identified with ultrasound as early as:

−1. 3–4 weeks

+2. 5–6 weeks

−3. 7–8 weeks

−4. 9–10 weeks

24. A biophysical profile includes all of the following EXCEPT:

−1. fetal movement

−2. amniotic fluid measurement

−3. fetal breathing

+4. fetal size

25. Ultrasound in labor and delivery is useful to determine:

−1. fetal gender

−2. fetal lung maturity

+3. fetal position

−4. fetal foot size

26. Doppler ultrasound is used to measure:

−1. placental resistance

+2. blood flow velocity

−3. fetal hearing

−4. fetal tone

27. Fetal weight is estimated using all of the following EXCEPT:

−1. biparietal diameter

−2. femur

−3. abdominal circumference

+4. chest circumference

28. The major phospholipid component of surfactant at term is:

−1. sphingomyelin

+2. lecithin

−3. phosphatidyl glycerol

−4. trypsin

−5. serine

29. Which of the following statements *is false* regarding the risk of a genetic amniocentesis at 16–20 weeks using standard procedures?

−1. The risk includes an increased risk of infection.

−2. The risk includes an increase in premature rupture of membranes.

−3. The risk includes an increased incidence of in utero fetal demise.

+4. The risk of a fetal loss secondary to the procedure, is approximately 10–fold greater than the risk of a spontaneous loss at that time.

−5. The risk of spontaneous loss is at least 10–fold greater than the risk of induced loss.

30. Physiologic changes in pituitary function during pregnancy include all of the following EXCEPT:

-1. decreased gonadotropin levels

-2. decreased growth hormone stimulation

-3. increased ACTH levels

+4. decreased TSH levels

-5. increased prolactin levels

31. Which of the following is the most important utero/placental/fetal response to diminished uterine blood flow:

-1. a decrease in the tone of uterine arteries resulting in improved blood flow

-2. enhanced fetal cardiac contractility (Frank-Starling mechanism)

+3. fetal bradycardia

-4. fetal heart rate accelerations

32. Fetal weight estimates by ultrasound are usually accurate to within:

-1. 5%-10%

+2. 10%-15%

-3. 15%-20%

-4. 20%-25%

33. In the pregnant woman, insulin:

+1. has less biologic activity

-2. freely passes the placenta

-3. has normal secretory patterns in response to glucose stimuli

-4. does not alter placental metabolism

-5. has a reduced metabolic clearance rate

34. Ultrasound at 6-11 weeks' gestation is considered confirmatory of gestational dates if agreement with menstrual dates is within:

-1. 1 day

-2. 3days

+3. 1 week

-4. 2 weeks

-5. 3 weeks

35. Physiological changes seen in pregnancy:

-1. Heart rate increases by 30 % in the second trimester

-2. RBC folate concentration increases

+3. Increased renal plasma flow

+4. Blood pressure drops in the first trimester

-5. Increased blood urea levels

36. Maternal changes in normal pregnancy include:

+1. an increase in fibrinogen level in blood

+2. an increase in the stroke volume during the second trimester

-3. an increase in blood supply to the liver

-4. an increase in total peripheral resistance

+5. an increase in red cell mass

37. 26. Elevated levels of AFP in maternal blood at 16 weeks' gestation may suggest all of the following fetal problems EXCEPT:

-1. twins

-2. neural tube defects

-3. fetal growth retardation

+4. polyhydramnios

38. Regarding renal changes in pregnancy:

-1. Increase in size of the kidney

-2. Increase in glomerular filtration rate

-3. Increase in incidence of hydronephrosis

-4. Increase in incidence of urinary tract infection

+5. All of the above

39. Regarding reproductive system changes in pregnancy

-1. Uterine smooth muscles undergo hypertrophy

-2. Significant increase in uterine blood flow

-3. Prolactin induces milk production

-4. Cervix secretes more alkaline secretions

+5. All of the above

40. Maternal changes during pregnancy:

-1. Increase minute ventilation

-2. Increase in kidney size

-3. Increase in corticosteroids

-4. Decreased peripheral resistance

+5. All of the above

41. Regarding respiratory changes in pregnancy:

-1. Total pulmonary resistance is reduced

-2. PaO2 increases

-3. Functional residual capacity decreases

-4. O2 consumption increases

+5. All of the above

42. Regarding gastro intestinal changes in pregnancy:

-1. Increase in gastric motility

-2. Intestinal motility is unchanged

-3. Hepatic blood flow is increased

-4. Telengiactasia is a feature

+5. Increased incidence of gastro – oesophageal reflux disease

43. Regarding endocrine changes in pregnancy:

+1. Bi-temporal hemianopia is a transient feature

-2. Rise in free T4 during first trimester

-3. Insulin activity decreases

-4. TSH increases

44. Abnormal features in CTG:

-1. baseline fetal heart rate 90 beats per minute

-2. baseline variability of 4 beats per minute

-3. presence of late decelerations

-4. presence of variable decelerations

+5. All of the above

45. Which of the following regarding abnormal CTG:

-1. An acceleration lasting for 15 seconds

-2. Baseline heart rate of 150 beats / mins at term

-3. Baseline variability of 15 beats / mins

+4. Reactive trace would have one acceleration in 20 minutes

46. Regarding CTG:

-1. Baseline rate is low in preterm fetus

-2. Presence of type 1 deceleration at 2nd stage indicates immediate delivery

-3. Reduces the overall incidence of caesarean section

+4. Reduction in baseline variability indicate fetal hypoxia

47. Ultrasound examination during pregnancy:

-1. Contra indicated in first trimester

-2. Best performed at 28th weeks of pregnancy to exclude fetal anomalies

-3. Used to confirm meconium in amniotic fluid

+4. Useful to locate the placenta

-5. Causes increase risk of developing leukaemia in children

48. During normal pregnancy:

-1. -Blood flow to liver is increased by 30%

-2. -Blood pressure rises in third trimester

-3. -Estradiol is the principal circulating estrogen

-4. -Hydroureter is a always pathological

+5. The erythrocyte sedimentation rate increases

49. Physiological changes in pregnancy include:

-1. Increase in stroke volume by 5%

-2. Rise in the haematocrit

-3. Increase in plasma folate concentration

-4. Increased loudness of both heart sounds (S1 and S2)

+5. Modestly increased ACTH levels

**Topic 3.**

**PHYSIOLOGICAL LABOR**

1. Which is a primary power of labor?

+1. uterine contractions

–2. pushing of the mother

–3. intrathoracic pressure

–4. abdominal contraction

2. The lower uterine segment is formed from the:

–1. cervix

+2. isthmus

–3. body of the uterus

1. Dilatation of the cervix occurs during the:

+1. first stage

–2. second stage

–3. third stage

4. In the second stage of labor, uterine contraction last:

–1. 20 seconds

–2. 30 seconds

+3. 60 seconds

–4. 120 seconds

5. The time between uterine contractions is:

–1. intensity

+2. interval

–3. duration

–4. frequency

6. Which is the fastest Stage of labor:

–1. 1st Stage

–2. 2nd Stage

+3. 3rd Stage

–4. Pre–1st Stage

7. During the 1st Stage of Labor there are a few phases, what are not the phases?

–1. Latent

–2. Active

+3. Agonal

–4. Slow

8. What is the Cervical Dilation for the Latent phase?

–1. 4–8 cm

+2. 0–4 cm

–3. 8–12 cm

–4. 12–14 cm

9. In the active phase of the first stage of labor, the cervix of a parous patient should dilate at least:

–1. 0.5 cm per hour

–2. 1.0 cm per hour

+3. 1.5 cm per hour

–4. 2.0 cm per hour

10. The normal basal uterine tone in labor is:

+1. 10–15 mm Hg

–2. 20–25 mm Hg

–3. 30–35 mm Hg

–4. 40–45 mm Hg

11. What marks the beginning of the active phase of the first stage of labor?

−1. the contractions occur every 3 min

−2. 2–cm dilatation

−3. 3–cm dilatation

+4. 4–cm dilatation

−5. 100% effacement

12. The onset of labor in women is associated with:

−1. a fall in serum progesterone concentration

−2. a surge in fetal Cortisol secretion

−3. a decrease in oxytocin receptors

+4. an increase in myometrial gap junctions

−5. a decrease in prostaglandin production

13. In the active phase of the first stage of labor, the cervix of a multiparous patient should dilate at least:

−1. 0.5 cm per hour

−2. 1.0 cm per hour

+3. 1.5 cm per hour

−4. 2.0 cm per hour

−5. 2.5 cm per hour

14. The normal basal uterine tone in labor is:

+1. 10–15 mm Hg

−2. 20–25 mm Hg

−3. 30–35 mm Hg

−4. 40–45 mm Hg

−5. 50–55 mm Hg

15. The pain of a uterine contraction is first perceived when the intraamniotic pressure achieves what value above resting tonus?

−1. 5 mm Hg

−2. 10 mm Hg

+3. 15 mm Hg

−4. 20mmHg

−5. 30mmHg

16. Respiratory depression occurring after epidurally administered morphine is *best* antagonized by the administration of which one of the following:

−1. nalorphine

−2. Flumazenil

−3. Duramorph

+4. naloxone

−5. physostigmine

17. The pain associated with uterine contractions can usually be alleviated by all of the following regional blocks EXCEPT:

+1. pudendal block

−2. epidural block

−3. spinal block

−4. paracervical block

−5. lumbar sympathetic block

18. Which of the following drugs, administered during labor to control pain and/or anxiety, has the shortest duration of action:

−1. meperidine

−2. morphine

−3. butorphanol

−4. nalbuphine

+5. Fentanyl

19. The onset of labor

−1. is associated with a marked maternal oxytocin release

−2. can be predicted in man by a sudden fall in blood progesterone levels

−3. is unaffected by administering antitoxemia drugs such as Apresoline or MgS04

−4. results from phospholipase A2 release from nuclei and the synthesis of palmitic acid

+5. none of the above

20. In the normal first stage of labor, the fetal head:

-1. Enters the pelvis in antero – posterior diameter

+2. Rotates when it comes into contact with pelvic floor

-3. Extends in the mid cavity

-4. Descends in occipito – anterior position

-5. Is responsible for dilating the cervix

21. The normal second stage of labo:r:

+1. Begins with full dilatation of cervix

-2. Lasts for 4 hours in a primigravida

-3. Ends with delivery of anterior shoulder

+4. Involves extension of fetal head

+5. Involves external roatation of fetal head to face laterally

22. In third stage of labor:

-1. The uterus must be contracted

+2. Vaginal bleeding is a sign of placental separation

-3. Fundal massage is a component of active management

-4. Active management is indicated only in high risk pregnancies

-5. Ergometrine is contraindicated

23. Progress of labor is measured by:

-1. Frequency of uterine contractions

-2. Force of uterine contractions

+3. Dilatation of cervix

-4. Descent of the presenting part

-5. Length of time since rupture of membranes

24. Regarding labor:

-1. Epidural anaesthesia slow the progress of the first stage of labor

+2. extension of the fetal head will increase the presenting diameters

-3. in the latent phase, cervix dilates at the rate of 1 cm per hour in a multi

-4. the fetal heart rate of 180 beats per minute is normal

25. The second stage of labor:

-1. Duration is shorter in primi- compared to multiparous woman

-2. Ends with delivery of anterior shoulder

-3. Hydration is maintained by allowing the woman to take oral fluids

+4. Needs to be shortened in heart disease complicating pregnancy

26. The second stage of labor:

+1. Can causes bradycardia with contractions

-2. Duration is shorter in primi- compared to multiparous woman

-3. Ends with delivery of anterior shoulder

-4. Hydration is maintained by allowing the woman to take oral fluids

27. Active management of the 3rd stage do not include:

+1. Injection of 0.6 mg ergometrine IV with the delivery of the anterior shoulder

-2. Apply controlled cord traction if the placenta is not delivered by 30 min if you are skilled birth attendants

-3. Delayed cord clamping for 1-3 minutes to reduce the incidence of neonatal anaemia

-4. Oxitocin 10 IU, IV/IM immediately after the delivery of the baby for all births

-5. Ensure a continuous supply of high-quality oxitocine 10 IU intravenously

28. True contractions are characterized by all EXCEPT:

-1. Occur at regular intervals

-2. Intervals get gradually smaller

-3. Intensity of the contractions increase

+4. Pain stops with sedation

-5. Cervix Dilates

**Topic 4.**

**PHYSIOLOGY OF THE PUERPERAL PERIOD.**

**PATHOLOGY OF THE PUERPERAL PERIOD.**

1. Sudden gush of blood or lengthening of the cord after the delivery of infant should warn the doctor of:

–1. placenta accreta

+2. placental separation

–3. placental retention

–4. abruption placenta

2. When separation begins at the center of the placenta and slides down the birth canal is referred as:

–1. Duncan mechanism

+2. Shultz mechanism

–3. Brandt Andrews mechanism

–4. Ritgen’s maneuver

3. Which of the following is not true regarding the third stage of labor?

+1. Care should be taken in the administration of bolus of oxytocin because it can cause hypertension

–2. Signs of placental separation are lengthening of the cord, sudden gush of blood and sudden change in shape of the uterus

–3. It ranges from the time of expulsion of the fetus to the delivery of the placenta

–4. The placenta is delivered approximately 5–15 minutes after delivery of the baby

4. Demi, a 38 y/o multipara is admitted with a tentative diagnosis of femoral thrombophlebitis. The doctor assesses the patient with:

–1. burning on urination

+2. leg pain

–3. abdominal pain

–4. increased lochial flow

5. Fever, foul lochial discharge and subinvolution of the uterus are signs of:

–1. puerperal psychosis

+2. puerperal sepsis

–3. postpartum hemorrhage

–4. hypertensive disorder

6.The 2nd phase of postnatal infection includes:

–1. Endometritis, parametritis

–2. Limited ulcer

–3. Adnexitis.

–4. Pelvioperitonitis.

+5. All of the listed.

7. The 3rd phase of post–natal infection includes:

+1. Puerperal peritonitis.

+2. Septic shock.

+3. progressing thrombophlebitis.

–4. Pelviperitonitis.

–5. Adnexitis.

8. The 4th phase of post–natal infection include:

+1. Sepsis

–2. peritonitis.

–3. Pelvioperitonitis.

–4. Parametritis.

9. Post–natal Epithelization ends on when?

–1. 10th–12th day.

–2. 4th–5th day.

–3. After one month.

+4. 8th day.

–5. At the end of two months.

10. Clinical signs of post–natal endometritis:

–1. The temperature of 38–39 degrees celsius

–2. Cervical trauma.

–3. The sensitivity of the uterus during palpation.

–4. Bloody purulent lochia with smell

+5. All of the listed.

11. The causes of lochiometra:

+1. Insufficient reduction of the cervix.

+2. Decreased uterine contraction

–3. Complication of the endometritis.

–4. Intoxication.

+5. Deviation of the uterus backward.

12. The main symptoms of post–natal ulcers are:

–1. Pain.

–2. Temperature rise.

–3. General weakness.

+4. Superficial necrosis, the wound is covered with pus.

–5. Intoxication.

13. Causes of post–natal thrombophlebitis are:

–1. Changes in the inner surface of the vascular wall.

–2. Blood clotting disorders.

–3. Blood stagnation in the true pelvis during pregnancy.

+4. All of the listed.

14. The term of post–natal parametritis:

+1. With 10–12 day.

–2. Immediately after the birth.

–3. After 2–3 days

–4. In a month.

–5. In a week the week.

15. Reasons for "obliterated" forms of post natal septic diseases:

+1. The lack of reactivity and resistance of organism.

+2. Resistance of pathogens infection to applied antibiotics.

–3. Massive antibacterial therapy.

–4. The lack of treatment.

–5. All of the listed.

16. The treatment of post–natal endometritis (General principles):

+1. Antibacterial therapy.

+2. Desensitization.

+3. Detoxification.

+4. Supportive therapy

17. The general principles of the treatment of post–natal parametritis:

+1. Antibiotics

+2. detoxification.

+3. desensibilisation.

+4. Vitamin therapy.

+5. suppuration–drainage.

18. On the basis of septic shock?

+1. Hemodynamic disorder.

–2. hypertension

–3. High temperature.

–4. Septic endocarditis.

–5. Puerperal infections.

19. Patients with chorioamnionitis need all of the following :

−1. extraperitoneal cesarean section

+2. intravenous fluids

+3. fetal heart rate monitoring

+4. intravenous antibiotics

+5. oxytocin induction of labor

20. The time of greatest risk for obstetrical thromboembolic complications is:

-1. first trimester

-2. second trimester

-3. third trimester

-4. labor and delivery

+5. early puerperium

**Topic 5.**

**PERINATOLOGY. PRETERM AND POSTDATE PREGNANCY.**

1. What factors causes symmetric or asymmetric fetal grow retardation?

–1. Etiology.

–2. For a period of pregnancy

–3. The degree of disturbance of the fetus state.

+4. All these factors.

2 Abortion is the interruption of pregnancy in the duration:

–1. Up to 16 weeks.

–2. Up to 28 weeks.

+3. Up to 22 weeks.

–4. Up to 20 weeks.

–5. Up to 36 weeks.

3 In what stages of abortion is the continuation of pregnancy impossible:

–1. Abortus imminence (threatened)

–2. Abortus incipiens (inevitable)

+3. Abortus prodigens (in progress)

+4. Complete Abortion

+5. Incomplete abortion.

4. What childbirth pathology often presents with acute fetal hypoxia

–1. Ruptured ectopic pregnancy.

–2. Premature rupture of waters.

–3. The weakness of labor activities.

+4. premature detachment of placenta from its mormal location.

–5. Placenta insufficiency.

5. What are the methods used to diagnose fetal status?

+1. Amnioscopy.

–2. Colpotsitology.

–3. Colposcopy.

+4. Ultrasound.

+5. Cardiomonitoring

6. What does this placenta thickness (up to50 mm) in the IIIrd trimester indicate?

–1. The first degree of maturity.

–2. On the second degree of maturity.

–3. On the third degree of maturity.

+4. The placental deficiency.

7. What researches should be to determine the cause of the familiar miscarriages?

+1. Hysterosalpingography.

+2. Ultrasound.

+3. Bacteriological study.

+4. The definition of the hormones in the blood and urine.

+5. The survey of the physician, an endocrinologist, genetic–counselor.

8. Specify the signs of threatening the interruption of pregnancy, indicated by the ultrasound?

–1. Changing of Fetal Movement.

–2. Change in heart activity.

+3.Increased tone of the myometrium.

–4. Changes in placenta

–5. oligohydroamnion.

9. The causes of spontaneous abortion:

+1. Infection.

+2. The cervical insufficiency.

+3. Trauma.

+4. Hormonal insufficiency.

+5. Genetic changes.

10. The cause of the loss of the fetus in post–term pregnancy:

–1. Infection.

–2. The anomalies of development.

+3. Asphyxia.

–4. Birth trauma.

–5. Anemia.

11. In II trimester of pregnancy may take place the following complications:

+1. Premature births

+2. The cervical insufficiency.

+3. Premature rupture of amniotic membranes

+4. Ruptured ectopic pregnancy

12. Neonatal problems associated with IUGR include

–1. hypoglycemia

–2. polycythemia

–3. hypoxia

+4. all of the above

13. The *most* common clinical cause of *serious* IUGR is:

–1. smoking

+2. hypertension

–3. drug use

–4. trisomy

–5. Obesity

14. A good predictor of IUGR is

–1. amniotic fluid index of 11 cm

–2. uterine fundal height in 80th percentile

+3. oligohydramnios

–4. maternal smoking

–5. maternal anemia

15. The fetus in a postdate pregnancy can have problems with each of the following EXCEPT:

–1. macrosomia

–2. oligohydramnios

+3. polycystic kidneys

–4. placental insufficiency

–5. meconium passage

16. A live fetus with no abnormalities is demonstrated by ultrasound at 10 weeks' gestation in a secundigravida who has had one previous miscarriage. You can inform this woman that her chance of a miscarriage or fetal death in this pregnancy

−1. is less than 1 %

+2. is less than 5%

−3. is about 10% to 15%, the same as if she had not had a prior miscarriage

−4. is increased to about 25% because of the previous miscarriage

−5. may be as high as 50%, since she has not had a complete evaluation for the cause of the miscarriage.

17. It is estimated that 25% of all pregnancies are complicated by:

−1. anembryonic abnormality

+2. first trimester bleeding

−3. undetected early pregnancy loss

−4. low progesterone levels

−5. a lack of blocking antibodies

18. Which of the following is the most common potential cause of recurrent miscarriage:

−1. gestational diabetes mellitus

−2. uterine anomaly

−3. luteal phase defect

−4. lupus anticoagulant

+5. idiopathic

19. Which complication has been reported in newborn of recurrent miscarriage patients who have been immunized with paternal leukocytes:

−1. an increased incidence of congenital anomalies

−2. an increased incidence of neonatal viral infections

+3. an increased incidence of fetal growth retardation

−4. AIDS

−5. sudden infant death syndrome

20. Which of the following is the most reliable way to make a diagnosis of incompetent cervix:

+1. history of painless premature dilatation of the cervix before 20 weeks' gestation

−2. biopsy of the cervix

−3. ultrasonography

−4. ease of passage of Hegar dilators

−5. hysterosalpingogram

21. The most common single–specific karyotypic abnormality in first trimester abortuses is:

−1. mosaicism

−2. translocation

−3. triploidy

−4. tetraploidy

+5. monosomy X 45

22. The only treatment for threatened abortion proven to be effective is:

−1. bed rest

−2. progesterone

−3. low–dose aspirin

−4. tocolysis

+5. none of the above

23. Choose the correct statement about the management of incompetent cervix:

+1. The overall success rate with cervical cerclage is 80% to 90%.

−2. The McDonald cerclage is usually accompanied by greater blood loss and longer operative time than is the Shirodkar procedure.

−3. The success rate is higher with the McDonald procedure than with the Shirodkar procedure.

−4. With the development of clinical infection, the cerclage should be left undisturbed and the patient treated with antibiotics.

−5. Postoperative β–mimetic tocolysis, progesterone, and prophylactic antibiotics decrease the risk of premature labor and infection.

24. Which of the following indicates a pregnancy that is low risk for preterm labor?

−1. prior history of a preterm birth

−2. prior history of premature rupture of membranes

−3. twins

+4. low serum a–fetoprotein at 16 weeks

−5. bacterial vaginosis

25. Pregnant women successfully treated for preterm labor should avoid all EXCEPT:

−1. smoking

−2. dehydration

−3. nipple stimulation

+4. bed rest

26. A woman 33 weeks pregnant in early preterm labor should NOT receive:

−1. betamethasone

+2. oxytocin

−3. hydration

−4. electronic uterine monitoring

−5. magnesium sulfate

27. Women at risk for preterm delivery should receive prenatally:

−1. home uterine activity monitoring

−2. oral tocolytics

−3. thyrotropin releasing factor

−4. phenobarbital

+5. dexamethasone

28. The best predictor of preterm labor is:

−1. hematocrit >34%

−2. vaginal bleeding

+3. prior preterm delivery

−4. low socioeconomic status

−5. Trichomonas vaginalis

29. The tocolytic agent with the most fetal risk at 34 weeks gestation is:

−1. ritodrine

−2. magnesium sulfate

−3. terbutaline

−4. calcium channel blocker

+5. indomethacin

30. The frequency of premature rupture of fetal membranes in pregnancy is:

−1. 1%

−2. 3%

+3. 10%

−4. 20%

−5. 34%

31. The most common cause of premature labor is:

–1. cervical incompetence

–2. bicornuate uterus

–3. bacterial vaginosis

–4. smoking

+5. premature rupture of membranes

32. Complications of premature rupture of fetal membranes include all EXCEPT

–1. fetal infection

–2. prolapsed cord

–3. chorioamnionitis

–4. preeclampsia

–5. labor

33. Tests for premature rupture of membranes include all EXCEPT:

–1. AF dye injections

–2. vaginal pH

–3. vaginal inspection

–4. ferning

+5. vaginal creatinine

34. The patient with preterm premature rupture of the membranes who is being expectantly followed needs all of the following serial exams EXCEPT:

−1. white blood cell count/C–reactive protein test

−2. fetal heart rate monitoring

−3. ultrasound amniotic fluid assessment

+4. bimanual vaginal exams

−5. temperature

35. The best ultrasound indicator of IUGR is:

−1. biparietal diameter

−2. umbilical vein diameter

−3. femur diameter

−4. abdominal circumference

+5. cerebellum diameter

35. IUGR frequently produces which of the following neonatal problems:

−1. anemia

−2. hypercalcemia

−3. respiratory distress

−4. alkalosis

+5. hypoglycemia

36. Neonatal problems associated with IUGR include:

−1. anomalies

−2. hypoglycemia

−3. polycythemia

−4. hypoxia

+5. all of the above

37. Problems related to the mother which can predispose the fetus to IUGR include all of the following EXCEPT:

+1. Rh disease

−2. cyanotic heart disease

−3. heroin addiction

−4. smoking

−5. hypertension

38. The management of IUGR includes all EXCEPT which one of the following:

−1. 2100–2300–calorie diet per day

−2. cessation of smoking

−3. weekly NST

−4. bed rest

+5. amniotic fluid albumin injections

39. Nutritional studies show that the critical component of a mother's diet which can prevent IUGR is:

+1. adequate calories

−2. essential amino acids

−3. vitamin B6 (pyridoxine)

−4. zinc

−5. arachidonic acid

40. Normal fetal nutrition and growth are dependent upon:

−1. passive diffusion of amino acids from the mother

−2. active transport of lipids from the mother

+3. facilitated diffusion of glucose from the mother

−4. an active role of fetal growth hormone

−5. fetal interleukin–6

41. Postdate pregnancy can result from:

−1. bacterial vaginosis infection

+2. X–linked sulfatase deficiency

−3. high–dose aspirin use

−4. fetal renal agenesis

−5. fetal hypothyroidism

42. Infant risk(s) from postdate pregnancy include:

−1. abruptio placentae

−2. respiratory distress

+3. cord compression

−4. precipitous delivery

−5. more than one of the above

43. The reported frequency of pregnancies lasting more than 42 weeks' gestation is:

−1. 0%–l%

+2. 3%–12%

−3. 15%–20%

−4. 20%–25%

−5. 26%–31%

44. Monitoring the postdate pregnancy should include each of the following on a weekly basis EXCEPT:

–1. fetal heart rate tests

–2. ultrasound exam

–3. vaginal exam

–4. maternal blood pressure

+5. α–fetoprotein levels

45. Causes of postdate pregnancies include all of the following EXCEPT:

–1. prior oral contraceptive usage

–2. placental sulfatase deficiency

–3. prolonged follicular phase

+4. arachidonic acid deficiency

–5. anencephaly

46. A major risk of postdate pregnancy is:

–1. abruptio placentae

–2. hyaline membrane disease

+3. cord compression

–4. precipitous delivery

–5. placentae previae

47. This abnormality rarely develops prior to the third trimester:

−1. spina bifida

−2. hypoplastic left ventricle

+3. microcephaly

−4. Omphalocele

48. Oligohydramnios is associated with:

+1. intrauterine growth retardation

-2. hydrops

-3. tracheoesophageal fistula

-4. Hydrocephaly

49. Fetal age assessment with ruptured membranes is best done with:

+1. ultrasound femur length

-2. ultrasound biparietal diameter

-3. ultrasound abdominal circumference

-4. uterine fundal height measurement

-5. last menstrual period

50. Preterm labor treatment with β -adrenergic agents increases the neonate's risks of:

-1. hyperglycemia

-2. bradycardia

-3. pulmonary edema

+4. intraventricular hemorrhage

-5. mental retardation

51. β-Mimetic drugs do which of the following:

+1. inhibit uterine activity by cyclic-AMP stimulation

-2. inhibit fetal growth in utero if given over a long period

-3. tend to produce maternal hypertension

-4. decrease glucose

-5. increase potassium

52. A 2 year old child ame to the paediatric clinic for abnormal limb development. His mother has taken medicine for acne during pregnancy. The commonest drug that causes this problem is?

-1. Benzoyl peroxide

-2. Doxycycline

-3. Erythromycin

-4. Clindamycin

+5. Retinoids

53. Asymmetrical intrauterine growth retardation (IUGR):

-1. is diagnosed when all biometric measurements are below the 5th percentile

+2. is diagnosed when the femur length is below the 5th percentile

-3. is commonly associated with gestational diabetes mellitus

54. Preterm labor treatment with β -adrenergic agents increases the neonate's risks of:

-1. hyperglycemia

-2. bradycardia

-3. pulmonary edema

+4. intraventricular hemorrhage

-5. mental retardation

**Topic 6.**

**BREECH PRESENTATION. MALPOSITIONS AND PRESENTATIONS.**

**MULTIPLE PREGNANCY**

1. Complications of face presentation:

–1. Obstructed labor and ruptured uterus

–2. Cord prolapse

–3. Facial bruising

–4. Cerebral haemorrhage (bleeding inside the fetal skull).

+5. All variants

2. Twin to twin transfusion can be excluded with ultrasound by seeing:

–1. oligohydramnios in one sac

–2. a single placenta

–3. the sex of the fetuses

+4. multilayered central membrane

–5. concordant fetal size

3.Monoamniotic twins have:

+1. low mortality after 30 weeks

–2. low amniotic fluid index

–3. two separate placentas

–4. high risk of locked twins at delivery

–5. discordance in fetal weight

4. The frequency of twin pregnancies:

–1. varies because of the differences in monozygotic pairs

+2. is lowest in Asians

–3. is highest at the maternal age of 20–25 years

–4. is lowest in African Americans

–5. is a function of high HPL levels

5. The diagnosis of twins:

–1. can generally be made clinically

–2. is made with high β–HCG levels

–3. is made with low α–fetoprotein levels

+4. is made with ultrasound examinations

–5. is made with elevated estriol levels

6. Women carrying twin infants:

–1. have the same blood volume expansion as in singleton pregnancies

–2. have a higher chance for diabetes mellitus

+3. have a 2%–3% chance of hydramnios

–4. have the same frequency of anemia as in singleton pregnancies

–5. have a lower risk of preeclampsia

7. A twin infant:

+1. is usually delivered 2–3 weeks before estimated date of birth

–2. infrequently has intrauterine growth retardation

–3. has a higher risk of ABO incompatibility

–4. has a 30% chance of being breech

+5. has a higher frequency of congenital anomalies than does a single birth

8. Fetal transfusion syndrome in twins:

–1. occurs with dichorionic placentas

+2. causes heart failure in the small infant

–3. is diagnosed by a placental examination

–4. results in a hemoglobin difference of 2 g% in the infants

–5. is associated with a lower perinatal mortality rate

9. A suspicion of twins on blood testing can occur with all of the following EXCEPT:

+1. elevated albumin

–2. elevated α–fetoprotein

–3. elevated HCG

–4. elevated estriol

10. Twin pregnancies cause increased risk of all of the following EXCEPT:

–1. cord entanglement

–2. postpartum hemorrhage

+3. diabetes mellitus

–4. preeclampsia

–5. premature labor

11. What is the leading factor in multiple pregnancies?

–1. The anomalies of cervix.

–2. Age.

+3. Hereditary.

–4. estrangement.

–5. The impact of toxic factors.

12. Causes of malpresentations and malpositions:

–1. Abnormally increased or decreased amount of amniotic fluid

–2. Abnormal shape of the pelvis

–3. Multiple pregnancy

–4. Placenta previa

+5. All variants

13. There is an increased risk of complications with malpresentations and malpositions, including:

+1. Premature rupture of the fetal membranes

+2. Premature labor

–3. Anemia

+4. Postpartum hemorrhage

–5. diabetes mellitus

14. Types of breech presentation

+1. Complete breech

+2. Footling breech

–3. Full breech

–4. Main breech

15. Regardless of the type of breech presentation, there are significant associated risks to the baby. They include:

+1. The fetal head gets stuck (arrested) during delivery

–2. Thrombophlebitis

+3. Cord prolapse

16. How many degrees of extension presentation?

–1. 1

–2. 2

+3. 3

–4. 4

17. Causes of face presentation:

+1. Laxity (slackness) of the uterus after many previous full–term pregnancies

+2. Multiple pregnancy

+3. Polyhydramnios (excessive amniotic fluid)

+4. Congenital abnormality of the fetus (e.g. anencephaly, which means no or incomplete skull bones)

+5. Abnormal shape of the mother’s pelvis.

18. The frequency of twin pregnancies:

–1. varies because of the differences in monozygotic pairs

+2. is lowest in Asians

–3. is highest at the maternal age of 20–25 years

–4. is lowest in African Americans

–5. is a function of high HPL levels

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+2. causes heart failure in the small infant

–3. is diagnosed by a placental examination

–4. results in a hemoglobin difference of 2 g% in the infants

–5. is associated with a lower perinatal mortality rate

22. The antepartum treatment of twin pregnancies includes:

–1. a diet of 28 cal/kg/day

–2. a diet of 1.0 g protein/kg/day

–3. a diet with 100 micrograms folic acid supplement/day

–4. a diet with 10 mg ferrous iron supplement/day

+5. ferrous iron and folic acid supplements early in pregnancy

23. All of the drugs listed below are known to increase the rate of twin pregnancies EXCEPT:

–1. methadone

–2. oral contraceptives

–3. Pergonal

+4. Valium

–5. Clomid

24. Twin pregnancies cause increased risk of all of the following EXCEPT:

–1. cord entanglement

–2. postpartum hemorrhage

+3. diabetes mellitus

–4. preeclampsia

–5. premature labor

25. After the delivery of twin girls, examination of the single placenta reveals frequent arterial anastomoses between the two umbilical circulatory systems. Microscopic sections of the area dividing the two amniotic cavities reveal two amnions and no evidence of chorionic membrane. Which of the following statements about the twin girls is correct:

–1. They are monoamniotic, monochorionic twins

–2. They are definitely dizygotic

–3. They may be monozygotic or dizygotic

–4. They are diamniotic, dichorionic twins.

+5. They are definitely monozygotic

26. 25 year old primi at 40 weeks + 4 days presents in labor. She complains of rupture of membranes, and painful uterine contractions every 2 to 3 minutes. On digital examination her cervix is 8cm dilated, completely effaced, and fetal feet are palpable. CTG is reactive and normal. Estimated fetal weight is 2.2kg. Which of the following is the best method to achieve the delivery.

-1. Deliver the fetus vaginally by breech extraction.

-2. Deliver the baby vaginally after ECV

+3. Perform emergency CS

-4. Perform forceps assisted vaginal delivery

**Topic 7.**

**ANOMALIES OF UTERINE ACTIVITY. СONTRACTED PELVIS.**

1. How many bones fuse in adulthood to form the pelvis bone?

–1. 2

+2. 3

–3. 4

–4. 5

2. Which component forms the superior part of the pelvis bone?

+1. ilium

–2. pubis

–3. ischium

–4. Sacrum

3. Which of the following supports body weight when sitting?

–1. iliac crest

+2. ischial tuberosity

–3. ischiopubic ramus

–4. pubic body

4. Which of the following provides a quantitative measurement of the strength of uterine contractions?

–1. Manual palpation of maternal abdomen;

+2. Intrauterine pressure catheter;

–3. "Indentation" of uterus on palpation during contraction;

–4. Tocodynamometer.

5. The pelvis :

+1. has a subpubic angle that is larger in females

–2. consists of the two hip bones, but does not include the sacrum or coccyx

–3. has an obturator foramen, an opening that is defined in part by the sacrospinous and sacrotuberous ligaments

–4. has a space located inferior to the pelvic brim called the greater pelvis

6. The human pelvis is characterized by all of the following statements EXCEPT:

+1. Absolute fetal pelvic disproportion is common.

–2. The pelvic outlet is composed of two triangular areas which are not in the same plane, but share the same base.

–3. The posterior wall of the pelvis measures approximately 10 cm.

–4. The pelvic inlet is bounded laterally by the iliopectineal line.

–5. The obstetrical conjugate is usually greater than 10 cm.

7. Which of the following is MOST correct:

–1. Approximately 80% of women have a gynecoid pelvis.

–2. The android pelvis has a narrow fore pelvis and parallel sidewalls.

+3. The sacrum of the anthropoid pelvis contains 6 segments.

–4. A platypelloid pelvis is characterized by a large anterior–posterior diameter.

–5. The android pelvis has the most appropriate dimensions for breech delivery.

8. Which of the following statements characterizes fetal presentation during active labor?

–1. The suboccipital bregmatic diameter is the largest presenting dimension of the fetal skull.

–2. Fetal malpresentation is the most common etiology for dystocia.

–3. Fetal face presentation can only deliver vaginally if the chin presents posteriorly.

–4. Occiput posterior occurs in approximately 25% of vertex deliveries.

+5. Asynclitism is when the vertex does not orient the sagittal suture in the mid–plane of the pelvis.

9. Which of the following statements concerning fetal macrosomia and shoulder dys­tocia is MOST correct?

–1. Complications of shoulder dystocia include meconium aspiration, asphyxia, Bell's palsy, and traumatic mid–forceps.

–2. Sonographic estimations of fetal weight are most accurate when the fetus is macrosomic.

–3. Most cases of shoulder dystocia are predictable.

+4. Diabetics with an estimated fetal weight over 4500 g should have cesarean delivery.

–5. The McRoberts maneuver involves delivery of the posterior arm.

10. Choose the correct statement concerning control of uterine contractility.

+1. Oxytocin is an octapeptide that is synthesized in the hypothalamus.

+2. Ocytocin is released in pulses occurring in 3– to 5–minute intervals during normal labor.

–3. Oxytocin and prostaglandins increase calcium binding and decrease its release.

–4. Stimulation of β–receptors causes inhibition of adenylate cyclase with increased cyclic AMP and subsequent decreased contractility.

–5. Intrinsic nervous control is essential for normal uterine contractility.

11. Which statement about uterine contractility is NOT correct?

–1. Nitrous oxide and halothane can be used to achieve uterine relaxation.

+2. Epidural anesthesia is associated with prolonged second stage.

+3. Local prostaglandin E2 is thought to ripen the cervix only via contractions.

–4. Pulsatile administration of oxytocin results in a smaller total amount of drug used to achieve adequate contractions.

–5. Epidural anesthesia is associated with an increased risk of operative delivery.

12. If there has been no descent of the presenting part for over 1 hour during the second stage of labor, this would be classified as:

–1. Prolonged latent phase;

–2. Protraction disorder;

+3. Arrest disorder;

–4 Normal labor.

13. Which statement regarding normal and abnormal labor is most correct?

+1. There is active descent of the vertex during the deceleration phase.

–2. The cervix dilates at least 1.5 cm per hour in nulliparous women during active phase.

–3. Latent phase arrest is predictive of fetal macrosomia.

–4. Protracted active phase dilation is an indication for vacuum delivery.

–5. Secondary arrest of dilation is most sensitive to pulsatile oxytocin.

14. The hypotonic uterine dysfunction may be managed by:

–1. Augmentation with oxytocin;

–2. Amniotomy;

+3. All of above.

15. All of the following are risks to the fetus from prolonged labor EXCEPT:

–1. Sepsis;

–2. subdural hematoma;

–3. Cerebral damage;

+4. Hemorrhage.

16. A 32 year old G3P2 at 39 weeks of gestation presented to the hospital with ruptured membranes, and 4cm dilatation. She had a history of 2 prior vaginal deliveries, with her largest child weighing 3.8kg at birth. Over the next 2 hrs, she progresses to 7 cm dilatation. 4 hrs later, she remains 7 cm. The estimated fetal weight is 3.2 kg. which of the following labor abnormality best describes this patient

-1. Prolonged latent phase

-2. Protracted active phase dilatation

-3. Hypertonic dysfunction

+4. Secondary arrest of dilatation

Topic 1.

GESTOSIS

1. What is not a symptom for early pregnancy gestosis?

–1. hypersalivation

–2. hyperemesis grividarum

+3. pre-eclampsia

–4. urinary infections

–5. skin diseases

2. Which of the below is not a feature of early gestosis ?

–1. occurs in pregnant women

–2. usually subside after pregnancy

+3. infusion is the best treatment

–4. if happens in background of other diseases then its called, combined toxicosis

–5. if its GRAVE, then symptoms of early gestosis can remain

3. What will be given to control vomiting in a pregnant woman?

+1. Procaine hydrochloride

–2. Panadol

+3. Droperidol

–4. Beclamethasone

+5. Aminazine

4. What is not a feature of preeclampsia?

+1. anticoagulation

–2. hypertension

–3. occur in the 2nd half of pregnancy

–4. edema

–5. protenuria

5. What are the rare forms of Gestosis?

+1. dermatosis

+2. yellow liver

–3. candidiasis

+4. osteomalacia

–5. vomiting

6. Which is not a period of Eclampsia?

–1. Clonic period

–2. Tonic convulsions period

–3. resolution of the seizure

+4. Severe period

–5. preconvulsive period

7. What is the best-choice medication for the convulsions in eclampsia?

–1. Barbiturate

–2. Benzodiazepam

+3. Mgso4

–4. Nitric oxide

–5. Haloethane

8. What period of eclampsiadoes the tongue protrude out

+1. Clonic period

–2. Tonic convulsions period

–3. resolution of the seizure

–4. Severe period

–5. preconvulsive period

9. Complications of severe preeclampsia

-1. Cerebrovascular accident

-2. Intra uterine fetal death

-3. IUGR

-4. Retinal hemorrhage and detachment

+5. All of the above

10. What are the indications for termination of pregnancy due to early gestosis:

–1. Hyperbilirubinemia 40-80 mmol/l

–2. Vomiting that does not stop

–3. Continued body weight loss, despite intensive treatment

–4. Increasing dehydration, despite intensive treatment

+5. All of the above

11. The most common early clinical manifestation of preeclampsia is

+1. hypertension

+2. proteinuria

-3. edema

-4. headache

-5. thrombocytopenia

12. A previously normotensive 20-year-old primigravida admitted at 32 weeks' gestation has a blood pressure of 140/90 mm Hg with edema of the lower extremities and no proteinuria. Appropriate management of this patient includes

-1. diuretics

+2. antihypertensive drugs such as methyldopa

+3. intravenous magnesium sulfate

-4. immediate delivery

13. Preeclampsia is characterized by

-1. decreased vascular sensitivity to pressor peptides

-2. increased plasma prostacyclin levels

-3. decreased thromboxane levels

+4. reduced uteroplacental blood flow

-5. lowered serum uric acid levels

14. Severe preeclampsia is characterized by

-1. increased plasma volume

-2. 1+ proteinuria

+3. blood pressure 160/110 mm Hg

+4. hemoconcentration

-5. 50% incidence of antiphospholipid antibodies

15. Eclampsia

-1. never occurs without proteinuria

-2. is best treated with intravenous diazepam

+3. is an indication for delivery regardless of gestational age

-4. is always preventable if the patient receives low-dose aspirin throughout pregnancy

-5. does not develop beyond 24 hours postpartum

16. The most commonly used and safest antihypertensive drug for chronic hypertension in pregnancy is

+1. methyldopa

-2. captopril

-3. minoxidil

-4. diazoxide

-5. reserpine

17. The least common finding in the HELLP syndrome is

-1. right upper quadrant pain

-2. hemolysis of red blood cells

-3. abnormal liver function tests

-4. low platelets

+5. shock

18. Aspirin therapy to prevent preeclampsia is currently reasonable to use in which patients:

-1. all nulliparas

-2. a woman with a previous placental abruption

-3. a woman with previous asymptomatic mild hypertension

+4. a woman with a history of recurrent preeclampsia and growth retarded fetuses

-5. all pregnant women

19. What is the risk of recurrent superimposed preeclampsia in multiparous women with chronic hypertension who have had preeclampsia or eclampsia?

+1. up to 70%

-2. up to 40%

-3. up to 20%

-4. up to 10%

-5. 5%

20. Preeclampsia, except

-1. Causes placental abruption

+2. Prevented by salt restriction

-3. Causes elevated liver enzymes

-4. Associated with thrombocytopenia

-5. Is associated with failure of 2nd wave of trophoblastic invasion

21. The therapeutic range of magnesium levels in blood to prevent eclampsia is

-1. 1-2 mmol/L

+2. 2-4 mmol/L

-3. 4-8 mmol/L

-4. 8-10 mmol/L

22. All of the following dermatologic conditions are associated with pruritus EXCEPT

-1. intrahepatic cholestasis of pregnancy

+2. impetigo herpetiformis

-3. herpes gestationis

-4. contact dermatitis

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-1. all nulliparas

-2. a woman with a previous placenta praevia

-3. a woman with previous asymptomatic mild hypertension

+4. a woman with a history of recurrent preeclampsia and growth retarded fetus

-5. all pregnant women

24. A 23 year old nulliparous woman who is 36 weeks and 5 days pregnant has been admitted with suspected preeclampsia. While you are doing a first visit clerking of another patient, you are called for an emergency to attend the antenatal ward by the midwife. You found a patient flat on the bed, and having a general Tonic-Clonic seizure. What is your immediate management?

-1. Call for help, ABC, nasopharyngeal airway, IV access, and wait for fit to stop

-2. Call for help, ABC, protect the airway, prepare for urgent CS

-3. Call for help, ABC, left lateral tilt, wait for seizure to end, listen to the fetus

+4. Call for help, ABC, left lateral tilt, protect the airway, prepare magnesium

-5. Call for help, ABC, protect the airway, prepare magnesium, and listen to the fetus.

25. A 26 year old primiparous presents to the clinic at 38 weeks of gestation. Her first trimester BP was 100/72. Today the BP was 170/110 and she has 3+ proteinuria on clean catch specimen of urine. She has significant swelling on her face and extremities. She denies having contractions. Her cervix is closed and uneffaced. Baby is in breech on ultrasound. Movements of the fetus have reduced in the last 24 hrs. Which of the following is the best next step in the management?

-1. Arrange USS and CTG

-2. Send her home, with instructions to stay in bed rest until swelling and BP settle

-3. Admit to the ward for enforced bed rest and diuretics for swelling

-4. Admit to the hospital for induction of labor

+5. Admit to the hospital for CS

26. A 26 year old primiparous presents to the clinic at 38 weeks of gestation. Her first trimester BP was 100/72. Today the BP was 170/110 and she has 3+ proteinuria on clean catch specimen of urine. She has significant swelling on her face and extremities. She denies having contractions. Her cervix is closed and uneffaced. Baby is in breech on ultrasound. Movements of the fetus have reduced in the last 24 hrs. What diagnosis is it:

-1. Mild preeclampsia

-2. Hypertension during pregnancy

+3. Severe preeclampsia

-4. Chronic hypertension

Topic 2.

OBSTETRIC BLEEDING

1. A 24 years old G2P1A0 had last menstrual period 9 weeks ago. She presents with bleeding and passage of tissues through vagina. Bleeding is associated with lower abdominal pain. The most likely diagnosis is:

–1. Threatened abortion.

–2. Inevitable abortion.

+3. Incomplete abortion.

–4. Twin pregnancy.

–5. Ectopic pregnancy.

2. A 30 years old G5P4 is admitted in labor room with 32 weeks gestation, mild vaginal bleeding and abdominal pain. Her blood pressure 140/100 mm Hg, abdomen is tense, tender and hard. Fetal heart sounds are not audible. What is the most likely diagnosis:

–1. Placenta praevia.

+2. Placental abruption.

–3. Preterm labour.

–4. Urinary tract infection.

–5. Vasa praevia.

3. A 25 years old P2 comes to emergency, after home delivery with heavy bleeding per vaginum. After evaluation and emergency resuscitation she is diagnosed as a case of uterine atony. What is the appropriate medicine in the management of this case:

+1. Oxytocin.

–2. Salbutamol.

–3. Beta blockers.

–4. Magnesium sulphate.

–5. Hydralazine.

4. Vaginal examination is contraindicated in pregnancy in which situation:

–1. Carcinoma of cervix.

–2. Gonorrhoea.

–3. Prolapsed cord.

+4. Placenta previa.

–5. Active labour.

5. Common causes of antepartum haemorrhage after the 20 weeks gestation include which of the following?

–1. Vasa praevia

– 2. Undetermined origin

+3. Placenta praevia

–4. Uterine rupture

+5. Placental abruption

–6. None of the above

6. Regarding placenta praevia, which of the following are true?

+1. Placenta praevia complicates about 0.4% of pregnancies at term.

–2. Placenta praevia cannot be diagnosed with ultrasound.

–3. The majority of ‘low-lying’ placentas diagnosed at 20 weeks will remain so at term.

+4. The patient should be carefully managed until term of delivery the patient at which time caesarean section will be performed.

+5. Complications of placenta praevia include need for caesarean section, haemorrhage, placenta accreta, placenta percreta and hysterectomy.

–6. Placenta praevia is typically more painful than an abruption.

7. Placental abruption: which of the following are true?

–1. Abruption is usually painless.

–2.Most of the blood loss is fetal.

+3. Visible haemorrhage is absent in 20%.

+4. Risk factors for abruption include preeclampsia, autoimmune disease, maternal smoking, cocaine use and previous history of placental abruption.

–5. Abruption is best diagnosed by ultrasound.

8. What is the definition of postpartum haemorrhage?

–1. Loss of >200ml of blood from the vagina during delivery

+2. Loss of >500ml of blood from the vagina within 24 hours of delivery

–3. Loss of >500ml of blood from the vagina during delivery

–4. Loss of >200ml of blood from the vagina within 24 hours of delivery

9. What is the most common cause of postpartum haemorrhage?

–1. Vulval or vaginal lacerations

+2. Uterine atony

–3. Retained placenta

–4. Uterine rupture

10. When separation begins at the center of the placenta and slides down the birth canallike a folded umbrella this is referred as:

–1. Duncan mechanism

+2. Shultz mechanism

–3. Brandt Andrews mechanism

–4. Ritgen’s maneuver

11. Which of the following histories is most suspicious for antiphospholipid syndrome -associated recurrent pregnancy loss:

−1. a 38-year-old G-3 P-O whose pregnancies have been lost between 6 and 8 weeks' gestation, with the last two documented to be anembryonic abnormalities by first trimester ultrasound

−2. a 24-year-old G-2 P-O who wants you to initiate a workup for recurrent pregnancy loss because her husband is anxious to have children

−3. a 30-year-old woman whose chronologic pregnancy history is: (1) spontaneous abortion at 8 weeks' gestation, (2) unexplained fetal death at 18 weeks' gestation, (3) spontaneous abortion at 6 weeks' gestation, (4) spontaneous abortion at 10 weeks' gestation, and (5) 3200-g term male infant, now alive and well

+4. a 28-year-old whose two pregnancies have ended in fetal death at 18 and 20 weeks' gestation and whose last pregnancy was complicated by a postpartum deep venous thrombosis

−5. a 20-year-old G-2 P-l whose second pregnancy resulted in spontaneous ruptured membranes and rapid delivery of an immature infant at 20 weeks' gestation that did not survive

12.The frequency of clinically recognized miscarriage is

−1. 1%

−2. 5%

+3. 15%

−4. 30%

−5. 50%

13. Most common cause for placental abruption is

+1. hypertension

-2. trauma

-3. twins

-4. cocaine use

-5. maternal parity

14. Of the known etiologic or predisposing factors for placenta previa, the most common is

-1. poor socioeconomic situation

-2. environmental factors

-3. malnutrition

+4. multiparity

-5. familial tendency

15. Choose the correct statement about the diagnosis of placental abruption.

-1. Hypotension and anemia are present in 90% of cases.

-2. Fetal distress is more common

+3. A normal sonogram excludes life-threatening abruption.

-4. External hemorrhage is more frequent than concealed hemorrhage

-5. An abnormal fetal lie is characteristic

16. The worst prognosis for the fetus with antepartum bleeding during the 2nd trimester is associated with which condition?

-1. placenta previa

+2. placental abruption

-3. vasa previa

-4. undetermined cause

17. What are the most common clinical findings in patients with placental abruption:

+1. uterine tenderness or back pain

+2. vaginal spotting

-3. vaginal bleeding

+4. fetal distress

+5. dead fetus

18. A patient in normal labor has the sudden onset of painless vaginal bleeding following artificial rupture of membranes at 5 cm cervical dilatation, and the fetus is soon noted to have a sinusoidal heart rate pattern. What is the most likely diagnosis:

-1. marginal sinus rupture

-2. low-lying placenta

-3. unrecognized partial previa

+4. vasa previa

19. Vaginal delivery is preferable in which situation:

-1. a multiparous patient with a partial placenta previa who is in early labor

-2. a patient with a complete placenta previa who requires delivery at 27 weeks' gestation because of severe vaginal bleeding

-3. a primigravida with a known vasa previa who begins to have vaginal bleeding

-4. a patient with a suspected abruption in early labor whose fetus is having late decelerations on the FHT tracing

+5. a patient with a dead fetus and coagulopathy from acute placental abruption who is in active labor

20. A 25-year-old gravida 5 para 4 presents for her routine antepartum visit at 18 weeks' gestation. She is upset because she was told at her ultrasound visit the day before that the placenta was partially covering the cervix. Which of the following is the most reasonable to tell the patient?

-1. She has a placenta previa and will definitely require a cesarean section.

+2. Although the ultrasound shows placenta previa, as the uterus grows there is a good chance that the placenta will "migrate away" from the cervix so that she can deliver vaginally.

-3. Since she has a placenta previa this early in gestation, she should consider terminating the pregnancy because of the increased risk of severe hemorrhag-

-4. She has a vasa previa and will definitely require a cesarean section.

-5. She has a placental abruption and may require a cesarean section.

21. Which of the following is least likely to be an indication for invasive hemodynam¬ic monitoring in an obstetrical patient:

+1. severe hypovolemic shock

-2. early septic shock

-3. late septic shock

-4. severe preeclampsia with pulmonary edema

22. Which of the following statements regarding amniotic fluid embolism is NOT true?

-1. The most significant hemodynamic aberration observed or documented in human patients involves decreased ventricular performanc-

-2. A consumptive coagulopathy may dominate the clinical pictur-

+3. The detection of fetal cells in an aspirate from the distal port of a pulmonary artery catheter is pathognomonic for amniotic fluid embolism.

-4. With expert care, maternal mortality is approximately 80%.

23. Choose the correct statement about placenta previa.

+1. The diagnostic accuracy with ultrasound is about 95%.

-2. Disseminated intravascular coagulation is associated with 40% of the cases.

-3. Fetal death is usually associated with the initial bleeding episode.

24. A 28 year old woman with a BMI of 28kg/m2 had a forceps delivery after prolonged 2nd stage of labour. After 8 days of delivery, she presents with heavy, fresh per vaginal bleeding and clots. She felt unwell, and complained of cramping abdominal pain. Her temperature is 39.2 - On examination she passes blood clots, and no products of conception. Review of case notes found complete delivery of the placent- What is the most likely diagnosis of this condition?

-1. Primary PPH due to septicaemia

-2. Primary PPH due to cervical tear

-3. Secondary PPH due to DIC

+4. Secondary PPH due to endometritis

-5. Secondary PPH due to cervical tear

25. All is true for antepartum haemorrhage, except

+1. Is always painful

-2. Is defined as bleeding from the genital tract in pregnancy

-3. May be caused by cervical carcinoma

-4. May be complicated with hypofibrinogenemia

-5. Requires digital vaginal examination to exclude placenta praevia

26. What causes late pregnancy bleeding?

+1. placenta praevia

+2. placental abruption.

+3.Ruptured uterus

- 4.Ruptured cervix

-5. Atony of uterus

27. The placenta normally implants:

+1. in the upper segment;

-2. in the low segment of uterus;

-3. in the cervix.

Topic 3.

BIRTH TRAUMA (INJURY). OPERATIVE DELIVERY METHODS

1. A G2P1 with previous cesarean section due to obstructed labour comes for first antenatal visit at 34 weeks of gestation. She is seeking advice for home delivery this time. What will be the most dangerous complication in her case if we allow her to deliver at home by untrained birth attendent:

–1. Prolonged latent phase.

–2. Arrest in second stage of labour.

–3. Delayed progress in active phase of labour.

+4. Rupture uterus.

–5. Placental retention.

2. The pathological retraction ring of Bandle is associated with:

–1. Preterm labour.

+2. Obstructed labour.

–3. Precipitate labour.

–4. Abruptio placenta.

–5. Chorioamnionitis.

3. Regarding forceps and Ventouse delivery, which of the following are true?

+1. Failure of instrumental delivery is more common with the Ventouse.

+2. Ventouse is less safe for the fetus.

–3. If traction with a Ventouse does not produce immediate and progressive descent, forceps must be used.

–4. Instrumental delivery requires epidural analgesia.

–5. Instrumental delivery can be used once the cervix is 8 cm dilated.

4. Which of the following are complications of induction?

+1. Uterine rupture

+2. Uterine hyper-stimulation

+3. Prolapsed cord

+4. Caesarian section

–5. IUGR

5. The reasons for perineal tear:

+1. The fast delivery

+2. Large fetus.

+3. Rigidity of tissue, scars after the previous childbirth.

+4. High perineum.

+5. Incorrect provision of midwifery services.

6. A 2nd degree tear in the perineum indicates

+1. Violation of the skin of the perineum.

–2. Rupture of the External urethral sphincter.

–3. Rupture of the rectum.

+4. Rupture of the wall of the vagina.

+5. Rupture of the superficial perineal muscles.

7. Signs of threatened perineal tear:

+1. Perineal protrusion.

+2. Cyanosis.

+3. Edema.

–4. Pain.

8. Indications for perineotomy:

+1. Threatened perineal tear.

+2. Asphyxia.

+3. High perineum.

+4. Premature birth.

9. Prevention of perineal tear;

–1. Correct management of the 1st period of labor.

+2. Correct assistance during the crowning and extension of the head.

+3. Careful implementation of episiotomy

10. What structures are damaged in 3rd degree perineal tear:

+1. Posterior commissure

+2. The skin of the perineum.

+3. The wall of the vagina.

+4. The muscles of the perineum.

+5. The external sphincter and Rectal wall.

11. Forceps is applied during the 2nd stage for

-1. After coming head of assisted vaginal breech delivery

-2. Mento anterior face presentation

-3. For delivery at the head at CS

-4. Vertex presentation with the occiput anterior

+5. All of the above

12. True/false regarding normal labor

-1. Pain is a good indicator of strength of uterine contraction

-2. Induction aims to complete labor within 3 hours

+3. Forceps causes more maternal injuries than vacuum aspiration

-4. Total placenta previa is compatible with vaginal delivery

13. Indications for immediate delivery using forceps include

-1. Delay in active phase of 1ststage

+2. Delay in the second stage

+3. Persistent fetal bradycardia in 2ndstage

-4. Severe fetal distress in 1ststage

-5. Type 1 decelerations during second stage

14. Regarding operative delivery

+1. Cephalhematoma occurs in vacuum delivery

-2. Forceps used in obstructed labor

+3. Keelands forceps is used to deliver occipitoposterior position

-4. Forceps delivery is contraindicated in face presentation

+5. Causes more neonatal trauma compared to forceps scalp

15. Regarding vaccum delivery

+1. Contraindicated in gestations less than 34 weeks

-2. Has significant risk of anal sphincter injury when compared to forceps

+3. require full dilatation of the cervix

-4. used to deliver the after coming head in breech presentation

16. Which of the following are associated with forceps delivery

+1. Stress incontinence of urine

+2. Fecal incontinence

+3. Dyspareunia

-4. Menorrhagia

-5. Hypertrophic elongation of cervix

17. Regarding mode of delivery

+1. Maternal motility in caesarean section is higher than normal vaginal delivering

+2. There is no role of prophylactic antibiotic in caesarean section

-3. Vacuum delivery has less maternal morbidity than forceps delivery

+4. Use of vacuum extractor is associated with fewer cephalhaematoma

-5. Use of vacuum extractor compared to forceps results in significantly better Apgar score

18. Regarding caesarean section

-1. upper segment scar can be ruptured before labor

-2. ovaries must be examined before closure

-3. early mobility reduces the thromboembolic phenomenon

+4. All of the above

19. Complication of upper segment caesarean section

+1. Uterine rupture in subsequent pregnancies

-2. Placenta praevia

+3. Adhesions

+4. More intensive intraoperative bleeding

-5. Disseminated intravascular coagulation

20. Episiotomy

+1. Must be made in one single cut

+2. Repaired using Non-absorbable suture materials

-3. Antibiotics are administered routinely

-4. Is indicated in all vaginal deliveries

21. The best uterine scar a patient can have for Caesarian section is

 -1.Transverse upper segment

-2.Longitudinal upper segment

+3.Transverse lower segment

-4.Longitudinal lower segment

-5.A T-shaped incision

22. Advantage of lower segment caesarean section over the classic incision includes:

 -1.Ease of repair

-2.Decreases blood loss

-3.Lower probability of subsequent uterine rupture

-4.Decreases danger of intestinal obstruction

+5.All of the above

23. Immediate complications of caesarean section include all the following, EXCEPT :

-1.Complications of anesthesia.

-2.Bladder injury.

+3.Thromboembolism.

-4.Colon injury.

-5.Hemorrhage

24. One of the following is an indication for urgent C-section

-1.Transverse position

+2.Abruptio placenta.

-3.Cervical cerculage.

-4.Breech presentation.

-5.Twins pregnancy

Topic 4.

PREGNANCY AND BIRTH IN WOMEN WITH DISEASES OF THE CARDIOVASCULAR SYSTEM, ENDOCRINE PATHOLOGY, WITH BLOOD DISEASES, WITH LIVER DISEASES

1.35 years old woman who is now in her 5th pregnancy with 4 alive children presented in the antenatal clinic and in diagnosed as a case of anemia. Cause of anemia in her case is:

–1. Folate deficiency.

–2. Sickle cell anemia.

+3. Iron deficiency.

–4. Pernicious anemia.

–5. Thalassemia.

2. Cardiac output is highest in:

–1. 1st trimester.

–2. 2nd trimester.

–3. 3rd trimester.

–4. During labor.

+5. During delivery.

3. What changes occurs in circulatory system during pregnancy?

+1. Cardiac output increases

+2. Heart muscle hypertrophies

+3. Blood volume increasing

+4. Heart rate increases

4. What period of childbirth is difficult in women with cardiovascular pathologies?

–1. 1st period of childbirth.

+2. 2nd period childbirth.

–3. 3rd of the period of childbirth.

–4. The early post-partum period.

–5. The post-partum period in the first two weeks.

5. The best period for a pregnancy after the mitral commissurotomy is:

+1. The first 2 years

–2. 3 years

–3. 5 years

–4. More than 5 years.

–5. The term does not have a value.

6. Pregnancy anemia is due to:

+1. Deficit Fe.

–2. Rh-negative blood.

–3. Available universally.

–4. Splenomegaly.

–5. The lack of protein.

7. Specify the most frequent complication for the fetus in pregnancy anemia

+1. Chronic intrauterine fetal hypoxia

–2. The innate pneumonia.

–3. Ceasing of development.

8. In what period of pregnancy is true pregnancy anemia?

–1. Up to 12 weeks.

–2. 12-16 weeks

–3. 16-20 weeks

+4. After 20 weeks

–5. After 35 weeks

9. What is the development of megaloblastic Anemia?

–1. Deficiency of Fe.

+2. Deficiency of vitamin b12.

+3. Deficit of folic acid.

10. Pregnancy 10 weeks. The combined Mitral Valvular Disease with predominantly stenosis. The pulmonary hypertension is absent. Can the woman save the pregnancy?

+1. Yes

–2. No

11. All of the following reflect biliary tract function in pregnancy EXCEPT:

-1. Frequency of biliary disease during pregnancy is unchange-

-2. Symptoms of biliary tract disease are identical to those in the nonpregnant stat-

-3. Fifty percent of pregnant women with cholelithiasis will be asymptomati-

+4. Increased gall bladder volume on ultrasound indicates duct obstruction.

-5. Murphy's sign should be present with biliary tract diseas

12. All of the following are true about viral hepatitis during pregnancy EXCEPT:

-1. There is no increase in birth defects with concurrent hepatitis A infection.

-2. Hepatitis В is the most common cause of viral hepatitis during pregnancy.

-3. Hepatitis В is associated with an increased incidence of premature labor and delivery.

-4. Hepatitis С antibody testing remains unreliable

+5. Hepatitis D usually occurs in association with hepatitis В and С

13. Which of the following is not true of hyperthyroidism during pregnancy?

-1. complicates 1 in every 500 pregnancies

-2. resting maternal heart rate over 100

-3. elevated free thyroid index

+4. thyroid storm should not occur with adequate treatment

-5. treatment is not a contraindication to breast-feeding

14 Which of the following symptoms in pregnancy is most suggestive of heart disease ?

 -1.Tachypnea.

+2.Syncope with exertion.

-3.Tachycardia.

-4.Peripheral edema.

-5.Fatigue

15. The leading cause of death of pregnant women with uncorrected ventricular septal defects is

-1. endocarditis

+2. shunt reversal blood flow

-3. arrhythmia

-4. paradoxical embolism

-5. congestive failure

15. Which of the following is an indication for first trimester pregnancy termination in a patient with the tetralogy of Fallot?

+1. hematocrit of 65%

-2. peripheral arterial oxygen saturation of 85%

-3. right ventricular pressure of 90 mm Hg

-4. clubbing of the fingers

-5. exertional dyspnea

16. Which of the following classes of antihypertensive drugs is absolutely contraindi-cated during pregnancy?

-1. nonspecific β-adrenergic blockers

-2. postsynaptic -adrenergic blockers

-3. thiazide diuretics

+4. angiotensin-converting enzyme inhibitors

-5. calcium channel blockers

17. The optimal daily amount of elemental iron for dietary supplementation in nonanemic pregnant women is

-1. none

+2. 60 mg (300 mg ferrous sulfate)

-3. 120 mg (600 mg ferrous sulfate)

-4. 180 mg (900 mg ferrous sulfate)

18. Pregnant women with sickle cell anemia are at increased risk for which of the following?

-1. maternal anemia

+2. urinary tract infections

-3. fetal growth retardation

-4. painful crises

-5. intrauterine fetal death

19. Regarding management of diabetes in pregnancy

-1. Diet plays a major role

-2. Metformin is contraindicated

-3. Insulin administration is the management of choice

+4. All of the above

20. Management of diabetes mellitus complicating pregnancy includes

+1. Administration of soluble insulin as bolus at the time of delivery

-2. HbA1C has no place in monitoring glycemic control during pregnancy

-3. Lente insulin is contraindicated

-4. Routine caesarean section at 39 weeks

21. Management of diabetes mellitus complicating pregnancy includes

+1. Fasting blood sugar is done every week

-2. HbA1C has no place in monitoring glycemic control during pregnancy

-3. Lente insulin is contraindicated

-4. Routine caesarean section at 36 weeks

22. Which of the following accounts for most heart disease in pregnancy ?

 -1.Cardiomyopathy

-2.Previous myocardial infarction

-3.Hypertension

-4.Thyroid disease

+5.Congenital heart disease (CHD)

Topic 5.

PREGNANCY AND BIRTH IN WOMEN WITH ENDOCRINE PATHOLOGY, WITH DISEASES OF THE URINARY SYSTEM, WITH ACUTE SURGICAL AND GYNECOLOGICAL PATHOLOGY

1. Diabetic control is important before conception to reduce the incidence of:

–1. Maternal nephropathy.

–2. Diabetic ketoacidosis.

+3. Congenital anomalies.

–4. Maternal retinopathy.

–5. C-section.

2. A 30 years old G3P2 at 28 weeks of gestation presents with severe pain in the right flank radiating to her groin. She also complaints of rigors and chills. Urine analysis

Reveals numerous leucocytes. The most likely diagnosis is:

–1. Appendicitis.

+2. Pyelonephritis.

–3. Round ligament torsion.

–4. Meckel’s diverticulum.

–5. Torsion of ovarian cyst.

3. 4. What is the upper limit of the normal number of erythrocytes in the sample on Nechiporenko?

+1. 1x106/l.

–2. 2x106/l.

–3. 4x106/l.

–4. 5x106/l.

–5. 6x106/l.

4. What is the upper limit of the normal number of leukocytes in the sample on Nechiporenko?

–1. 1x106/l.

–2. 2x106/l.

+3. 4x106/l.

–4. 5x106/l.

–5. 6x106/l.

5. All are characteristics of pregnancy caused pyelonephritis except;

–1. Leukocytosis.

–2. The acceleration of ESR

+3. Lymphocytosis.

–4. Increased number of leukocytes in urine.

–5. The pain in the backache.

6. Please specify what complications of pregnancy are often seen in pregnant women with diabetes?

+1. The premature termination of pregnancy.

–2. The premature rupture of the membranes.

+3. Gestosis.

–4. Fetal hypotrophy.

+5. Polyhydramnios.

7. What are the most dangerous complications for a diabetic mother?

+1. Heavy acidosis.

–2. Polyhydramnios.

–3. Pyelonephritis.

+4. Diabetic coma.

+5. Preeclampsia.

8. The healing of the wounds in the postoperative period in diabetes contributes to

–1. Antibiotics

–2. proteolytic enzymes

–3. Vasodilator medicines

–4. Immunocorrecting medicines

+5. Rational insulin

9. Untreated hyperthyroidism during pregnancy may result in all of the following except:

–1. Premature birth and miscarriage

–2. Low birth weight

+3. Autism

–4. Preeclampsia

10. Subclinical hypothyroidism, defined as a TSH level greater than the upper limit of normal range (4.5−5.0 mIU/L) with normal FT4 levels, is associated with which of the following adverse reproductive outcomes?

–1. Delayed fetal neurodevelopment

–2. Miscarriage

–3. Placental abruption

–4. Preterm premature rupture of membranes

+5. All of the above

11. In insulin-requiring diabetic pregnancy, the highest positive correlation has been noted between the size of the infant at birth and the maternal

-1. height and weight

-2. weight gain in pounds per week

-3. obesity greater than 115% of ideal body weight

+4. fasting plasma glucose concentration

-5. plasma triglyceride concentration

12. Patients with diabetes mellitus complicating pregnancy

-1. should not receive long-acting insulin immediately before delivery as it will persist in the neonate for 24-26 hours.

-2. need monitoring with blood insulinase studies to detect placental insufficiency

+3. may produce neonates with respiratory problems secondary to insulin blockage of Cortisol activity on the lungs

-4. can be expected to require approximately 475 KCal more of food intake during the last half of their gestation

-5. more than one of the above

13. Congenital abnomalies in infants of diabetic mothers

-1. occur late in gestation (10-13 weeks)

-2. are related to hypoglycemia

-3. are unrelated to hemoglobin glycosylated levels

+4. are related to hyperglycemia

-5. more than one of the above

14. Hypoglycemia complicating a diabetic (insulin-dependent) pregnancy

-1. is due to decreased insulin receptor binding

-2. is due to increased insulin secretion

+3. occurs mostly in first 20 weeks

-4. causes fetal sacral agenesis

-5. causes fetal mental retardation

15. The major infant risk of gestational diabetes is

-1. anomalies

-2. hypoglycemia

+3. macrosomia

-4. respiratory distress

-5. seizures

16. Laboratory indices of thyroid function during pregnancy include all of the following EXCEPT

-1. increased TBG concentration

-2. increased total thyroxine concentrations

-3. increased free thyroxine concentrations

-4. decreased resin Ts uptake

+5. decreased thyroxine turnover

17.Which of the following is NOT true about appendicitis during pregnancy?

-1. Initial visceral symptoms are not altere-

-2. Parietal irritation will be varied during pregnancy.

-3. Leukocytosis will be altere-

+4. Guarding and rebound tenderness should be present.

-5. Concomitant cesarean section is not generally necessary.

18. Which of the following is not associated with pancreatitis during pregnancy:

-1. cholelithiasis

+2. hypoparathyroidism

-3. infection

-4. preeclampsia

-5. ethanol abuse

19. The leading cause of acute renal failure in obstetric patients is

-1. preeclampsia/eclampsia

-2. postpartum hemorrhage

+3. abruptio placentae

-4. acute fatty liver of pregnancy

-5. acute pyelonephritis

20. The following are expected complications in pre existing diabetes complicating pregnancy

-1. Diabetic cardiomyopathy

-2. Diabetic nephropathy

-3. Diabetic poly neuropathy

-4. Hypoglycaemia

-5. Proliferative retinopathy

+6. All of the above

21. Regarding risk factors for gestational diabetes mellitus

+1. Advanced maternal age

-2. Caucasian race

+3. Family history of diabetes

-4. Partner diagnosed with type 2 diabetes mellitus

+5. Previous child with macrosomia

22. Which of the following are diagnostic investigations to detect glucose intolerance in pregnancy?

-1. Urine for sugar

-2. 50g Glucose Challenge Test

-3. 75g Glucose Tolerance Test

+4. 75g Oral Glucose Tolerance Test

+5. Fasting Blood Sugar

23. In a pregnant patient with diabetes mellitus

-1. All patients should be admitted to hospital for glycaemic control

-2. All patients should be delivered by 38 weeks

+3. Glycosuria is a reliable sign of poor glycaemic control

-4. Insulin requirements decrease with gestational age

24. Gestational diabetes is associated with an increase risk of all the following, EXCEPT:

 -1.Cesarean section

-2.Shoulder dystocia

-3.Fetal macrosomia

-4.Intrauterine fetal death

+5.Intrauterine growth restriction

25. Control of gestational diabetes is accomplished with the following, EXCEPT:

 -1.Insulin

-2.Diet

+3.Oral hypoglycaemic agents

-4.Exercise

-5.Insulin and diet

26. Infants of mother with gestational diabetes have an increased risk of the following, EXCEPT:

+1.Hypoglycemia

-2.Hypoinsulinemia

-3.Hypocalcemia

-4.Hyper bilirubine

-5.Polycythemia

27. The best screening test for gestational diabetes:

 -1.Fasting blood sugar

-2.Random blood sugar

+3.Glucose challenge test

-4.Glucose tolerance test

-5.Blood sugar series

28. Glucose tolerance test:

 -1.Is used as a screening test for diabetes.

+2.Is considered to be a diagnostic test for diabetes.

-3.Is performed in a non-fasting state.

-4.Should be avoided during pregnancy as it needs a loading dose of glucose.

-5.50 mg of glucose should be given to the patient.

29.Indications of glucose tolerance test GTT in pregnancy include all the following

 -1.Previous Hx of gestational diabetes mellitus.

-2.Hx of macrosomic baby.

+3.Glycosuria in one occasion.

-4.Hx of unexplained fetal death.

-5.Hx of babies with congenital sacral agenesis.

30. Regarding good control of diabetes in pregnancy :

 -1. Maintains blood glucose level between 8 and 12 mmol/L.

+2.Is achieved by twice daily injection of insulin.

-3.Increases the incidence of polyhydramnios.

-4.Has no effect on the incidence of congenital abnormalities.

-5.Is aimed of increasing fetal hyperinsulinisim

31. Maternal complications associated with polyhydramnios include :

 -1.High blood pressure.

-2.Urinary tract anomalies.

+3.Diabetes.

-4.Postmature pregnancy.

-5.All of the above.

32. Which of the following items in a pregnant patient's History suggests the possibility of her having diabetes :

-1.IUGR.

-2.Past Hx of twins.

-3.1st trimester bleeding.

-4.Diabetic husband.

+5.Unexplained stillbirths

33. Oligohydramnios is associated with

+1. intrauterine growth retardation

-2. hydrops

-3. tracheoesophageal fistula

-4. hydrocephaly

Topic 6.

PREGNANCY AND BIRTH IN WOMEN WITH INFECTIOUS DISEASES

1. The Ultrasonic signs of fetal rubella disease are:

+1. Thickness of the placenta by 0.5 cm and more.

+2. An increase in the size of the fetal stomach due to hepatomegaly.

+3. Ascites in the fetus

–4. Polyhydramnios.

+5. Double contour of head and torso of fetus.

2. Due to the risk of development of congenital malformations, it is suggested that during pregnancy, women should not eat or undercooked meat because:

–1. Listeria is heat resistant

+2. Listeria can grow at regular refrigeration temperatures

–3. It will give you morning sickness

–4. The consumption of excess mercury can be fatal

3. Molecules that can cause cellular defects in growth, i.e. induce fetal malformations, are known as

–1. Secretagogues

+2. Teratogens

–3. Hematotrophic

–4. Cytopathogenic

4. A distinguishing factor between viral teratogens (rubella) and other teratogens (drugs, radiation) would be that

–1. Only viral teratogens cause retarded fetal growth

–2. Fetal death is only a possibility with other teratogens, not viral

–3. Maternal effects are only seen with viral teratogens

+4. Genetic factors are not present with viral teratogens

5. Congenital rubella is associated with the development of what clinical condition in 80% of infants infected?

–1. Blindness

+2. Deafness

–3. Obesity

–4. Diabetes mellitus

6. What antibody, produced by the fetus, can be detected in the cord blood of an infant infected with the rubella virus?

–1. IgA

–2. IgD

–3. IgG

+4. IgM

7. Congenital HIV is most likely transmitted to the fetus during what stage or pregnancy?

–1. First 3 months

+2. Late pregnancy or during delivery

–3. No known susceptibility during any stage

8. Chorioamnionitis and maternal fever can be the result of bacterial infections

–1. Caused by colonized flora in the vagina and rectum, such as

–2. Group A hemolytic streptococci

+3. Group B hemolytic streptococci

–4. Candida

–5. Staph. auerus

9. Congenital rubella is completely preventable by

–1. Isolation

+2. Vaccination

–3. Having a superb immune system

10. Congenital HIV infections can be controlled or prevented by

–1. Offering antiviral drugs during pregnancy

–2. Having an elective cesarean section

–3. Avoid breast feeding

+4. All of the above

11. Primary infection of the mother, rather than re-activation, tends to have a worse fetal consequence.

+1. True

–2. False

12. Clinical features such as hepatosplenomegaly, skin and mucosal lesions, and a saddle-shaped nose are associated with what congenital infection?

–1. Congenital rubella

–2. Congenital CMV

+3. Congenital syphilis

–4. Congenital HIV

13. Which of the following is NOT associated with intraamniotic infections:

-1. bacteremia

+2. decreased oxytocin requirements for labor augmentation

-3. postpartum endomyometritis

-4. increased cesarean section rate

-5. preterm delivery

14. Which of the following situations is NOT an indication for intrapartum chemo-prophylaxis for group В streptococcal (GBS) disease:

-1. intrapartum temperature 38.3 degrees Centigrade

-2. sibling with invasive GBS infection

-3. preterm labor

+4. rupture of membranes >6 hours

-5. twin gestation

15. HIV-infected pregnant patients should be screened for all of the following sexually transmitted diseases EXCEPT

+1. herpes simplex

-2. gonorrhea

-3. syphilis

-4. chlamydia

-5. hepatitis В

16. Which of the following statements concerning perinatal cytomegalovirus (CMV) infections is incorrect?

+1. Most women in lower socioeconomic populations are susceptibl-

-2. Pregnancy may cause reactivation of latent CMV.

-3. Primary maternal infections cause more fetal damage than recurrent infections.

-4. Most infants infected in the third trimester do not have sequela-

-5. Most infants with congenital CMV are asymptomatic at birth.

17. The greatest risk for vertical transmission of hepatitis В virus (HBV) occurs in which of the following maternal situations:

-1. first trimester maternal HBV infection

+2. asymptomatic, HBsAg positive, HBeAg positive

-3. asymptomatic, HBsAg positive, HBeAg negative

-4. asymptomatic, HBsAg positive, anti HBe positive

18. The majority of neonates with severe herpes simplex virus (HSV) infections are born to mothers with which of the following conditions:

-1. antepartum first-episode genital HSV infection

-2. intrapartum first-episode genital HSV infection

-3. intrapartum symptomatic recurrent genital HSV infection

+4. intrapartum asymptomatic recurrent genital HSV infection

19. Which of the following statements concerning syphilis in pregnancy is true?

-1. Routine antenatal screening is not cost-effective.

-2. Penicillin-allergic patients should be treated with erythromycin.

-3. Most infections are clinically evident.

+4. Serologic tests are not substitutes for darkfield microscopic examination of chancres.

-5. Jarisch-Herxheimer reactions are unusual in pregnancy

20. 30 year old mother in her first pregnancy attends for a routine anomaly scan at 20 weeks of gestation. She has no family history, or past medical history of not- On USS ventricles of the fetus are enlarged, fetal ascites and skin edema is present. What is the most likely cause for this fetal anomaly?

-1. Folic acid deficiency

-2. Gestational Diabetes mellitus

+3. 1st trimester cytomegalovirus infection

-4. Taking ciprofloxacin for UTI in the first trimester

-5. Taking vitamin A supplements in the first trimester

21. Which of the following isn't considered a high risk pregnancy?

-1.Gestational diabetes.

-2.Cardiac disease in pregnancy.

+3.Candida infection in pregnancy.

-4.Bleeding in pregnancy.

22. Genital Herpes :

+1.Herpes is caused by Herpes Simplex Virus type 1 – (HSV-1) or type 2 (HSV-2).

+2. When present during late pregnancy, it can be transmitted to the fetus resulting in neonatal herpes.

+3. The highest risk to the fetus is if the woman acquires the infection for the first time during late pregnancy

-4.Genital Herpes is spread through body fluids such as blood

+5. Transmission to the fetus is almost always by direct contact through infected secretions.

23. Clinical assessment of Genital Herpes:

- 1. The primary infection is a typical viral illness associated with flu-like symptoms.

- 2. The rash is maculo-papular initially, followed quickly by a vesicular eruption.

+3. Presentation is usually with painful vulval lesions, initially vesicles followed by ulceration.

+4. On examination one can see vesicles or ulcers (which may become secondarily infected)

24. Genital Herpes :

+1. Antiviral therapy– aciclovir should be administered to a woman who contracts primary herpes in the late third trimester (after appropriate confirmation).

+2. For women who experience primary HSV in early pregnancy, there is no evidence for benefit of antiviral therapy at the time of delivery.

+3. Caesarean section should be recommended to all women who have a confirmed primary HSV infection in the last 6 weeks of pregnancy.

+4. Women with secondary infection in late pregnancy, should be offered the option of caesarian section.

- 5.Caesarean section should be recommended to all women who have a confirmed HSV infection.

25. Diagnosis of toxoplasmosis:

 -1. Most people infected may experience mild flu-like symptoms.

+2. On examination the most people infected there are no sigs

+3. Antibodies to Toxoplasma can be measured in the blood

- 4. Woman infected complains of the maculo-papular rash initially

26. Complications of toxoplasmosis:

+1. Toxoplasmosis increases the risk of early pregnancy loss

+2. Children with congenital toxoplasmosis may have cephalomegaly, or a small head

+3. Often there are no symptoms at birth, but develop symptoms of vision loss, intellectual disability and fits.

+4. The infection by the parasites is chronic and can be reactivated, especially if the person becomes immune-compromised

27. Listeria

+1. Whilst Listerosis is rare in the population pregnant women are ten times more likely to get listeria.

+2. Women get infected by eating contaminated food e.g. Uncooked meat, cheeses, processed meat and smoked seafood.

- 3. Once someone is infected they carry the listeria for life, but it is usually harmless.

- 4. Infected cats pass the parasites in their faeces.

28. Listerosis, complications

+1. early pregnancy loss,

+2. stillbirth,

+3. premature delivery,

+4. life threatening infection in the newborn,

+5.meningitis and septicaemia in immune-comprimised adults.

29. Toxoplasmosis

-1. Infected cats pass the parasites in their faeces.

-2. The woman may be infected by contaminated soil, fruit or vegetables, or from raw meat that is contaminated by the excrement of infected cats

-3. The foetus is at risk if the mother acquires the infection during pregnancy.

-4.With chronic infection (>6 months) the mother’s immunity protects the child.

+5. All of the above is correct

30. Regarding toxoplasmosis

–1. Toxoplasmosis decreases the risk of early pregnancy loss

+2. Often there are no symptoms at birth, but develop symptoms of vision loss, intellectual disability and fits.

31. Cytomegalo Virus (CMV):

-1. CMV is one of the herpes viruses.

-2. Once someone is infected they carry the virus for life, but it is usually harmless.

-3. when CMV is acquired in utero, it can cause hearing loss or developmental delay.

-4. For the majority of fetuses who are infected with CMV the outcome is good.

+ All of the above

32. CMV:

+1. Neonatal CMV infection is acquired through the placenta, with the virus passing into the fetus’ circulation.

-2. CMV infection after birth commonly causes problems

- 3. Most CMV infections are symptomatic: fever sore throat, or fatigue lymphadenopathy may be detected;

+4. Children known to be infected with CMV at birth should have regular checks of hearing and eyesight.

+5. Virus can be detected in blood, saliva or urine confirming the presence of infection