**Subject 5.**

**Perinatology. Preterm and postdate pregnancy.**

MSQs

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

1. Etiology.

2. Term of pregnancy

3. The degree of disturbance of the fetus state.

4. All these factors.

2. Abortion is the interruption of pregnancy:

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. Complete 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. Abruption placenta.

5. Placenta insufficiency.

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

1. Amnioscopy.

2. Colpotsitology.

3. Colposcopy.

4. Ultrasound.

5. Cardiomonitoring

6. Placenta thickness up to 50 mm in the IIIrd trimester indicates?

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 investigations should be done to determine the cause of 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. 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

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. The following complications may take place in the II trimester of pregnancy:

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. Related to IUGR::

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. 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

17. 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

18. Preterm labor treatment with β –adrenomimeticincreases the neonate's risk of:

1. hyperglycemia

2. bradycardia

3. pulmonary edema

4. intraventricular hemorrhage

5. mental retardation

19. Which of the following is the most reliable way to make a diagnosis of cervical insufficiency:

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

20. The most common singlespecific karyotypic abnormality in first trimester abortuses is:

1. mosaicism

2. translocation

3. triploidy

4. tetraploidy

5. monosomy X 45

21. 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

22. 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

23. Which of the following indicates 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 ά-fetoprotein at 16 weeks

5. bacterialvaginosis

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

1. smoking

2. dehydration

3. nipple stimulation

4. bed rest

25. 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

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

1. home uterine activity monitoring

2. oraltocolytics

3. thyrotropin releasing factor

4. phenobarbital

5. dexamethasone

27. The best predictor of preterm labor is:

1. hematocrit>34%

2. vaginal bleeding

3. prior preterm delivery

4. low socioeconomic status

5. Trichomonasvaginalis

28. 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

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

1. 1%

2. 3%

3. 10%

4. 20%

5. 34%

30. The most common cause of premature labor is:

1. cervical incompetence

2. bicornuate uterus

3. bacterialvaginosis

4. smoking

5. premature rupture of membranes

31. Complication of preterm rupture of fetal membranes includes all EXCEPT:

1. fetal infection

2. prolapsed cord

3. chorioamnionitis

4. preeclampsia

5. labor

32. Tests for diagnosing premature rupture of membranes include all EXCEPT:

1. vaginal examination

2. fern test

3. vaginal creatinine

33. The patient with preterm 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

34. 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. 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

37. A 2 year old child came 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

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

1. 2100-2300 calorie diet per day

2. cessation of smoking

3. weekly CTG

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. Which of the following indicates 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 ά-fetoprotein at 16 weeks

5. bacterialvaginosis

41. Postdate pregnancy can result from:

1. bacterialvaginosis 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. placentaepreviae

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

1. Abortion is the interruption of pregnancy:

1. Before16 weeks.

2. Before 28 weeks.

3. Before 22 weeks.

4. Before 20 weeks.

5. Before 36 weeks.

51. In what stages of abortion the continuation of pregnancy is impossible:

1. Abortus imminence (threatened)

2. Abortusincipiens (inevitable)

3. Abortusprodigens (in progress)

4. Complete abortion

5. Incomplete abortion.

52. What examinations should be done to determine the cause of reccurent pregnancy loss?

1. Hysterosalpingography.

2. Ultrasound.

3. Bacteriological study.

4. Determination of the hormones in the blood and urine.

5. Endocrinologist, genetic consultation

53. Indicate signs of threatened preterm labor?

1. Regular uterine contractions - at least one in every 10 minutes;
2. Dilatation and effacement of the cervix;
3. Shortning of the cervix;
4. Pelvic pressure, backache and/or vaginal discharge
5. All of the above.

54.The causes of spontaneous abortion:

1. Infection.

2. The cervical incompetence

3. Trauma.

4. Hormonal insufficiency.

5. Genetic changes.

55. The cause of fetal death in post-term pregnancy:

1. Infection.

2. Abnormalities of development.

3. Asphyxia.

4. Birth trauma.

5. Anemia.

56. In the 2d trimester of pregnancy the following complications may take place:

1. Pre-term birth

2. The cervical incompetence

3. Premature rupture of amniotic membranes

4. Ruptured ectopic pregnancy

57. Mature newborn is:

1. Weight 2350 g, length 41 cm;

2. Weight 3350 g, length 51 cm;

3. Weight 2550 g, length 47 cm;

4. Weight 1500 g, length 35 cm.

58. Which of the following fetuses are viable:

1. Weight 450 g, length 28 cm;

2. Weight 1000 g, length 35 cm;

3. Weight 520 g, length 30 cm;

4. Weight 1500 g, length 35 cm.

59. Which of the following is not the cause of premature labor?

1. Polyhydramnios;

2. Multiple pregnancy;

60. Sexually transmitted diseases;

4. Cervical incompetence;

5. A history of gestosis in the first half of pregnancy.

61. What is the main criterion for differential diagnosis of prolonged and post-term pregnancy?

1. Term of pregnancy;

2. Quantity and quality of amniotic fluid;

3. The state of the birth canal;

4. The condition of the fetus.

62. The choice of delivery method for post-term pregnancy depends on:

1. the degree of cervical ripening;

2. the sizeof the maternal pelvis;

3. the condition of the fetus;

4. a complicated obstetric history.

63. What are the clinical signs of post-term pregnancy:

1. reduction in the circumference of the abdomen;

2. reduction in body weight of a pregnant woman;

3. reduction of gross body movements of the fetus;

4. changes in the fetal heart beats.

64. Which methodsof induction of laborcan be usedwhen post-term pregnancy presents:

1. amniotomy;

2. insertion of laminaria into the cervical canal;

3. intravenous drip of prostaglandin preparations;

4. intramuscular administration of oxytocin.

65. Pregnancy is called post-term if it continues

1. more than 280 days

2. more than 294 days

3. more than 42 weeks

4. more than 41 weeks

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

1. anembryonic abnormality

2. first trimester bleeding

3. early spontanious abortion

4. low progesterone levels

5. absence of blocking antibodies

67. At what stage of spontaneous abortionis the continuation of pregnancy possible.

1. inevitable;

2. threatened;

3. incomplete

68. The most common causes of miscarriage are

1. genital infections;

2. immunological factors;

3. hormonal insufficiency

4. history of abortions

69. The most effective treatment method of threatened abortion is:

1. bed rest

2. progesterone

3. lowdose aspirin

4. tocolysis

5. none of the above

70. Which of the following is the most reliable way to diagnose cervical incompetence:

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

2. biopsy of the cervix

3. ultrasonography

4. ease of Hegar dilators passage

5. hysterosalpingogram

71. Women at risk for preterm labor should receive prenatally:

1. home uterine activity monitoring

2. oral tocolytics

3. thyrotropin releasing factor

4. phenobarbital

5. dexamethasone

72. The best predictor of preterm labor is:

1. hematocrit >34%

2. vaginal bleeding

3. prior preterm delivery

4. low socio-economic status

5. Trichomonasvaginalis

73. Causes of post-term pregnancies include all of the following EXCEPT:

1. oral contraceptive usage

2. sulfatase placental deficiency

3. prolonged follicular phase

4. arachidonic acid deficiency

5. anencephaly

74.Main complications of post-term pregnancy are:

1. placental insufficiency due to placental aging

2. hyaline membrane disease

3. cord compression

4. fetal hypoxia and fetal distress

5. placenta previa

75. This abnormality rarely develops before the third trimester:

1. spina bifida

2. hypoplastic left ventricle

3. microcephaly

4. Omphalocele

Clinical cases:

1. A 23-year-old [primigravida](https://translate.academic.ru/primigravida/xx/en/) was admitted to the hospital with complaints of pulling pains in the lower abdomen and back.

Anamnesis: menstruation starts at the age of 16, becomes regular in a year. The cycle is 30 days, menstruation lasts for 3-4days, it’s painful, blood loss is moderate.

The last menstruation was 8 weeks ago. On specula examination: the cervix has conical shape, mucosa is cyanotic, a round external os closed. On vaginal examination: the cervical canal is closed, the body of the uterus corresponds to a 7-8-week pregnancy, and the tone of the uterus is increased. Appendages on both sides are without masses or tenderness.

Diagnosis?

1. A pregnant woman visited the clinic for women with complaints of cramping pain in the lower abdomen, small bloody discharge from the vagina. The term of pregnancy is 12 weeks. This pregnancy is the 2nd. The first one ended in premature labor at 36 weeks.

Vaginal examination: the cervix has tubular shape; external os is slit-shaped and closed. The uterine body is enlarged up to 12 weeks of pregnancy, the tone of the uterus is increased. Both adnexa are without masses or tenderness. There's blood on the glove.

Diagnosis? Treatment.

1. A 28-year-old pregnant woman has complaints of aching pain in the lower abdomen and lower back. The term of gestation is 17-18 weeks. In the anamnesis there are one labor and three artificial abortions.

Vaginal examination: the cervix is 2.5 cm long, the cervical canal admits one finger till the internal os, the uterine body is enlarged according to the term of pregnancy, vaginal discharge is mucous, in moderate amount.

What is the most likely diagnosis? Tactics.

1. A 28-year-old pregnant woman with a 32-week gestation was admitted to the maternity hospital complaining of cramping pains in the lower abdomen in 8-9 minutes. On examination, the uterus corresponds to the term of pregnancy, its tone is increased, the lie of the fetus is longitudinal, the head is pressed to the pelvis inlet, the fetal heartbeat sound is distinct, rhythmic, 146 beats/min.

On vaginal examination: the cervix is effaced, thin, dilatation is 2 cm. The amniotic membranes are intact. The head is pressed to the pelvis inlet, the bones of the skull are not firm, the sagittal suture and the fontanels are wide. The promontory is not reached.

Diagnosis? Tactics.

5. A 30-year-old primiparous woman was admitted to the hospital at 42 weeks and 4 days of pregnancy (298 days). On external examination the tone of the uterus is normal, the lie of the fetus is longitudinal, the fetal head is pressed to the pelvis inlet. Fetal heartbeat is quiet, rhythmic, 110 beats per minute. The estimated weight of the fetus is 4200 g, the pelvis is normal. CTG and ultrasound reveales signs of fetal intrauterine hypoxia (fetal biophysical profile-4 points, Impaired  uteroplacental blood flow of the 3d degree, low amniotic fluid index). On amnioscopy, the amount of amniotic fluid is reduced, and the water is green.

On vaginal examination: the cervix is 3 cm long, dense, deviated posteriorly, the cervical canal admits one finger, the amniotic membranes are intact. The head is pressed to the pelvis inlet, the bones of the skull are hard, the sagittal suture occupies the left oblique diameter, is closed.

Diagnosis? Tactics?

6. A woman in labor is taken to the hospital by an ambulance. This pregnancy is the third, full-term. The first pregnancy ended with a normal delivery, the second - with a miscarriage.

Contractions are regular. The fetal lie is longitudinal, the presenting part is head. On vaginal examination the rupture of amniotic membranes happened, after which there was a decrease in the fetal heartbeat up to 100 beats per minute.

There is complete ditatation of the cervix, amniotic membranes are absent, a pulsating loop of umbilical cord is felt in the vagina. The head of the fetus is pressed to the pelvic inlet.

Diagnosis. Tactics.

1. A pre-pregnant woman came to the antenatal clinic with complaints of weak fetal movement during the last three days. The gestational age at the time of treatment is 36 weeks. The fundus of the uterus is midway between the navel and the xiphoid process. Abdominal circumference 78 cm, height of the uterus fundus - 30 cm. Fetal heartbeat is muffled, rhythmic. Presenting part is the head, pressed to the pelvis inlet. Ultrasound revealed: in the uterus, one fetus in a cephalic presentation without visible developmental anomalies. The placenta is located on the right side wall of the uterine body, 3rd degree of maturity. The biparietal head size is 90 mm (corresponds to 36 weeks), the circumference of the tummy is 286 mm (corresponds to -33 weeks), the length of the thigh is -65 mm (corresponds to 36 weeks). Doppler imaging revealed impaired blood flow in the umbilical artery.

According to CTG, the state of the fetus is compensated.

Diagnosis, treatment.