

QUESTION

A 29-year-old with symptomatic uterine prolapse wants uterine preservation. A fertility-preserving sling cervicopexy is planned. Match the procedure to its anchoring structure.

1. Shirodkar
 2. Purandare
 3. Khanna
- A) Anterior superior iliac spine
B) Rectus sheath
C) Sacrum via lumbosacral fascia

A 1-C, 2-B, 3-A

CORRECT

B 1-B, 2-C, 3-A

C 1-C, 2-A, 3-B

D 1-A, 2-B, 3-C

RIGHT ANSWER

OK A. 1-C, 2-B, 3-A

WHY THIS IS RIGHT

Fertility-preserving sling cervicopexy procedures are differentiated by the structure to which the sling is anchored.

- Shirodkar sling is anchored posteriorly to the sacrum via the lumbo-sacral fascia.
- Purandare sling is anchored to the rectus sheath.
- Khanna sling is anchored laterally to the anterior superior iliac spine (ASIS).

Therefore, the correct matching is 1-C, 2-B, 3-A.

- Sling cervicopexy is a uterine-preserving procedure used in women desiring future fertility.
- Posterior anchoring to sacrum provides strong apical support but needs careful dissection to avoid pre sacral bleeding.
- Anterior anchoring to rectus sheath and lateral anchoring to ASIS are alternative designs with different vectors of support.

QUESTION

From which spinal segment is the sympathetic nerve supply to the ovary derived?

A S2-S4

B T9-T10

C L4-L5

D T10-T11

CORRECT

RIGHT ANSWER

OK

D. T10-T11

WHY THIS IS RIGHT

The ovary receives sympathetic innervation from spinal segments T10-T11, which travel via the ovarian plexus accompanying the ovarian vessels.

- Sympathetic supply: T10-T11
- Fibers arise from the thoracic sympathetic chain -> pass through aortic/ovarian plexus -> reach the ovary along the ovarian artery.
- These fibers mainly mediate vasomotor control and pain sensation from the ovary.

Ovarian pain (e.g., ovarian torsion, follicular rupture) is typically referred to the T10-T11 dermatomes, producing pain in the periumbilical or lower abdominal region.

Important contrast:

- Ovary: Sympathetic T10-T11
- Uterus: Sympathetic T12-L2
- Pelvic parasympathetic supply (pelvic organs): S2-S4 via pelvic splanchnic nerves

QUESTION

A 65-year-old man with advanced prostate cancer and bone metastases has been treated with a GnRH agonist for the last 4 months, which has reduced his bone pain. He now reports discomfort in the anterior chest wall. Physical examination reveals bilateral, mildly tender gynaecomastia (enlargement of breast tissue behind the nipple-areolar complex). Which medication would be most appropriate to start early to prevent these breast symptoms?

- A Danazol
- B Finasteride
- C Spironolactone

D Tamoxifen

CORRECT

RIGHT ANSWER

D. Tamoxifen

WHY THIS IS RIGHT

Gynecomastia in men receiving androgen deprivation therapy (ADT) occurs due to hormonal imbalance between estrogen and androgens. GnRH agonists suppress testosterone production, leading to relative estrogen predominance --> stimulates proliferation of breast glandular tissue.

Tamoxifen, a selective estrogen receptor modulator (SERM), is the most appropriate drug to prevent or treat gynecomastia and breast pain in these patients.

- Tamoxifen blocks estrogen receptors in breast tissue
- Prevents estrogen-mediated breast glandular proliferation ; Reduces breast enlargement and tenderness

Why other options are incorrect:

- Danazol: Synthetic androgen used in endometriosis and fibrocystic breast disease; not standard for ADT-induced gynecomastia.
- Finasteride: 5-alpha reductase inhibitor; can cause gynecomastia.
- Spironolactone: Antiandrogenic effect and commonly causes gynecomastia.

QUESTION

A 54-year-old postmenopausal woman presents to the OPD with increasing vaginal pressure for the past 3 months. She reports no vaginal bleeding or abnormal discharge. Her BMI is 18 kg/m², and vital signs are normal. On speculum examination, the anterior vaginal wall bulges with the Valsalva maneuver. On bimanual examination, the uterus is small and mobile. Which of the following is the most likely underlying cause of this patient's presentation?

- A** Chronic endometriosis
- B** Prior uterine artery ligation
- C** Pudendal nerve injury
- D** Uterine leiomyomas

CORRECT

RIGHT ANSWER

- OK** C. Pudendal nerve injury

WHY THIS IS RIGHT

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QUESTION

A woman, G3P2L0, presents with 9 weeks of amenorrhea. She has a history of cervical conization performed one year ago and is currently on follow-up, with no recurrence on Pap smear. What is the most appropriate management in this pregnancy?

A Ultrasound to assess cervical length

CORRECT

B Cervical Cerclage

C Complete Bed rest

D Abdominal cerclage

RIGHT ANSWER

OK

A. Ultrasound to assess cervical length

WHY THIS IS RIGHT

Women with a history of cervical surgery (e.g., cervical conization /LEEP) are at increased risk of cervical insufficiency and preterm birth; but prophylactic cerclage is not routinely recommended unless there is a history of second-trimester loss or documented cervical shortening.

Recommended management:

- Perform transvaginal ultrasound surveillance of cervical length during pregnancy (usually from 16-24 weeks).
- Cerclage is considered only if cervical length <25 mm or if there is a history of recurrent mid-trimester losses.
- > Why other options are incorrect:
 - > * Cervical cerclage: not done prophylactically without evidence of cervical shortening or prior losses.
 - > * Bed rest: not proven to prevent preterm birth.
 - > * Abdominal cerclage: reserved for severe cervical insufficiency or failed prior vaginal cerclage.

QUESTION

Which of the following is a criterion for classifying a vesicovaginal fistula as complication?

A Location above the trigone

B Size is 4 cm

CORRECT

C No prior radiation

D Normal vaginal length

RIGHT ANSWER

OK

B. Size is 4 cm

WHY THIS IS RIGHT

- Large vesicovaginal fistulas are classified as complicated because they are technically difficult to repair and have a higher recurrence rate.
- Size, location, prior radiation, and scarring influence management and prognosis.
- A vesicovaginal fistula is classified as complicated if it has features such as large size (≥ 3 cm), involvement of the trigone/urethra, prior radiation, malignancy, recurrent fistula, or associated vaginal scarring.

QUESTION

A young woman presents with vault prolapse. It is being fixed to a bony point with a mesh. Where is this mesh fixed to?



A Ischial spine

B Ischial tuberosity

C Sacral promontory

CORRECT

D Pubic symphysis

RIGHT ANSWER

OK

C. Sacral promontory

WHY THIS IS RIGHT

In sacrohysteropexy, the mesh is attached from the cervix/uterus to the sacral promontory, providing strong apical support. Ischial structures are not used for mesh fixation. Gold standard surgery for vault prolapse = sacrocolpopexy.

The Sacral Promontory provides:

Advantage	Reason
Strong fixation	Firm bony landmark
Restores vaginal axis	Anatomical alignment
Durable repair	Low recurrence rate

QUESTION

A 30-year-old P2L2 woman presents with cervical elongation. Her family is complete. What is the preferred surgery advised?

A Fothergill repair

CORRECT

B McCall Culdoplasty

C Le Fort procedure

D Shirodkar sling

RIGHT ANSWER

OK A. Fothergill repair

WHY THIS IS RIGHT

For cervical elongation in women with completed family, the preferred procedure is Fothergill (Manchester repair). Sling procedures are fertility-preserving; Le Fort is for very elderly non-sexually active women.

Cervical amputation



Shortening of elongated cervix



Reattachment of cardinal (Mackenrodt) ligaments



Restoration of uterine support

Fothergill repair is the operation of choice for cervical elongation.

B) McCall Culdoplasty

- Used during hysterectomy to prevent vault prolapse.

C) Le Fort procedure

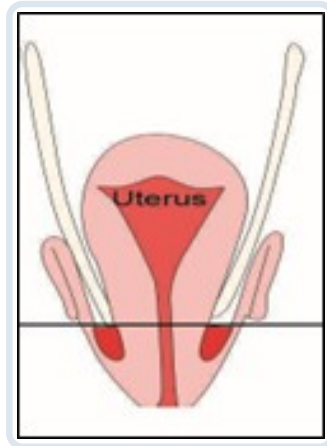
- Done for elderly women who do not desire intercourse.

D) Shirodkar sling

- Used mainly for uterine prolapse, not isolated cervical elongation.

QUESTION

Identify the grade of prolapse?



A Grade 3 prolapse

CORRECT

B Grade 2 prolapse

C Grade 1 prolapse

D Procidentia

RIGHT ANSWER

OK A. Grade 3 prolapse

WHY THIS IS RIGHT

First-degree prolapse:-

- Cervix descends into the vagina
- Does not reach the introitus
- Often asymptomatic or mild symptoms

Second-degree prolapse:-

- Cervix reaches the level of the introitus
- May be seen at the vaginal opening on straining

Third-degree prolapse:-

- Cervix protrudes outside the introitus
- Body of uterus remains inside the vagina

Procidentia (Complete prolapse):-

- Entire uterus lies outside the introitus
- Severe form, often associated with ulceration and discharge

QUESTION

The classification shown is for?

Anterior wall Aa	Anterior wall Ba	Cervix or cuff C
Genital hiatus gh	Perineal body pb	Total vaginal length tvL
Posterior wall Ap	Posterior wall Bp	Posterior fornix D

A Cervical cancer

B Pelvic organ prolapse

CORRECT

C Vulvar cancer

D Uterine anomalies

RIGHT ANSWER

OK

B. Pelvic organ prolapse

WHY THIS IS RIGHT

This diagram represents the POP-Q (Pelvic Organ Prolapse Quantification) system, used to objectively measure pelvic organ prolapse.

Key Points

- Uses specific vaginal reference points measured in cm relative to the hymen.
- Negative values = above hymen; positive values = below hymen (prolapse).
- Anterior vaginal wall: Aa, Ba
- Posterior vaginal wall: Ap, Bp
- Cervix/vaginal cuff: C
- Posterior fornix: D (only if cervix present)

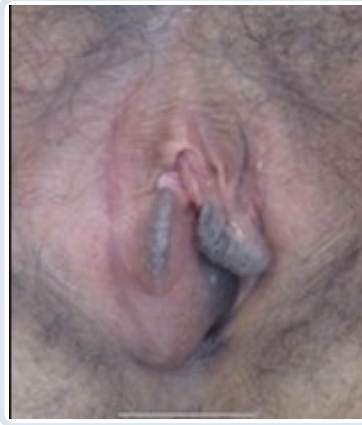
Additional measurements

- GH (Genital hiatus) - distance from urethral meatus to posterior hymen
- PB (Perineal body) - posterior hymen to anus
- TVL (Total vaginal length) - vaginal depth when prolapse reduced

Purpose: Standardized assessment and staging of pelvic organ prolapse (POP).

QUESTION

A woman comes with complaints of pain and swelling in the perineal area, difficulty in walking and sitting. She has a history of multiple sexual partners. On examination, a tender swelling is seen with redness on the labia, as shown in the image given below. What is the most likely diagnosis?



A Skene duct abscess

B Bartholin abscess

CORRECT

C Genital Tuberculosis

D Gartner duct cyst

RIGHT ANSWER

B. Bartholin abscess

WHY THIS IS RIGHT

It develops when the Bartholin duct becomes obstructed and infected.

- A unilateral, very painful, erythematous, fluctuant swelling at the posterior vulva (4-8 o'clock position) is typical of Bartholin abscess.
- Skene duct cyst will be para-urethral whereas Gartner duct cyst --> present in the anterior vaginal wall.
- Management is Incision and drainage followed by catheter insertion.

Common Causative Organisms

Organism	Source
Neisseria gonorrhoeae	STI
Escherichia coli	Enteric flora
Staphylococcus	Skin flora

A) Skene Duct abscess:

- Swelling occurs near urethral meatus, not labia.

C) Genital tuberculosis

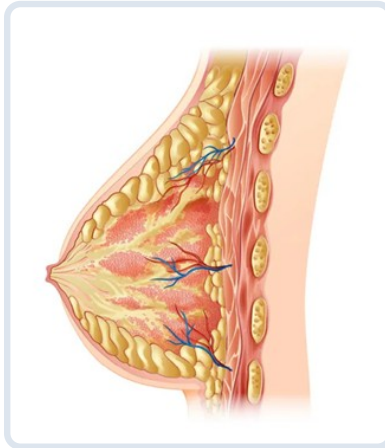
- Usually causes infertility, not painful vulvar swelling.

D) Gartner duct cyst

- Usually painless cyst in lateral vaginal wall.

QUESTION

| Which hormone is primarily responsible for the growth of breast tissue?



A Oxytocin

B Estrogen

C Prolactin

D Progesterone

CORRECT

RIGHT ANSWER

OK

D. Progesterone

WHY THIS IS RIGHT

The growth and development of mammary alveoli (as shown in the diagram) is primarily stimulated by progesterone. Progesterone is the primary hormone responsible for mammary alveolar growth and development, while estrogen primarily stimulates ductal growth. This hormonal distinction is crucial for understanding mammary gland development and the cyclical changes that occur during the menstrual cycle.

Hormone	Function
Estrogen	Ductal growth of breast
Progesterone	Lobuloalveolar development
Prolactin	Milk production
Oxytocin	Milk ejection (let-down reflex)

QUESTION

Injury to the deepest part of the perineal body, leading to cystocele, enterocele, and urethral descent, involves which of the following muscles?

A Pubococcygeus

CORRECT

B Bulbospongiosus

C Ischiocavernosus

D Superficial transverse perineal

RIGHT ANSWER

OK A. Pubococcygeus

WHY THIS IS RIGHT

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QUESTION

A 55-year-old woman presents with complaints of continuous urinary dribbling from the vagina. A Methylene blue three-swab test is performed, and the middle swab is stained blue. Which of the following is the least likely cause of the underlying condition?

A Pelvic inflammatory disease (PID)

CORRECT

B Direct infiltration from carcinoma

C Neglected labor

D Complication of hysterectomy

RIGHT ANSWER

OK

A. Pelvic inflammatory disease (PID)

WHY THIS IS RIGHT

The methylene blue three-swab test is used to identify the type of urogenital fistula causing continuous urinary leakage per vagina.

Interpretation of the test:

- Upper swab-stained blue -> vesicovaginal fistula (VVF)
- Middle swab-stained blue -> vesicovaginal fistula (leak from bladder into vagina)
- Upper swab wet but not blue -> ureterovaginal fistula

Common causes of vesicovaginal fistula:

- Neglected/obstructed labor (most common in developing countries)
- Gynecologic surgery, especially hysterectomy
- Direct tumor invasion, e.g., carcinoma of cervix or bladder

Least likely cause:

- Pelvic inflammatory disease (PID) rarely leads to vesicovaginal fistula, making it the least likely cause.

QUESTION

A 63-year-old woman is found to have a right-sided ovarian mass incidentally on transvaginal ultrasound. Surgery is planned to remove the right ovary along with the mass. To avoid excessive bleeding during the oophorectomy, which of the following structures should the surgeon ligate?

- A Mesosalpinx
- B Ovarian ligament
- C Round ligament of the uterus
- D Suspensory ligament of the ovary**

CORRECT

RIGHT ANSWER

- OK D. Suspensory ligament of the ovary**

WHY THIS IS RIGHT

During oophorectomy, the major vascular supply to the ovary comes through the suspensory ligament of the ovary (infundibulopelvic ligament).

- The suspensory ligament of the ovary connects the ovary to the lateral pelvic wall.
- It contains the ovarian artery, ovarian vein, lymphatics, and nerves.
- These vessels arise from the abdominal aorta (ovarian artery).

Surgical importance:

- During removal of the ovary, the infundibulopelvic ligament must be ligated to control the ovarian vessels and prevent significant bleeding.

> Other options:

>

- > * Mesosalpinx: part of the broad ligament supporting the fallopian tube.
- > * Ovarian ligament: connects ovary to the uterus but contains no major vessels.
- > * Round ligament: maintains uterine anteversion and passes to the labia majora.

QUESTION

A 25-year-old woman presents soon after home delivery by an untrained Dai with a vaginal mass. On examination, the finding is shown below. This condition occurs due to weakening of which ligament?



A Mackenrodt ligaments

CORRECT

B Sacroiliac ligaments

C Round ligament

D Ovarian ligament

RIGHT ANSWER

OK A. Mackenrodt ligaments

WHY THIS IS RIGHT

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QUESTION

In a regular 28-day menstrual cycle, which of the following hormonal patterns is typically seen between days 21 and 25 of the cycle?

A Estrogen and progesterone high, FSH and LH low

CORRECT

B Estrogen increase progesterone low, FSH increase LH low

C Estrogen decreases progesterone high, FSH decrease and LH high

D Estrogen increases and progesterone low, LH and FSH low

RIGHT ANSWER

OK

A. Estrogen and progesterone high, FSH and LH low

WHY THIS IS RIGHT

This is the luteal phase (secretory phase)

☐ Dominant structure: Corpus luteum

☐ Hormonal environment:

- Progesterone ↑↑ (peak)

- Estrogen ↑ (moderate)

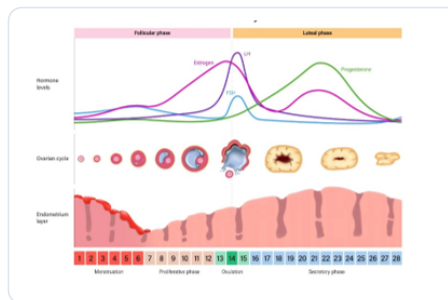
- FSH ↓

- LH ↓

Days 21-25 correspond to the mid-luteal phase dominated by the corpus luteum. Progesterone is high and estrogen is moderately elevated due to luteal secretion.

These steroids exert negative feedback on the pituitary--> suppressing FSH and LH.

This pattern maintains luteal support while preventing another ovulatory surge.



QUESTION

A 28-year-old nulliparous woman being evaluated for infertility comes to the office due to clear vaginal discharge for the past 2 days. The patient and her partner have been trying to conceive for several months. Menstrual cycles occur every 29 days with 4 days of flow. Last week, she took penicillin for a sore throat. The patient has no medical issues and has had no surgeries. She takes a daily prenatal vitamin. Pelvic examination shows clear mucus at the cervical os. Which of the following is the most likely explanation for this patient's discharge?

A Bacterial vaginosis

B Candidiasis

C Cervical mucus plug

D Ovulation

CORRECT

RIGHT ANSWER

OK D. Ovulation

WHY THIS IS RIGHT

Around ovulation, rising estrogen levels stimulate the cervix to produce thin, clear, stretchy cervical mucus (often described as "egg-white" mucus).

- Facilitates sperm transport through the cervix
- Increases sperm survival and motility
- Indicates the fertile window of the menstrual cycle.

Typical features of ovulatory cervical mucus:

- Clear, watery, and elastic
- Appears mid-cycle
- Non-irritating and odorless

QUESTION

| In which stage of puberty does estrogen not have a major role?

A Pubarche

CORRECT

B Thelarche

C Menarche

D Growth spurt

RIGHT ANSWER

OK

A. Pubarche

WHY THIS IS RIGHT

Puberty involves several milestones regulated by different hormones.

Hormonal Control:

- Thelarche (breast development): Estrogen-mediated
- Menarche (onset of menstruation): Estrogen-driven endometrial proliferation
- Growth spurt: Estrogen stimulates GH-IGF axis and epiphyseal maturation
- Pubarche (pubic/axillary hair): Caused by adrenal androgens (DHEA, DHEA-S), not estrogen

QUESTION

A 16-year-old girl presents to the OPD for evaluation of painful menstrual periods. She attained menarche at age 13 and initially had irregular menses. Her cycles are now regular, occurring every 30 days with 4 days of moderate bleeding. Her menses have become increasingly painful; lower abdominal pain begins a few hours before menstruation and lasts 1-2 days, accompanied by fatigue, dizziness, and diarrhea. She misses school at least one day per month due to pain but maintains her grades and has no symptoms outside of menses. She has a history of depression, managed with therapy, with no recent mood changes. Vital signs are normal. Pelvic examination reveals normal external genitalia and clear cervical discharge. On bimanual examination, the uterus is mobile, nontender, and normal in size and contour. Which of the following is the most likely diagnosis?

- A** Adenomyosis
- B** Endometriosis
- C** Primary dysmenorrhea
- D** Somatic symptom disorder

CORRECT

RIGHT ANSWER

- OK** **C. Primary dysmenorrhea**

WHY THIS IS RIGHT

Primary dysmenorrhea is caused by excess prostaglandin ($\text{PGF}\alpha$) production from the endometrium during menstruation, leading to uterine hypercontractility, reduced uterine blood flow, and ischemic pain.

- Occurs in adolescents soon after ovulatory cycles begin
- Crampy lower abdominal pain starting just before or at onset of menses
- Pain lasts 24-48 hours
- Associated symptoms: nausea, diarrhea, fatigue, dizziness
- Normal pelvic examination with no structural pathology

Why not the other options:

- Adenomyosis: Usually in multiparous women >35 years with heavy menstrual bleeding and enlarged tender uterus.
- Endometriosis: Causes chronic pelvic pain, dyspareunia, infertility, and pain not limited only to menses.
- Somatic symptom disorder: Pain not cyclic with menstruation and no clear physiologic pattern.

QUESTION

Hormone replacement therapy (HRT) should be prescribed to which of the following patients?

A

A 35-year-old woman who has undergone Total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH + BSO)

CORRECT

B

A 9-year-old girl who has Turner syndrome

C

A 47-year-old woman with hot flushes and history of breast cancer

D

A 60-year-old woman with a history of ischemic heart disease

RIGHT ANSWER

OK

A. A 35-year-old woman who has undergone Total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH + BSO)

WHY THIS IS RIGHT

Hormone Replacement Therapy (HRT) is indicated in women with premature or surgical menopause, --> especially younger than 40-45 years, to prevent complications of estrogen deficiency such as osteoporosis, cardiovascular disease, and vasomotor symptoms.

Correct indication:

- Women undergoing TAH + BSO at a young age -> sudden loss of ovarian estrogen -> HRT recommended until the natural age of menopause (~50 years).

Why other options are incorrect:

- Turner syndrome (9-year-old): requires puberty induction with estrogen, not menopausal HRT.
- History of breast cancer: HRT contraindicated because estrogen may stimulate tumor recurrence.
- Ischemic heart disease: HRT generally avoided due to thrombotic and cardiovascular risk.

*

QUESTION

| What hormone levels are typical during days 21-25 of a 28-day cycle?

CORRECT

A Estrogen ↑, Progesterone ↑ ; FSH ↓, LH ↓

B Estrogen ↓, Progesterone ↓ ; FSH ↓, LH ↓

C Estrogen ↓, Progesterone ↑ ; FSH ↑, LH ↑

D Estrogen ↓, Progesterone ↓ ; FSH ↓, LH ↑

RIGHT ANSWER

OK

A. Estrogen ↑, Progesterone ↑ ; FSH ↓, LH ↓

WHY THIS IS RIGHT

Days 21-25 correspond to the mid-luteal phase, when the corpus luteum is fully functional. Progesterone peaks, and estrogen remains moderately elevated. High steroid levels exert negative feedback on the pituitary, suppressing FSH and LH, matching option A.

QUESTION

| The most potent natural estrogen is?

- A** Estrone
- B** Estradiol
- C** Estriol
- D** Conjugated equine estrogen

CORRECT

RIGHT ANSWER

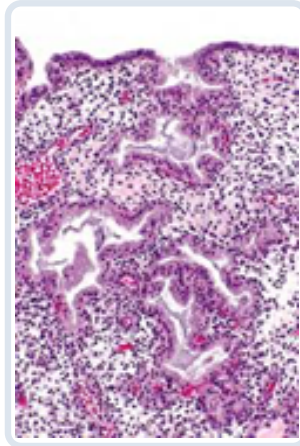
OK B. Estradiol

WHY THIS IS RIGHT

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QUESTION

An HPE image of the endometrium is shown. The hormone responsible is secreted by?



A Corpus luteum

CORRECT

B Primary follicle

C Granulosa cell

D Theca interna

RIGHT ANSWER

OK A. Corpus luteum

WHY THIS IS RIGHT

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QUESTION

A 13-year-old girl is brought to the office for evaluation of acne. She began to develop acne over her forehead and chin 4 months ago. She used over-the-counter topical salicylic acid without improvement. She now has painful acne over the face and upper chest. The patient has not yet attained menarche. She has grown 10.1 cm in the past year, and her height and weight are at the 70th percentile for age. Vital signs are normal.

Physical examination reveals nodulocystic acne over the face and upper chest. There is no breast bud development. The abdomen is nontender with no palpable masses. External genital examination shows clitoromegaly and bilateral masses in the labia majora. Which of the following is the most likely diagnosis in this patient?

A 5-alpha-reductase deficiency

CORRECT

B Androgen insensitivity-syndrome

C Nonclassical congenital adrenal hyperplasia

D PCOD

RIGHT ANSWER

OK A. 5-alpha-reductase deficiency

WHY THIS IS RIGHT

5- α -reductase deficiency is a 46,XY disorder of sex development --> caused by impaired conversion of testosterone --> dihydrotestosterone (DHT).

> Role of DHT: Required for development of male external genitalia and prostate in the fetus.

- 46,XY karyotype
- Undervirilized or female-appearing external genitalia at birth
- Testes present in inguinal canal or labia
- Clitoromegaly/ambiguous genitalia
- No uterus (due to anti-Müllerian hormone)
- Virilization at puberty due to increased testosterone
- Acne and increased muscle mass

Why not other options:

- AIS: Normal female genitalia, breast development present, no clitoromegaly.
- Nonclassical CAH: Mild androgen excess; no labial testes.
- PCOD: Occurs after puberty, causes irregular menses, not ambiguous genitalia.

QUESTION

A 17-year-old adolescent presents to the gynecology clinic with a history of severe menstrual pain and recurrent pelvic infections since the onset of menstruation. She reports cyclical pain coinciding with menstruation and has experienced recurrent urinary tract infections. On physical examination, there is a palpable pelvic mass. Ultrasound imaging reveals a duplicated uterine cavity with one side showing an hematometra and absence of the left kidney. What is the most likely diagnosis?

A Mayer-Rokitansky-Küster-Hauser (MRKH) Syndrome

B Asherman's Syndrome

C Herlyn-Werner-Wunderlich syndrome

CORRECT

D Endometriosis

RIGHT ANSWER

OK C. Herlyn-Werner-Wunderlich syndrome

WHY THIS IS RIGHT

Herlyn-Werner-Wunderlich syndrome (HWW syndrome) is a rare Müllerian duct anomaly characterised by :

1. Uterus didelphys (double uterus)
2. Obstructed hemivagina leading to hematometra/hematocolpos
3. Ipsilateral renal agenesis

This is the classical triad of HWW syndrome.

Clinical Features:

- Cyclical pelvic pain after menarche
- Pelvic mass due to hematometra
- Recurrent pelvic infections or urinary symptoms
- Associated renal anomalies

> Why not other options:

> A) MRKH syndrome:

- Absent uterus, primary amenorrhea.
- Here duplicated uterus + hematometra present.

> B) Asherman syndrome:

- Intrauterine adhesions after curettage.
- Causes secondary amenorrhea, not congenital anomaly with renal agenesis.

> D) Endometriosis:

- Causes cyclical pain, but no uterine duplication or renal anomaly.

QUESTION

If bilateral tubal block is seen on hysterosalpingography (HSG), which of the following is the next best step?

- A IVF
- B Hysteroscopy
- C Hysteroscopy with dilation and curettage (D&C)

D Laparoscopic chromopertubation

CORRECT

RIGHT ANSWER

D. Laparoscopic chromopertubation

WHY THIS IS RIGHT

Hysterosalpingography (HSG) is a screening test used to assess uterine cavity and tubal patency in infertility evaluation.

However, it may produce false-positive tubal blockage, commonly due to tubal spasm, mucus plugs, or technical factors.

Therefore, when bilateral tubal block is detected on HSG, the next best step is confirmation with laparoscopic chromopertubation, which is the gold standard test for tubal patency.

- A dye (usually methylene blue) is injected through the cervix.
- During laparoscopy, direct visualization of dye spilling from the fimbrial ends confirms tubal patency.
- Also allows detection of associated pelvic pathologies such as:
 - Endometriosis
 - Pelvic adhesions
 - Tubal disease

Why other options are incorrect:

- IVF: Considered only after confirming true tubal blockage.
- Hysteroscopy: Evaluates uterine cavity, not tubal patency.
- Hysteroscopy with D&C: Not useful for assessing fallopian tubes.

QUESTION

A 14-year-old girl is brought to the OPD for a routine physical examination. The patient has not yet attained menarche. Height and weight are at the 85th percentile for age. Physical examination shows sexual maturity rating (Tanner stage) IV breast development with absent pubic hair. The abdomen is soft, nontender, and nondistended. A small, nonreducible mass is palpated in the left inguinal area. On pelvic examination, the external genitalia appear normal, and the vagina ends in a blind pouch. Ultrasonography confirms the absence of the uterus, cervix, and ovaries. Karyotype analysis reveals 46,XY.

Which of the following is the best next step in the management of this patient?

A Elective gonadectomy procedure

CORRECT

B Estrogen therapy

C Growth hormone therapy

D Reassurance and no further treatment

RIGHT ANSWER

OK A. Elective gonadectomy procedure

WHY THIS IS RIGHT

This patient has Complete Androgen Insensitivity Syndrome (CAIS), characterized by:

- 46, XY karyotype
- Female external genitalia
- Absent uterus and cervix (due to anti-Müllerian hormone from testes)
- Blind-ending vagina
- Absent pubic/axillary hair (androgen resistance)
- Testes located in inguinal canal or abdomen

Management:

- Elective gonadectomy (removal of testes) after puberty to prevent malignant transformation (e.g., gonadoblastoma).
- Gonadectomy is delayed until after puberty because testicular androgens are aromatized to estrogen, allowing normal breast development.

QUESTION

A 15-year-old girl comes to the OPD due to pelvic and crampy lower abdominal pain that seems to recur at the beginning of each month and resolves after a day or two. The pain began approximately 6 months ago and has significantly worsened each month. The patient has never had a menstrual period. Breast and pubic hair development are at sexual maturity rating (Tanner stage) 5. Digital rectal examination reveals a palpable mass anterior to the rectum. A pregnancy test is negative. Which of the following is the most likely diagnosis?

A Androgen insensitivity syndrome

B Asherman syndrome

C Endometriosis

D Imperforate hymen

CORRECT

RIGHT ANSWER

OK D. Imperforate hymen

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1a” here and does not include a written explanation for this item.

QUESTION

| All of the following can be used to evaluate the cervical factor in infertility EXCEPT:

- A Sims test
- B Huhner test
- C Postcoital test

D HSG

CORRECT

RIGHT ANSWER

OK D. HSG

WHY THIS IS RIGHT

Cervical factor infertility occurs when abnormalities in cervical mucus or cervical anatomy --> interfere with sperm transport through the cervix.

- Tests used to evaluate cervical factor:
- Huhner test (Postcoital test) -> evaluates interaction between sperm and cervical mucus after intercourse during ovulation
- Postcoital test -> assesses sperm motility and survival in cervical mucus
- Sims test -> evaluates sperm penetration through cervical mucus

These tests help determine whether cervical mucus is hostile to sperm.

- *Test not used for cervical factor:*
- *Hysterosalpingography (HSG)* ; it evaluates:-
- Uterine cavity abnormalities
- Tubal patency

It does not assess cervical mucus or sperm-cervical interaction--> so it is not used to evaluate cervical factor infertility.

*

QUESTION

A 15-year-old girl is brought to the OPD due to primary amenorrhea. Her height and weight are at the 60th percentile. Vital signs are normal. Physical examination shows Tanner stage IV breast development and pubic hair, normal external female genitalia, and axillary hair. Pelvic ultrasonography shows absence of the uterus. Which of the following is the most likely cause of this patient's condition?

- A** Complete defect in androgen receptor function
- B** Congenital absence of an X chromosome
- C** Defective conversion of testosterone to dihydrotestosterone
- D** Developmental failure of Müllerian duct formation

CORRECT

RIGHT ANSWER

- OK** **D. Developmental failure of Müllerian duct formation**

WHY THIS IS RIGHT

Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome results from failure of Müllerian duct development, leading to --> congenital absence of the uterus and upper vagina.

- Primary amenorrhea
- Normal breast and pubic hair development
- Normal external female genitalia
- Normal ovarian function (46,XX karyotype)
- Absent uterus on ultrasound

> Pathophysiology:

- Müllerian ducts normally form the uterus, fallopian tubes, cervix, and upper two-thirds of the vagina.
- Failure of their development causes uterine agenesis, while ovaries remain normal because they arise from gonadal ridges.

QUESTION

The results of semen analysis of a young male have been given below. What is the appropriate diagnosis?

- Sperm concentration: 5 million/mL
- Progressive motility: 50%
- Normal morphology: 8%

A Oligospermia

CORRECT

B Teratozoospermia

C Asthenozoospermia

D Oligoasthenoteratozoospermia

RIGHT ANSWER

OK A. Oligospermia

WHY THIS IS RIGHT

Oligospermia is defined as a reduced sperm concentration (<15 million sperm/mL) on semen analysis (according to WHO criteria)

Interpretation of the given semen analysis:

- Sperm concentration: 5 million/mL -> Low (oligospermia)
- Progressive motility: 50% -> Normal
- Normal morphology: 8% -> Normal ($\geq 4\%$ normal forms by strict criteria)

> Why other options are incorrect:

>

> * Asthenozoospermia: decreased motility ($<32\%$ progressive).

> * Teratozoospermia: abnormal morphology ($<4\%$ normal forms).

> * Oligoasthenoteratozoospermia : reduction in count, motility, and morphology simultaneously.

*

QUESTION

| What is the likely diagnosis?



A Hydrosalpinx

CORRECT

B Ovarian cancer

C Endometriosis

D Dermoid cyst

RIGHT ANSWER

OK A. Hydrosalpinx

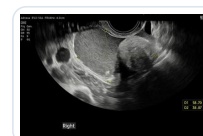
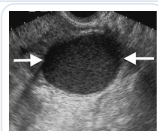
WHY THIS IS RIGHT

Cogwheel sign is due to longitudinal folds seen in a dilated fallopian tube filled with fluid.

- It is characteristic of chronic hydrosalpinx.

Ovarian carcinoma: A cyst with suspicious features

- Dermoid cyst: Heterogenous/ Dot-dash, Rokitansky nodule
- Endometrioma: Ground glass appearance with dense echoes



QUESTION

A 25-year-old woman with primary infertility is found to have bilateral tubal block on HSG. The next best step is?

A Laparoscopy with chromopertubation

CORRECT

B IVF

C IUI

D Letrozole

RIGHT ANSWER

OK

A. Laparoscopy with chromopertubation

WHY THIS IS RIGHT

HSG is a screening test for tubal patency.

- HSG findings must be confirmed --> by laparoscopy with chromopertubation.
- This allows direct visualization and dye testing for tubal patency.

> IVF is considered only after confirmation, IUI and Letrozole are ineffective with bilateral block.

>

- Methylene blue dye injected through cervix

↓

Dye passes through uterus

↓

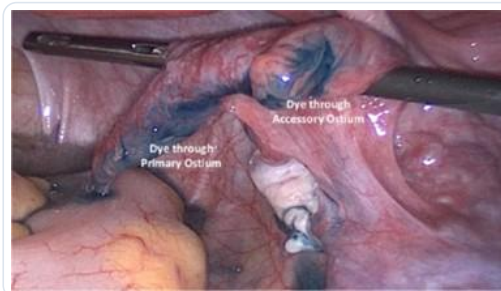
Spillage from fimbrial end

↓

Confirms tubal patency

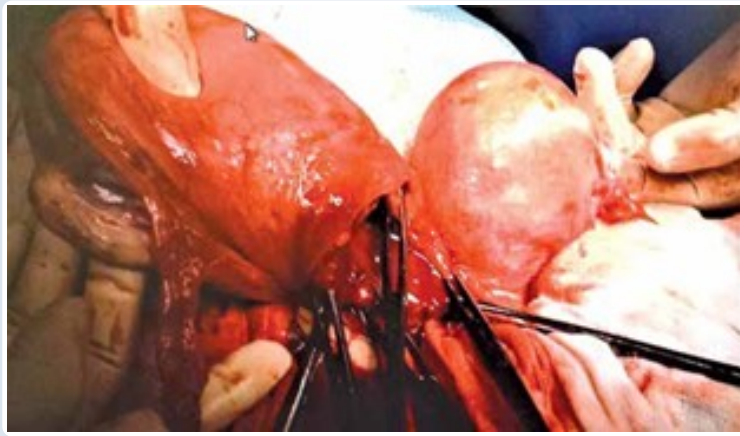
If no dye spill is seen, tubal obstruction is confirmed.

*



QUESTION

LSCS (Lower Segment Cesarean Section) for breech was done. Intraoperatively, finding is shown. What is the diagnosis?



- A Arcuate uterus
- B Bicornuate uterus
- C Unicornuate uterus
- D Uterine didelphys**

CORRECT

RIGHT ANSWER

- OK
- D. Uterine didelphys**

WHY THIS IS RIGHT

Presence of two separate uterine cavities indicates uterine didelphys. --> results from failure of Müllerian duct fusion.

> Arcuate uterus shows only mild indentation, bicornuate has one cervix, and unicornuate has a single horn.

The female reproductive tract develops from Müllerian ducts.

Two Müllerian ducts develop

↓

Fusion normally occurs

↓

Single uterus formed

• In uterine didelphys:

Complete failure of fusion

↓

Two separate uterine cavities

↓

Two cervices (sometimes double vagina)

*

QUESTION

A 28-year-old woman with a history of multiple sexual partners presents with lower abdominal pain for 1 month. She experiences minimal discharge and complaints of intermenstrual bleeding. What is the most likely cause?

A Herpes simplex

B Genital tuberculosis

C Candida

D **Neisseria gonorrhoea**

CORRECT

RIGHT ANSWER

OK

D. Neisseria gonorrhoea

WHY THIS IS RIGHT

History of *multiple partners*, *chronic lower abdominal pain*, *abnormal bleeding* and *per vaginal discharge* are *suggestive of pelvic inflammatory disease.*

- Among the given options, N. gonorrhoea is a classic sexually transmitted pathogen causing PID.

Common causative organisms:

Organism	Type
Neisseria gonorrhoeae	STI
Chlamydia trachomatis	STI
Mixed anaerobes	Secondary infection

- Mechanism of upstream infection:-

Sexually transmitted infection

↓

Cervicitis

↓

Ascending infection

↓

Endometritis and salpingitis

↓

Pelvic inflammatory disease

This leads to pelvic pain and abnormal bleeding.

*

QUESTION

A 23-year-old woman accompanied by her mother-in-law comes to the infertility clinic. She has been having regular intercourse for 6 months but is not able to conceive. What is the next best step?

A Semen analysis for husband

B Reassure and review the couple after 6 months

CORRECT

C Hysterolaparoscopy

D Diagnostic hysteroscopy

RIGHT ANSWER

OK

B. Reassure and review the couple after 6 months

WHY THIS IS RIGHT

Infertility is defined as failure to conceive after 12 months of unprotected intercourse in women <35 years.

- She has tried only for 6 months--> so no investigation is indicated yet.
- Reassurance and review after another 6 months is appropriate. If >35yrs, evaluation can start at 6months.
- With regular intercourse : The chance of conception per cycle $\approx$ 20-25%

Cumulative probability:

Duration	Chance of conception
3 months	$\sim$ 50%
6 months	$\sim$ 75%
12 months	$\sim$ 85%

Infertility is diagnosed only after 12 months of trying (<35 years).

- Situation | Action |
- | ----- | ----- |
- | Young (<35), <12 months trying | ☐ Reassure |
- | $\geq$ 12 months trying | Start workup |
- | Red flags (amenorrhea, PID, etc.) | Early workup |

QUESTION

In which of the following conditions, hysteroscopy can be done?

A Tubal ligation

B Asherman syndrome

CORRECT

C Endocervical polyp

D Subserosal fibroid

RIGHT ANSWER

OK

B. Asherman syndrome

WHY THIS IS RIGHT

It is characterized by fibrous adhesions inside the uterine cavity--> Causes of Asherman Syndrome

Common causes include:

Cause	Example
Post-curettage trauma	After abortion
Postpartum curettage	Retained placenta
Uterine surgery	Myomectomy

Asherman syndrome consists of intrauterine adhesions and hysteroscopy is the investigation and treatment of choice (hysteroscopic adhesiolysis).

- Hysteroscopy is both diagnostic and therapeutic.

Direct visualization of uterine cavity

↓

Identify intrauterine adhesions

↓

Hysteroscopic adhesiolysis

- Tubal ligation is laparoscopic, subserosal fibroids are extrauterine, and endocervical polyps are usually removed by simple excision.

QUESTION

A 14-year-old girl presents with primary amenorrhea. Examination reveals normal breast development with absent axillary and pubic hair. Pelvic examination shows a normally developed vagina with clitoromegaly and a microphallus. Ultrasound reveals masses in the inguinal region. What is the most likely diagnosis?

- A Complete androgen insensitivity syndrome
- B Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome
- C Partial androgen insensitivity syndrome**
- D Gonadal dysgenesis

CORRECT

RIGHT ANSWER

- OK
- C. Partial androgen insensitivity syndrome**

WHY THIS IS RIGHT

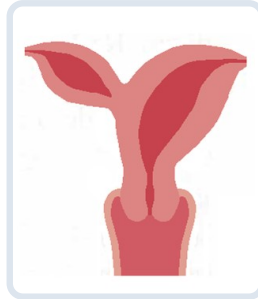
Partial androgen insensitivity syndrome (PAIS) is a disorder of sex development (DSD) caused by partial resistance of tissues to androgens due to mutations in the androgen receptor.

- 46, XY karyotype
- Testes present (often located in inguinal canal or abdomen)
- Variable virilization due to partial androgen action
- Ambiguous genitalia (e.g., clitoromegaly or microphallus)
- Primary amenorrhea
- Breast development may be present due to aromatisation of testosterone to estrogen
- Reduced or absent pubic/axillary hair due to impaired androgen effect
- Why other options are incorrect:
 - Complete androgen insensitivity syndrome (CAIS): normal female external genitalia ; without clitoromegaly.
 - MRKH syndrome: 46,XX with normal pubic/axillary hair and absent uterus/vagina, normal ovaries.
 - Gonadal dysgenesis: streak gonads and poor breast development.

*

QUESTION

The following image shows an uterine anomaly. This anomaly occurs due to which of the following developmental defects?



- A** Mesonephric duct; complete non-fusion
- B** Para mesonephric duct; complete non-fusion
- C** Mesonephric duct; partial fusion
- D** Para mesonephric duct; partial fusion

CORRECT

RIGHT ANSWER

- OK** **D. Para mesonephric duct; partial fusion**

WHY THIS IS RIGHT

The female reproductive tract develops from the Paramesonephric Duct, also known as the Müllerian duct.

These ducts form:

Structure formed Organ
----- ----
Fallopian tubes From upper duct
Uterus Fusion of both ducts
Cervix From fused ducts
Upper vagina From fused ducts

Mechanism of the Anomaly

Two paramesonephric ducts develop

↓

They normally fuse in midline

↓

Uterus and cervix formed

If fusion is incomplete or partial: Müllerian duct anomaly develops

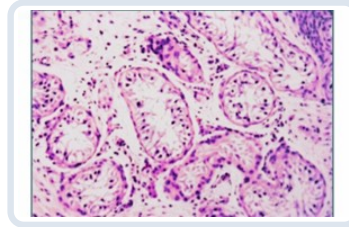
In this case: Partial fusion defect of paramesonephric ducts

Common uterine anomalies arise due to fusion or resorption defects-

Defect Resulting anomaly
----- -----
Complete non-fusion Uterus didelphys
Partial fusion Bicornuate uterus
Failure of septal resorption Septate uterus
Complete agenesis MRKH syndrome

QUESTION

A 25-year-old male patient is evaluated for primary infertility. Semen analysis shows azoospermia. A testicular biopsy is done and the image is shown below. The shown finding is consistent with?



A Sertoli cell only syndrome

CORRECT

B Testicular atrophy

C Benign testicular neoplasm

D Orchitis

RIGHT ANSWER

OK A. Sertoli cell only syndrome

WHY THIS IS RIGHT

Sertoli Cell Only Syndrome is a cause of non-obstructive azoospermia. Normal seminiferous tubules contain:

- Spermatogonia
- Spermatocytes
- Spermatids
- Sertoli cells

In Sertoli cell only syndrome:

Seminiferous tubules

↓

Germ cells absent

↓

Only Sertoli cells remain

↓

No spermatogenesis

↓

Azoospermia

| Type | Cause |

| --- | ---- |

| Obstructive | Vas deferens obstruction |

| Non-obstructive | Spermatogenic failure |

B) Testicular atrophy

Shows shrunken seminiferous tubules, not selective germ cell absence.

C) Benign testicular neoplasm

Shows tumor cells, not normal Sertoli cells.

D) Orchitis

Shows inflammatory infiltrates and edema.

QUESTION

An 18-year-old woman comes to the OPD with primary amenorrhea. Ambiguous external genitalia were noted at birth, and a laparotomy performed at 17 months of age revealed a normal uterus and fallopian tubes. An ovarian biopsy at that time shows normal-appearing primordial follicles. Her blood pressure is 120/78 mm Hg, and height is 160 cm (5 ft 3 in). She has nodulocystic acne over the chest and back. There is no breast development, normal pubic and axillary hair, and marked clitoromegaly. Laboratory investigations reveal a normal female karyotype (46,XX), normal glucose, and normal serum electrolytes. Serum FSH, LH, testosterone, and androstenedione levels are elevated. Pelvic imaging shows multiple ovarian cysts. Which of the following is the most likely?

A Aromatase deficiency

CORRECT

B Congenital adrenal hyperplasia

C Kallmann syndrome

D Swyer syndrome

RIGHT ANSWER

OK A. Aromatase deficiency

WHY THIS IS RIGHT

Aromatase deficiency is a rare disorder in which the enzyme aromatase (which converts androgens to estrogens) is deficient.

Clinical features:

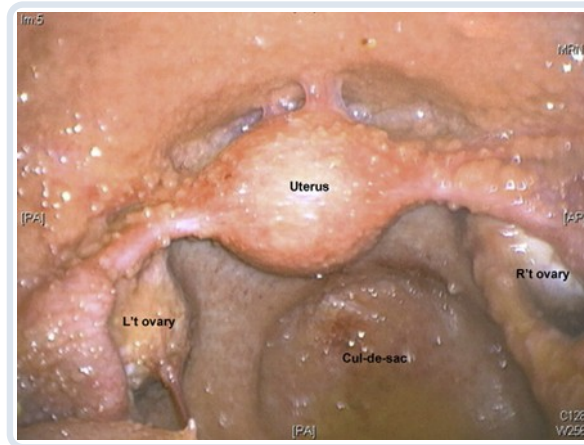
- Primary amenorrhea
- Ambiguous genitalia or clitoromegaly
- No breast development due to lack of estrogen
- Normal uterus and ovaries
- Normal pubic/axillary hair because androgens are present
- Elevated FSH and LH due to lack of estrogen feedback
- Ovarian cysts due to gonadotropin stimulation
- Severe acne from androgen excess

Differentiation from other conditions:

- CAH: electrolyte abnormalities and adrenal androgen excess
- Kallmann syndrome: low FSH/LH with anosmia
- Swyer syndrome: 46,XY gonadal dysgenesis with streak gonads

QUESTION

A 25-year-old woman whose last delivery was 5 years back presents with secondary amenorrhea of 2 years. She does not bleed on giving estrogen and progesterone. A laparoscopy shows the following. What is the diagnosis?



A Endometriosis

B Fibroids

C Sarcoidosis

D Genital TB

CORRECT

RIGHT ANSWER

OK

D. Genital TB

WHY THIS IS RIGHT

Absence of withdrawal bleeding after estrogen-progesterone challenge indicates endometrial damage. Laparoscopic caseous nodules and tubercles are classic for genital tuberculosis, which destroys the endometrium and causes amenorrhea.

QUESTION

A 20-year-old woman is evaluated for primary infertility. Hysterosalpingography reveals the given finding. What is the anomaly seen?



A Septate uterus

B Uterine didelphys

C Bicornuate uterus

CORRECT

D Unicornuate uterus

RIGHT ANSWER

OK

C. Bicornuate uterus

WHY THIS IS RIGHT

HSG showing two closely placed cavities with a narrow angle ($<75^\circ$) suggests a septate uterus. Widely divergent horns ($>105^\circ$) indicate bicornuate, and didelphys shows two completely separate cavities. It occurs due to partial failure of fusion of the paramesonephric (Müllerian) ducts during embryonic development. Characteristic feature: Two uterine horns giving a “heart-shaped” or “rabbit-ear” appearance.

During development:

Two Müllerian ducts

↓

Fusion in midline

↓

Formation of uterus

If fusion fails partially:

Partial fusion defect

↓

Two uterine horns

↓

Bicornuate uterus

Bicornuate uterus = partial fusion defect of Müllerian ducts.

QUESTION

Based on this laparoscopic image showing free spillage on chromotubation in an infertility patient, what is the most likely diagnosis?



A Endometriosis

B Ovarian cyst

C PCOS

CORRECT

D Tubo ovarian mass

RIGHT ANSWER

OK

C. PCOS

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1b" here and does not include a written explanation for this item.

QUESTION

| Which of these is not a test for the measurement of ovarian reserve?

A Serum FSH in the early follicular phase

B Antral follicular count

C Anti mullerian hormone

D Serum Estradiol in the early follicular phase

CORRECT

RIGHT ANSWER

OK D. Serum Estradiol in the early follicular phase

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A 14-year-old girl presents with primary amenorrhea. On examination, a bluish hue is seen in vagina. What is the most likely cause?

A Imperforate Hymen

CORRECT

B Transverse vaginal septum

C Mayer-Rokitansky-Küster-Hauser syndrome

D OHVIRA syndrome

RIGHT ANSWER

OK A. Imperforate Hymen

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1d” here and does not include a written explanation for this item.

QUESTION

A couple has been attempting to conceive for the past two years with unprotected intercourse yet without success. What percentage of infertile women have unexplained infertility?

A 5%

B 10%

C 15%

CORRECT

D 20%

RIGHT ANSWER

OK
C. 15%

WHY THIS IS RIGHT

Infertility is defined as:

- Failure to conceive after 12 months of regular unprotected intercourse.

Evaluation usually includes assessment of:

- Ovulation
- Tubal patency
- Uterine cavity
- Male factor

If all tests are normal but pregnancy still does not occur, the condition is called unexplained infertility.

Unexplained infertility occurs when:

- Ovulation is normal
- Tubes are patent
- Semen analysis is normal
- No uterine pathology is detected

Yet the couple is unable to conceive.

Prevalence- Approximately 10-20% of infertile couples have unexplained infertility.

Major steps in infertility evaluation:

Investigation Purpose
----- -----
Semen analysis Male factor
Ovulation assessment (progesterone, LH) Ovulatory function
Hysterosalpingography (HSG) Tubal patency
Ultrasound pelvis Ovarian and uterine structure
Laparoscopy Endometriosis or adhesions

QUESTION

Based on this laparoscopic image showing free spillage on chromopertubation in an infertility patient, what is the most likely diagnosis?



A Endometriosis

B Ovarian cyst

C PCOS

CORRECT

D Tubo ovarian mass

RIGHT ANSWER

OK C. PCOS

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1e" here and does not include a written explanation for this item.

QUESTION

| Which of these is not a test for the measurement of ovarian reserve?

A Serum FSH in the early follicular phase

B Antral follicular count

C Anti mullerian hormone

D Serum Estradiol in the early follicular phase

CORRECT

RIGHT ANSWER

OK D. Serum Estradiol in the early follicular phase

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

A 14-year-old girl is brought to the hospital by her mother because she has not started menstruating. She is otherwise healthy and has no chronic medical conditions. The patient takes no daily medications and does not use tobacco, alcohol, or illicit drugs. She is not sexually active. Her mother and older sister underwent menarche at age 13. Height is at the 15th percentile and weight is at the 20th percentile for age. Vital signs are normal. Physical examination shows normal heart sounds without murmur. There is no breast development or axillary hair. The abdomen is soft, nontender, and nondistended. Pelvic examination reveals normal external female genitalia and no pubic hair. Ultrasound confirms the presence of a uterus. Which of the following is the best next step in management of this patient?

A Estrogen level

B FSH level

CORRECT

C GnRH stimulation test

D Karyotype analysis

RIGHT ANSWER

OK B. FSH level

WHY THIS IS RIGHT

In primary amenorrhea with absent secondary sexual characteristics, the first investigation is measurement of serum FSH to determine whether the cause is gonadal failure (hypergonadotropic hypogonadism) or hypothalamic-pituitary dysfunction (hypogonadotropic hypogonadism).

- Interpretation:
- High FSH -> Primary ovarian failure/gonadal dysgenesis (e.g., Turner syndrome).
- Low or normal FSH -> Hypothalamic or pituitary cause (e.g., delayed puberty, GnRH deficiency).
- Key points in this patient:

Primary amenorrhea

- No breast development or pubic hair
- Uterus present on ultrasound
- This suggests lack of oestrogen production, so the next step is FSH measurement.

*

QUESTION

A 16-year-old girl presents with a 3-week history of nausea, increased urinary frequency, and breast tenderness. She has never had a menstrual period. She is actively involved in her school's volleyball team. She is 173 cm tall and weighs 54 kg (BMI 18 kg/m²). Breast and pubic hair development are Tanner stage V. Which of the following serum assays is the most appropriate next step in diagnosis?

A Estriol

B TSH

C Human chorionic gonadotropin

CORRECT

D Luteinizing hormone

RIGHT ANSWER

OK

C. Human chorionic gonadotropin

WHY THIS IS RIGHT

In the evaluation of primary amenorrhea, the first step is always to rule out pregnancy, regardless of the patient's age or reported menstrual history.

This patient has:

- Primary amenorrhea (no menarche)
- Normal secondary sexual characteristics (Tanner stage V)

Symptoms suggestive of pregnancy:

- Nausea
- Breast tenderness
- Urinary frequency

These symptoms strongly suggest pregnancy, so the most appropriate initial test is measurement of serum or urine β -hCG (human chorionic gonadotropin).

> Why other options are incorrect

>

- > • TSH -> evaluated after pregnancy is excluded if endocrine causes are suspected.
- > • LH -> used to assess ovarian failure or hypothalamic causes later in the workup.
- > • Estriol -> mainly used in fetal/placental assessment during pregnancy.

QUESTION

In which of the following patients is a karyotype most likely required?

- A** 20-year-old with amenorrhea and hirsutism
- B** 18-year-old with amenorrhea and an elevated prolactin level
- C** 16-year-old with amenorrhea with normal secondary sexual characters and no mullerian structures on sonography **CORRECT**
- D** 16-year-old with amenorrhea with normal secondary sexual characters and uterus seen on imaging

RIGHT ANSWER

- OK** **C. 16-year-old with amenorrhea with normal secondary sexual characters and no mullerian structures on sonography**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$19" here and does not include a written explanation for this item.

QUESTION

A 16-year-old girl presents in OPD with complaints of cyclical pain in abdomen. On examination, a suprapubic bulge can be seen in the pelvic area. PR examination reveals a swelling in the anterior aspect. What is the most likely diagnosis?

A Transverse vaginal septum above the vagina

B Vaginal atresia

C Imperforate hymen

CORRECT

D Cervical agenesis

RIGHT ANSWER

OK C. Imperforate hymen

WHY THIS IS RIGHT

Cyclical pain with outflow obstruction and suprapubic bulge plus PR swelling along the anterior wall indicate hematocolpos due to imperforate hymen (cryptomenorrhea). Transverse septum and vaginal atresia present differently and do not show a tense bulging hymen. It is the most common obstructive anomaly of the female genital tract. Normally the hymen perforates before birth.

In imperforate hymen:

Hymenal membrane fails to perforate

↓

Menstrual blood cannot exit

↓

Blood accumulates in vagina

↓

Hematocolpos

| Feature | Reason |

| ----- | ----- |

| Primary amenorrhea | Menstrual blood cannot exit |

| Cyclical abdominal pain | Uterine contractions during menses |

| Suprapubic mass | Accumulated blood |

| Bluish bulging hymen | Blood behind hymen |

QUESTION

A 16-year-old girl is seen for primary amenorrhea. She has not development of breasts or hair in the pubic or axillary region. Her height is 155cm and her weight is 48 kg. She has bilateral inguinal masses. On USG examination, the uterus, fallopian tube, and ovary are absent. What is the most likely diagnosis?

A Complete androgen insensitivity syndrome

B Hypergonadotropic hypogonadism

CORRECT

C Turner syndrome

D Polycystic ovary syndrome

RIGHT ANSWER

OK

B. Hypergonadotropic hypogonadism

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1a” here and does not include a written explanation for this item.

QUESTION

A 16-year-old girl presents with primary amenorrhea. On examination, breast development is present but pubic and axillary hair are absent. Ultrasound shows an absent uterus. Karyotype is 46,XY. What is the most likely diagnosis?

A Androgen insensitivity syndrome

CORRECT

B Mullerian agenesis

C 46XY gonadal dysgenesis

D Turner syndrome

RIGHT ANSWER

OK **A. Androgen insensitivity syndrome**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

A patient develops secondary amenorrhea for 9 months following a dilatation and curettage (D&C). Both the progesterone challenge test and the estrogen + progesterone challenge test are negative. What is the most probable diagnosis?

A Asherman syndrome

CORRECT

B Premature ovarian failure

C PCOS

D Sheehan syndrome

RIGHT ANSWER

OK

A. Asherman syndrome

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1c” here and does not include a written explanation for this item.

QUESTION

12-year-old girl is brought to the OPD by her mother because she has not started menstruating. Height is at the 15th percentile and weight is at the 20th percentile for age. Vital signs are normal. There is no breast development or axillary hair. Pelvic examination reveals normal external female genitalia and no pubic hair. Ultrasound confirms the presence of a uterus. Which of the following is the best next step in management of this patient?

A Reassurance

CORRECT

B Serum FSH level

C Serum B-HCG

D Karyotype analysis

RIGHT ANSWER

OK A. Reassurance

WHY THIS IS RIGHT

Evaluation of primary amenorrhea is guided by age and presence of secondary sexual characteristics.

- Primary amenorrhea is investigated when:
 - o No menarche by 15 years with secondary sexual characteristics, or
 - o No secondary sexual characteristics by 13 years

Case interpretation:

- Patient is 12 years old
- No breast development, pubic hair, or axillary hair
- Uterus present on ultrasound
- Age is below the threshold for evaluation

At this stage, absence of secondary sexual characteristics may represent normal variation or constitutional delay of puberty.

Therefore, the best next step is reassurance with periodic follow-up rather than immediate investigations.

QUESTION

A 12-year-old girl is brought to the OPD by her mother because she has not yet started menstruating. Her height is at the 15th percentile and weight is at the 20th percentile for age. Vital signs are normal. There is no breast development or axillary hair. Pelvic examination reveals normal external female genitalia with no pubic hair. Ultrasound confirms the presence of a uterus. Which of the following is the best next step in management?

A Reassurance

CORRECT

B FSH level

C Serum B-HCG

D Karyotype analysis

RIGHT ANSWER

OK

A. Reassurance

WHY THIS IS RIGHT

Evaluation of primary amenorrhea depends on the age and development of secondary sexual characteristics. Definition of primary amenorrhea:

- No menarche by age 15 with secondary sexual characteristics, or
- No menarche by age 13 with no secondary sexual characteristics

In this case:

- Age 12 years
- No breast development (Tanner stage I)
- No pubic/axillary hair
- Uterus present on ultrasound

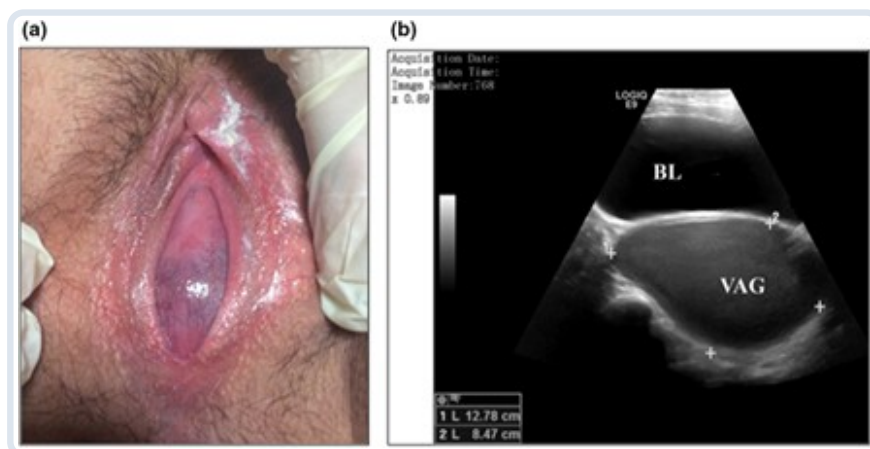
Since she is only 12 years old, she does not yet meet the age criteria for primary amenorrhea evaluation. Absence of secondary sexual characteristics at this age may still be physiologically normal (constitutional delay of puberty). Therefore, the best next step is reassurance and observation.

Investigations like FSH or karyotype are indicated only if:

- Age ≥ 13 with no secondary sexual characteristics, or
- Age ≥ 15 with no menarche.

QUESTION

A 16 year old girl with primary amenorrhea with secondary sexual characters present, uterus and ovaries present with an image as shown. What is the likely karyotype?



A 45 XO

B 46 XX

CORRECT

C 47 XXY

D 46 XY

RIGHT ANSWER

OK

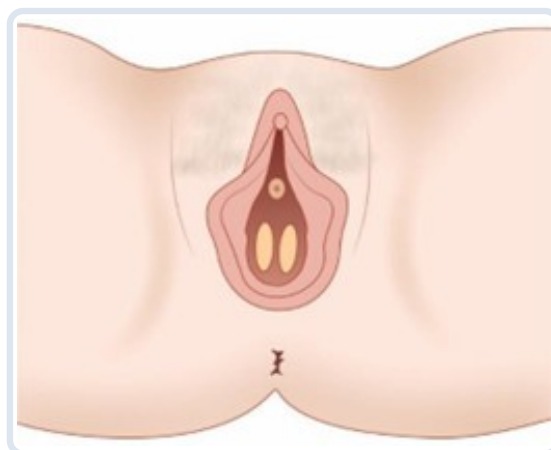
B. 46 XX

WHY THIS IS RIGHT

Primary amenorrhea with secondary sexual characteristics and normal uterus + ovaries and bluish bulge with USG suggesting blood accumulation in the vagina suggests imperforate hymen, which has a 46 XX karyotype, since internal structures are normal.

QUESTION

Identify the type of hymen shown in the image.



A Imperforate hymen

B Semilunar hymen

C **Septate hymen**

CORRECT

D Annular hymen

RIGHT ANSWER

OK C. **Septate hymen**

WHY THIS IS RIGHT

Septate Hymen

In this condition, a fibrous band runs across the hymenal opening, dividing it into two openings. The hymen forms from the junction of the Müllerian ducts and urogenital sinus.

Incomplete degeneration of hymenal membrane

↓

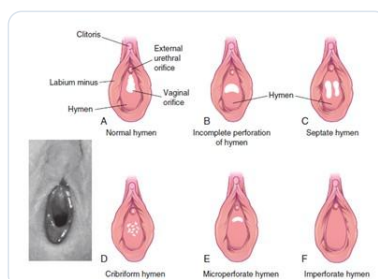
Persistence of central septum

↓

Septate hymen

Treatment is simple:

- Minor surgical excision of the septum
- Done under local anesthesia



QUESTION

A 35-year-old woman with secondary amenorrhea shows high FSH/LH and AMH 0.05. What is the most likely diagnosis?

A PCOD

B Premature ovarian failure

CORRECT

C Hyperprolactinemia

D Sheehan syndrome

RIGHT ANSWER

OK

B. Premature ovarian failure

WHY THIS IS RIGHT

Primary Ovarian Insufficiency is defined as: Loss of ovarian function before 40 years of age

It results in amenorrhea, estrogen deficiency, and elevated gonadotropins.

Hormone	Level
FSH	↑ High
LH	↑ High
Estrogen	↓ Low
AMH	↓ Very low

AMH reflects ovarian reserve. Very low AMH suggests depleted follicles.

Clinical Features

Feature	Explanation
Secondary amenorrhea	Loss of ovulation
Infertility	No follicular development
Hot flashes	Estrogen deficiency
Vaginal dryness	Hypoestrogenism

Causes of Premature Ovarian Failure

Cause	Example
Genetic	Turner syndrome
Autoimmune	Autoimmune oophoritis
Iatrogenic	Chemotherapy / radiotherapy
Idiopathic	Most common

QUESTION

A young girl presents with retention of urine and cyclical abdominal pain. On examination, there is a tense bluish bulge seen at the introitus. The diagnosis is?

A Imperforate hymen

CORRECT

B Transverse vaginal septum

C Vertical vaginal septum

D Mullerian agenesis

RIGHT ANSWER

OK A. Imperforate hymen

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

An 18-year-old girl with primary amenorrhea presents to the OPD. She has Tanner stage IV secondary sexual characters. Her karyotype is 46XX. FSH is 5 and LH is 13. What is the likely diagnosis?

A Gonadal dysgenesis

B Mullerian agenesis

CORRECT

C Kallmann syndrome

D Androgen insensitivity syndrome

RIGHT ANSWER

OK B. Mullerian agenesis

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

A 24-year-old athlete woman with secondary amenorrhea. Biochemical evaluation reveals LH=0.3, FSH=2, BMI 17.5. She likely suffers from which of the following conditions?

- A** Primary ovarian insufficiency
- B** Hypogonadotropic hypogonadism
- C** Hypergonadotropic hypogonadism
- D** Normogonadotropic normogonadism

CORRECT

RIGHT ANSWER

- OK** **B. Hypogonadotropic hypogonadism**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1f” here and does not include a written explanation for this item.

QUESTION

A 42-year-old woman presents to a district hospital in India with 6 months of heavy menstrual bleeding and fatigue. BMI is 33 kg/m². She has no intermenstrual bleeding. Urine pregnancy test is negative. The exam is normal. A bimanual exam suggests a normal-sized uterus. What is the most appropriate next step to evaluate the cause of bleeding?

- A Start tranexamic acid and review in 3 months
- B Endometrial biopsy directly without imaging
- C Transvaginal ultrasound as the first-line investigation**
- D Diagnostic hysteroscopy for all cases

CORRECT

RIGHT ANSWER

- OK C. Transvaginal ultrasound as the first-line investigation**

WHY THIS IS RIGHT

In women with abnormal uterine bleeding (AUB), the first-line investigation is transvaginal ultrasound (TVS) to evaluate uterine and endometrial pathology.

- Assess endometrial thickness
- Detect fibroids, polyps, adenomyosis
- Evaluate ovaries and adnexa

If TVS shows endometrial thickening or suspicious lesions, then endometrial biopsy or hysteroscopy is performed.

QUESTION

Which of the following is a false statement regarding uterine artery embolization (UAE) for fibroids?

- A Done under radiological guidance
- B PVA particles and glue are used as embolising agents
- C Ovarian failure is one possible complication
- D It can be done in nulliparous women**

CORRECT

RIGHT ANSWER

- OK
- D. It can be done in nulliparous women**

WHY THIS IS RIGHT

Uterine artery embolization (UAE) is a minimally invasive radiological procedure used to treat symptomatic uterine fibroids by blocking their blood supply.

- Performed under fluoroscopic/radiological guidance.
- Embolizing agents such as polyvinyl alcohol (PVA) particles or glue are used.
- A possible complication is ovarian failure due to reduced ovarian blood supply.

UAE is not preferred in women desiring future fertility (e.g., nulliparous women) because it may affect uterine and ovarian function.

QUESTION

A 48-year-old postmenopausal woman presents with vaginal bleeding. Transvaginal ultrasound shows an endometrial thickness of 6 mm. What is the next best step in management?

A

EA/ECC

CORRECT

B

Start tamoxifen therapy

C

Hysterectomy

D

Perform saline infusion sonohysterography

RIGHT ANSWER

OK

A. EA/ECC

WHY THIS IS RIGHT

Postmenopausal bleeding (PMB) must always be evaluated to exclude endometrial malignancy.

Role of Transvaginal Ultrasound (TVS):

- Endometrial thickness ≤ 4 mm -> Low risk of malignancy -> Usually observation.
- Endometrial thickness > 4 mm -> Endometrial sampling is required to rule out pathology such as Endometrial cancer or Endometrial hyperplasia.

In this case:

- Postmenopausal bleeding + endometrial thickness 6 mm (> 4 mm)

-> Next step: Endometrial aspiration / Endometrial curettage (EA/ECC) for histopathological diagnosis.

- > Why other options are incorrect:

>

> * Tamoxifen therapy: Not a treatment here; it can actually increase the risk of endometrial pathology.

> * Hysterectomy: Definitive treatment but not done before histologic confirmation.

> * Saline infusion sonohysterography: Useful for evaluating focal intrauterine lesions (polyps, submucous fibroids) but biopsy is required first in PMB with thickened endometrium.

QUESTION

A 42-year-old woman, gravida 4 para 4, presents with heavy and painful menstrual bleeding for the past 3 months. Her last menstrual period was 3 weeks ago. Menarche occurred at age 10, and her cycles last 3-5 days every 30 days. She is sexually active and denies dyspareunia. She underwent bilateral tubal ligation 3 years ago. On bimanual exam, the uterus is uniformly enlarged and tender. Urine hCG is negative. Which of the following is the most likely cause of her symptoms?

- A** Benign myometrial smooth muscle cell proliferation
- B** Blastocyst implantation in the fallopian tube
- C** Endometrial glands and stroma within the myometrium CORRECT
- D** Localized overgrowth of endometrium into the uterine cavity

RIGHT ANSWER

- OK** C. Endometrial glands and stroma within the myometrium

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$19” here and does not include a written explanation for this item.

QUESTION

A 25-year-old woman with a submucosal fibroid is undergoing hysteroscopic myomectomy using 1.5% glycine as the distension medium. During surgery, a 500 mL fluid deficit is noted. What is the next best step?

- A** Stop the surgery
- B** Change the fluid to normal saline
- C** Continue the surgery with careful monitoring of fluid status
- D** Give furosemide to the patient and continue surgery

CORRECT

RIGHT ANSWER

OK

C. Continue the surgery with careful monitoring of fluid status

WHY THIS IS RIGHT

During hysteroscopic procedures, distension media (eg, 1.5% glycine) are used to expand the uterine cavity for visualisation.

These hypotonic, electrolyte-free fluids can be absorbed into the systemic circulation, potentially causing fluid overload and hyponatremia.

Therefore, fluid deficit (difference between infused and recovered fluid) must be carefully monitored.

Recommended limits for fluid deficit:

- Hypotonic fluids (eg, 1.5% glycine, sorbitol, mannitol): ---> ≤ 1000 mL in healthy women
- Isotonic fluids (eg, normal saline, Ringer lactate): ≤ 2500 mL

In this case, the fluid deficit is 500 mL, which is below the safety threshold, so the procedure can be continued with close monitoring.

When to stop the procedure:

- Fluid deficit ≥ 1000 mL with hypotonic media.
- Signs of hyponatremia, pulmonary edema, or fluid overload.

QUESTION

A 39-year-old nulliparous woman presents to the OPD with pelvic pressure and constipation that have progressively worsened over the past year. She frequently experiences a sensation of incomplete evacuation after defecation. Her menstrual cycles are regular (every 28 days) without heavy bleeding or severe pain. She has no dyspareunia and uses of condoms for contraception. Examination reveals an irregularly enlarged uterus and normal rectal tone. What is the most likely etiology of this patient's constipation?

- A** Adenomyosis
- B** Posterior subserosal uterine leiomyoma

CORRECT

- C** Posterior vaginal wall prolapse
- D** Rectovaginal endometriosis

RIGHT ANSWER

- OK** **B. Posterior subserosal uterine leiomyoma**

WHY THIS IS RIGHT

A posterior subserosal uterine leiomyoma (fibroid) can cause pressure symptoms by compressing adjacent pelvic organs, particularly the rectum, leading to constipation and a sensation of incomplete evacuation.

- Subserosal fibroids grow outward from the uterine surface.
- When located posteriorly, they may compress the rectum.
- This results in pelvic pressure, constipation, and tenesmus-like symptoms.
- Menstrual cycles may remain normal because subserosal fibroids usually do not distort the endometrial cavity.

Constipation with pelvic pressure and an irregularly enlarged uterus in a reproductive-age woman suggests a posterior subserosal leiomyoma causing rectal compression.

QUESTION

A pregnant woman with a fibroid uterus develops severe acute abdominal pain at 28 weeks' gestation. There is no history of fever, and the white blood cell count is 8,000 cells/ μ L. What is the most likely diagnosis?

A Red degeneration of fibroid

B Preterm labor

C Torsion of fibroid

CORRECT

D PID

RIGHT ANSWER

OK C. Torsion of fibroid

WHY THIS IS RIGHT

Torsion of a pedunculated fibroid is a complication of uterine fibroids during pregnancy in which the fibroid twists around its vascular stalk, causing acute ischemia and severe abdominal pain. It should be suspected in a pregnant woman with:

- Known fibroid uterus / Sudden severe abdominal pain
- No fever / Normal or mildly elevated WBC count / Signs of acute abdomen
- A subserosal pedunculated fibroid may twist around its vascular pedicle, leading to:
 - Venous obstruction
 - Ischemia
 - Severe abdominal pain

> Why Other Options Are Incorrect:

>

> * Red degeneration of fibroid: Usually presents with pain, low-grade fever, and leukocytosis due to hemorrhagic infarction.

> * Preterm labor: Characterised by uterine contractions with cervical changes, not isolated severe abdominal pain.

> * PID: Rare in pregnancy and typically presents with fever, leukocytosis, and pelvic infection signs.

QUESTION

A 56-year-old postmenopausal woman presents with irregular vaginal bleeding for the past 4 months. On transvaginal ultrasound, the overall endometrial thickness is 2 mm, but a focal area measures 6 mm. What is the next best step to diagnose the cause of bleeding in this patient?

A Fractional curettage of the endometrium and endocervix

B Dilatation and curettage of the endometrium

C Hysterectomy

D Hysteroscopic inspection with selective biopsy

CORRECT

RIGHT ANSWER

OK

D. Hysteroscopic inspection with selective biopsy

WHY THIS IS RIGHT

In postmenopausal bleeding, transvaginal ultrasound (TVUS) is the initial investigation. An endometrial thickness ≤ 4 mm generally suggests a low risk of endometrial carcinoma. However, the presence of a focal thickened area (as in this case) raises suspicion for localized pathology such as an endometrial polyp or focal carcinoma.

Best diagnostic approach:

- Hysteroscopy with directed (selective) biopsy allows direct visualization of the uterine cavity and targeted sampling of the abnormal area.

Why other options are incorrect:

- Fractional curettage or blind D&C: may miss focal lesions because sampling is not targeted.
- Hysterectomy: not performed without establishing a diagnosis.

QUESTION

A 30-year-old married woman presents for infertility evaluation. Investigations reveal intramural fibroids measuring 7×5 cm and 5×3 cm at the right and left cornual ends of the uterus. Her husband's semen analysis is normal. What is the most appropriate management?

A Uterine artery embolization

B Laparoscopic Myomectomy

CORRECT

C Artificial reproductive techniques

D GnRH analogues

RIGHT ANSWER

OK

B. Laparoscopic Myomectomy

WHY THIS IS RIGHT

Intramural fibroids, especially those large or located near the cornual region --> can impair fertility by distorting uterine architecture, affecting tubal patency, and interfering with implantation.

- In women with infertility and significant intramural fibroids (>4-5 cm), the preferred treatment is myomectomy to restore normal uterine anatomy and improve fertility.

> Why not other options:

> A) Uterine artery embolization: Used for symptomatic fibroids, but not preferred in women desiring fertility (may impair uterine blood supply).

> C) Assisted reproductive techniques: Structural uterine pathology should be corrected first before ART.

> D) GnRH analogues: Cause temporary fibroid shrinkage only; fibroids recur after stopping and do not improve fertility long-term.

QUESTION

A 35-year-old woman (G2P2) is found to have a 2 x 3 cm uterine fibroid on routine pre-placement abdominal and pelvic ultrasonography. She is asymptomatic. What is the next best step in management?



- A** Hysterectomy
- B** Myomectomy
- C** Reassure and follow up
- D** Medical management with combined oral contraceptive pills

CORRECT

RIGHT ANSWER

OK

C. Reassure and follow up

WHY THIS IS RIGHT

Asymptomatic small uterine fibroids discovered incidentally on imaging do not require active treatment.

Management principle:

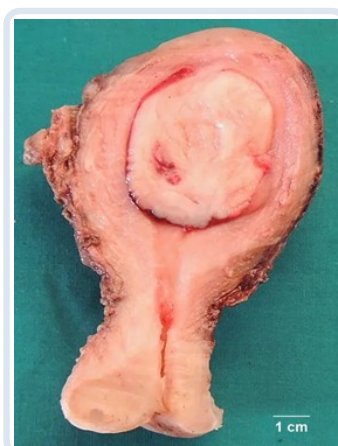
- If the patient is asymptomatic and the fibroid is small (<4-5 cm) -> expectant management with reassurance and periodic follow-up.

Indications for treatment include:

- Heavy menstrual bleeding
- Pelvic pain or pressure symptoms
- Infertility or recurrent pregnancy loss
- Rapidly enlarging fibroid
- Large fibroids causing mass effect
- Why other options are incorrect:
 - Hysterectomy: reserved for symptomatic women who have completed childbearing.
 - Myomectomy: used when symptoms or fertility issues are present.
 - COCPs: used to control symptoms like heavy bleeding, not for asymptomatic fibroids.

QUESTION

Identify the image.



A Fibroid

CORRECT

B Adenomyosis

C Endometrial polyp

D Endometrial cancer

RIGHT ANSWER

OK A. Fibroid

WHY THIS IS RIGHT

A well-circumscribed whitish lesion in uterine cavity is a submucosal fibroid. Fibroids are benign smooth muscle tumors, distinct from adenomyosis (diffuse thickening), polyps (soft mucosal growths), or cancer (irregular invasive mass). Depending on location:

Type Location
--- -----
Intramural Within uterine wall
Submucosal Beneath endometrium
Subserosal Beneath serosa

Submucosal fibroids are most associated with abnormal uterine bleeding (AUB).

QUESTION

A 40-year-old woman presents with heavy menstrual bleeding and something coming out of the vagina. Her last childbirth was 10 years back. On bimanual palpation, the uterus is palpable. On examination, the cervix admits 1 finger, and the following is seen. What is the probable diagnosis?



A Adenomyoma

B **Leiomyomatous polyp**

CORRECT

C Intramural fibroid

D Inversion

RIGHT ANSWER

OK **B. Leiomyomatous polyp**

WHY THIS IS RIGHT

Heavy bleeding with a mass protruding through cervix suggests a Leiomyomatous polyp.

Leiomyomatous Polyp-It is a type of submucosal fibroid that grows inside the uterine cavity and may prolapse through the cervical os.

It is a submucosal fibroid extending into uterine cavity and vagina. Adenomyoma is intramural, inversion presents with absent uterine fundus in the context of shock during labour. Mass through cervix + uterus palpable -> prolapsed fibroid polyp.

Management usually includes:

- Vaginal myomectomy (polypectomy)

If multiple fibroids are present:

- Hysterectomy may be considered.

QUESTION

A 49-year-old well-off businesswoman presents with irregular, heavy bleeding. Her mother tells her this is normal at her age, but she seeks medical advice. What is the next best step?

A Start her on HRT

B Reassure

C Endometrial ablation

D TVS

CORRECT

RIGHT ANSWER

OK

D. TVS

WHY THIS IS RIGHT

Abnormal Uterine Bleeding is common in perimenopausal women due to hormonal imbalance but must always be evaluated to rule out pathology.

Common causes are classified using the PALM-COEIN system.

Structural causes	Non-structural causes
P - Polyp	C - Coagulopathy
A - Adenomyosis	O - Ovulatory dysfunction
L - Leiomyoma	E - Endometrial
M - Malignancy	I - Iatrogenic
	N - Not classified

In perimenopausal women (40+ years) with heavy bleeding: irregular cycles may be normal but heavy bleeding always requires evaluation with endometrial sampling to exclude malignancy, hyperplasia, and structural lesions before considering any treatment options. TVS is needed to see any structural cause and endometrial thickness.

QUESTION

| Which of the following statements is true regarding endometrial hyperplasia?

A Diagnosed by a hysteroscopic guided biopsy or a D & C

CORRECT

B After biopsy, no other follow-up is required

C Hysterectomy should be done in all cases

D Majority will regress without any treatment

RIGHT ANSWER

OK A. Diagnosed by a hysteroscopic guided biopsy or a D & C

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

A 40-year-old woman presents with a history of abdominal discomfort and abdominal pain. What is the most likely diagnosis?

A Adenomyosis

CORRECT

B Fibroid

C Endometriosis

D Endometrial hyperplasia

RIGHT ANSWER

OK A. Adenomyosis

WHY THIS IS RIGHT

Adenomyosis is a condition where *endometrial tissue grows inside the uterine muscle (myometrium)*. This leads to:

- Diffuse uterine enlargement
- Painful menstruation
- Heavy menstrual bleeding

Imaging Findings (TVS)

- Heterogeneous myometrium
- Myometrial cysts
- Globular uterus

MRI *may show junctional zone thickening (>12 mm).*

QUESTION

A 46-year-old nulliparous woman is found to have an endometrial thickness of 16 mm on TVS. What is the most appropriate next step in management?

A Endometrial biopsy

CORRECT

B Hysterectomy

C Reassure

D Repeat TVS after 1 month

RIGHT ANSWER

OK A. Endometrial biopsy

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1b" here and does not include a written explanation for this item.

QUESTION

A 45-year-old woman with irregular bleeding is found to have an endometrial thickness of 15 mm. What is the most appropriate next step in management?

A Endometrial biopsy

CORRECT

B Hysterectomy

C MRI Pelvis

D Hysteroscopy and fractional curettage

RIGHT ANSWER

OK A. Endometrial biopsy

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A 45-year-old woman with irregular bleeding is found to have an endometrial thickness of 15 mm. What is the most appropriate next step in management?

A Endometrial biopsy

CORRECT

B Hysterectomy

C MRI Pelvis

D Hysteroscopy and fractional curettage

RIGHT ANSWER

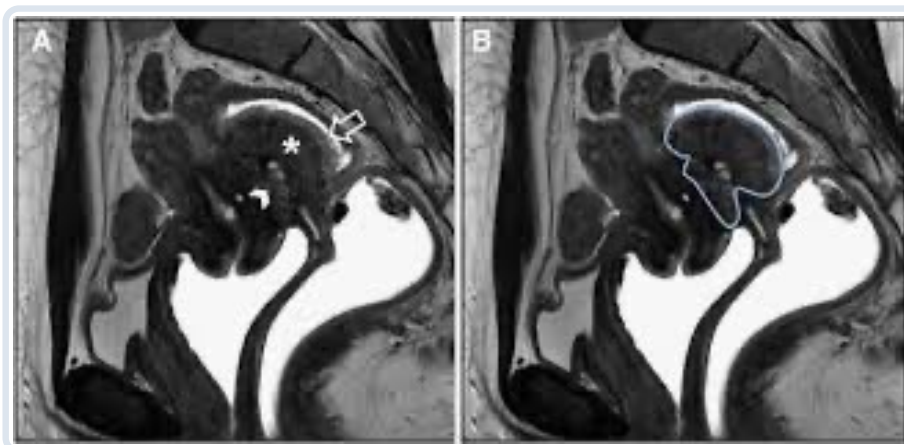
OK A. Endometrial biopsy

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

A 36-year-old woman has severe dyschezia and cyclical rectal pain. MRI suggests deep rectosigmoid endometriosis. The MRI sign as shown in the image is classically associated with deep rectosigmoid endometriosis. What is this sign called?



A Double decidual sac sign

B Mushroom cap sign

CORRECT

C Cogwheel sign

D Beads-on-string sign

RIGHT ANSWER

OK

B. Mushroom cap sign

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

A 14-year-old girl presents to a government adolescent clinic with severe progressive dysmenorrhea since menarche, deep dyspareunia is not applicable, and a tender adnexal mass is felt on bimanual examination. Ultrasound suggests an ovarian cyst with internal echoes. There is no history of sexual activity. What is the most important associated condition to suspect in her?

A Mullerian malformation

CORRECT

B Cervical carcinoma

C Premature ovarian insufficiency

D Polycystic ovarian syndrome

RIGHT ANSWER

OK **A. Mullerian malformation**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

Arrange the following sites of endometriosis in decreasing order of frequency of involvement:

1. Pouch of Douglas
2. Uterosacral ligament
3. Broad ligament
4. Ovary
5. Fallopian tube

A 4 > 5 > 2 > 1 > 3

B 4 > 1 > 3 > 2 > 5

CORRECT

C 4 > 5 > 1 > 3 > 2

D 5 > 4 > 2 > 3 > 1

RIGHT ANSWER

OK B. 4 > 1 > 3 > 2 > 5

WHY THIS IS RIGHT

Endometriosis most commonly involves pelvic organs and peritoneal surfaces, particularly areas where retrograde menstruation implants endometrial tissue.

Decreasing Order of Frequency:

1. Ovary (most common)
2. Pouch of Douglas
3. Broad ligament
4. Uterosacral ligament
5. Fallopian tube

The ovary is the most frequent site due to formation of endometriomas ("chocolate cysts").

*

QUESTION

A 27-year-old woman presents for evaluation of infertility. She has been unable to conceive for the past 2 years. Her menses occur at 45-80 day intervals. She is 168 cm (5 ft 6 in) tall and weighs 77 kg (170 lb); BMI is 27.4 kg/m². Physical examination reveals facial acne and pigmented hair on the upper lip. Serum studies show elevated testosterone levels and an LH:FSH ratio of 4:1. Treatment with the appropriate drug for this patient's infertility is initiated. Which of the following is the primary mechanism of action of this drug?

- A** Activation of pituitary dopamine receptors
- B** Inhibition of endometrial progesterone receptors
- C** Activation of ovarian luteinizing hormone receptors
- D** Inhibition of hypothalamic estrogen receptors

CORRECT

RIGHT ANSWER

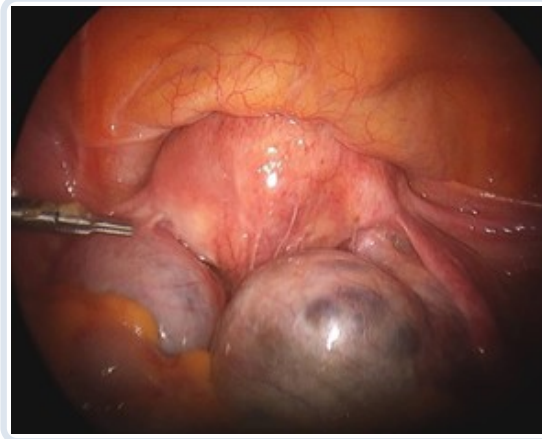
- OK** **D. Inhibition of hypothalamic estrogen receptors**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A 34-year-old woman is undergoing diagnostic laparoscopy for infertility. The laparoscopic image is shown reveals characteristics pelvic findings. What is the likely diagnosis?



- A** Adenomyosis
- B** Endometriosis
- C** Polycystic ovary syndrome (PCOS)
- D** Salpingitis

CORRECT

RIGHT ANSWER

B. Endometriosis

WHY THIS IS RIGHT

Endometriosis is characterized by the presence of functional endometrial tissue outside the uterine cavity. Commonly involving the ovaries, pelvic peritoneum, and uterosacral ligaments.

Typical laparoscopic findings:

- “Chocolate cyst” (ovarian endometrioma) containing old altered blood
- Powder-burn or bluish-black lesions on peritoneum
- Pelvic adhesions and fibrosis

Clinical relevance:

- Common cause of infertility and chronic pelvic pain --> May cause dysmenorrhea, dyspareunia, and subfertility
- Laparoscopy is the gold standard for diagnosis.

QUESTION

A group of premenopausal women participate in a clinical trial for a medication administered as a depot intramuscular injection to treat endometriosis. Prior to initiation of therapy, all women had normal premenopausal levels of gonadotropin-releasing hormone (GnRH), follicle-stimulating hormone (FSH), and estrogen. Hormone levels are measured over the next two months, with the following results:

Which of the following medications is most consistent with these findings?

Day	GnRH	FSH	Estrogen
3	Normal	High	High
60	Low	Low	Low

A Clomiphene citrate

B Danazol

C Letrozole

D Leuprolide

CORRECT

RIGHT ANSWER

OK

D. Leuprolide

WHY THIS IS RIGHT

GnRH agonists (e.g., leuprolide) initially cause a transient increase (flare effect) in FSH, LH, and estrogen, followed by downregulation of pituitary GnRH receptors, leading to suppression of GnRH, FSH, and estrogen with continued use.

Mechanism pattern:

- Early phase (first few days): ↑ FSH and ↑ estrogen due to GnRH receptor stimulation
- Chronic use: ↓ GnRH receptor sensitivity → ↓ FSH, ↓ LH → ↓ estrogen

Clinical relevance:

- Used in endometriosis, uterine fibroids, and prostate cancer
- Produces a hypoestrogenic state (medical menopause) that suppresses ectopic endometrial tissue.

QUESTION

A 30-year-old woman presents to the gynecology clinic with severe pelvic pain, especially during menstruation, and dyspareunia for several years. On pelvic examination, there is tenderness of the posterior vaginal fornix and palpable nodules along the uterosacral ligaments. Ultrasound findings are suggestive of endometriosis.

All of the following drugs may be useful in the management of this condition except:



A Medroxyprogesterone acetate

B Cabergoline

C Estradiol

CORRECT

D Letrozole

RIGHT ANSWER

OK C. Estradiol

WHY THIS IS RIGHT

Endometriosis is an estrogen-dependent condition, where ectopic endometrial tissue proliferates in response to estrogen. Therefore, medical therapy focuses on reducing estrogen levels or creating a progesterone-dominant state.

Drugs useful in endometriosis:

- Progestins (e.g., Medroxyprogesterone acetate) -> suppress endometrial proliferation
- Aromatase inhibitors (e.g., Letrozole) -> decrease estrogen production
- Dopamine agonists (e.g., Cabergoline) -> may reduce angiogenesis in endometriotic lesions (experimental/adjunct)

Why estradiol is incorrect:

- Estradiol increases estrogen levels, which stimulates growth of endometriotic implants and worsens symptoms.

QUESTION

A patient comes after 6 months of vaginal delivery with an episiotomy repair with pain at the site of episiotomy which increases during her periods. On palpation, a nodular lesion is felt. The probable diagnosis is?

A Endometriosis

CORRECT

B Retained suture

C Inclusion cyst

D Melanoma

RIGHT ANSWER

OK

A. Endometriosis

WHY THIS IS RIGHT

Endometrial tissue implanted in surgical scar

↓

Hormonal stimulation during menstrual cycle

↓

Bleeding within scar tissue

↓

Painful nodular swelling

Cyclical pain in surgical scar = scar endometriosis

Cyclic pain at scar site with nodular lesion is classic for scar endometriosis.

Ectopic endometrial tissue responds to hormones, causing swelling and pain during menses.

Definitive treatment is: Wide Local Excision--> Hormonal therapy has limited benefit.

- B) Retained suture
- Causes localized discomfort, but not cyclical pain.

C) Inclusion cyst

- Usually painless cystic swelling, not menstrual pain.

D) Melanoma

- Presents as pigmented lesion, unrelated to menstrual cycle.

*

QUESTION

A 36-year-old woman (P2L2) who previously underwent tubectomy and surgical management of endometriosis (adhesiolysis and excision of lesions), now presents with recurrence of the symptoms. What is the definitive treatment for this patient?

- A Hysterectomy alone
- B Hysterectomy with bilateral salpingo-oophorectomy**
- C LNG-IUS
- D Resection of endometriotic nodules

CORRECT

RIGHT ANSWER

- OK
- B. Hysterectomy with bilateral salpingo-oophorectomy**

WHY THIS IS RIGHT

Endometriosis is a chronic estrogen-dependent condition.

Common sites:

- Ovary
- Uterosacral ligaments
- Pelvic peritoneum
- Rectovaginal septum

Definitive Treatment : Total Hysterectomy with Bilateral Salpingo-Oophorectomy (TAH + BSO)

Removes uterus ; Removes ovaries -> eliminates estrogen source

- A) Hysterectomy alone
- Ovaries remain -> estrogen production continues -> recurrence possible.

C) LNG-IUS

Used for symptom control, not definitive treatment.

D) Resection of nodules

Conservative surgery may lead to recurrence.

*

QUESTION

A 34-year-old woman presents with dysmenorrhea. Laparoscopic finding is as shown. What is the diagnosis?



A Endometriosis

CORRECT

B Dermoid cyst

C PID

D Fibroid

RIGHT ANSWER

OK A. Endometriosis

WHY THIS IS RIGHT

A cyst filled with dark brown “chocolate” fluid is an endometrioma, a hallmark of endometriosis.

Ectopic endometrial tissue bleeds cyclically, forming old blood-filled cysts, and dysmenorrhea is the most common presenting symptom.

QUESTION

A woman presents to the emergency department with abdominal pain and fever. On examination, cervical motion tenderness and mucopurulent vaginal discharge are noted. Which of the following investigations will you undertake to definitively establish the diagnosis of pelvic inflammatory disease (PID), according to CDC criteria?

1. Laparoscopy
2. MRI
3. Biopsy and histopathological examination
4. Blood tests for ESR and CRP

A 1, 2, 3, 4

CORRECT

B 1, 3

C 2, 4

D 2, 3, 4

RIGHT ANSWER

OK A. 1, 2, 3, 4

WHY THIS IS RIGHT

Pelvic inflammatory disease is usually diagnosed clinically, but laparoscopy provides definitive confirmation.

- Other investigations just help in supportive diagnosis, but are not confirmatory.
- Early diagnosis is important to prevent infertility and ectopic pregnancy.
- Laparoscopy: Considered the gold standard
- Allows direct visualization of inflamed fallopian tubes, purulent exudate or pelvic adhesions)
- Confirms PID beyond doubt. Hence, definitive

MRI:

- Helpful for complications (e.g., tubo-ovarian abscess) not diagnostic for PID itself.

Biopsy and histopathological examination:

- Endometrial biopsy can show endometritis
- Supports diagnosis but not definitive for PID

Blood tests (ESR, CRP):

- Indicate inflammation, Nonspecific, cannot confirm PID

*

QUESTION

What are the diagnostic criteria for Polycystic Ovary Syndrome (PCOS) as defined by the Modified Rotterdam Criteria?

1. Obesity
2. Delayed menstruation
3. Hirsutism
4. Insulin resistance

A 1, 2 and 3

B 1 and 2

C 2 and 3

CORRECT

D 1 and 4

RIGHT ANSWER

OK

C. 2 and 3

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1d” here and does not include a written explanation for this item.

QUESTION

A young girl presents with menstrual irregularity, acne, increased hair growth with a Ferriman Gallway score of 8, and a BMI of 29. Her mother has diabetes. Which is not a management option?

A OCP

B OCP + Anti androgen

CORRECT

C Yoga + Exercise

D Counsel for metabolic syndrome

RIGHT ANSWER

OK

B. OCP + Anti androgen

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

What are the diagnostic criteria for Polycystic Ovary Syndrome (PCOS) as defined by the Modified Rotterdam Criteria?

1. Obesity
2. Delayed menstruation
3. Hirsutism
4. Insulin resistance

A 1, 2 and 3

B 1 and 2

C 2 and 3

CORRECT

D 1 and 4

RIGHT ANSWER

OK

C. 2 and 3

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1f” here and does not include a written explanation for this item.

QUESTION

A 49-year-old multiparous woman with chronic PID presents with persistent lower abdominal pain.

What is the most appropriate treatment?

- A** Supracervical hysterectomy with bilateral salpingectomy
- B** Radical hysterectomy
- C** Abdominal hysterectomy with bilateral salpingo-oophorectomy CORRECT
- D** Supracervical hysterectomy with tuboplasty

RIGHT ANSWER

- OK** **C. Abdominal hysterectomy with bilateral salpingo-oophorectomy**

WHY THIS IS RIGHT

In chronic pelvic inflammatory disease (PID) with persistent pain and completed family, the definitive treatment is total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH + BSO).

- Removes chronically infected uterus, tubes, and ovaries
- Prevents recurrent infection and chronic pelvic pain
- Preferred in multiparous or perimenopausal women

Why not other options:

- A) Supracervical hysterectomy + bilateral salpingectomy: Cervix and ovaries remain, infection may persist.
- B) Radical hysterectomy: Done for cervical cancer, not PID.
- D) Supracervical hysterectomy + tuboplasty: Tuboplasty is fertility surgery; not useful in chronic PID with completed family.

QUESTION

Which of the following selective estrogen receptor modulators (SERMs) is approved for the treatment of senile vaginitis?

A Ospemifene

CORRECT

B Clomiphene

C Tamoxifen

D Raloxifene

RIGHT ANSWER

OK A. Ospemifene

WHY THIS IS RIGHT

Ospemifene is a selective estrogen receptor modulator (SERM) approved for the treatment of senile (atrophic) vaginitis.

Ospemifene acts as an estrogen agonist on vaginal epithelium, leading to:

- Thickening of the vaginal mucosa
- Improved lubrication
- Reduced vaginal dryness and dyspareunia

> Clinical use: Treatment of dyspareunia and vaginal atrophy in postmenopausal women

Why other options are incorrect:

- Clomiphene-> used for ovulation induction in infertility (PCOS).
- Tamoxifen-> used in estrogen receptor-positive breast cancer.
- Raloxifene-> used for osteoporosis prevention and breast cancer risk reduction.

*

QUESTION

A 29-year-old nulligravid woman presents for evaluation of infertility. She has been unable to conceive for 14 months. One year ago, she stopped taking oral contraceptive pills, which she had used since age 17. Her husband's semen analysis is normal. Four years ago, she had an episode of pelvic tenderness and vaginal discharge that resolved without treatment. Her menses occur at regular 28-day intervals. Prior to marriage, she was sexually active with three male partners and used condoms inconsistently. She is 169 cm (5 ft 6 in) tall and weighs 86 kg (190 lb); BMI is 31.6 kg/m². Physical examination is unremarkable. Which of the following is the most likely cause of this patient's infertility?

- A Insulin resistance
- B Loss of ciliary action**
- C Ectopic endometrial tissue
- D Primary ovarian insufficiency

CORRECT

RIGHT ANSWER

- B. Loss of ciliary action**

WHY THIS IS RIGHT

Tubal factor infertility commonly results from prior pelvic inflammatory disease (PID) due to sexually transmitted infections such as *Chlamydia trachomatis* or *Neisseria gonorrhoeae*.

PID causes inflammation and scarring of the fallopian tubes, which leads to:

- Damage to the ciliated epithelial cells of the tube
- Loss of normal ciliary movement required to transport the ovum toward the uterus
- Tubal obstruction or impaired ovum transport, resulting in infertility or ectopic pregnancy
- Why other options are less likely:
 - Insulin resistance -> associated with PCOS, usually with irregular cycles
 - Ectopic endometrial tissue -> endometriosis, typically causes pelvic pain/dysmenorrhea
 - Primary ovarian insufficiency -> amenorrhea with elevated FSH

QUESTION

A 22-year-old woman comes to the clinic for a routine examination. She is a gymnast. Three months ago, she sustained a vulvar contusion during a competition but otherwise she has been healthy. The patient is sexually active with a male partner and uses an intrauterine device for contraception. She does not use tobacco, alcohol, or illicit drugs. Examination shows a mobile, soft, nontender, flesh-coloured, 2-cm cystic mass at the 4 o'clock position at the base of the left labium majus. Which of the following is the most likely diagnosis for this patient?

A Bartholin duct cyst

CORRECT

B Condylomata acuminata

C Gartner duct cyst

D Hematoma

RIGHT ANSWER

OK

A. Bartholin duct cyst

WHY THIS IS RIGHT

A Bartholin duct cyst occurs due to obstruction of the Bartholin gland duct, leading to accumulation of mucus and formation of a cystic swelling in the posterolateral vaginal introitus.

- Located at 4 o'clock or 8 o'clock position of the vaginal opening
- Soft, cystic, mobile, and usually painless if not infected
- Size may vary from 1-4 cm
- Occurs in sexually active women of reproductive age

When infected, it becomes a Bartholin abscess, presenting with:

- Severe pain
- Tender swelling
- Erythema and difficulty walking/sitting

Why other options are incorrect:

- Condylomata acuminata -> multiple cauliflower-like warts caused by HPV (types 6,11)
- Gartner duct cyst -> arises from mesonephric duct remnants, located on the lateral vaginal wall, not the vulva
- Hematoma -> painful, bluish swelling following trauma

QUESTION

A 30-year-old P1 woman whose last menstrual period was 10 days ago presents to the emergency department with worsening right-sided pelvic pain. The pain began suddenly after bending over to pick up her child, did not respond to acetaminophen, and has worsened intermittently over several hours. She has had two episodes of vomiting. Examination shows abdominal guarding. Transvaginal ultrasound demonstrates an 8-cm enlarged right ovary with high-impedance arterial flow on color Doppler. These findings are most consistent with which diagnosis?

A Appendicitis

B Ovarian torsion

CORRECT

C Haemorrhagic cyst

D Red degeneration of uterus

RIGHT ANSWER

B. Ovarian torsion

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$19” here and does not include a written explanation for this item.

QUESTION

While discharging a patient who underwent a vesicovaginal fistula repair, which of the following would you recommend?

A Sexual abstinence for 3 months and avoid pregnancy for a year

CORRECT

B Sexual abstinence for 3 weeks and avoid pregnancy for 6 months

C Sexual abstinence for 6 weeks and avoid pregnancy for a year

D Sexual abstinence for 6 months and avoid pregnancy for 6 years

RIGHT ANSWER

OK **A. Sexual abstinence for 3 months and avoid pregnancy for a year**

WHY THIS IS RIGHT

Vesicovaginal Fistula

This condition results in continuous leakage of urine through the vagina.

| Cause | Example |

| ---- | ----- |

| Obstructed labor | Most common in developing countries |

| Gynecologic surgery | Post-hysterectomy |

| Radiation therapy | Pelvic cancers |

| Trauma | Difficult instrumental delivery |

Most common cause worldwide -> obstructed labor.

Postoperative Care After VVF Repair

Key recommendations after surgery:

| Advice | Reason |

| ----- | ----- |

| Sexual abstinence for 3 months | Allow complete tissue healing |

| Avoid pregnancy for 1 year | Prevent stress on repair site |

| Continuous bladder drainage | Prevent pressure on suture line |

QUESTION

A 45-year-old woman undergoes a Pap smear as part of a cervical cancer screening program. To preserve the cellular morphology for cytological examination, the smear must be immediately fixed. Which concentration of ethanol is most appropriate for fixation in this case?

A 50% ethanol

B 70% ethanol

C 95% ethanol

CORRECT

D 100% ethanol

RIGHT ANSWER

OK C. 95% ethanol

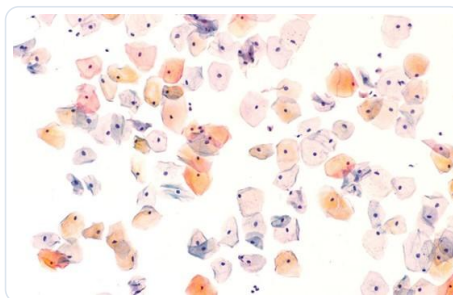
WHY THIS IS RIGHT

Pap smear cytology requires immediate wet fixation to preserve nuclear and cytoplasmic details. 95% ethanol is the standard fixative used to prevent air-drying artifacts.

Normal Pap Smear

Lower concentrations cause cellular swelling, while absolute alcohol leads to excessive dehydration. Thus, 95% ethanol best preserves cellular morphology for cytological evaluation.

Concentration	Use
95% ethanol	Pap smear (best)
70% ethanol	General fixation
100% ethanol	Too harsh
50% ethanol	Inadequate



QUESTION

All of the following are features of granulosa cell tumor of the ovary except:

- A Presence of Call Exner body
- B Expression of inhibin A
- C Coffee bean nucleus
- D Increased CA 125 levels**

CORRECT

RIGHT ANSWER

- OK
- D. Increased CA 125 levels**

WHY THIS IS RIGHT

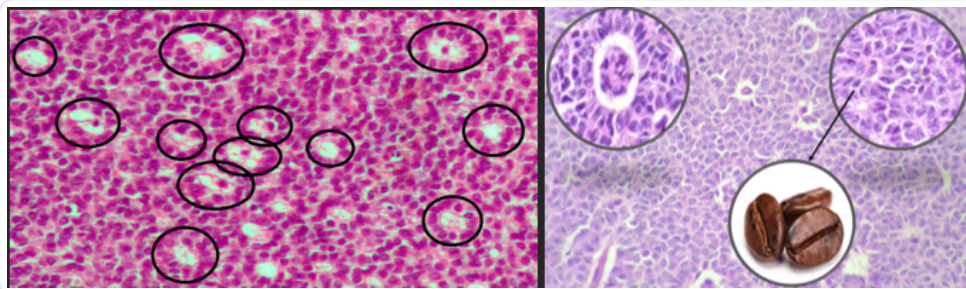
Granulosa cell tumors characteristically show Call-Exner bodies and “coffee-bean” nuclei due to nuclear grooves. They secrete estrogen and express inhibin A, which serves as a useful tumor marker. These tumors are sex-cord stromal in origin, not epithelial.

Call-Exner bodies marked with black circles micrograph of a [granulosa cell tumour](https://en.wikipedia.org/wiki/Granulosa_cell_tumour "Granulosa cell tumour"), a type of sex cord stromal tumour. Think of granulosa tumor as a tiny ovary trying to act like a full endocrine gland

-> making estrogen

-> forming mini follicles (Call-Exner bodies)

CA-125 is typically elevated in epithelial ovarian cancers, not granulosa cell tumors.



QUESTION

Match the following clinical scenarios with the most appropriate management:

1. 35-year-old female with simple endometrial hyperplasia without atypia	A. Cyclical MPA (Provera) 10-20mg
2. 58-year-old female with ET-6mm on TVS	B. High-dose progestin therapy, megestrol acetate 80 mg orally twice daily
3. 35-year-old female with no children simple endometrial hyperplasia with atypia	C. Hysterectomy
4. 53-year postmenopausal female, with endometrial hyperplasia with atypia	D. Endometrial biopsy
	E. Mirena

A 1-A, 2-D, 3-B, 4-C

CORRECT

B 1-A, 2-D, 3-B, 4-E

C 1-D, 2-C, 3-B, 4-E

D 1-B, 2-A, 3-E, 4-C

RIGHT ANSWER

OK A. 1-A, 2-D, 3-B, 4-C

WHY THIS IS RIGHT

Management of endometrial hyperplasia depends on presence of atypia, age, menopausal status, and fertility desire.

1). Simple endometrial hyperplasia without atypia (reproductive age)

-> Cyclic progestin therapy (e.g., Medroxyprogesterone acetate) to counteract unopposed estrogen.

2). Postmenopausal woman with increased endometrial thickness (>4 mm on TVS)

-> Endometrial biopsy to rule out malignancy.

3). Endometrial hyperplasia with atypia in women desiring fertility

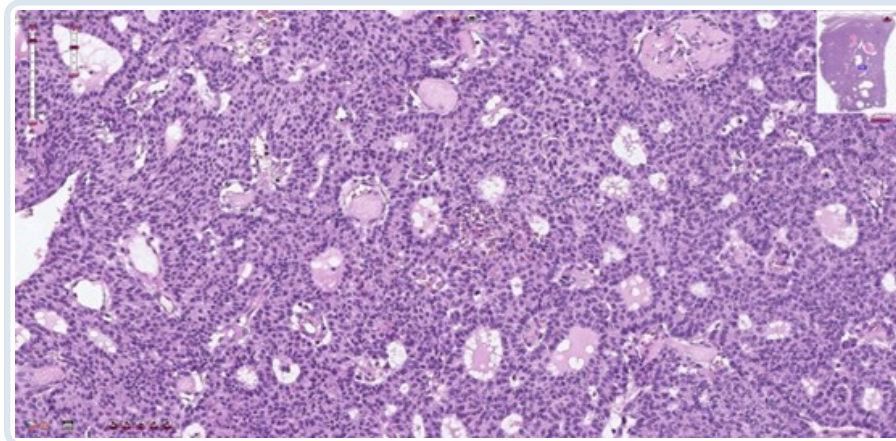
-> High-dose progestin therapy (e.g., Megestrol acetate) with close surveillance.

4). Postmenopausal endometrial hyperplasia with atypia

-> Total hysterectomy due to high risk of progression to endometrial carcinoma.

QUESTION

A 46-year-old woman presents with 4 months of heavy irregular bleeding and breast tenderness. Examination shows a unilateral adnexal mass. TVS shows a solid-cystic ovarian tumor. Endometrial thickness is 16 mm. An HPE from the mass(as shown in the image) shows multiple small follicle-like spaces filled with eosinophilic material and surrounded by uniform tumor cells. Which is the most appropriate additional evaluation for the suspected diagnosis?



A Serum testosterone and DHEAS

B Serum HCG, LDH

C Serum AFP and LDH

D Endometrial sampling

CORRECT

RIGHT ANSWER

OK

D. Endometrial sampling

WHY THIS IS RIGHT

The histology showing multiple follicle-like spaces with eosinophilic material (Call-Exner bodies) surrounded by uniform tumor cells is characteristic of a granulosa cell tumor of the ovary.

Granulosa cell tumors are estrogen-secreting sex-cord stromal tumors. Excess estrogen causes:

- Abnormal uterine bleeding
- Endometrial hyperplasia
- Increased risk of endometrial carcinoma

Because of prolonged unopposed estrogen exposure, patients require endometrial sampling to rule out endometrial hyperplasia or carcinoma.

Why not other options:

- A) Testosterone/DHEAS -> androgen tumors.
B) hCG, LDH -> germ cell tumors.
C) AFP, LDH -> yolk sac/dysgerminoma.

QUESTION

A 32-year-old married woman presents to an NCD clinic screening camp. She is asymptomatic. Cytology (Pap) returns ASC-US. She is not pregnant and is immunocompetent. On speculum exam, cervix looks normal. What is the best next step?

A Reflex HPV DNA testing

CORRECT

B Repeat Pap smear after 1 year

C Immediate colposcopy for all ASC-US

D Start VIA and treat if VIA positive

RIGHT ANSWER

OK

A. Reflex HPV DNA testing

WHY THIS IS RIGHT

ASC-US (Atypical Squamous Cells of Undetermined Significance) on Pap smear is the most common abnormal cervical cytology finding. The recommended next step in women ≥ 30 years who are non-pregnant and immunocompetent is reflex high-risk HPV DNA testing.

- High-risk HPV infection (especially types 16 and 18) is the main cause of Cervical cancer.
- Reflex HPV testing helps triage ASC-US into low-risk vs high-risk groups.

Management based on HPV result:

- HPV positive -> Colposcopy
- HPV negative -> Routine screening (repeat cytology in ~3 years)

Why other options are incorrect:

- Repeat Pap in 1 year: Used mainly when HPV testing is not available or in younger women.
- Immediate colposcopy: Not required for all ASC-US because many cases are transient HPV infections.
- VIA and treat: Used mainly in low-resource "screen-and-treat" programs, not when cytology and HPV testing are available.

QUESTION

Which of the following statements is incorrect regarding Type I endometrial carcinoma?

A It is associated with obesity and diabetes

B Smoking is a high-risk factor

CORRECT

C Endometrioid morphology is typical

D Associated with PTEN mutation

RIGHT ANSWER

OK B. Smoking is a high-risk factor

WHY THIS IS RIGHT

Type I endometrial carcinoma is the estrogen-dependent form of endometrial cancer and usually arises from endometrial hyperplasia.

- Associated with unopposed estrogen exposure
- Common risk factors: obesity, diabetes, PCOS, nulliparity
- Histology: Endometrioid adenocarcinoma
- Common genetic mutation: PTEN

Smoking is not a risk factor for Type I endometrial carcinoma; it may actually reduce estrogen levels and slightly lower risk.

QUESTION

A 40-year-old nulligravida woman comes to the office with a 2-month history of worsening right pelvic pain. She experiences the pain daily, and its intensity does not vary during her menstrual cycle. In addition, the patient's waist size has increased despite a decreased appetite. Pelvic examination shows an irregularly shaped, fixed adnexal mass. One week later, she undergoes surgery to remove a large ovarian neoplasm. Within the true pelvis, the surgeon can most likely palpate the right ureter immediately anterior to which of the following structures?

A Gonadal vein

B Inferior vena cava

C Internal iliac artery

CORRECT

D Uterine artery

RIGHT ANSWER

OK C. Internal iliac artery

WHY THIS IS RIGHT

In the true pelvis, the ureter runs anterior to the internal iliac artery after crossing the pelvic brim.

Important Ureteric Relationships:

- At the pelvic brim -> ureter crosses anterior to the bifurcation of the common iliac artery.
- In the true pelvis -> ureter passes anterior to the internal iliac artery.
- Near the cervix -> "water under the bridge" (ureter passes under the uterine artery).

Knowledge of these relationships is important during pelvic surgeries (e.g., hysterectomy, ovarian tumor surgery) to prevent ureteric injury.

QUESTION

A 30-year-old nulliparous woman comes to the OPD for evaluation of infertility. The patient has been attempting to conceive for the past 2 years. Menarche was at age 11, and her menstrual cycles occur 2-3 times per year and last 7-10 days. BMI is 35 kg/m². Physical examination shows mild acne and hair growth on the upper lip and chin. This patient is at greatest risk for which of the following complications?

A Adrenal atrophy

B Cushing syndrome

C Ovarian carcinoma

D Endometrial carcinoma

CORRECT

RIGHT ANSWER

OK D. Endometrial carcinoma

WHY THIS IS RIGHT

This patient has features of polycystic ovary syndrome (PCOS):

- Oligomenorrhea (cycles 2-3 times/year)
- Infertility
- Obesity (BMI 35)
- Hyperandrogenism (acne, hirsutism)

Pathophysiology:

- Chronic anovulation -> no corpus luteum formation
- Low progesterone levels
- Unopposed estrogen stimulation of the endometrium

Consequence:

- Continuous endometrial proliferation -> endometrial hyperplasia -> increased risk of endometrial carcinoma.

QUESTION

A 35-year-old nulliparous woman is diagnosed with cervical intraepithelial neoplasia grade 3. The patient has been sexually active for 15 years and has had 3 lifetime partners. She has been monogamous with her current partner for several months and has a progestin-releasing intrauterine device for contraception. The patient has never used condoms. Menarche occurred at age 9, and menses recur every 28 days and last 3 days. The patient had a plantar wart a few years ago which resolved on its own, but otherwise has no chronic medical conditions. Her mother was diagnosed with endometrial cancer at age 42. Which of the following factors most significantly contributed to the development of this patient's cervical intraepithelial neoplasia?

- A Early menarche
- B Family history of endometrial cancer History of plantar warts
- C History of plantar warts

D Lack of barrier contraception use

CORRECT

RIGHT ANSWER

OK D. Lack of barrier contraception use

WHY THIS IS RIGHT

The most important risk factor for cervical intraepithelial neoplasia (CIN) is persistent infection with high-risk human papillomavirus (HPV), especially HPV types 16 and 18.

Role of barrier contraception:

- Condoms reduce transmission of HPV during sexual contact.
- Lack of barrier contraception increases the risk of persistent HPV infection, which can lead to CIN and cervical cancer.

Why other options are less relevant:

- Early menarche: not a major risk factor for CIN.
- Family history of endometrial cancer: unrelated to cervical dysplasia.
- Plantar warts: caused by low-risk HPV types that infect skin, not associated with cervical cancer.

QUESTION

Choose the correct order of the following steps performed during a total abdominal hysterectomy:

- A) Clamp, cut, and ligate the infundibulopelvic ligament
- B) Clamp, cut, and ligate uterine vessels
- C) Clamp, cut, and ligate the round ligament
- D) Open the uterovesical fold of the peritoneum

A b-c-d-a

B d-a-b-c

C c-a-d-b

CORRECT

D c-b-d-a

RIGHT ANSWER

OK C. c-a-d-b

WHY THIS IS RIGHT

In a total abdominal hysterectomy (TAH), pedicles are sequentially clamped, cut, and ligated to safely mobilize the uterus while protecting nearby structures (especially the ureter and bladder).

Correct sequence:

1. Round ligament -> opened first to access the broad ligament
2. Infundibulopelvic ligament (ovarian vessels) -> ligated if ovaries are removed
3. Uterovesical peritoneal fold opened -> bladder reflected downward
4. Uterine vessels ligated -> done near the cervix after bladder mobilization

Order:

Round ligament -> Infundibulopelvic ligament -> Uterovesical fold -> Uterine vessels

QUESTION

A 45-year-old woman comes to the OPD due to unintentional weight loss of 6.8 kg over the past 6 months. She has also reported epigastric pain but denies dysphagia, regurgitation, vomiting, or diarrhea. Pelvic ultrasonography shows bilateral complex ovarian masses with solid and cystic components. Chest x-ray is normal. CT scan reveals gastric wall thickening in addition to the ovarian masses. Which of the following is most likely to be seen on histologic evaluation of the ovaries?

- A** Bilobed nuclei and inclusion-like nucleoli
- B** Intercellular bridges and keratin pearls
- C** Mucin-secreting signet ring cells CORRECT
- D** Nests of epithelial cells with abundant clear cytoplasm

RIGHT ANSWER

- OK** **C. Mucin-secreting signet ring cells**

WHY THIS IS RIGHT

Krukenberg tumor refers to metastatic ovarian tumors, most commonly originating from gastric adenocarcinoma.

- Bilateral ovarian masses
- Solid and cystic components
- Associated primary gastric carcinoma
- Histology shows mucin-producing signet ring cells

Gastric cancer spreads to the ovaries via lymphatic or hematogenous routes. Mucin accumulation displaces the nucleus to the periphery, creating the characteristic signet ring appearance. Usually bilateral ovarian involvement

Why not the other options:

- A) Bilobed nuclei and inclusion-like nucleoli -> Seen in papillary thyroid carcinoma, not ovarian metastasis from gastric cancer.
- B) Intercellular bridges and keratin pearls -> Characteristic of squamous cell carcinoma.
- D) Nests of epithelial cells with abundant clear cytoplasm -> Seen in clear cell carcinoma of the ovary or kidney, not metastatic gastric cancer.

QUESTION

A 27-year-old woman presents to the clinic for cervical cancer screening. HPV testing is positive for HPV type 18. What is the next best step in management?

- A LLETZ
- B Acyclovir and review after 6 weeks with repeat testing
- C HPV vaccination

D Colposcopy and biopsy

CORRECT

RIGHT ANSWER

OK D. Colposcopy and biopsy

WHY THIS IS RIGHT

Detection of high-risk HPV types (especially HPV 16 or 18) during cervical cancer screening requires immediate colposcopic evaluation, even if cytology is normal.

- HPV 16 and HPV 18 are the highest-risk oncogenic HPV types associated with cervical intraepithelial neoplasia (CIN) and cervical cancer.
- A positive result for these types warrants colposcopy with directed biopsy to identify any precancerous lesions or early malignancy.

Why other options are incorrect:

- LLETZ: performed only after biopsy confirms high-grade lesions (CIN 2/3).
- Acyclovir: ineffective because HPV is not treated with antivirals.
- HPV vaccination: preventive, not used as treatment for existing infection.

*

QUESTION

| All of the following can be indicators of choriocarcinoma except:

A Increased number of theca lutein cysts

CORRECT

B Persistently enlarged uterus

C Plateau of high serum hCG

D Sub-urethral nodule

RIGHT ANSWER

OK

A. Increased number of theca lutein cysts

WHY THIS IS RIGHT

Choriocarcinoma is a malignant gestational trophoblastic neoplasia characterized by persistent or rising β -hCG levels and early hematogenous metastasis.

Indicators suggestive of choriocarcinoma include:

- Plateau or rise of serum β -hCG levels after evacuation of a molar pregnancy
- Persistently enlarged uterus due to invasive trophoblastic tissue
- Metastatic lesions, which may present as vaginal/sub-urethral nodules (bluish, highly vascular metastases that bleed easily)

Theca lutein cysts, however, are not indicators of choriocarcinoma. They occur due to excess β -hCG stimulation of the ovaries, most commonly seen in hydatidiform mole, multiple pregnancy, or ovarian hyperstimulation. They are benign, bilateral ovarian cysts that usually regress after hCG levels fall.

QUESTION

55-year-old postmenopausal woman comes to the OPD for evaluation of breast tenderness. She has had no breast masses or nipple discharge. The patient has also noticed an increase in her weight, particularly around the abdomen, despite not being able to eat as much. She went through menopause 5 years ago. Breast examination shows bilateral, diffuse fibrocystic changes. The abdomen is distended, and a large right lower quadrant mass is palpable. Pelvic ultrasound reveals a 12-cm complex right ovarian mass with solid components and multiple septations, a slightly enlarged uterus, and a 9-mm endometrial stripe. Which of the following tumor markers is most likely to be elevated in this patient?

A Alpha-fetoprotein

B Estradiol

CORRECT

C hCG

D Lactate dehydrogenase

RIGHT ANSWER

OK B. Estradiol

WHY THIS IS RIGHT

A postmenopausal woman with an ovarian mass and signs of estrogen excess should raise suspicion for a granulosa cell tumor, a type of sex cord-stromal tumor that secretes estrogen (estradiol).

Granulosa cell tumors produce excess estradiol, which causes:

- Endometrial hyperplasia
- Postmenopausal uterine enlargement
- Breast tenderness
- Increased risk of endometrial carcinoma

The tumor marker most likely to be elevated is Estradiol (often also inhibin B, which is commonly used clinically).

Why Other Options Are Incorrect:

- Alpha-fetoprotein (AFP): elevated in yolk sac tumors.
- hCG: elevated in choriocarcinoma or embryonal tumors.
- Lactate dehydrogenase (LDH): elevated in dysgerminoma.

*

QUESTION

A 22-year-old nulligravid woman presents to the OPD with worsening acne on her face and body for the past 6 months. She initially attributed the acne to her diet and has been eating healthier to improve her acne and lose weight. She has lost 6.8 kg over the last 3 months; however, her acne has not improved. Her BMI is 42 kg/m². Coarse hair is noted on the chin and upper lip. Pelvic examination reveals clitoromegaly, with otherwise normal external genitalia. Laboratory evaluation shows elevated total testosterone levels with normal dehydroepiandrosterone sulfate levels. Which of the following is the most likely diagnosis?

A 21-hydroxylase deficiency

B Adrenocortical carcinoma

C Polycystic ovary syndrome

D Sertoli-Leydig cell tumor

CORRECT

RIGHT ANSWER

OK

D. Sertoli-Leydig cell tumor

WHY THIS IS RIGHT

Sertoli-Leydig cell tumors are rare androgen-secreting ovarian tumors that cause rapid virilization in women.

- Marked hyperandrogenism -> severe acne, hirsutism
- Virilization signs -> clitoromegaly, deep voice, male-pattern hair
- Elevated testosterone with normal DHEA-S -> indicates ovarian (not adrenal) source

Testosterone ↑ + DHEA-S normal -> ovarian androgen-secreting tumor (e.g., Sertoli-Leydig cell tumor).

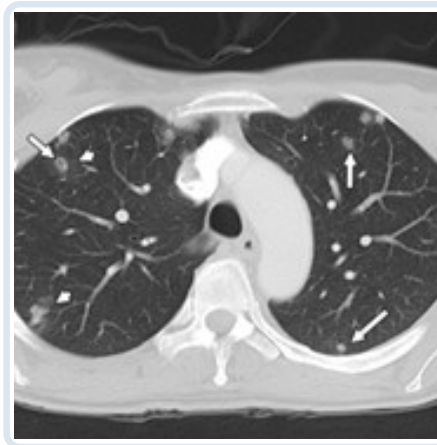
Why not other options:

- A) 21-hydroxylase deficiency: ↑ adrenal androgens -> ↑ DHEA-S (not seen here).
B) Adrenocortical carcinoma: adrenal source -> very high DHEA-S.
C) PCOS: mild hyperandrogenism; virilization (clitoromegaly) uncommon.

QUESTION

A 32-year-old woman presents to the emergency department with vaginal bleeding, pelvic pain, and shortness of breath. She reports having a molar pregnancy that was treated a few months ago. She initially had a complete hydatidiform mole, and dilation and curettage (D&C) was performed. Her human chorionic gonadotropin (hCG) levels remained persistently elevated during the follow-up. On examination, she appears pale and distressed. Vital signs reveal tachycardia and tachypnea. Pelvic ultrasound shows multiple irregular uterine masses. A high-resolution (HRCT) of the chest is shown.

What is the stage of her disease?



A 1

B 2

C 3

CORRECT

D 4

RIGHT ANSWER

OK C. 3

WHY THIS IS RIGHT

Gestational trophoblastic neoplasia (GTN) is staged using the FIGO staging system, which is based on the extent of metastasis. FIGO Staging for GTN:

- Stage I: Disease confined to the uterus
- Stage II: Extends to genital structures (ovary, vagina, broad ligament)
- Stage III: Lung metastasis with or without genital tract involvement
- Stage IV: Metastasis to other distant organs (brain, liver, etc.)

In this case:

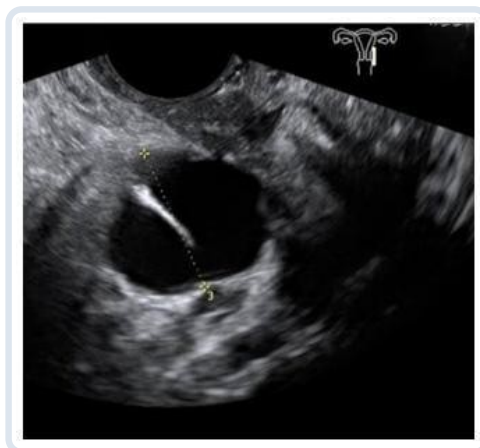
- History of complete hydatidiform mole
- Persistently elevated hCG
- Uterine masses
- Multiple pulmonary nodules on HRCT

These findings indicate metastasis to the lungs -> FIGO Stage III GTN.

QUESTION

Which are the tumor markers for the ultrasound image shown below?

1. CA 125
2. LDH
3. AFP
4. hCG
5. CA 19-9



A 1,2,4

B 2,3,5

C 1,2,3

D 1,2,3,4,5

CORRECT

RIGHT ANSWER

OK D. 1,2,3,4,5

WHY THIS IS RIGHT

Tumor Marker	Associated Ovarian Tumor
CA-125	Epithelial ovarian cancer (especially serous carcinoma)
LDH	Dysgerminoma
AFP	Yolk sac tumor (Endodermal sinus tumor)
β -hCG	Choriocarcinoma, Embryonal carcinoma
CA 19-9	Mucinous ovarian tumors

QUESTION

A 45-year-old woman with a history of cervical erosion and spotting since 2 months. What is the next best step?

A LBC + HPV + cervical biopsy

CORRECT

B Pap smear + HCV

C Pap smear + HBV

D VDRL + Liquid cytology

RIGHT ANSWER

OK **A. LBC + HPV + cervical biopsy**

WHY THIS IS RIGHT

Liquid Based Cytology

Advantages:

- Better sample preservation
- Reduced false negatives
- Allows HPV testing from same sample

Human Papillomavirus

High-risk types:

- HPV 16
- HPV 18

These cause ~70% of cervical cancers.

Cervical Biopsy

This confirms the definitive diagnosis.

Suspicious cervix

↓

Screening test (LBC)

↓

HPV testing

↓

Biopsy for confirmation

In a 45-year-old with persistent spotting and cervical erosion, cervical cancer must be ruled out. Liquid-Based-Cytology + HPV testing is the recommended screening combination. Biopsy is mandatory when symptoms persist or lesion appears suspicious.

QUESTION

A 52-year-old woman came to the OPD with a diagnosis of advanced cervical cancer. She has a 14-year-old daughter. What advice would you give for her daughter?

A Advise HPV vaccine

CORRECT

B Screen for BRCA mutation

C Screen for PTEN mutation

D Perform pap smear

RIGHT ANSWER

OK A. Advise HPV vaccine

WHY THIS IS RIGHT

Most cases of cervical cancer are caused by Human Papillomavirus infection.

High-risk oncogenic types include:

- HPV 16
- HPV 18

These account for ~70% of cervical cancers.

| Age group | Schedule |

| ----- | ----- |

| 9-14 years | 2 doses (0 and 6 months) |

| ≥15 years | 3 doses |

Best time for HPV vaccination is before sexual debut.

Since the daughter is 14 years old, she falls into the ideal vaccination age group.

At 14 years, the best preventive strategy is HPV vaccination (primary prevention). Screening with Pap/HPV testing starts later (usually ≥25 years). BRCA/PTEN mutations are linked to other cancers, not typical cervical carcinoma.

QUESTION

A 52-year-old woman presents with foul-smelling bloody discharge per vagina mixed with mucous discharge. On examination, a necrotizing growth is seen in the cervix with lateral parametrium involvement. What will be the management for this patient?

A Chemotherapy

B Brachytherapy

C Chemoradiation

CORRECT

D Surgery

RIGHT ANSWER

OK C. Chemoradiation

WHY THIS IS RIGHT

Lateral parametrium involvement = FIGO Stage IIB carcinoma cervix. Standard of care from Stage IIB onwards is concurrent chemoradiation (external beam + brachytherapy). Surgery is reserved for earlier stages (up to 2A1). For Stage IIB cervical cancer, the treatment of choice is: Concurrent chemoradiation

This involves:

Treatment	Purpose
External beam radiotherapy	Destroy tumor
Cisplatin	Enhances radiation effect
Brachytherapy	Internal radiation

Once parametrium is involved, surgical removal becomes difficult because:

Tumor extends into parametrium

↓

Cannot obtain clear surgical margins

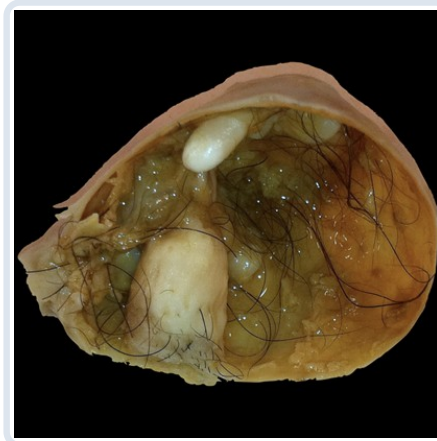
↓

Higher recurrence risk

Thus chemoradiation is preferred.

QUESTION

A female patient undergoes surgery for an abdominal mass associated with pain. The excised specimen appears as shown in the image below. What is the most likely diagnosis?



A Mucinous cystadenoma

B Serous cystadenoma

C Teratoma

CORRECT

D Chocolate cyst

RIGHT ANSWER

OK

C. Teratoma

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

In a Pap smear, which fixative agent is commonly used to fix the slides immediately after sample collection?

A 95% ethanol

CORRECT

B Air fixation

C Mathanol

D 25% ethanol

RIGHT ANSWER

OK A. 95% ethanol

WHY THIS IS RIGHT

Pap Smear is used to detect precancerous and cancerous changes in cervical cells. After collecting the sample, immediate fixation is essential to preserve cellular morphology.

The smear must be fixed immediately after spreading the cells on the slide.

Standard fixative: 95% ethanol

Purpose:

Function	Explanation
Prevent drying artifact	Maintains cell morphology
Preserve nuclear details	Important for detecting dysplasia
Improve staining quality	Essential for Pap stain

Delayed fixation causes:

- Nuclear distortion
- Poor staining
- Diagnostic errors.

The smear is stained using the Papanicolaou Stain.

It helps identify:

- Dysplasia
- Carcinoma in situ
- Cervical cancer.

QUESTION

In the context of cervical cancer screening protocols, co-testing refers to performing which of the following diagnostic tests together?

A HPV testing + Pap smear

CORRECT

B VIA + Pap smear

C Antibody testing + Pap smear

D HPV testing + VIA

RIGHT ANSWER

OK

A. HPV testing + Pap smear

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1b" here and does not include a written explanation for this item.

QUESTION

A 76-year-old woman presented with a non-healing ulcer on the labia majora midline for the past 6 months, measuring 2 cm x 3 cm. No inguinal lymph nodes are palpable. A biopsy shows squamous cell carcinoma. What is the most appropriate management?

A Radical vulvectomy with unilateral lymph node dissection

B Radical vulvectomy with bilateral lymph node dissection

CORRECT

C Simple vulvectomy

D Chemoradiation with resection

RIGHT ANSWER

OK

B. Radical vulvectomy with bilateral lymph node dissection

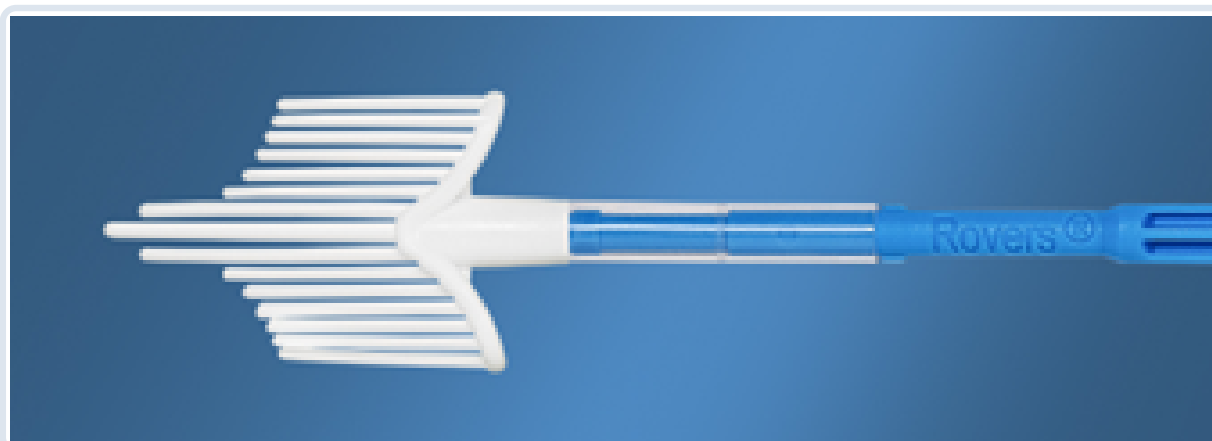
WHY THIS IS RIGHT

In squamous cell carcinoma of the vulva involving the midline (e.g., labia majora, clitoris, posterior fourchette), lymphatic drainage occurs bilaterally to the inguinal lymph nodes. Therefore, the standard surgical management is radical vulvectomy with bilateral inguinal lymph node dissection, even if lymph nodes are not clinically palpable.

- Midline vulvar lesions -> bilateral lymphatic drainage -> bilateral inguinal node dissection required.
- Lateral lesions (>1 cm from midline) may be managed with unilateral node dissection.
- Early-stage disease is primarily treated with surgery, while chemoradiation is reserved for advanced or unresectable disease.

QUESTION

What is correct regarding the use of the instrument shown in the image below?



A Five rotations in the same direction

CORRECT

B Only one full rotation

C One-quarter to one-half rotation

D Four rotations with alternating directions

RIGHT ANSWER

OK A. Five rotations in the same direction

WHY THIS IS RIGHT

The instrument shown is a Cervex-Brush (Rovers brush) used for liquid-based cervical cytology (Pap smear). The correct technique is to rotate the brush 5 times in the same direction at the cervical os to obtain adequate ectocervical and endocervical cells, including cells from the transformation zone.

- Designed to sample both ectocervix and endocervical canal simultaneously.
- Insert central bristles into the external os until lateral bristles contact the ectocervix.
- Rotate 5 times in the same direction to collect sufficient epithelial cells.
- The brush is then rinsed or detached into liquid-based cytology medium.

Clinical significance:

- Ensures adequate sampling of the transformation zone, where most cervical intraepithelial neoplasia (CIN) and cervical cancers arise.

QUESTION

A 27-year-old woman, gravida 2 para 1, at 28 weeks' gestation presents for follow-up of an abnormal Pap test. The Pap smear shows a high-grade squamous intraepithelial lesion (HSIL). Which of the following is the best next step in management?

- A** Human-papillomavirus (HPV) co-testing
- B** Immediate colposcopy
- C** Loop electrosurgical excision procedure (LEEP)
- D** Repeat Pap test postpartum

CORRECT

RIGHT ANSWER

- OK** **B. Immediate colposcopy**

WHY THIS IS RIGHT

In pregnant women with HSIL (High-grade Squamous Intraepithelial Lesion) on Pap smear, the next step is immediate colposcopic evaluation to assess for possible invasive cervical cancer.

- Immediate colposcopy is recommended for HSIL cytology.
- Biopsy can be safely performed if suspicious lesions are seen.
- Excisional procedures (e.g., LEEP) are generally avoided during pregnancy unless invasive cancer is suspected.
- Definitive treatment of CIN 2/3 is usually deferred until postpartum.

Why other options are incorrect:

- HPV co-testing: not useful when HSIL is already detected.
- LEEP: avoided during pregnancy due to risk of bleeding and pregnancy complications unless malignancy suspected.
- Repeat Pap postpartum: delays evaluation and risks missing invasive disease.

QUESTION

A 30-year-old woman undergoes surgery for an ovarian cyst. The specimen image is shown below. Based on the appearance, identify the type of cyst?



A Mature cystic teratoma

CORRECT

B Dysgerminoma

C Serous cystadenoma

D D. Mucinous cystadenoma

RIGHT ANSWER

OK

A. Mature cystic teratoma

WHY THIS IS RIGHT

Mature Cystic Teratoma is the most common benign ovarian tumor in reproductive-age women. It arises from totipotent germ cells, which can differentiate into multiple tissue types.

Typical gross findings:

- Sebaceous material
- Hair
- Teeth or bone
- Thick cyst wall

Characteristic structure: Rokitansky Protuberance

- Dysgerminoma :Features-
- Solid tumor
- Occurs in younger women
- No hair/teeth components.
- Serous Cystadenoma
- Thin-walled cyst
- Clear serous fluid.
- Mucinous Cystadenoma
- Multiloculated cyst
- Thick mucinous fluid.



QUESTION

A patient presented to the OPD as a known case of cervical cancer. On further evaluation, the pelvic side wall was found to be involved, and hydronephrosis was also seen. Identify the stage of cervical cancer.

A 2B

B 3A

C 3B

CORRECT

D 3C

RIGHT ANSWER

OK C. 3B

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1c” here and does not include a written explanation for this item.

QUESTION

A postmenopausal woman with ovarian mass and CA-125 = 1000 U/mL. What is the most probable diagnosis?



CORRECT

A Serous cystadenocarcinoma

B Immature teratoma

C Sertoli cell tumor

D Granulosa cell tumor

RIGHT ANSWER

OK A. Serous cystadenocarcinoma

WHY THIS IS RIGHT

Serous Cystadenocarcinoma is the most common ovarian malignancy, especially in postmenopausal women.

Feature	Explanation
Age	Postmenopausal women
Tumor marker	CA-125 ↑
Laterality	Often bilateral
Gross appearance	Papillary cystic masses

CA-125 is commonly elevated in epithelial ovarian tumors, particularly serous carcinoma.

Interpretation:

CA-125 Level	Significance
<35 U/mL	Normal
Mild elevation	Benign conditions
Very high (>500)	Suggests malignancy

Spread of Serous Ovarian Cancer

Common spread:

- Transcoelomic spread in peritoneal cavity
- Omental metastasis (omental cake)
- Ascites formation

QUESTION

A 54-year-old woman with cervical cancer shows parametrial involvement and bilateral hydroureteronephrosis. What is the FIGO stage?

A Stage IIIA

B Stage IIIB

CORRECT

C Stage IIIC

D Stage IV

RIGHT ANSWER

OK B. Stage IIIB

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

A 65-year-old postmenopausal woman presents with blood-stained vaginal discharge. On examination, her BP is 160/100 mmHg. What is the most appropriate next step in management?

A Urgent cardiology opinion

B TVS

CORRECT

C CECT pelvis

D MRI pelvis

RIGHT ANSWER

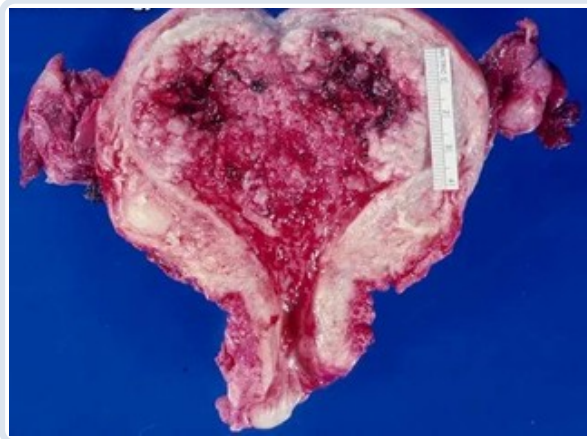
OK B. TVS

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

A hysterectomy specimen was obtained from a woman with postmenopausal bleeding. The cut section of the uterus is examined and shown below. What is the most likely diagnosis?



- A** Fibroid
- B** Adenomyosis
- C** Endometriosis
- D** Endometrial cancer

CORRECT

RIGHT ANSWER

OK

D. Endometrial cancer

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

Which of the following represents the correct sequence of steps for performing a Pap smear?

1. Lithotomy position
2. Per speculum examination
3. Per vaginal examination
4. Take sample with Ayre's spatula

A 1, 2, 3, 4

B 1, 3, 4

C 1, 2, 4

CORRECT

D 1, 3, 2, 4

RIGHT ANSWER

OK C. 1, 2, 4

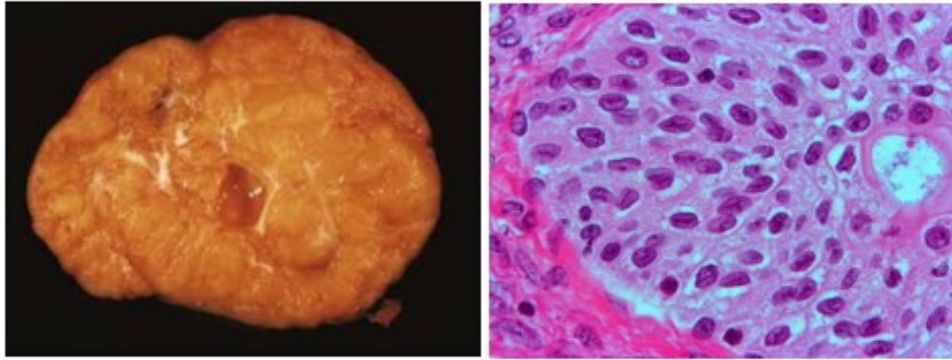
WHY THIS IS RIGHT

The source quiz contains the placeholder "\$20" here and does not include a written explanation for this item.

QUESTION

Based on the gross pathology and histopathology images shown, which of the following statements are correct?

1. It is a sex cord stromal tumor
2. Inhibin-B is increased
3. Ca 125 is raised
4. Call Exner bodies are seen on HPE



A 1, 2, 3 and 4

B 1, 2, 4

C 1 and 4

CORRECT

D 2, 3 and 4

RIGHT ANSWER

OK C. 1 and 4

WHY THIS IS RIGHT

Granulosa cell tumor belongs to sex cord-stromal tumors of the ovary.

Key features

- Usually unilateral
- Yellowish solid tumor (due to lipid content)
- Produces estrogen

Hormonal effect

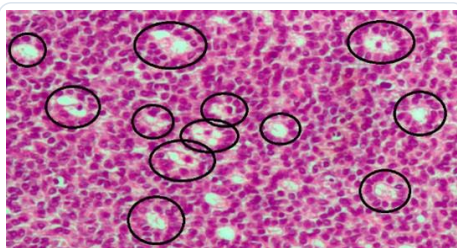
Excess estrogen causes:

- Precocious puberty in children
- Menorrhagia / irregular bleeding in reproductive age
- Postmenopausal bleeding in elderly women

Call-Exner bodies are small follicle-like structures filled with eosinophilic material.

They resemble immature ovarian follicles and are considered the histologic hallmark of granulosa cell tumors.

Granulosa cell tumor = Coffee-bean nuclei + Call-Exner bodies



Tumor	Marker	Key Histology
Granulosa cell tumor	Inhibin	Call-Exner bodies
Dysgerminoma	LDH	Clear cells
Yolk sac tumor	AFP	Schiller-Duval bodies
Choriocarcinoma	β -hCG	Cytotrophoblast + syncytiotrophoblast
Serous carcinoma	CA-125	Psammoma bodies

QUESTION

A 65-year-old postmenopausal woman presents with abdominal distension and discomfort. Imaging reveals an ovarian mass with solid components, ascites, and omental caking. Her serum CA-125 level is markedly elevated at 990 U/mL. What is the most likely diagnosis?

A Mucinous cystadenocarcinoma

B Serous cystadenocarcinoma

CORRECT

C Endometrioid tumor

D Granulosa cell tumor

RIGHT ANSWER

OK

B. Serous cystadenocarcinoma

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$21” here and does not include a written explanation for this item.

QUESTION

A 35-year-old woman presents with intermenstrual bleeding. Atypical glandular cells are seen on a pap smear. What is the most appropriate next step in management?

A Repeat Pap smear after 6 months

B Colposcopy and endometrial sampling

CORRECT

C Punch biopsy from cervix

D Conisation

RIGHT ANSWER

OK B. Colposcopy and endometrial sampling

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$22" here and does not include a written explanation for this item.

QUESTION

Reinke crystals are seen in which of the following gonadal tumours:

A Seminoma

B Yolk sac tumor

C Leydig cell tumor

CORRECT

D Sertoli cell tumor

RIGHT ANSWER

OK C. Leydig cell tumor

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$23" here and does not include a written explanation for this item.

QUESTION

Which of the following is a risk factor for progression to borderline ovarian tumor?

- A OCP
- B Functional ovarian cyst
- C Nulliparity**
- D PCOS

CORRECT

RIGHT ANSWER

- OK C. Nulliparity**

WHY THIS IS RIGHT

Borderline Ovarian Tumor are epithelial tumors that show cellular proliferation and atypia but no stromal invasion. They are also called tumors of low malignant potential (LMP).

Several reproductive factors increase the risk of epithelial ovarian tumors and borderline tumors.

Risk factor	Reason
Nulliparity	More ovulatory cycles
Early menarche	Increased ovulation
Late menopause	Prolonged estrogen exposure
Infertility	Hormonal imbalance

Protective factor	Mechanism
OCP use	Suppresses ovulation
Pregnancy	Anovulation
Breastfeeding	Reduced ovulatory cycles

QUESTION

| What is the antigen present in the recombinant HPV vaccine?

A E1 + E2

B E6 + E7

C L1

CORRECT

D L2

RIGHT ANSWER

OK C. L1

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$24" here and does not include a written explanation for this item.

QUESTION

| Which of the following is a virilizing ovarian tumor?

- A** Brenner tumor
- B** Arrhenoblastoma
- C** Carcinoid tumor of the ovary
- D** Theca cell tumor

CORRECT

RIGHT ANSWER

- OK** **B. Arrhenoblastoma**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$25" here and does not include a written explanation for this item.

QUESTION

| Which of the following is not classified as a germ cell tumor of the ovary?

A Yolk sac tumor

B Dysgerminoma

C Choriocarcinoma

D Granulosa cell tumor

CORRECT

RIGHT ANSWER

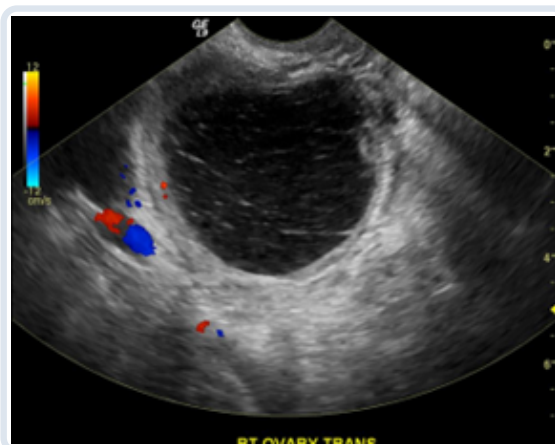
OK D. Granulosa cell tumor

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$26" here and does not include a written explanation for this item.

QUESTION

A 24-year-old P1L1 woman with acute abdominal pain undergoes a USG revealing 6×8 cm ovarian cyst with reticular markings as shown below. She is currently on warfarin. Which of the following is the next best step?



A MRI

B Surgical exploration

C Follow up after 6-8 weeks

CORRECT

D Measure Ca-125

RIGHT ANSWER

OK

C. Follow up after 6-8 weeks

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$27” here and does not include a written explanation for this item.

QUESTION

Dr. Savita is training her interns who are being posted for rural posting. Which is appropriate for cervical cancer screening?

- A Pap smear alone every 5 yearly
- B Pap smear + HPV DNA every 5 yearly
- C Pap smear alone every 3 yearly**
- D Pap smear in high-risk individuals

CORRECT

RIGHT ANSWER

- OK C. Pap smear alone every 3 yearly**

WHY THIS IS RIGHT

Cervical Cancer Screening- The most widely used screening test is the Pap smear (cervical cytology). The Pap smear detects precancerous lesions (CIN) before they progress to invasive cancer. It samples cells from the transformation zone of the cervix, where most cervical cancers originate.

For low-resource settings (such as rural areas), the recommended approach is:

Age Group	Screening Method	Interval
21-29 years	Pap smear alone	Every 3 years
30-65 years	Pap smear every 3 years OR HPV testing	Depending on resources

Because HPV testing may not be widely available in rural setups, Pap smear every 3 years is considered practical and effective.

QUESTION

Which of the following represents the correct sequence of steps for performing a Pap smear?

1. Lithotomy position
2. Per speculum examination
3. Per vaginal examination
4. Take sample with Ayre's spatula

A 1, 2, 3, 4

B 1, 3, 4

C 1, 2, 4

CORRECT

D 1, 3, 2, 4

RIGHT ANSWER

OK C. 1, 2, 4

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$28” here and does not include a written explanation for this item.

QUESTION

Which strain of Human Papillomavirus (HPV) is most commonly linked to the development of cervical cancer?

A 41, 42

B 6, 11

C 16, 18

CORRECT

D 31, 33

RIGHT ANSWER

OK C. 16, 18

WHY THIS IS RIGHT

Persistent infection with high-risk HPV types leads to cervical intraepithelial neoplasia (CIN) and eventually cervical carcinoma.

The two most important oncogenic strains are:

- HPV 16
- HPV 18

Together they cause ~70% of cervical cancers worldwide.

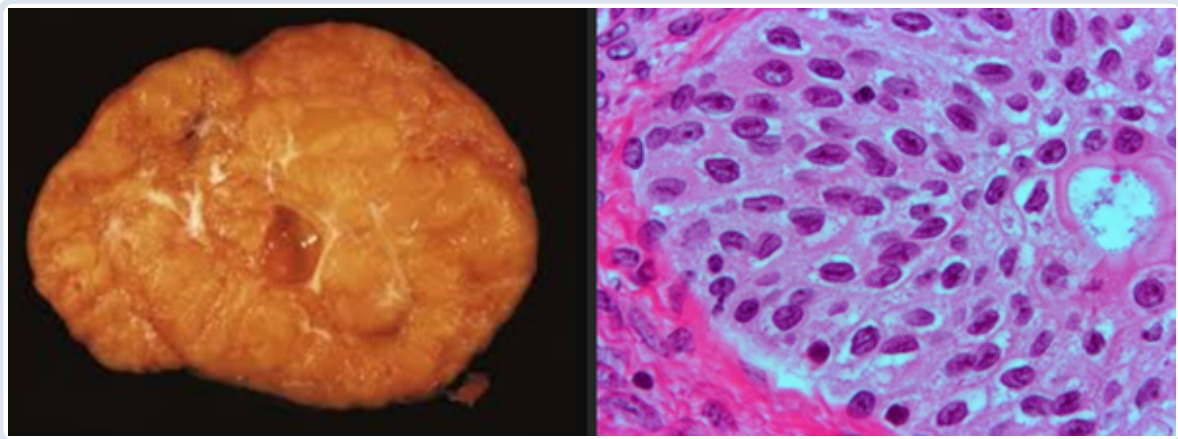
High-risk HPV strains produce two key oncogenic proteins:

Viral Protein	Target	Effect
E6	p53 tumor suppressor	Inhibits apoptosis
E7	Rb tumor suppressor	Uncontrolled cell cycle

QUESTION

Based on the gross pathology and histopathology images shown, which of the following statements are correct?

1. It is a sex cord stromal tumor
2. Inhibin-B is increased
3. Ca 125 is raised
4. Call Exner bodies are seen on HPE



A 1, 2, 3 and 4

B 1, 2, 4

C 1 and 4

CORRECT

D 2, 3 and 4

RIGHT ANSWER

OK

C. 1 and 4

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$29" here and does not include a written explanation for this item.

QUESTION

A 65-year-old postmenopausal woman presents with abdominal distension and discomfort. Imaging reveals an ovarian mass with solid components, ascites, and omental caking. Her serum CA-125 level is markedly elevated at 990 U/mL. What is the most likely diagnosis?

A Mucinous cystadenocarcinoma

B Serous cystadenocarcinoma

CORRECT

C Endometrioid tumor

D Granulosa cell tumor

RIGHT ANSWER

OK

B. Serous cystadenocarcinoma

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2a” here and does not include a written explanation for this item.

QUESTION

A 35-year-old woman presents with intermenstrual bleeding. Atypical glandular cells are seen on a pap smear. What is the most appropriate next step in management?

A Repeat Pap smear after 6 months

B Colposcopy and endometrial sampling

CORRECT

C Punch biopsy from cervix

D Conisation

RIGHT ANSWER

OK B. Colposcopy and endometrial sampling

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2b" here and does not include a written explanation for this item.

QUESTION

A 37-year-old woman, gravida 2 para 1, at 8 weeks' gestation comes to the office for a follow-up visit. Earlier in the pregnancy, the patient had nausea and breast tenderness that resolved several days ago. At her initial prenatal visit 1 week ago, ultrasonography revealed an intrauterine gestational sac with a yolk sac but no fetal pole. The β -hCG level at that visit was 27,325 IU/L. She is taking a prenatal vitamin and does not use tobacco, alcohol, or illicit drugs. Her current blood pressure is 140/80 mm Hg, pulse is 68/min, and BMI is 23 kg/m². Pelvic examination reveals a closed cervix and no vaginal discharge or bleeding. Bimanual examination reveals a normal-sized, retroverted uterus with no cervical motion or adnexal tenderness. A repeat transvaginal ultrasound is unchanged from the prior visit. The β -hCG level is now 25,659 IU/L. Which of the following is the most likely diagnosis?

A Ectopic pregnancy

B Hydatidiform mole

C Missed abortion

CORRECT

D Threatened abortion

RIGHT ANSWER

OK C. Missed abortion

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$19" here and does not include a written explanation for this item.

QUESTION

Which of the following is not considered an advantage of using norgestimate-containing oral contraceptives?

A Reduces acne and hirsutism

B Reduces venous thrombosis

CORRECT

C Lower cardiovascular risk

D Fewer metabolic side effects

RIGHT ANSWER

OK B. Reduces venous thrombosis

WHY THIS IS RIGHT

Norgestimate-containing combined oral contraceptives (COCs) use a third-generation progestin with low androgenic activity.

Advantages:

- Improves acne and hirsutism due to antiandrogenic effect
- Fewer metabolic side effects (less impact on lipids and glucose)
- Lower cardiovascular risk compared with older progestins

Like all estrogen-containing contraceptives, they increase the risk of venous thromboembolism (VTE) rather than reduce it.

QUESTION

A 32-year-old lady underwent copper-T IUCD insertion 2 months post-partum. She has now presented with pain abdomen. The thread of the IUCD is not visible. Her pelvic radiograph is shown below. What is the appropriate step in the management of this patient?



A Call police for MLC

B Urgent exploratory laparotomy

CORRECT

C TVS

D Remove by Shirodkar's hook

RIGHT ANSWER

OK B. Urgent exploratory laparotomy

WHY THIS IS RIGHT

Missing IUCD strings with abdominal pain after insertion raises suspicion of uterine perforation with migration of the IUCD into the peritoneal cavity.

- Postpartum uterus is softer and more prone to perforation, increasing the risk during IUCD insertion.
- Pelvic X-ray showing IUCD outside the uterine cavity confirms migration.
- A displaced IUCD in the abdomen must be removed surgically to prevent complications such as bowel injury, adhesions, or infection.

Management:

- Urgent surgical removal (exploratory laparotomy/laparoscopy).

QUESTION

A 34-year-old P2L2 is taking “Chhaya” for contraception. She has been taking it for 9 months. She reports to you that she has missed taking the pill for the last 2 weeks as she had been traveling and forgot to carry the pill with her. How many tablets has she missed?

A 1

B 2

CORRECT

C 7

D 14

RIGHT ANSWER

OK

B. 2

WHY THIS IS RIGHT

Chhaya (Centchroman/Ormeloxifene) is a non-hormonal weekly oral contraceptive used in the Indian national family planning program.

Dosing schedule:

- First 3 months: 1 tablet twice weekly
- After 3 months: 1 tablet once weekly

In this case:

- She has been using it for 9 months -> maintenance phase (once weekly).
- Missing pills for 2 weeks means she has missed 2 tablets.

QUESTION

Which of the following is the mechanism of action of the first drug used in the regimen for medical termination of pregnancy (MTP) in first trimester?

A Cyclooxygenase inhibitor

B Prostaglandin analogue

C Oxytocin receptor agonist

D Progesterone antagonist

CORRECT

RIGHT ANSWER

OK D. Progesterone antagonist

WHY THIS IS RIGHT

The first drug used in first-trimester medical termination of pregnancy is mifepristone, a progesterone receptor antagonist.

Mechanism:

- Blocks progesterone receptors in the endometrium and decidua
- Causes decidual breakdown and detachment of the gestational sac
- Softens and dilates the cervix
- Increases uterine sensitivity to prostaglandins

Regimen:

1. Mifepristone (progesterone antagonist)
2. Followed by misoprostol (prostaglandin analogue) -> induces uterine contractions and expulsion

QUESTION

Ms. T visits the OPD for a routine check-up. She has a copper-containing intrauterine device (IUD) inserted 6 months ago and is concerned because she cannot feel the IUD threads. Her last menstrual period was 2 weeks ago. On speculum examination , the finding shown in the image below is noted. Which of the following is the most appropriate next year?



A Obtain a transvaginal ultrasound

CORRECT

B Obtain a KUB radiograph

C Attempt IUD removal using an IUD hook or long artery forceps

D Continue the examination by twirling a cytologic brush in the endocervical canal

RIGHT ANSWER

OK **A. Obtain a transvaginal ultrasound**

WHY THIS IS RIGHT

When IUD strings are not visible on speculum examination, the first step is to confirm the location of the IUD with transvaginal ultrasound.

• Missing IUD strings may occur due to:

- o Retraction into the cervical canal or uterus
- o Expulsion
- o Uterine perforation

• Transvaginal ultrasound is the initial investigation to determine whether the IUD is still within the uterine cavity.
• If the IUD is not visualized in the uterus, further imaging (e.g., abdominal X-ray) may be done to detect perforation or migration.

QUESTION

A 24-year-old P2L2 woman who does not desire further pregnancies presents to the OPD because she cannot feel the thread of a Multiload-375 IUCD inserted 3 years ago. Her last menstrual period was 3 weeks ago. On examination, the cervix appears normal, and the thread is not visible. A transvaginal ultrasound shows the IUCD in situ within the uterine cavity. What is the next best step?



A Hysteroscopic IUCD removal

B Reassure her

CORRECT

C Remove the IUCD with a hook

D X-Ray Abdomen and Pelvis

RIGHT ANSWER

OK

B. Reassure her

WHY THIS IS RIGHT

When IUCD strings are not visible on speculum examination, the first step is to confirm the location of the device.

Stepwise approach:

1\ Speculum examination

- If threads are visible -> remove with forceps if needed.

2\ If threads are not visible -> perform transvaginal ultrasound\.

- If IUCD is seen inside the uterine cavity and the patient is asymptomatic -> reassure the patient.
- The IUCD is still effective and no intervention is required.

3\ If IUCD is not seen in the uterus on ultrasound -> Perform X-ray abdomen/pelvis to rule out uterine perforation and migration\.

4\ If IUCD is intrauterine but removal is desired and threads are missing -> Remove with IUCD hook or hysteroscopy\.

Intervention is only required if:

- IUCD is malpositioned
- Patient wants removal
- IUCD not visualized in uterus.

QUESTION

Which of the following is not a long-acting reversible contraceptive (LARC) method?

- A Copper T
- B Implanon
- C Laparoscopic tubal ligation
- D DMPA injection

CORRECT

RIGHT ANSWER

- OK
- C. Laparoscopic tubal ligation

WHY THIS IS RIGHT

Long-acting reversible contraception (LARC) refers to contraceptive methods that provide prolonged contraception without requiring user action and are reversible upon removal or discontinuation.

Examples of LARC:

- Copper IUCD (Copper T)
- Levonorgestrel intrauterine system (LNG-IUS)
- Subdermal implants (e.g., Implanon)
- Injectable contraceptives (e.g., DMPA)

Why the other option is incorrect:

- Laparoscopic tubal ligation is a permanent sterilization method, not reversible contraception.

QUESTION

A 32-year-old woman, gravida 4 para 4, comes to the OPD for a routine check-up 6 weeks after an uncomplicated vaginal delivery of a healthy baby. She has no current complaints and wishes to discuss contraception options. She has a history of heavy menstrual bleeding and was previously found to be mildly anemic. She is breastfeeding exclusively. Pelvic examination reveals a small, mobile uterus with no abnormalities. Which of the following is the preferred method of contraception for this patient?

A Combined estrogen-progestin oral contraceptives

B Copper intrauterine device

C Levonorgestrel-containing intrauterine device

CORRECT

D Medroxyprogesterone injection

RIGHT ANSWER

OK

C. Levonorgestrel-containing intrauterine device

WHY THIS IS RIGHT

In breastfeeding women with heavy menstrual bleeding, the levonorgestrel-releasing intrauterine device (LNG-IUD) is the preferred contraceptive method because it provides highly effective long-acting reversible contraception (LARC) and reduces menstrual blood loss, thereby improving iron-deficiency anemia.

LNG-IUD (e.g., Mirena):

- Decreases endometrial proliferation
- Causes marked reduction in menstrual bleeding
- Safe during breastfeeding

Why not other options:

- Combined OCPs: Avoid early postpartum and during breastfeeding due to estrogen reducing milk production and VTE risk.
- Copper IUD: May increase menstrual bleeding, worsening anemia.
- Medroxyprogesterone injection: Safe in lactation but may cause irregular bleeding and does not treat heavy menstrual bleeding as effectively.

QUESTION

| The most common site of tubal ligation and the reason for ligation at this site is?

- A** Isthmus because of more uniform muscle thickness CORRECT
- B** Isthmus because of narrowest area
- C** Ampulla because of more circular muscles than longitudinal muscles
- D** Ampulla because of narrowest area

RIGHT ANSWER

- OK** **A. Isthmus because of more uniform muscle thickness**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

A 26-year-old conceives on the IUCD. She wants to continue pregnancy. The IUCD threads are visible. What would be the next best step?

A Remove the IUCD gently

CORRECT

B Leave the IUCD in situ

C MTP for medical indication

D Remove with Shirodkar hook

RIGHT ANSWER

OK

A. Remove the IUCD gently

WHY THIS IS RIGHT

If pregnancy occurs with an IUCD and threads are visible, removal is recommended because the device increases risk of:

Complication	Reason
Miscarriage	Intrauterine irritation
Infection	Foreign body
Preterm labor	Inflammation

If pregnancy continues with an IUCD in situ, the safest approach is gentle removal if strings are visible. Leaving it increases risks of preterm labor, infection, and miscarriage. Removal slightly increases miscarriage risk but is still preferred.

Removal with Shirodkar hook indicated for CuT when threads are not visible.

Situation	Management
Threads visible	Remove IUCD
Threads not visible	Leave IUCD in situ

Attempting blind removal may cause abortion.

QUESTION

Which of the following is a contraindication to the use of a long-acting subcutaneous contraceptive implant?

A HTN

B DM

C PID

D Undiagnosed genital bleeding

CORRECT

RIGHT ANSWER

OK

D. Undiagnosed genital bleeding

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

According to the WHO Medical Eligibility Criteria (MEC-1), in which of the following conditions can combined oral contraceptives (OCPs) be safely used?

A Diabetes Mellitus

B Hypertension

C Hyperlipidemia

D HIV

CORRECT

RIGHT ANSWER

OK

D. HIV

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

Combined oral contraceptive pills (OCPs) provide protection against several cancers. Which of the following cancers is not protected against by their use?

A Colorectal cancer

B Cervical cancer

CORRECT

C Endometrial cancer

D Ovarian cancer

RIGHT ANSWER

OK B. Cervical cancer

WHY THIS IS RIGHT

Combined Oral Contraceptive Pills are widely used for contraception and also provide non-contraceptive health benefits. They work by:

- Suppressing ovulation
- Thickening cervical mucus
- Altering endometrium

Long-term use of OCPs reduces the risk of several cancers.

Cancer	Effect
Endometrial Cancer	↓ Risk
Ovarian Cancer	↓ Risk
Colorectal Cancer	↓ Risk

Mechanisms include suppression of ovulation and reduced endometrial proliferation.

Cervical Cancer is not protected against by OCP use.

In fact:

- Long-term OCP use may slightly increase cervical cancer risk in women with persistent HPV infection.

Reason:

HPV infection

↓

Persistent viral replication

↓

Cervical intraepithelial neoplasia

↓

Cervical cancer

Hormonal exposure may enhance HPV persistence.

OCP protects -> Ovarian + Endometrial + Colon

OCP does NOT protect -> Cervical cancer

QUESTION

A 37-year-old woman, gravida 2 para 1, at 8 weeks' gestation comes to the office for a follow-up visit. Earlier in the pregnancy, she experienced nausea and breast tenderness which resolved several days ago. At her initial prenatal visit one week ago, ultrasound revealed an intrauterine gestational sac with a yolk sac but no fetal pole. Pelvic examination reveals a closed cervix with no vaginal discharge or bleeding. A repeat transvaginal ultrasound shows findings unchanged from the prior visit. Which of the following is the most likely diagnosis?

A Ectopic pregnancy

B Hydatidiform mole

C Missed abortion

CORRECT

D Threatened abortion

RIGHT ANSWER

OK C. Missed abortion

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

A 24-year-old lactating female with an 18-month-old child comes with a history of irregular, heavy bleeding seeking contraceptive advice. Which is the contraceptive of choice?

A Progestasert

B Copper-T 380A

C Mala N

CORRECT

D Norethisterone enanthate - depot

RIGHT ANSWER

OK
C. Mala N

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

Which of the following is the primary mechanism of action of ulipristal 30mg when used for emergency contraception?

- A Inhibition of maintenance of corpus luteum
- B Interference with sperm penetration
- C Inhibition of ovulation by suppressing or delaying the LH surge**
- D Thickening of the endometrium to prevent implantation

CORRECT

RIGHT ANSWER

- OK C. Inhibition of ovulation by suppressing or delaying the LH surge**

WHY THIS IS RIGHT

Ulipristal acetate (30 mg) is used as an emergency contraceptive and acts as a selective progesterone receptor modulator (SPRM).

Primary mechanism:

- Delays or inhibits ovulation by suppressing or postponing the LH surge from the pituitary.

Because ovulation is prevented, fertilization cannot occur, making it effective even when taken close to the time of ovulation.

- Can be used up to 120 hours (5 days) after unprotected intercourse.
- More effective than levonorgestrel when taken near ovulation.

Why other options are incorrect:

- Maintenance of corpus luteum inhibition: not the primary mechanism.
- Interference with sperm penetration: mechanism of barrier methods.
- Endometrial thickening: does not occur; emergency contraceptives mainly prevent ovulation, not implantation.

QUESTION

IUCD can be inserted after delivery till?

CORRECT

A 48 hrs

B 48 hrs - 6 weeks

C 24 hrs

D 12 hrs

RIGHT ANSWER

OK

A. 48 hrs

WHY THIS IS RIGHT

Postpartum IUCD insertion is safe within 10 minutes up to 48 hours after delivery. The period between 48 hours-6 weeks should be avoided due to highest expulsion risk. Insertion after 6 weeks is classified as interval IUCD placement.

QUESTION

Which of the following is an absolute contraindication for the insertion of the device shown in the image?



- A Menstruation
- B Trophoblastic disease**
- C Immediately after delivery
- D Ruptured condom during intercourse

CORRECT

RIGHT ANSWER

- OK
- B. Trophoblastic disease**

WHY THIS IS RIGHT

Gestational Trophoblastic Disease

Examples include:

- Hydatidiform mole
- Choriocarcinoma

In this condition:

Abnormal trophoblastic proliferation

↓

High β -hCG levels

↓

Risk of bleeding and malignancy

Insertion of an IUCD can:

- Increase risk of infection
- Cause uterine bleeding
- Delay diagnosis of complications

IUCD is contraindicated in gestational trophoblastic disease.

IUCD Indications

| Situation | Use |

| ----- | --- |

| Long-term contraception | 5-10 years |

| Emergency contraception | Within 5 days of intercourse |

| Spacing method | Reversible |

QUESTION

Which of the following timings for intrauterine device (IUD) insertion is recommended?

1. Immediate postpartum
2. Within 48 hr of delivery
3. Within 5-7 days of menses
4. Within 5-7 days of next menstrual cycle

A 1, 2, 3

CORRECT

B 1, 2, 4

C 2, 3, 4

D 1, 3, 4

RIGHT ANSWER

OK
A. 1, 2, 3

WHY THIS IS RIGHT

Postpartum IUD Timing
Mechanism of Action of Copper IUD
Copper ions released
↓
Local inflammatory reaction
↓
Toxic to sperm
↓
Prevents fertilization

1) IUD can be inserted within 10 minutes after placental delivery.

Advantages:

- Woman already in hospital
- High motivation for contraception
- Immediate protection

2) Insertion during the first 48 hours postpartum is also recommended.

However:

- If >48 hours and <6 weeks postpartum, insertion is not recommended because of increased expulsion risk.

3) Within 5-7 Days of Menses

This timing is preferred because:

- Cervix is slightly dilated
- Pregnancy is ruled out
- Insertion is easier and safer

Timing	Recommendation
Within 10 min of placental delivery	✓ <u>Postplacental</u> insertion
Within 48 hours of delivery	✓ Allowed
48 hours – 6 weeks postpartum	✗ Not recommended
After 6 weeks postpartum	✓ Safe

QUESTION

A female patient taking DMPA came 14 days late. What should be advised to her?

A Do UPT and then give DMPA

B DMPA + 7 days backup

C DMPA from next cycle

D Give DMPA, no backup required

CORRECT

RIGHT ANSWER

OK **D. Give DMPA, no backup required**

WHY THIS IS RIGHT

Depot Medroxyprogesterone Acetate is a progestin-only injectable contraceptive.

It is commonly given as:

- 150 mg intramuscular injection
- Every 3 months (12 weeks)

The WHO and CDC guidelines allow a grace period of up to 2 weeks after the scheduled injection.

| Timing | Recommendation |

| ----- | ----- |

| On time (12 weeks) | Give injection |

| ≤2 weeks late (up to 14 weeks) | Give injection immediately, no backup needed |

| >2 weeks late | Pregnancy test + backup contraception |

Since this patient is 14 days late, she is within the grace period.

Advantages of DMPA

| Benefit | Explanation |

| ----- | ----- |

| Highly effective | <1% failure |

| Long acting | 3 months protection |

| Safe in breastfeeding | Progestin-only |

| Decreases menstrual bleeding | Amenorrhea common |

QUESTION

Which of the following timings for intrauterine device (IUD) insertion is recommended?

1. Immediate postpartum
2. Within 48 hr of delivery
3. Within 5-7 days of menses
4. Within 5-7 days of next menstrual cycle

A 1, 2, 3

CORRECT

B 1, 2, 4

C 2, 3, 4

D 1, 3, 4

RIGHT ANSWER

OK
A. 1, 2, 3

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1f” here and does not include a written explanation for this item.

QUESTION

Arrange the following antenatal investigations in chronological order:

1. MSAFP, E3, HCG, Inhibin-A
2. TIFA scan
3. Growth-Liquor scan
4. NT-NB

A 4-2-3-1

B 1-4-2-3

C 4-1-2-3

CORRECT

D 3-4-1-2

RIGHT ANSWER

OK C. 4-1-2-3

WHY THIS IS RIGHT

Antenatal screening investigations are performed at specific gestational ages to assess chromosomal abnormalities, fetal anatomy, and fetal growth.

Chronological order:

- 1\ NT-NB scan (Nuchal translucency & nasal bone)
 - 11-13+6 weeks
 - Screening for chromosomal anomalies (e.g., Down syndrome)
 - 2\ Quadruple marker test (MSAFP\, β -hCG\, estriol\, inhibin-A)
 - 15-20 weeks
 - Screening for chromosomal abnormalities and neural tube defects
 - 3\ TIFA scan (Targeted Imaging for Fetal Anomalies)
 - 18-22 weeks
 - Detailed anomaly scan
 - 4\ Growth-Liquor scan
 - Third trimester (~28-34 weeks)
 - Assess fetal growth and amniotic fluid volume
- Correct order: NT-NB -> Quadruple test -> TIFA -> Growth-Liquor scan (4-1-2-3)

QUESTION

A 23-year-old female is being evaluated for infertility. Hormone studies reveal a normal rise in the blood estradiol level during the first phase of the menstrual cycle. Androgens synthesized in this patient's ovaries are converted to estradiol in which of the following cell types?

A Theca interna

B Theca externa

C Granulosa

CORRECT

D Leydig

RIGHT ANSWER

OK C. Granulosa

WHY THIS IS RIGHT

Estrogen synthesis in the ovary follows the two-cell, two-gonadotropin theory.

Key steps:

- Theca interna cells (stimulated by LH) convert cholesterol -> androgens (androstenedione/testosterone).
- These androgens diffuse into granulosa cells.
- Granulosa cells (stimulated by FSH) contain the enzyme aromatase, which converts androgens -> estradiol.

QUESTION

| During pregnancy, which of the following parameters increases?

A Total oxygen-carrying capacity of blood

CORRECT

B Serum iron concentration

C Serum potassium

D Serum ferritin

RIGHT ANSWER

OK

A. Total oxygen-carrying capacity of blood

WHY THIS IS RIGHT

During pregnancy, total oxygen-carrying capacity of blood increases due to a rise in maternal red blood cell (RBC) mass stimulated by increased erythropoietin production.

- Plasma volume: ↑ ~40-50%
- RBC mass: ↑ ~20-30%
- Because plasma volume increases more than RBC mass -> physiological (dilutional) anemia of pregnancy occurs.
- Despite dilutional anemia, the overall oxygen-carrying capacity increases because the absolute RBC mass is higher.

Why other options are incorrect:

- Serum iron concentration: ↓ (due to increased fetal demand and expanded erythropoiesis)
- Serum ferritin: ↓ (reflects depleted maternal iron stores)
- Serum potassium: Usually unchanged or slightly decreased due to hemodilution.

QUESTION

Which of the following statements is incorrect about non-invasive prenatal testing (NIPT)?

- A It uses cell-free circulating fetal DNA in the maternal serum.
- B It is used for the confirmation of trisomy 13, 18 and 21**
- C It can be performed after 10 weeks of gestation.
- D It is done after the routine first trimester ultrasound assessment.

CORRECT

RIGHT ANSWER

- B. It is used for the confirmation of trisomy 13, 18 and 21**

WHY THIS IS RIGHT

Non-invasive prenatal testing (NIPT) is a screening test, not a diagnostic test, used to assess the risk of common fetal aneuploidies by analyzing cell-free fetal DNA (cffDNA) circulating in maternal blood.

Key Features of NIPT:

- Uses cell-free fetal DNA derived from placental trophoblasts present in maternal serum.
- Can be performed from 10 weeks of gestation onwards.
- Commonly screens (not confirms) for trisomies associated with conditions like Down syndrome Trisomy 21), Edwards syndrome (Trisomy 18), and Patau syndrome Trisomy 13).
- Usually performed after routine first-trimester ultrasound (which includes nuchal translucency assessment).

QUESTION

A 28-year-old woman, gravida 3 para 2, at 31 weeks gestation comes for a prenatal visit. She reports increasing shortness of breath while climbing stairs and during long walks for the past few weeks. She has no cough, hemoptysis, chest pain, orthopnea, or sick contacts.

Vital signs:

BP: 110/80 mm Hg

Pulse: 70/min

RR: 18/min

Fetal heart tones are normal and lungs are clear.

Which of the following arterial blood gas findings is most likely in this patient?

A pH 7.3, PaCO₂ 45, PaO₂ 101

B pH 7.45, PaCO₂ 29, PaO₂ 101

CORRECT

C pH 7.8, PaCO₂ 60, PaO₂ 101

D pH 7.1, PaCO₂ 30, PaO₂ 90

RIGHT ANSWER

OK

B. pH 7.45, PaCO₂ 29, PaO₂ 101

WHY THIS IS RIGHT

Normal pregnancy causes a physiologic respiratory alkalosis due to the effect of progesterone on the respiratory center. Progesterone stimulates the medullary respiratory center, leading to increased tidal volume and mild hyperventilation. This results in increased CO₂ elimination.

Typical Arterial Blood Gas Changes in Pregnancy

Parameter	Change	Reason
pH	Slightly ↑ (~7.44-7.46)	Respiratory alkalosis
PaCO ₂	↓ (~28-32 mm Hg)	Increased ventilation
PaO ₂	Slightly ↑ (~100-105 mm Hg)	Improved oxygenation
HCO ₃ ⁻	Slightly ↓	Renal compensation

Thus, the typical ABG in pregnancy is:

pH ≈ 7.45, PaCO₂ ≈ 29 mm Hg, PaO₂ ≈ 100 mm Hg → mild respiratory alkalosis with renal compensation.

QUESTION

Which of the following should be administered to a newborn delivered to a mother who is HBsAg positive?

A Hepatitis B vaccine + Immunoglobulin

CORRECT

B HBIG

C Hepatitis B vaccine only

D Immunoglobulin, followed by vaccine at 6 weeks

RIGHT ANSWER

OK A. Hepatitis B vaccine + Immunoglobulin

WHY THIS IS RIGHT

Newborns born to HBsAg-positive mothers require immediate post-exposure prophylaxis to prevent perinatal transmission of hepatitis B virus (HBV).

Recommended management:

- Hepatitis B vaccine + Hepatitis B immunoglobulin (HBIG)
- Both should be given within 12 hours of birth at different injection sites.

Rationale:

- HBIG provides passive immunity.
- Hepatitis B vaccine stimulates active immunity.
- Combined prophylaxis reduces perinatal transmission by >90%.

QUESTION

A 32-year-old woman (G1P0) at 18 weeks gestation presents for discussion of abnormal prenatal screening results. She has no medical problems and takes no medications. The results of the quadruple screen are:

- AFP: High
- Unconjugated estriol: Low
- β -hCG: Low
- Inhibin A: Low

Which of the following is the most likely diagnosis?

A Gastroschisis

CORRECT

B Trisomy 21

C Trisomy 18

D Multifetal pregnancy

RIGHT ANSWER

OK A. Gastroschisis

WHY THIS IS RIGHT

The quadruple screening test (performed at 15-20 weeks of gestation) measures four maternal serum markers to screen for fetal chromosomal abnormalities and neural tube defects.

Markers in Quadruple Test:

- AFP (Alpha-fetoprotein)
- β -hCG
- Unconjugated estriol (uE3)
- Inhibin A

Condition	AFP	β -hCG	Estriol	Inhibin A
Trisomy 21 (Down syndrome)	↓	↑	↓	↑
Trisomy 18 (Edwards syndrome)	↓	↓	↓	Normal/↓
Open neural tube defects / abdominal wall defects	↑	Normal	Normal	Normal
Multifetal pregnancy	↑	↑	↑	↑

The markedly elevated AFP suggests a fetal open abdominal wall defect, most commonly gastroschisis, due to leakage of fetal proteins into the amniotic fluid and maternal circulation.

QUESTION

All of the following are included in high-risk pregnancy under Government of India guidelines except:

A Previous h/o LSCS

B Maternal age >30 years

CORRECT

C Low lying placenta

D Syphilis

RIGHT ANSWER

OK

B. Maternal age >30 years

WHY THIS IS RIGHT

A high-risk pregnancy is one in which the mother, fetus, or newborn has an increased risk of morbidity or mortality and therefore requires special monitoring and management under Government of India antenatal care guidelines.

Conditions considered high-risk:

Examples include:

- Previous cesarean section (LSCS) -> increased risk of uterine rupture, placenta previa, placenta accreta
- Low-lying placenta / placenta previa -> risk of antepartum hemorrhage
- Maternal infections such as syphilis -> risk of congenital infection, stillbirth, neonatal complications

These conditions require closer antenatal surveillance and institutional delivery.

Not considered high-risk in GOI criteria:

- Maternal age >30 years alone is not categorized as high-risk under Government of India guidelines.
- However, extreme maternal ages (e.g., <18 years or >35 years) are generally considered higher risk in obstetrics literature.

QUESTION

A 35-year-old woman, gravida 1 para 0, comes to the OPD for an initial prenatal visit. The patient has had no vaginal bleeding or abdominal pain and has not yet felt fetal movement. The patient's estimated gestational age based on her last menstrual period is 16 weeks. She has type 1 diabetes mellitus that is controlled with insulin. She smokes a pack of cigarettes daily. As part of her prenatal laboratory screening, a second-trimester maternal serum quadruple screen is performed and reveals an elevated alpha-fetoprotein level. Which of the following is the most likely etiology of this patient's abnormal screening result?

CORRECT

A Dating error**B** Down syndrome**C** Edwards syndrome**D** Fetal growth restriction

RIGHT ANSWER

OK A. Dating error

WHY THIS IS RIGHT

Maternal serum alpha-fetoprotein (AFP) is measured during the second-trimester quadruple screen (15-20 weeks) to screen for fetal abnormalities.

Causes of elevated maternal AFP:

- Incorrect gestational dating (most common cause)
- Open neural tube defects (e.g., spina bifida, anencephaly)
- Abdominal wall defects (e.g., omphalocele, gastroschisis)
- Multiple pregnancy
- Fetal demise

Reason for dating error:

- AFP levels increase with advancing gestational age.
- If the pregnancy is further along than estimated, AFP appears artificially elevated.

QUESTION

Identify the correct statements

1. The secondary oocyte arrested in meiosis II is released during ovulation
2. Tubectomy is done at ampulla due to uniform muscle thickness
3. External cephalic version (ECV) is contraindicated in a primigravida with twin pregnancy
4. In the treatment of vault prolapse, the mesh is fixed to the sacral promontory

A 1, 2, 3, 4

B 3, 2

C 1, 2, 4

D 1, 3, 4

CORRECT

RIGHT ANSWER

OK D. 1, 3, 4

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

23-year-old woman, gravida 1, para 0, comes to the OPD for a routine prenatal care visit. She is at 35 weeks gestation and feels well. She reports regular fetal movement and no contractions, loss of fluid, or vaginal bleeding. She signed up for a clinical trial investigating prolactin. At 34 weeks gestation, she had a serum prolactin level several times higher than what was recorded prior to pregnancy. Which of the following hormones prevents lactation in this patient?

A β -hCG

B Insulin

C LH

D Progesterone

CORRECT

RIGHT ANSWER

OK D. Progesterone

WHY THIS IS RIGHT

During pregnancy, high levels of progesterone (and estrogen) inhibit the lactogenic effect of prolactin, preventing milk secretion despite elevated prolactin levels.

Mechanism:

- Prolactin stimulates milk production.
- During pregnancy, the placenta produces high progesterone and estrogen, which block prolactin's action on the breast alveoli.
- After delivery of the placenta, progesterone levels fall -> prolactin can act, leading to lactogenesis (milk production).

QUESTION

A 25-year-old primigravida presents with a history of a dog bite. Her neighbour's pet dog has bitten her on the leg. She is currently 10 weeks pregnant. What is the next best step in management?

A Clean the wound, administer tetanus and rabies vaccine

CORRECT

B Clean the wound, administer only tetanus vaccine

C Clean the wound, administer antibiotics

D Clean the wound, reassure her

RIGHT ANSWER

OK

A. Clean the wound, administer tetanus and rabies vaccine

WHY THIS IS RIGHT

Rabies post-exposure prophylaxis (PEP) is safe and indicated during pregnancy. Pregnancy is not a contraindication to rabies vaccination.

Management of dog bite in pregnancy:

1. Immediate wound cleaning with soap and water.
2. Tetanus prophylaxis (if immunization status uncertain).
3. Rabies vaccination $\pm$ rabies immunoglobulin depending on exposure category.

Important point:

Because rabies is almost universally fatal once symptoms develop, post-exposure vaccination must be given even in pregnant women.

QUESTION

A 24-year-old primigravida is in labor. The baseline FHR is 110bpm. All of the following are possible causes of fetal bradycardia, except:

A Maternal beta blocker therapy

B Hypothermia

C Hypoglycemia

D Maternal fever

CORRECT

RIGHT ANSWER

OK

D. Maternal fever

WHY THIS IS RIGHT

Fetal bradycardia is defined as baseline fetal heart rate (FHR) <110 bpm for ≥10 minutes. It usually occurs due to reduced fetal oxygenation, fetal cardiac suppression, or maternal factors affecting fetal circulation.

Common causes of fetal bradycardia include:

- Maternal β -blocker therapy -> crosses placenta and suppresses fetal heart rate
- Maternal hypothermia -> decreases fetal metabolic rate and FHR
- Maternal hypoglycemia -> reduces fetal energy supply leading to decreased FHR
- Fetal hypoxia/acidosis
- Cord compression
- Congenital heart block

Maternal fever, however, typically causes fetal tachycardia (>160 bpm) due to increased fetal metabolic rate and sympathetic stimulation (often seen in chorioamnionitis or maternal infection).

QUESTION

A 32-year-old woman is evaluated at 32 weeks' gestation. Laboratory results are as follows:

Arterial pH: 7.45

PaO₂: 110 mm Hg

PaCO₂: 30 mm Hg

Bicarbonate: 20 mEq/L

Hemoglobin: 11 g/dL

Blood urea nitrogen: 5 mg/dL

Creatinine: 0.6 mg/dL

Which of the following best explains this patient's status?

A Anemia

B Hyperemesis gravidarum

C Normal pregnancy

CORRECT

D Preeclampsia

RIGHT ANSWER

OK C. Normal pregnancy

WHY THIS IS RIGHT

In normal pregnancy, progesterone stimulates the respiratory center leading to chronic hyperventilation. This causes physiologic respiratory alkalosis characterized by:

- ↓ PaCO₂ (~28-32 mm Hg) due to hyperventilation
- Slight ↓ bicarbonate (~18-21 mEq/L) due to renal compensation
- pH slightly alkalemic (~7.44-7.46)
- ↑ PaO₂ (~100-110 mm Hg)
- ↓ BUN and creatinine because GFR increases by ~50% in pregnancy

Thus, the given values (pH 7.45, PaCO₂ 30, HCO₃⁻ 20, PaO₂ 110, low BUN/creatinine) represent normal physiologic changes of pregnancy, not pathology.

QUESTION

A 32-year-old woman, gravida 2 para 1, at 30 weeks gestation comes to the OPD for a routine prenatal visit. Her pregnancy has been uncomplicated, with no vaginal bleeding or contractions. Blood pressure is 110/70 mm Hg, pulse is 76/min, and respirations are 20/min.

Compared with the nonpregnant state, which of the following hematologic changes is most likely in this patient?

	Plasma volume	Red blood cell mass	Hemoglobin concentration
A	↑	↑	↓
B	↑	↓	↓
C	↓	↑	↑
D	No change	No change	No change

A A

CORRECT

B B

C C

D D

RIGHT ANSWER

OK A. A

WHY THIS IS RIGHT

During normal pregnancy, there is physiologic hemodilution (physiologic anemia of pregnancy) due to disproportionate increases in plasma volume and red cell mass.

Typical hematologic changes in pregnancy:

- Plasma volume: ↑ ~40-50%
- Red blood cell mass: ↑ ~20-30% (due to erythropoietin)
- Hemoglobin concentration: ↓ because plasma volume increases more than RBC mass

This leads to dilutional anemia, which is a normal physiologic adaptation in pregnancy.

Correct combination:

- Plasma volume ↑
- RBC mass ↑
- Hemoglobin concentration ↓

QUESTION

I All of the following are true regarding vaccination in pregnancy, except:

- A** Vaccines that contain toxoids may be administered during pregnancy
- B** The hepatitis B vaccine series may be administered during pregnancy
- C** **Receiving the varicella vaccine is an indication for pregnancy termination**
- D** Conception should be delayed by 1 month after receiving the rubella vaccine

CORRECT

RIGHT ANSWER

OK

C. Receiving the varicella vaccine is an indication for pregnancy termination

WHY THIS IS RIGHT

Vaccination during pregnancy depends on whether the vaccine is live attenuated or inactivated. Vaccines Safe in Pregnancy:

- Inactivated vaccines and toxoids are safe during pregnancy.
- Examples:
 - Tetanus toxoid (Td/Tdap)
 - Hepatitis B vaccine
 - Influenza (inactivated)

Therefore:

- Vaccines containing toxoids can be given in pregnancy.
- Hepatitis B vaccination can be safely administered during pregnancy.

Live vaccines are generally contraindicated during pregnancy due to a theoretical risk of fetal infection. Examples:

- Rubella vaccine
- Varicella vaccine
- MMR vaccine

Women are advised to avoid conception for 1 month after receiving rubella or varicella vaccines.

QUESTION

A patient with 6 weeks amenorrhea and a positive pregnancy test presents with lower abdominal pain and moderate per vaginam bleeding. She is hemodynamically stable. Transvaginal ultrasound shows no gestational sac in the uterus. The ovaries are normal, and there is no free fluid in the pouch of Douglas. What is the next best step in management?

A Declare as complete abortion and follow up after 15 days

B Administer methotrexate

C Diagnostic laparoscopy

D Follow-up with serial B-hCG levels

CORRECT

RIGHT ANSWER

OK

D. Follow-up with serial B-hCG levels

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

For a given drug, animal reproduction studies have shown an adverse effect on the fetus, but there are no adequate and well-controlled studies on humans. However, potential benefits may warrant the use of the drug in pregnant women despite potential risks. Such a drug would be classified as

A Category C

CORRECT

B Category B

C Category X

D Category D

RIGHT ANSWER

OK A. Category C

WHY THIS IS RIGHT

The FDA pregnancy drug risk categories describe the potential risk of medications to the fetus when used during pregnancy.

Category C drugs:

- Animal studies show adverse fetal effects, but
- No adequate, well-controlled human studies are available.
- The drug may still be used if the potential maternal benefit justifies the potential fetal risk.

Comparison with other categories:

- Category A: Controlled human studies show no fetal risk.
- Category B: Animal studies show no risk or animal risk not confirmed in humans.
- Category C: Animal risk present; human data lacking -> use if benefit outweighs risk.
- Category D: Positive evidence of human fetal risk, but may be used in life-threatening conditions.
- Category X: Contraindicated in pregnancy (risk clearly outweighs benefit).

QUESTION

Which of the following statements regarding hematological changes in pregnancy is false?

A Protein C, protein S, and antithrombin decrease

B Clotting time and bleeding time are unaffected

C Serum albumin decreases

D The viscosity of blood increases

CORRECT

RIGHT ANSWER

OK D. The viscosity of blood increases

WHY THIS IS RIGHT

Pregnancy produces a hypercoagulable state to protect against hemorrhage during delivery.

Hematological changes in pregnancy:

- Decrease in natural anticoagulants: particularly Protein S (Protein C usually normal/slightly reduced; antithrombin mostly unchanged).
- Increase in clotting factors: fibrinogen, factors VII, VIII, IX, X.
- Bleeding time and clotting time: generally unchanged.
- Serum albumin: decreases due to hemodilution from increased plasma volume.
- Blood viscosity: decreases, not increases, because plasma volume rises more than RBC mass.

Why option D is false: Blood viscosity falls in pregnancy due to physiological anemia and hemodilution.

QUESTION

Patient experiences softening of the cervix in early pregnancy. This sign is called as?

A Osiander

B Chadwick

C Goodell

CORRECT

D Hegar

RIGHT ANSWER

OK C. Goodell

WHY THIS IS RIGHT

Goodell's sign refers to the softening of the cervix, which is observed during early pregnancy. This sign occurs due to increased vascularization and changes in the connective tissue of the cervix, making it feel softer compared to the non-pregnant state, where the cervix feels firm like the tip of the nose.

| Probable Signs | Description |

| ----- | ----- |

| Goodell's sign | Soft cervix |

| Jacquemier's

Chadwick's sign | Bluish hue of ant vaginal wall |

| Osiander's sign | Increased pulsation felt through the lateral fornices |

| Piscacek's sign | Asymmetrical uterine enlargement in lateral implantation |

| Hegar's sign | On bimanual exam, the abdominal and vaginal finger appose below the body of the uterus |

| Palmer's sign | Rhythmic uterine contractions elicited on bimanual exam |

QUESTION

Identify the anomaly seen on the ultrasound.



A Anencephaly

CORRECT

B Encephalocele

C Lissencephaly

D Holoprosencephaly

RIGHT ANSWER

OK A. Anencephaly

WHY THIS IS RIGHT

Anencephaly shows the classic “frog-eye” appearance, with absence of cranial vault and cerebral hemispheres. Encephalocele presents as a sac; lissencephaly shows smooth brain; holoprosencephaly has midline defects, not frog-face.

QUESTION

A pregnant woman at 36 weeks of gestation presents to you with complaints of feeling light-headedness and dizziness when she lies on her back and feels relieved if she lies on her side or when walks. What is the most likely reason behind this?

A Increased intracranial pressure

B IVC compression

CORRECT

C Heavy meals

D Excessive venous pooling at the feet

RIGHT ANSWER

OK B. IVC compression

WHY THIS IS RIGHT

This condition is known as Supine Hypotensive Syndrome. In late pregnancy, the enlarged uterus compresses the inferior vena cava when the woman lies on her back.

Gravid uterus compresses IVC

↓

Reduced venous return to heart

↓

Decreased cardiac output

↓

Maternal hypotension

↓

Dizziness and light-headedness

Common features include:

Symptom Reason
----- -----
Dizziness Reduced cerebral perfusion
Nausea Hypotension
Pallor Decreased cardiac output
Tachycardia Compensatory response

It may also reduce uteroplacental blood flow.

Best management:

- Left lateral position

This shifts the uterus away from the vena cava.

Supine position -> IVC compression

Left lateral position -> venous return restored

QUESTION

A pregnant woman comes to the clinic. She already has twins by normal delivery. Which of the following is the correct representation of her obstetric score?

A G3P2

B G3P1

C G2P1

CORRECT

D G2P2

RIGHT ANSWER

OK C. G2P1

WHY THIS IS RIGHT

Each pregnancy counts once for gravida and parity, irrespective of number of fetuses. One prior twin pregnancy delivered at viability = G1P1, and current pregnancy makes her G2P1.

| Situation | Gravida | Para |

| ----- | ----- | ---- |

| One pregnancy with twins | G1 | P1 |

| Two pregnancies, one twin delivery | G2 | P1 |

| Three pregnancies, two singleton births | G3 | P2 |

Twin delivery counts as one parity event. Parity counts pregnancies, not number of babies.

QUESTION

| Testosterone helps in development of fetal organs. Which stimulates its production?

A LH from maternal pituitary

B HCG from placenta

CORRECT

C Inhibin from corpus luteum

D GnRH from fetal hypothalamus

RIGHT ANSWER

OK

B. HCG from placenta

WHY THIS IS RIGHT

Testosterone is produced by fetal Leydig cells in the testes and is essential for male genital differentiation. Human Chorionic Gonadotropin is secreted by the placenta during early pregnancy.

Mechanism:

Placenta releases hCG

↓

hCG acts like LH

↓

Stimulates fetal Leydig cells

↓

Testosterone production

Thus hCG acts as a substitute for LH in early fetal life.

Testosterone helps form:

| Structure | Development |

| ----- | ----- |

| Internal genitalia | Epididymis, vas deferens |

| External genitalia | Penis, scrotum |

| Secondary sexual differentiation | Later in puberty |

QUESTION

A 30-year-old woman presents to the OPD with a twin pregnancy at 10 weeks' gestation. She has 3-year-old female twins who were born at beginning of the 9th months of gestation. She also has a history of two first- trimester abortions. Which of the following correctly represents her obstetric score (formula)?

A G4 P2 L2 A2

B G4 P1 A2 L2

CORRECT

C G5 PO L1 A2

D G5 T1 A2 L1

RIGHT ANSWER

OK B. G4 P1 A2 L2

WHY THIS IS RIGHT

Obstetric score summarizes a woman's reproductive history using:

- G (Gravida): total number of pregnancies including the current one
- P (Para): number of pregnancies reaching viability (≥ 28 weeks), regardless of number of babies
- A (Abortions): pregnancy losses before viability
- L (Living): number of living children

In this case:

- Current pregnancy (twin, 10 weeks) -> counts in gravida
- Previous twin delivery at beginning of 9th month -> 1 para (counts as one delivery though twins were born)
- Two first-trimester abortions -> A2
- Two living children -> L2

Calculation:

- G = 1 (current) + 1 (previous twin pregnancy) + 2 abortions = 4
- P = 1
- A = 2
- L = 2

Therefore: G4 P1 A2 L2

QUESTION

Which cardiovascular change is more likely to be found in a 23-week Period of gestation (POG) woman?

A Mid-diastolic murmur

B Pansystolic murmur

C Bradycardia

D Lateral displacement of apical impulse

CORRECT

RIGHT ANSWER

OK

D. Lateral displacement of apical impulse

WHY THIS IS RIGHT

During mid-pregnancy (around 20-24 weeks gestation), several physiological cardiovascular changes occur due to increased blood volume and cardiac output.

- Increased plasma volume and cardiac output
- Increased heart rate
- Mild cardiac enlargement due to diaphragm elevation by the gravid uterus
- Lateral and slightly upward displacement of the apical impulse

Because the diaphragm is pushed upward by the enlarging uterus, the heart shifts leftward, causing the apical impulse to be displaced laterally.

Other Options:

- Mid-diastolic murmur and pansystolic murmur are pathological findings.
- Bradycardia is not typical; pregnancy usually causes mild tachycardia.

QUESTION

A primigravida woman at 12 weeks comes for nutritional advice. Which is recommended?

- A** Additional 300 kcal in 2nd trimester
- B** Additional 300 kcal in 1st trimester
- C** Additional 400 kcal in 3rd trimester
- D** Additional 300 kcal throughout pregnancy

CORRECT

RIGHT ANSWER

- OK** A. Additional 300 kcal in 2nd trimester

WHY THIS IS RIGHT

Pregnancy requires additional calories to support:

- Fetal growth
- Placental development
- Maternal metabolic changes

According to nutritional guidelines, extra calories are mainly required from the second trimester onwards. No extra calories are needed in 1st trimester. Second trimester requires ~300-340 kcal extra; third trimester ~450 kcal. Hence option A matches recommendations. Some sources say Additional 300 kcal throughout pregnancy but the above information is more accurate.

Nutrient	Requirement
Protein	~60 g/day
Iron	27 mg/day
Folic acid	400-600 µg/day
Calcium	1000-1200 mg/day

BMI Category	Weight gain
Normal BMI	11-16 kg
Underweight	12-18 kg
Overweight	7-11 kg

QUESTION

A 28-year-old G5L4 with all 4-girl children presents at 18 weeks and asks for the sex of the child on ultrasound. This is her first antenatal visit. What should be done?

- A Do ultrasound for gestational age, check for abnormalities, check sex, and tell the mother
- B Do ultrasound for gestational age, check for abnormalities, check sex but don't tell the mother
- C Do ultrasound for gestational age, check for abnormalities, don't check the sex or reveal to the mother**
- D Don't do ultrasound, do ANC only

CORRECT

RIGHT ANSWER

- OK C. Do ultrasound for gestational age, check for abnormalities, don't check the sex or reveal to the mother**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

| During examination of a normal umbilical cord, which structures are expected?

A 2 umbilical veins and 2 arteries

B 2 umbilical arteries and 1 umbilical vein

CORRECT

C Single umbilical artery and vein

D 2 umbilical arteries and 2 veins

RIGHT ANSWER

OK

B. 2 umbilical arteries and 1 umbilical vein

WHY THIS IS RIGHT

The Umbilical Cord normally contains three vessels embedded in Wharton's jelly. Normal cord = 3 vessels: two arteries carrying deoxygenated blood from fetus to placenta, one vein carrying oxygenated blood back.

Structure	Function
1 Umbilical vein	Carries oxygenated blood from placenta to fetus
2 Umbilical arteries	Carry deoxygenated blood from fetus to placenta
Wharton's jelly	Protects vessels

Sometimes one artery is absent, called Single Umbilical Artery.

Associated anomalies:

System	Examples
Renal	Renal agenesis
Cardiac	Congenital heart disease
Gastrointestinal	Atresia

SUA is commonly associated with congenital anomalies and IUGR.

QUESTION

A pregnant woman doesn't recall LMP. What is the best method to calculate period of gestation?

A Crown-rump length (CRL)

CORRECT

B Biparietal diameter (BPD)

C Abdominal circumference (AC)

D Femur length (FL)

RIGHT ANSWER

OK A. Crown-rump length (CRL)

WHY THIS IS RIGHT

Crown-Rump Length is the most accurate ultrasound parameter for determining gestational age in early pregnancy.

Feature	Explanation
Used in	First trimester (7-13 weeks)
Accuracy	$\pm 3-5$ days
Purpose	Dating pregnancy

These measurements are used later in pregnancy.

Parameter	Best Use
BPD (Biparietal diameter)	Second trimester dating
AC (Abdominal circumference)	Fetal growth assessment
FL (Femur length)	Growth evaluation in third trimester



QUESTION

A pregnant woman in her first trimester presents with lymphadenopathy and past history of toxoplasmosis. Current serology shows IgG Toxoplasma positive. What is the most appropriate advice?

A Advise MTP

B Advise fetal testing

C Safe to continue pregnancy

CORRECT

D Initiate pyrimethamine

RIGHT ANSWER

OK

C. Safe to continue pregnancy

WHY THIS IS RIGHT

Toxoplasmosis is a parasitic infection that can cause congenital infection if acquired during pregnancy. Transmission usually occurs via:

- Undercooked meat
- Cat feces
- Contaminated food or soil

Serology Result	Meaning
IgG positive, IgM negative	Past infection
IgM positive	Recent infection
IgG negative	No immunity

In this case: IgG positive = past infection

This means the mother already developed protective immunity.

Therefore fetal infection risk is extremely low.

Classic triad:

Feature	Explanation
Hydrocephalus	CSF obstruction
Intracranial calcifications	Brain damage
Chorioretinitis	Eye involvement

However, this occurs only if infection is acquired during pregnancy.

QUESTION

| Which infection contracted in pregnancy won't be teratogenic?

A Rubella

B CMV

C HSV 2

CORRECT

D Chicken pox

RIGHT ANSWER

OK

C. HSV 2

WHY THIS IS RIGHT

Herpes simplex virus type 2 usually causes neonatal infection during delivery, not congenital malformations. Herpes Simplex Virus Type 2 mainly causes neonatal herpes infection during delivery through contact with infected genital lesions. Certain infections during pregnancy can cross the placenta and cause congenital anomalies in the fetus. These are classically remembered under TORCH Infections. Common teratogenic infections

| Infection | Fetal effects |

| ----- | ----- |

| Rubella | Cataracts, PDA, deafness

Classic triad:

- Cataracts
- Patent ductus arteriosus
- Sensorineural deafness

|

| CMV | Microcephaly, periventricular calcification, Hearing loss |

| Varicella (Chickenpox) | Limb hypoplasia, skin scarring, Neurological defects |

| Toxoplasmosis | Hydrocephalus, chorioretinitis |

*

QUESTION

A patient presents at 18 weeks with raised AFP, low Estrol, low HCG, low Inhibin-A.
What is the next best step?

A Anomaly scan

CORRECT

B Amniocentesis

C Chorionic villous sampling

D NIPT

RIGHT ANSWER

OK
A. Anomaly scan

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

Which of the following statements regarding physiological changes in pregnancy is incorrect?

A Fasting Hypoglycemia and Postprandial Hyperglycemia

B Increase SBP and DBP at 6 weeks

CORRECT

C Increase in RBC mass

D Peripheral Insulin Resistance

RIGHT ANSWER

OK

B. Increase SBP and DBP at 6 weeks

WHY THIS IS RIGHT

Cardiovascular Changes in Pregnancy-

During pregnancy:

- Systemic vascular resistance decreases
- Cardiac output increases
- Blood pressure falls in early pregnancy

Trimester	Blood Pressure
-----	-----
Early pregnancy	↓ BP
Mid pregnancy	Lowest BP
Late pregnancy	Returns toward baseline

Glucose Metabolism in Pregnancy- Pregnancy is considered a diabetogenic state.

Hormones responsible include:

- Human placental lactogen (hPL)
- Progesterone
- Cortisol
- Estrogen

These hormones cause peripheral insulin resistance.

Hematological changes during pregnancy:

- RBC mass increases by ~20-30%
- Plasma volume increases by ~40-50%

This leads to physiological anemia of pregnancy.

Parameter	Change
-----	-----
RBC mass	↑
Plasma volume	↑↑
Hemoglobin concentration	↓

QUESTION

A 16 weeks pregnant woman is evaluated using Quadruple test. Which of the following is not part of it?

- A** Inhibin B
- B Beta hCG
- C AFP
- D Unconjugated Estriol

CORRECT

RIGHT ANSWER

- OK**
A. Inhibin B

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

Which of the following investigative modalities is generally considered unsafe for use during pregnancy?

A Ultrasound

B CT scan

CORRECT

C Doppler

D MRI

RIGHT ANSWER

OK B. CT scan

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

A 32-year-old woman presents with abdominal pain and vaginal bleeding. She has a positive pregnancy test, but transvaginal ultrasound does not show an intrauterine pregnancy. Endometrial biopsy reveals hypersecretory glands with nuclear atypia and poor decidualization. This histological finding is consistent with which of the following?

A Endometritis

B Arias-Stella reaction

CORRECT

C Decidual reaction

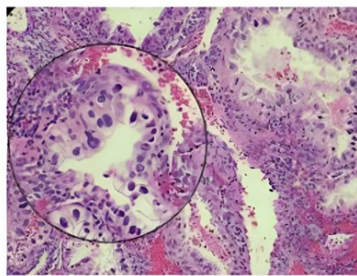
D Chronic inflammation

RIGHT ANSWER

OK B. Arias-Stella reaction

WHY THIS IS RIGHT

- The Arias-Stella reaction is a histological finding characterized by hypersecretory endometrial glands with nuclear atypia, often associated with ectopic pregnancy.
- This reaction occurs due to exposure of the endometrium to abnormal hormonal levels, particularly low progesterone, which leads to poor decidualization.
- The presence of these atypical hypersecretory changes is a key diagnostic clue when evaluating for ectopic pregnancy in a patient with a positive pregnancy test and no evidence of an intrauterine pregnancy.



QUESTION

A 29-year-old woman is brought to the emergency department after a syncopal episode while getting out of bed. Yesterday, she developed right-sided abdominal pain, which has spread across the lower abdomen over the past few hours. She also noticed blood staining on her underwear after the syncopal episode. Her last menstrual period was 8 weeks ago.

On Examination:

- Temperature: 37°C (98.6°F)
- Blood pressure: 90/60 mm Hg
- Pulse: 125/min

She has diffuse lower abdominal pain with rebound tenderness and voluntary guarding. Pelvic examination reveals cervical motion tenderness and right-sided adnexal tenderness, with no palpated masses. Which of the following is the most likely diagnosis?

- A** Acute appendicitis
- B** Pelvic inflammatory disease
- C** Ruptured ectopic pregnancy
- D** Tubo-ovarian abscess

CORRECT

RIGHT ANSWER

- OK** **C. Ruptured ectopic pregnancy**

WHY THIS IS RIGHT

Ruptured ectopic pregnancy should be suspected in a reproductive-age woman with amenorrhea, abdominal pain, vaginal bleeding, and hemodynamic instability.

- Amenorrhea (~6-8 weeks)
- Sudden abdominal pain
- Vaginal bleeding
- Syncope or shock (hypotension, tachycardia)
- Cervical motion and adnexal tenderness
- Signs of hemoperitoneum (rebound tenderness, guarding)

Most ectopic pregnancies occur in the fallopian tube. Tubal rupture causes intra-abdominal bleeding, leading to hypovolemic shock.

Clinical takeaway:

In suspected ruptured ectopic pregnancy with hemodynamic instability, the next step is immediate surgical management (emergency laparoscopy/laparotomy) rather than further diagnostic testing.

QUESTION

A 39-year-old woman, gravida 2 para 1, at 38 weeks gestation, comes to the office for a routine prenatal visit. The patient feels well and reports normal fetal activity. Last week, she had nausea, vomiting, and diarrhea for 24 hours, but she has been able to eat and drink normally for the past several days. For the past 2 days, the patient has had increased clear vaginal discharge with irregular, painful contractions but no vaginal bleeding. Temperature is 99.6 °F (37.6 °C), blood pressure is 132/86 mm Hg, and pulse is 96/ min. The uterus is nontender and the fundal height is 34 cm. Fetal heart tones are 135/ min. Fetal ultrasound shows a cephalic fetus, measuring at the 50th percentile for gestational age, and an amniotic fluid index of 2 cm (normal: >5 cm). Which of the following is the most likely cause of this patient's amniotic fluid level?

- A** Fetal congenital infection
- B** Maternal dehydration
- C** Normal gestational age variant
- D** Rupture of membranes

CORRECT

RIGHT ANSWER

- OK** **D. Rupture of membranes**

WHY THIS IS RIGHT

Oligohydramnios is defined as amniotic fluid index (AFI) ≤ 5 cm.

In late pregnancy, the most common cause of sudden oligohydramnios is rupture of membranes (ROM). When the amniotic sac ruptures, amniotic fluid leaks through the cervix and vagina, resulting in:

- Decreased amniotic fluid
- Oligohydramnios on ultrasound

Why Other Options Are Incorrect:

- Fetal congenital infection: usually causes fetal anomalies, growth restriction, or hydrops, not isolated oligohydramnios.
- Maternal dehydration: may cause mild reduction in fluid but not severe AFI of 2 cm.
- Normal gestational age variant: AFI < 5 cm is abnormal at any gestational age.

*

QUESTION

A 30-year-old woman, gravida 4 aborta 3, has a history of a miscarriage at 8 weeks, a second miscarriage at 11 weeks with absent cardiac activity, and a third pregnancy loss at 24 weeks due to preterm delivery associated with early-onset preeclampsia. What is the most probable diagnosis?

A Syphilis

B Antiphospholipid antibody syndrome

CORRECT

C TORCH infections

D Gestational diabetes mellitus

RIGHT ANSWER

OK

B. Antiphospholipid antibody syndrome

WHY THIS IS RIGHT

Antiphospholipid antibody syndrome is an autoimmune hypercoagulable disorder that leads to thrombosis in placental vessels, causing recurrent pregnancy loss and placental insufficiency.

It should be suspected in women with the following obstetric history:

- ≥ 3 consecutive miscarriages before 10 weeks
- Unexplained fetal death after 10 weeks
- Preterm birth (<34 weeks) due to severe preeclampsia, placental insufficiency, or fetal growth restriction

Antiphospholipid antibodies cause:

- Hypercoagulability
- Placental vascular thrombosis
- Placental infarction $\rightarrow$ fetal loss or severe preeclampsia

Important antibodies

- Lupus anticoagulant
- Anticardiolipin antibody
- Anti- $\beta 2$ glycoprotein I

Management during pregnancy

- Low-dose aspirin + heparin (usually LMWH) to prevent placental thrombosis and improve fetal survival.

QUESTION

A patient present at 9 weeks pregnancy. She asks for medical method of abortion. What will you advise her?

A Hyperosmolar saline

B Mifepristone and misoprostol

CORRECT

C Oxytocin

D Dinoprostone

RIGHT ANSWER

OK

B. Mifepristone and misoprostol

WHY THIS IS RIGHT

Medical termination of pregnancy (MTP) using mifepristone and misoprostol is recommended for up to 9 weeks of gestation.

Mifepristone 200 mg orally

Action:

Blocks progesterone

↓

Breakdown of endometrium

↓

Detachment of gestational sac

After 48 hours:

Misoprostol 800 µg

-> Vaginal / Buccal / Sublingual

Action:

Uterine contractions

↓

Expulsion of products of conception

Action:

Uterine contractions

↓

Expulsion of products of conception

QUESTION

| All are members of the medical board in MTP > 24 weeks, except?

A Radiologist

B Gynecologist

C Legal advisor

CORRECT

D Pediatrician

RIGHT ANSWER

OK C. Legal advisor

WHY THIS IS RIGHT

For MTP >24 weeks (special categories), the medical board includes gynecologist, radiologist, pediatrician, and a relevant specialist. A legal advisor is NOT part of the board, as decisions are medical, not legal.

QUESTION

A patient was undergoing a hysteroscopic removal of a submucosal fibroid, in which a fluid deficit of 2000 mL is estimated in a patient. What is the immediate complication of this?

A Acute tubular necrosis

B DIC

C Pulmonary edema

CORRECT

D Thromboembolism

RIGHT ANSWER

OK C. Pulmonary edema

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1a” here and does not include a written explanation for this item.

QUESTION

A 26-year-old woman who is being treated for infertility with human menopausal gonadotropin presented with complaints of sudden abdominal pain, nausea, vomiting, and breathlessness. The finding of the ultrasound is shown below. What is the most likely diagnosis?

A Ovarian hyperstimulation syndrome

CORRECT

B Polycystic ovarian syndrome

C Theca lutein cysts

D Granulosa cell tumor

RIGHT ANSWER

OK

A. Ovarian hyperstimulation syndrome

WHY THIS IS RIGHT

Ovarian Hyperstimulation Syndrome- It occurs most commonly after ovulation induction therapy.
Drugs That Cause OHSS

Commonly associated with:

Drug	Use
Human Menopausal Gonadotropin	Ovulation induction
hCG trigger	Final oocyte maturation
Clomiphene (rarely)	Ovulation induction

Excess ovarian stimulation

↓
High estrogen levels
↓
Release of VEGF
↓
Increased vascular permeability
↓
Fluid shifts to third spaces

This leads to:

- Ascites
- Pleural effusion
- Hemoconcentration

Ultrasound Findings

Typical findings:

- Enlarged multicystic ovaries
- Ascites

These features strongly suggest OHSS.

Severity	Features
Mild	Ovarian enlargement
Moderate	Ascites
Severe	Hemoconcentration, pleural effusion
Critical	Thrombosis, renal failure

QUESTION

A female presents to OPD with 6 weeks of amenorrhea complaints of bleeding per vagina and mild abdominal pain. The urine pregnancy test is positive and hCG level is 2800 IU/L. On investigation, mass is seen on the left adnexa measuring 3 x 2 cm. She is hemodynamically stable. How will you manage this patient?

- A** Oral methotrexate
- B** Single-dose methotrexate injection
- C** Serial methotrexate injections + leucovorin rescue
- D** Salpingectomy

CORRECT

RIGHT ANSWER

- OK** **B. Single-dose methotrexate injection**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

A patient in early pregnancy presents to the emergency department with vaginal spotting. On ultrasound, which of the following findings is diagnostic of a missed abortion?

A No cardiac activity at a CRL > 7mm

CORRECT

B No cardiac activity at a CRL < 7mm

C No cardiac activity at a CRL > 25mm

D No cardiac activity at a CRL < 12mm

RIGHT ANSWER

OK

A. No cardiac activity at a CRL > 7mm

WHY THIS IS RIGHT

Missed abortion is diagnosed when there is no cardiac activity detected on ultrasound at CRL $\geq$ 7mm. Typical presentation:

- Vaginal spotting
- Loss of pregnancy symptoms
- Closed cervical os

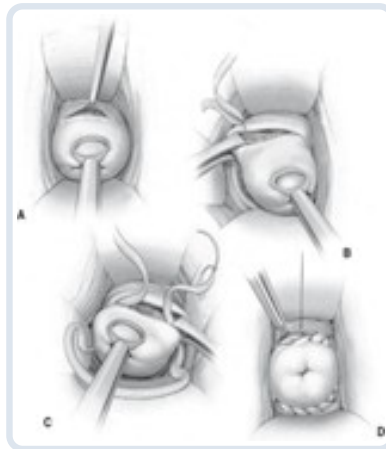
This threshold distinguishes between normal early development (cardiac activity not yet detectable) and embryonic demise (cardiac activity absent when it should be present).

Ultrasound finding	Diagnosis
CRL $\geq$ 7 mm with no cardiac activity	Diagnostic of missed abortion
Gestational sac $\geq$ 25 mm with no embryo	Anembryonic pregnancy

Finding	Interpretation
Gestational sac $\geq$ 25 mm with no embryo	Blighted ovum
No embryo after 2 weeks of sac seen	Pregnancy failure

QUESTION

An image shows a cervical cerclage being applied in a patient with cervical insufficiency. Identify the type of cerclage procedure?



A McDonald

B Modified McDonald

C Shirodkar

D Modified Shirodkar

CORRECT

RIGHT ANSWER

OK

D. Modified Shirodkar

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

Identify the clinical sign demonstrated in the image below?



A Chadwick sign

B Goodell sign

C Hegar sign

CORRECT

D Osiander sign

RIGHT ANSWER

OK

C. Hegar sign

WHY THIS IS RIGHT

Hegar sign is softening of the lower uterine segment, allowing fingers to approximate on bimanual exam in early pregnancy (6-10 weeks). Other signs relate to cervical softening or vascular changes.

During early pregnancy:

Hormonal changes (progesterone, estrogen)

↓

Increased uterine vascularity

↓

Softening of uterine isthmus

↓

Lower uterine segment becomes compressible

During examination:

- The cervix and uterine body feel separate
- Because the isthmus becomes very soft

During bimanual examination:

- One hand in vagina
- Other hand on abdomen

The uterine body and cervix feel disconnected due to soft isthmus.

Other Early Pregnancy Signs

| Sign | Finding |

| --- | ----- |

| Chadwick Sign | Bluish cervix |

| Goodell Sign | Soft cervix |

| Osiander Sign | Pulsation felt in lateral fornix |

| Hegar sign | Soft uterine isthmus |

QUESTION

A 20-year-old woman presented at 7 weeks of gestation, unwilling to continue the pregnancy. What are the drugs used for medical termination of pregnancy in this patient?

A Misoprostol + Medroxyprogesterone

B Misoprostol + Mifepristone

CORRECT

C Mifepristone + Methotrexate

D Mifepristone + Medroxyprogesterone

RIGHT ANSWER

OK B. Misoprostol + Mifepristone

WHY THIS IS RIGHT

Medical Termination of Pregnancy is commonly performed in early pregnancy (≤ 9 weeks) using a combination of two drugs.

Mifepristone

Mechanism:

- Blocks progesterone receptors
- Causes decidual breakdown
- Detaches the gestational sac

Misoprostol

Mechanism:

- Causes uterine contractions
- Leads to expulsion of products of conception

| Drug | Function |

| --- | ----- |

| Mifepristone | Sensitizes uterus to prostaglandins |

| Misoprostol | Induces uterine contractions |

Day 1 -> Mifepristone 200 mg orally

↓

24-48 hours later

↓

Misoprostol 800 µg vaginal / buccal

↓

Expulsion of pregnancy

QUESTION

A 22y primigravida is overdue by 2 weeks. She visits the OPD with complaints of vaginal bleeding and abdominal pain on the right side. On Examination, her vitals are stable. Abdomen examination is unremarkable. A bimanual examination reveals a bulky, soft uterus with no tenderness and no adnexal mass. Mild bleeding +. Beta hCG is 1400 IU. An ultrasound reveals a trilaminar endometrium, and both the adnexa are normal. The next best step is?

A Repeat serum beta HCG after 48h

CORRECT

B Diagnostic laparoscopy

C Repeat USG after 3 days

D Wait and watch

RIGHT ANSWER

OK A. Repeat serum beta HCG after 48h

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

A 39y G2P1 presents at 18 weeks 5 days for her routine targeted fetal anomaly ultrasound. The fetal anatomy appears normal, but the cervical length is 15mm. Despite being counselled that there is no clear proven benefit for the same; the patient insisted on a cervical cerclage. Which of the following is a complete contra-indication to cerclage?

A Positive fetal fibronectin test

B Membranes bulging into vagina

C Ruptured membranes

CORRECT

D Advanced maternal age

RIGHT ANSWER

OK C. Ruptured membranes

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

A 14-year-old girl, a victim of rape, presents at 22 weeks for abortion. What advice will you give her?

- A** MTP cannot be done as she has crossed 20 weeks
- B** MTP can be done till 24 weeks
- C** MTP can be done only if the mother's life is at risk
- D** MTP can only be done if there is a substantial fetal anomaly

CORRECT

RIGHT ANSWER

- B. MTP can be done till 24 weeks**

WHY THIS IS RIGHT

Termination of pregnancy in India is governed by the Medical Termination of Pregnancy Act.

The 2021 amendment expanded the upper gestational limit for certain categories.

Gestational Age	Requirement
Up to 20 weeks	Opinion of 1 registered medical practitioner
20-24 weeks	Opinion of 2 registered medical practitioners
>24 weeks	Allowed only for major fetal anomalies (medical board approval)

Special Categories Eligible for 20-24 Week Termination

The law specifically includes rape survivors.

Eligible groups:

Category
Survivors of rape or incest
Minors
Differently-abled women
Change in marital status (widow/divorce)
Severe fetal anomalies

QUESTION

According to the MTP Act Amendment of 2021, at what gestational age range is the opinion of two registered medical practitioners required for termination of pregnancy?

A < 12 weeks

B 12-20 weeks

C 20-24 weeks

CORRECT

D > 24 weeks

RIGHT ANSWER

OK C. 20-24 weeks

WHY THIS IS RIGHT

Medical Termination of Pregnancy (MTP) Act 2021

The 2021 amendment expanded access to abortion and modified the doctor approval requirements depending on gestational age.

| Gestational Age | Doctor Requirement |

| ----- | ----- |

| ≤20 weeks | Opinion of 1 Registered Medical Practitioner |

| 20-24 weeks | Opinion of 2 Registered Medical Practitioners |

| >24 weeks | Allowed only for fetal abnormalities with approval of a State Medical Board |

Thus, two doctors are specifically required for termination between 20 and 24 weeks.

QUESTION

A woman presents with bleeding for 2 days and abdominal pain. Her LMP was 6 weeks back. An ultrasound shows fluid in the pouch of Douglas. What is the diagnosis?

A Abruptio placentae

B Placenta previa

C Missed abortion

D Ruptured ectopic pregnancy

CORRECT

RIGHT ANSWER

OK

D. Ruptured ectopic pregnancy

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1f” here and does not include a written explanation for this item.

QUESTION

A 26-year woman presents with six weeks amenorrhea. Obstetrician notices right adnexal tenderness on cervical motion during examination. Which of the following is an incorrect statement?

A Abdominal pain is the commonest presentation

B Oral methotrexate is treatment of choice

CORRECT

C Chances of ectopic increase in PID

D Low progesterone is not diagnostic

RIGHT ANSWER

OK B. Oral methotrexate is treatment of choice

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$20” here and does not include a written explanation for this item.

QUESTION

According to the MTP Act Amendment of 2021, at what gestational age range is the opinion of two registered medical practitioners required for termination of pregnancy?

A < 12 weeks

B 12-20 weeks

C 20-24 weeks

CORRECT

D > 24 weeks

RIGHT ANSWER

OK C. 20-24 weeks

WHY THIS IS RIGHT

Medical Termination of Pregnancy (MTP) Act 2021

The 2021 amendment expanded access to abortion and modified the doctor approval requirements depending on gestational age.

| Gestational Age | Doctor Requirement |

| ----- | ----- |

| ≤20 weeks | Opinion of 1 Registered Medical Practitioner |

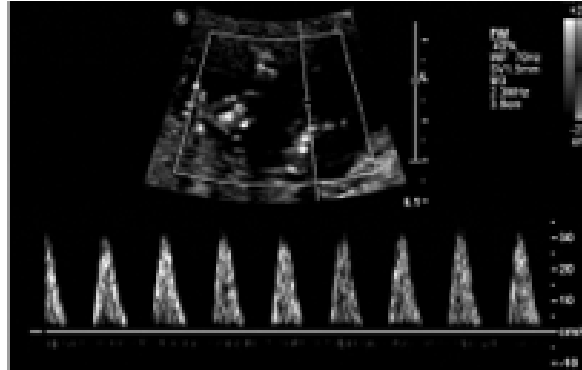
| 20-24 weeks | Opinion of 2 Registered Medical Practitioners |

| >24 weeks | Allowed only for fetal abnormalities with approval of a State Medical Board |

Thus, two doctors are specifically required for termination between 20 and 24 weeks.

QUESTION

A 28-week pregnant woman presents with fetal distress. An MCA Doppler study is provided. What is the next best step in management?



- A** Immediate termination of pregnancy
- B** Give steroid cover and monitor with Doppler and BPP, and plan delivery CORRECT
- C** Give steroid and take up for CS immediately
- D** Go for normal vaginal delivery as baby is very small

RIGHT ANSWER

- OK** **B. Give steroid cover and monitor with Doppler and BPP, and plan delivery**

WHY THIS IS RIGHT

Middle Cerebral Artery (MCA) Doppler is used to assess fetal anemia and fetal hypoxia, especially in conditions like IUGR, Rh isoimmunization, or fetal distress.

When the fetus becomes hypoxic or anemic, there is brain-sparing effect:

- Decreased cerebral vascular resistance
- Increased MCA peak systolic velocity

At preterm gestation (e.g., 28 weeks) with abnormal Doppler:

- Do not deliver immediately unless severe compromise
- Give antenatal corticosteroids for lung maturity
- Close surveillance with Doppler studies and Biophysical Profile (BPP)
- Plan timely delivery if deterioration occurs

QUESTION

A 30-year-old at 30 weeks is diagnosed with GDM. After 1 week of medical nutrition therapy, her 2-hour postprandial values remain 132 to 146 mg/dL. What is the next step?

A Continue MNT alone because 2-hour PP target is <140 mg/dL

B Add insulin plus continue MNT

CORRECT

C Start metformin as first-line in all GDM

D Begin NST weekly immediately and ignore glycemic escalation

RIGHT ANSWER

OK

B. Add insulin plus continue MNT

WHY THIS IS RIGHT

Gestational diabetes mellitus (GDM) is initially managed with medical nutrition therapy (MNT), exercise, and glucose monitoring.

Target Glucose Levels in GDM:

- Fasting: <95 mg/dL
- 1-hour postprandial: <140 mg/dL
- 2-hour postprandial: <120 mg/dL

If glycemic targets are not achieved within about 1-2 weeks of MNT, pharmacologic therapy should be started. Since the postprandial glucose remains elevated, the next step is to initiate insulin therapy while continuing dietary management.

- Insulin is the preferred and safest treatment in pregnancy
- It does not cross the placenta
- Provides better control of maternal hyperglycemia

Why Other Options Are Incorrect:

- Continue MNT alone: glucose levels exceed target.
- Metformin first-line in all GDM: may be used in some cases but insulin remains the preferred treatment when diet fails.
- Start NST and ignore glycemic control: fetal surveillance does not replace glycemic management.

QUESTION

A 28-year-old with gestational diabetes mellitus (GDM) is being counselled. Consider the following statements.

1. DIPSI requires fasting.
 2. Significant insulin resistance typically increases as pregnancy advances, with prominent rise in mid-second to early third trimester.
 3. GDM does not increase congenital malformation risk
 4. In pregestational diabetes, fetal echocardiography is indicated at 22 to 24 weeks.
- Choose the correct option.

A 1 and 2 only

B 1, 2 and 3 only

C 2 and 4 only

D 2, 3 and 4 only

CORRECT

RIGHT ANSWER

OK D. 2, 3 and 4 only

WHY THIS IS RIGHT

Gestational Diabetes Mellitus (GDM) is characterized by progressive insulin resistance during pregnancy due to placental hormones (human placental lactogen, cortisol, progesterone).

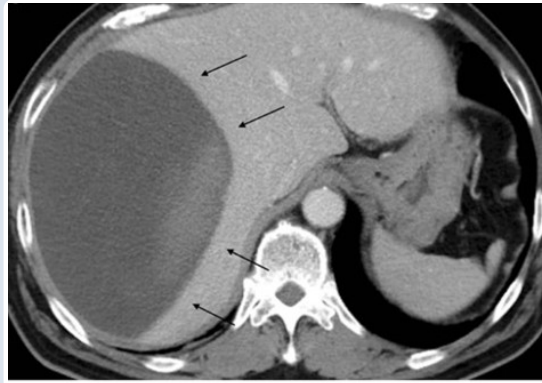
- Insulin resistance increases as pregnancy advances, especially in the mid-second to early third trimester.
- GDM does not increase congenital malformations because hyperglycemia develops after organogenesis.
- Pregestational diabetes carries a higher risk of fetal cardiac anomalies, so fetal echocardiography at 22-24 weeks is recommended.
- DIPSI test does not require fasting (75 g glucose given irrespective of last meal).

QUESTION

An 18-year-old primigravida at 27 weeks' gestation presents to the emergency department with severe right upper quadrant pain for the past 2 hours. She also reports nausea, vomiting, and irregular uterine contractions. Laboratory tests show:

- AST (SGOT): 220 U/L
- ALT (SGPT): 240 U/L

A contrast-enhanced CT scan is shown below. Which of the following complications is she most likely at risk for?



- A** Acute interstitial nephritis
- B** Bleeding esophageal varices
- C** Intraamniotic infection

D Seizures

CORRECT

RIGHT ANSWER

OK D. Seizures

WHY THIS IS RIGHT

Severe right upper quadrant (RUQ) pain in pregnancy with elevated liver enzymes suggests HELLP syndrome, a severe variant of Preeclampsia characterized by:

- Hemolysis
- Elevated Liver enzymes
- Low Platelets

The CT image shows a large hypodense subcapsular collection in the liver, consistent with a subcapsular hepatic hematoma, a known complication of HELLP syndrome.

- In HELLP syndrome:
- Endothelial injury and microvascular thrombosis occur in hepatic sinusoids.
- This leads to hepatic ischemia, necrosis, and subcapsular hematoma formation.
- Patients present with severe RUQ or epigastric pain, nausea, vomiting, and elevated AST/ALT.
- Patients with HELLP syndrome are at risk for:
- Eclampsia (seizures)
- Disseminated intravascular coagulation (DIC)
- Hepatic rupture
- Acute renal failure

Among the given options, the most likely complication is seizures, due to progression to Eclampsia.

QUESTION

I All are true regarding peripartum cardiomyopathy except?

A Development of cardiac failure within 5 months of delivery

B Left ventricular diastolic dysfunction

CORRECT

C Absence of identifiable cause

D Dilated left ventricle

RIGHT ANSWER

OK **B. Left ventricular diastolic dysfunction**

WHY THIS IS RIGHT

Peripartum cardiomyopathy (PPCM) is a form of dilated cardiomyopathy that occurs toward the end of pregnancy or within 5 months postpartum, without another identifiable cause of heart failure.

Diagnostic features:

- Heart failure developing in the last month of pregnancy or within 5 months after delivery
- No identifiable cause of cardiac failure
- Dilated left ventricle with reduced ejection fraction
- Left ventricular systolic dysfunction

PPCM primarily involves systolic dysfunction, not diastolic dysfunction.

QUESTION

A 35-year-old woman, gravida 2 para 1, at 16 weeks' gestation presents for a prenatal visit. She reports increased urinary frequency but otherwise feels well. Urinalysis reveals mild glucosuria. Laboratory studies show a non-fasting serum glucose concentration of 100 mg/dL. Which of the following is the most likely explanation for this patient's glucosuria?

- A Decreased SGLT2 expression
- B Increased glomerular filtration barrier permeability
- C Splay phenomenon

D Increased glomerular filtration rate

CORRECT

RIGHT ANSWER

OK D. Increased glomerular filtration rate

WHY THIS IS RIGHT

During normal pregnancy, there is a physiologic increase in renal plasma flow and glomerular filtration rate (GFR) by approximately 40-50%.

Because of this increased GFR, a larger amount of glucose is filtered at the glomerulus.

The renal tubules may not completely reabsorb this increased glucose load, resulting in mild physiologic glucosuria, even when serum glucose levels are normal.

Key features of physiologic glucosuria in pregnancy:

- Occurs due to increased GFR
- Normal blood glucose levels
- Common finding in pregnancy
- Not diagnostic of gestational diabetes

Why other options are incorrect:

- Decreased SGLT2 expression -> not the physiologic change in pregnancy
- Increased glomerular filtration barrier permeability -> would cause proteinuria, not glucosuria
- Splay phenomenon -> refers to variability in nephron glucose reabsorption but is not the primary mechanism here

QUESTION

A 31-year-old woman, gravida 3 para 2, at 28 weeks' gestation presents for a prenatal visit. She has chronic hypertension that was previously well controlled. At prior visits, her blood pressure ranged from 120/70 to 130/80 mmHg. Today, her blood pressure is 150/100 mmHg, and a repeat reading is 152/98 mmHg. Fundal height measures 24 cm. Urinalysis shows 2+ protein. Ultrasound reveals oligohydramnios and fetal growth restriction. Compared with normal placental parameters, which of the following hemodynamic changes is most likely present?

	Placental vascular resistance	Uteroplacental perfusion	Umbilical vein oxygen delivery
A	↓	↓	↑
B	↓	↑	↑
C	No change	↓	↑
D	↑	↓	↓

A A

B B

C C

D D

CORRECT

RIGHT ANSWER

OK

D. D

WHY THIS IS RIGHT

In preeclampsia with placental insufficiency, there is abnormal remodeling of spiral arteries, leading to high placental vascular resistance and reduced uteroplacental blood flow.

Hemodynamic consequences:

- Placental vascular resistance: ↑ (due to poor trophoblastic invasion and narrow spiral arteries)
- Uteroplacental perfusion: ↓
- Umbilical vein oxygen delivery to fetus: ↓

Clinical outcomes:

- Fetal growth restriction (FGR)
- Oligohydramnios
- Placental insufficiency

QUESTION

A 28-year-old primigravida with 33 weeks of gestation suddenly complains of headache, oliguria, and blurred vision. Her blood pressure is 180/110 mm Hg, and urine albumin is 3+. What is the next best step in management?

A Wait and watch

B LSCS

C Induction of labor

D Magnesium sulfate

CORRECT

RIGHT ANSWER

OK D. Magnesium sulfate

WHY THIS IS RIGHT

Severe preeclampsia (BP $\geq 160/110$ mmHg with symptoms such as headache, visual disturbance, oliguria) requires immediate seizure prophylaxis with magnesium sulfate.

- Symptoms like headache, blurred vision, and oliguria indicate severe features of preeclampsia.
- Magnesium sulfate is the drug of choice to prevent eclamptic seizures.
- After stabilization, blood pressure control and planning delivery are considered depending on gestational age and maternal-fetal status.

Mechanism:

Magnesium sulfate acts as a central nervous system depressant and NMDA receptor antagonist, reducing the risk of seizures (eclampsia).

QUESTION

A 23-year-old primigravida at 35 weeks' gestation presents to the emergency department with pedal edema. Her blood pressure is 140/90 mm Hg, and urine dipstick testing shows 2+ protein. Laboratory investigations reveal the following:

Hemoglobin: 9.2 g/dL

Random blood sugar (RBS): 123 mg/dL

SGOT: 250 IU/L

SGPT: 300 IU/L

Platelet count: 50,000/ μ L

Serum creatinine: 0.7 mg/dL

What is the next best step?

A Induction of labor

CORRECT

B Corticosteroids followed by induction of labor

C Start Labetalol and immediate LSCS

D Induction of labor at 37 weeks

RIGHT ANSWER

OK A. Induction of labor

WHY THIS IS RIGHT

This patient has preeclampsia with severe features consistent with HELLP syndrome, characterized by:

- H - Hemolysis
- EL - Elevated Liver enzymes
- LP - Low Platelet count

The definitive treatment of HELLP syndrome is delivery, regardless of gestational age once the diagnosis is made, especially after 34 weeks. Since this patient is 35 weeks pregnant, the next best step is immediate induction of labor (if there are no obstetric contraindications).

Why Other Options Are Incorrect:

- Corticosteroids followed by induction: Steroids are used before 34 weeks for fetal lung maturity.
- Start labetalol and immediate LSCS: Cesarean is not required unless there is an obstetric indication.
- Induction at 37 weeks: Delay is dangerous because HELLP can rapidly progress to DIC, liver rupture, renal failure, and maternal death.

*

QUESTION

| Which of the following statement is not true regarding lupus nephritis in pregnancy?

- A** Immunosuppression can be continued during pregnancy
- B** Pregnancy to be planned once the disease has been quiescent for at least 6 months and there is no evidence of renal dysfunction
- C** High-dose corticosteroids used for lupus flare during pregnancy are safe
- D** Ecospirin, methotrexate, cyclophosphamide, corticosteroids, and azathioprine are safe in pregnancy **CORRECT**

RIGHT ANSWER

OK

D. Ecospirin, methotrexate, cyclophosphamide, corticosteroids, and azathioprine are safe in pregnancy

WHY THIS IS RIGHT

Management of systemic lupus erythematosus (SLE) with lupus nephritis in pregnancy requires careful selection of immunosuppressive drugs, as some medications are teratogenic.

Safe/relatively safe drugs in pregnancy:

- Low-dose aspirin (Ecospirin) - used to reduce risk of preeclampsia and thrombosis
- Corticosteroids - used to treat lupus flares
- Azathioprine - considered safe immunosuppressant in pregnancy
- Hydroxychloroquine - recommended to continue during pregnancy

Contraindicated drugs:

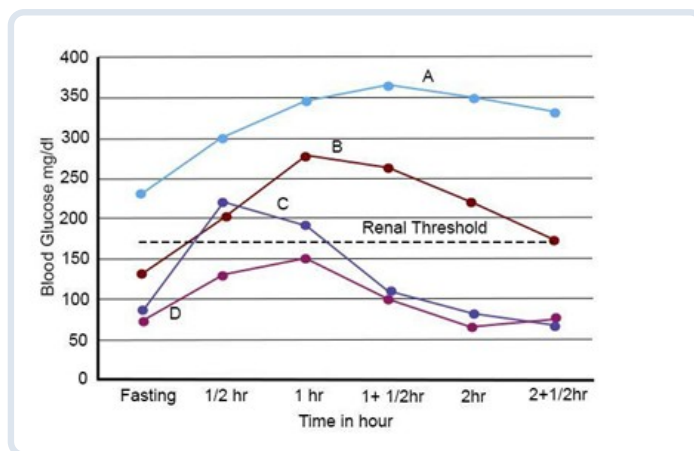
- Methotrexate -> strongly teratogenic
- Cyclophosphamide -> teratogenic and fetotoxic, avoided especially in early pregnancy
- Mycophenolate mofetil -> also contraindicated

Other important principles:

- Pregnancy should be planned when SLE has been quiescent for ≥ 6 months with stable renal function.
- Immunosuppressive therapy may be continued, but only pregnancy-safe drugs should be used.

QUESTION

Which of the following graphs represents normal response to an oral glucose tolerance test (OGTT)?



A Graph A

B Graph B

C Graph C

D Graph D

CORRECT

RIGHT ANSWER

OK

D. Graph D

WHY THIS IS RIGHT

A normal oral glucose tolerance test (OGTT) shows a moderate rise in blood glucose after oral glucose intake, followed by a return to near fasting levels within 2 hours.

Normal OGTT pattern:

- Fasting glucose: < 100 mg/dL
- Peak at 30-60 minutes: mild rise (<160-180 mg/dL)
- 2-hour value: returns to <140 mg/dL

Interpretation of curves:

- Graph A: Persistently very high levels -> severe diabetes
- Graph B: Elevated fasting and delayed fall -> diabetes mellitus
- Graph C: Higher peak with delayed normalization -> impaired glucose tolerance
- Graph D: Mild rise with return to baseline by 2 hours -> normal response

QUESTION

A 29-year-old woman, gravida 2 para 1, with gestational diabetes mellitus (GDM) is being treated with insulin. Which of the following statement is not true regarding the management of this patient?

- A** Fasting blood glucose for controlled GDM should be <95mg/dL
- B** Insulin is initiated when the 1-hour postprandial blood glucose is > 140 mg/dL
- C** Insulin must be continued after delivery CORRECT
- D** Insulin does not cross the placenta

RIGHT ANSWER

- OK** **C. Insulin must be continued after delivery**

WHY THIS IS RIGHT

In gestational diabetes mellitus (GDM), insulin therapy is used during pregnancy when glycemic targets are not achieved with diet and lifestyle modification. However, insulin is usually discontinued after delivery because placental hormones causing insulin resistance rapidly fall. Key management targets in GDM:

- Fasting glucose: < 95 mg/dL
- 1-hour postprandial: < 140 mg/dL
- 2-hour postprandial: < 120 mg/dL

Important facts:

- Insulin is the preferred pharmacologic treatment because it does not cross the placenta.
- Insulin therapy is started if glucose targets are exceeded despite diet control.
- After delivery, insulin resistance decreases, so insulin is generally stopped unless overt diabetes is present.

QUESTION

In a case of MgSO_4 toxicity, all of the following parameters are monitored except?

- A RR (Respiratory Rate)
- B Urine output
- C DTR (Deep Tendon Reflexes)
- D Serum Mg level**

CORRECT

RIGHT ANSWER

- OK
- D. Serum Mg level**

WHY THIS IS RIGHT

Magnesium toxicity is monitored clinically by RR, urine output, and DTR. Loss of patellar reflex is the earliest sign of MgSO_4 toxicity. Routine serum Mg levels are not required unless toxicity is suspected. Magnesium is cleared through the kidneys.

Reduced urine output

↓

Magnesium accumulation

↓

Risk of toxicity

Therefore: Urine output should be $>25\text{-}30$ mL/hour.

Clinical monitoring is more reliable and practical in obstetric practice.

| Serum Mg Level | Effect |

| ----- | ----- |

| 4-7 mEq/L | Therapeutic level |

| 7-10 mEq/L | Loss of DTR |

| 10-12 mEq/L | Respiratory depression |

| >15 mEq/L | Cardiac arrest |

Serum Mg Level Is Not Monitored Routinely

Although it can be measured, routine monitoring relies on clinical parameters because they are:

- Rapid
- Bedside accessible
- Clinically reliable

Antidote for Magnesium Toxicity- Calcium Gluconate

Dose:

- 10 mL of 10% calcium gluconate IV slowly

QUESTION

A primigravida presents at 37 weeks. She is a known case of heart disease with a prosthetic valve on warfarin. What is the next best step?

A Continue warfarin

B Switch to LMWH

CORRECT

C Immediate caesarean

D Immediate IOL

RIGHT ANSWER

OK B. Switch to LMWH

WHY THIS IS RIGHT

Warfarin is unsafe near term due to fetal and maternal bleeding risk. Near delivery, warfarin increases the risk of:

Complication	Reason
Fetal intracranial hemorrhage	Placental transfer
Maternal bleeding during labor	Anticoagulation
Neonatal bleeding	Long half-life

Therefore, warfarin is replaced by heparin near term.

At 36-37 weeks, anticoagulation is switched to LMWH, which does not cross the placenta. Delivery is planned only after stopping LMWH for an appropriate interval.

QUESTION

A 26-year-old G2P1 at 8 weeks diagnosed to have hyperthyroidism. What is the drug of choice?

A Methimazole

B Carbimazole

C Iodine 131

D Propylthiouracil

CORRECT

RIGHT ANSWER

OK

D. Propylthiouracil

WHY THIS IS RIGHT

PTU is preferred in the 1st trimester because methimazole/carbimazole are linked to congenital anomalies (e.g., aplasia cutis). Radioactive iodine is absolutely contraindicated. After 1st trimester, therapy is usually switched to methimazole. This switch reduces PTU-related hepatotoxicity later in pregnancy.

QUESTION

| A 32-year-old G2P1 is diagnosed to have DVT at 30 weeks. The drug of choice is?

- A** Warfarin
- B** LMWH (Low Molecular Weight Heparin) CORRECT
- C** Fondaparinux
- D** Apixaban

RIGHT ANSWER

- OK** **B. LMWH (Low Molecular Weight Heparin)**

WHY THIS IS RIGHT

LMWH is the treatment of choice for DVT in pregnancy because it does not cross the placenta and has a predictable safety profile. Warfarin and DOACs (e.g., apixaban) cross the placenta and are unsafe. Fondaparinux is reserved for HIT.

QUESTION

A primigravida presents to you in her early pregnancy with anemia. She is 7 weeks pregnant as seen on ultrasound. Her haemoglobin level is 9 g/dL. When should the iron supplements be started for her?

A 10 to 12 weeks

B 8 to 10 weeks

CORRECT

C After 14 weeks

D After 20 weeks

RIGHT ANSWER

OK B. 8 to 10 weeks

WHY THIS IS RIGHT

Iron supplementation is usually started after early organogenesis begins because:

Early pregnancy

↓

Organogenesis occurring

↓

Iron started after early weeks

↓

Better tolerance and absorption

Starting at 8-10 weeks ensures that:

- The fetus has begun significant hematopoiesis
- Maternal iron stores can be replenished early

Hb 9 g/dL denotes moderate anemia, which needs therapeutic iron without delay. Prophylactic iron starts at 14 weeks, but treatment of established anemia must begin earlier. Among options, 8-10 weeks is the earliest and therefore correct.

| Requirement | Approximate amount |

| ----- | ----- |

| Fetal development | ~300 mg |

| Placenta | ~50 mg |

| Maternal RBC expansion | ~500 mg |

Daily supplementation usually includes:

| Nutrient | Dose |

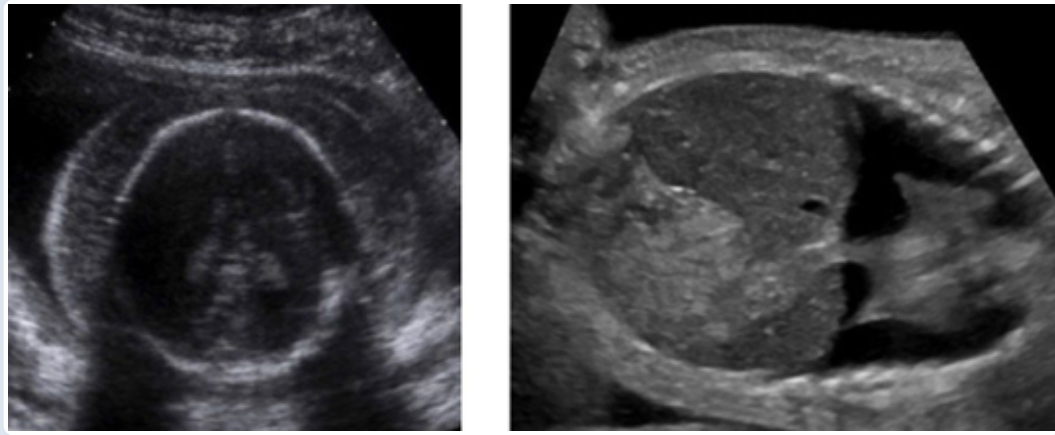
| ----- | ---- |

| Iron | 60 mg elemental iron |

| Folic acid | 400-500 µg |

QUESTION

A 24-year-old woman, G2P0A1, at 26 weeks' gestation comes to the OPD for an initial prenatal visit. Her blood type is O Rh-negative, and the indirect Coombs test is negative. Fundal height corresponds to 34 weeks' gestation. The ultrasound images are shown below. Which of the following factors most likely contributed to this fetal presentation?



- A** Exposure to a child with a rash
- B** Inadequate maternal folate supplementation
- C** Lack of Rh(D) immunization in a prior pregnancy
- D** Nonadherence to vaccination schedule

CORRECT

RIGHT ANSWER

- OK** **A. Exposure to a child with a rash**

WHY THIS IS RIGHT

Maternal Parvovirus B19 infection (often acquired after exposure to a child with a rash-erythema infectiosum/fifth disease) can cause fetal anemia leading to hydrops fetalis due to viral destruction of erythroid precursors in the fetal bone marrow.

- Parvovirus B19 infects erythroid progenitor cells -> severe aplastic anemia in the fetus.
- Resulting anemia causes high-output cardiac failure -> hydrops fetalis (ascites, skin edema, pleural/pericardial effusion) as seen on ultrasound.
- Maternal infection often occurs after contact with a child with "slapped cheek" rash.

Clinical relevance:

- Suspected cases are evaluated with maternal Parvovirus B19 IgM/IgG and fetal middle cerebral artery Doppler for anemia.
- Severe fetal anemia may require intrauterine transfusion.

QUESTION

A 35-year-old primigravida presents to the labor and delivery unit at 36 weeks' gestation with abdominal pain and blood-tinged vaginal discharge. She was diagnosed with gestational diabetes mellitus (GDM) at 27 weeks but has been noncompliant with diet and insulin therapy. On cervical examination, the cervix is 6 cm dilation and 100% effaced. Her blood glucose level on admission is 290 mg/dL, and insulin therapy is initiated. The patient subsequently has a spontaneous vaginal delivery of a male infant. Which of the following examination findings is most likely to be present in this neonate?

A Heart murmur

B Limb defects

C Respiratory distress

CORRECT

D Small for gestational age

RIGHT ANSWER

OK C. Respiratory distress

WHY THIS IS RIGHT

In gestational diabetes mellitus (GDM), maternal hyperglycemia leads to fetal hyperglycemia, which stimulates fetal pancreatic β -cells to produce excess insulin (hyperinsulinemia).

Effect on fetal lungs:

- High fetal insulin levels inhibit surfactant production by type II pneumocytes.
- This delays lung maturation.

Neonatal consequence: Respiratory distress syndrome (RDS) shortly after birth due to surfactant deficiency.

Other typical findings in infants of diabetic mothers:

- Macrosomia
- Neonatal hypoglycemia
- Polycythemia
- Hyperbilirubinemia
- Hypertrophic cardiomyopathy

Why other options are less likely:

- Heart murmur (congenital heart disease) is more associated with pregestational diabetes.
- Limb defects occur with early teratogenic exposure, also linked to pregestational diabetes.
- Small for gestational age is uncommon; infants are usually large for gestational age (macrosomic).

QUESTION

The diagnostic criteria for catastrophic antiphospholipid syndrome (CAPS) include all of the following EXCEPT:

- A Involvement of three or more organs
- B Development of clinical manifestations in less than one week
- C Histological evidence of hydropic degeneration of villi**
- D Presence of antiphospholipid antibodies on two occasions of least six weeks apart

CORRECT

RIGHT ANSWER

- OK** C. Histological evidence of hydropic degeneration of villi

WHY THIS IS RIGHT

Catastrophic Antiphospholipid Syndrome (CAPS) is a severe variant of antiphospholipid syndrome (APS) characterized by rapid, widespread small-vessel thrombosis leading to multiorgan failure.

Diagnostic criteria for CAPS include:

- Involvement of three or more organs, systems, or tissues
- Rapid development of manifestations (within ≤ 1 week)
- Histologic evidence of small-vessel thrombosis
- Presence of antiphospholipid antibodies (e.g., lupus anticoagulant, anticardiolipin, anti- $\beta 2$ glycoprotein I) on repeated testing

Incorrect statement:

- Histological evidence of hydropic degeneration of villi is not a criterion for CAPS; it is typically associated with molar pregnancy, not thrombotic APS.

QUESTION

A 21-year-old woman, gravida 1 para 0, at 36 weeks' gestation presents to the hospital after being found to have a blood pressure of 190/110 mm Hg in the office. Initial laboratory studies show elevated serum creatinine and transaminases. She is treated with nifedipine and magnesium sulfate, and labor is induced with oxytocin. Six hours later, her blood pressure is 150/90 mm Hg. She now complains of nausea, headache, generalized muscle weakness, and respiratory distress. On examination, deep tendon reflexes are absent. What is the most likely cause of the findings?

A Drug-drug interaction

B Hypocalcemia

C Oxytocin toxicity

D Renal insufficiency

CORRECT

RIGHT ANSWER

OK

D. Renal insufficiency

WHY THIS IS RIGHT

This patient with severe preeclampsia was treated with magnesium sulfate, which is used to prevent eclamptic seizures.

Magnesium sulfate is excreted by the kidneys, so renal impairment can lead to magnesium accumulation and toxicity.

Features of magnesium toxicity:

- Loss of deep tendon reflexes (early sign)
- Muscle weakness
- Nausea and headache
- Respiratory depression/distress
- Severe cases -> cardiac arrest

In this patient, elevated serum creatinine indicates renal insufficiency, which reduces magnesium excretion, leading to magnesium toxicity.

Management of magnesium toxicity:

- Stop magnesium sulfate
- Administer IV calcium gluconate as an antidote
- Provide respiratory support if needed

QUESTION

A 25-year-old woman with a history of peripartum cardiomyopathy following a previous pregnancy presents for preconception counselling. Her current echocardiography shows a left ventricular ejection fraction (LVEF) of 45%. What is the best advice regarding a future pregnancy?

- A** Pregnancy is contraindicated CORRECT
- B** Pregnancy is safe with lifestyle modifications
- C** Pregnancy is safe with close monitoring and medical management
- D** Pregnancy is safe as in the general population

RIGHT ANSWER

- OK** **A. Pregnancy is contraindicated**

WHY THIS IS RIGHT

Peripartum cardiomyopathy (PPCM) is a form of dilated cardiomyopathy occurring toward the end of pregnancy or in the postpartum period, characterized by left ventricular systolic dysfunction.

Risk in future pregnancy depends on recovery of left ventricular function:

- LVEF <50% (persistent dysfunction):
 - o High risk of heart failure recurrence and maternal morbidity in subsequent pregnancy.
 - o Pregnancy may be considered only with intensive counseling, close monitoring, and cardiology-obstetric care.
 - LVEF normalized (>50-55%):
 - o Lower risk but recurrence is still possible.
- Management approach in this case (LVEF 45%):
- Pregnancy not absolutely contraindicated but carries significant risk.
 - Requires close monitoring by a multidisciplinary team, optimization of cardiac medications, and frequent cardiac evaluation.

QUESTION

A 23-year-old woman with eclampsia is on a maintenance dose of MgSO₄. When will you stop MgSO₄?

A Knee jerk present

B RR 18/min

C Visual disturbance

D Urine output 60 ml in 4 hr

CORRECT

RIGHT ANSWER

OK

D. Urine output 60 ml in 4 hr

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

Under the Anemia Mukht Bharat (AMB) initiative, mild to moderate anemia in pregnant women at less than 34 weeks of gestation is treated with:

- A** 60 mg elemental iron and 500 mcg folic acid daily
- B** IV iron sucrose
- C** 45mg elemental iron and 400 mcg folic acid twice daily
- D** 60 mg elemental iron and 500 mcg folic acid twice daily

CORRECT

RIGHT ANSWER

- OK** D. 60 mg elemental iron and 500 mcg folic acid twice daily

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1b" here and does not include a written explanation for this item.

QUESTION

A pregnant woman with no other comorbid conditions develops preeclampsia. She enquires about the cause. The doctor explains that it is due to the failure of the invasion of?

- A Spiral artery by villous trophoblasts
- B Radial artery by cytotrophoblasts
- C Spiral artery by extravillous trophoblasts**
- D Arcuate artery by extravillous trophoblasts

CORRECT

RIGHT ANSWER

- OK
- C. Spiral artery by extravillous trophoblasts**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A 22y type 1 DM is in the post operative ward following a cesarean done for failed induction (for preeclampsia with severe features). She complains of drowsiness and altered sensorium. She is on maintenance MgSO₄ infusion and on IV infusion of insulin. On examination, her PR is 70/ min. BP is 140/ 98 mmHg. RR is 10/min. Auscultation of lungs reveals bilateral normal air entry. Abdominal examination reveals a firm uterus with normal tenderness. Pfannenstiel scar is intact and there is no significant vaginal bleeding. B/I patellar reflexes are absent. A urine dipstick for protein and sugar is negative and a capillary glucose sample is 270 mg%. The suspected diagnosis is?

A Magnesium sulphate toxicity

CORRECT

B Diabetic ketoacidosis

C Postpartum eclampsia

D Peripartum cardiomyopathy

RIGHT ANSWER

OK **A. Magnesium sulphate toxicity**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

A pregnant lady with 34 weeks of amenorrhea has the following findings: LDH - 700 IU/L, platelets - 75,000/ mm³, serum bilirubin - 1.5 mg/dL, SGOT - 200 U/L, SGPT - 150 U/L, and BP - 140/96 mm Hg. Her coagulation profile and renal function tests are normal. What is the diagnosis?

A HELLP syndrome

CORRECT

B Acute fatty liver of pregnancy

C Viral hepatitis

D Intrahepatic cholestasis

RIGHT ANSWER

OK A. HELLP syndrome

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

A woman post-emergency LSCS for preeclampsia with fetal distress. Which is the best drug for thromboprophylaxis postpartum?

A Warfarin

B Aspirin

C Clopidogrel

D LMWH

CORRECT

RIGHT ANSWER

OK
D. LMWH

WHY THIS IS RIGHT

Pregnancy and postpartum are hypercoagulable states due to physiological changes that prepare the body to prevent bleeding.

Risk factors present in this case:

Risk Factor	Reason
Cesarean section	Surgical trauma
Preeclampsia	Endothelial injury
Postpartum state	Hypercoagulability

This increases risk of Deep Vein Thrombosis and Pulmonary Embolism.

Low Molecular Weight Heparin- Inhibits Factor Xa

Examples:

- Enoxaparin
- Dalteparin

Advantage	Reason
Safe in breastfeeding	Minimal secretion in milk
Predictable pharmacokinetics	Less monitoring
Lower bleeding risk	Compared with UFH
Once daily dosing	Convenient

Duration of Postpartum Thromboprophylaxis

Risk level	Duration
Moderate risk	7-10 days
High risk	Up to 6 weeks

QUESTION

What is the total loading dose of magnesium sulfate (MgSO_4) in the Pritchard regimen?

A 4 g

B 10 g

C 14 g

CORRECT

D 15 g

RIGHT ANSWER

OK C. 14 g

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

A pregnant patient at 36 weeks of gestation has a blood pressure of 150/105 mmHg and a +3 albuminuria. The presence of which of the following are signs of impending eclampsia?

1. Headache
2. Persistent pedal edema
3. Blurring of vision
4. Epigastric pain

A 1, 2, 3, 4

CORRECT

B 1, 3, 4

C 1, 2, 3

D 1, 2, 4

RIGHT ANSWER

OK A. 1, 2, 3, 4

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$20” here and does not include a written explanation for this item.

QUESTION

A 65-year-old woman with epithelial ovarian cancer has peritoneal caking as shown in the CECT and ascites. What is the management?



A Debulking followed by radiotherapy

B Debulking followed by chemotherapy

C Chemotherapy followed by debulking

CORRECT

D Staging laparotomy

RIGHT ANSWER

OK C. Chemotherapy followed by debulking

WHY THIS IS RIGHT

Clinical clues

- 65-year-old woman
- Epithelial ovarian cancer
- Ascites
- Peritoneal / omental caking on CECT

These findings indicate advanced-stage disease.

Ovarian cancer commonly spreads by:

- Transcoelomic spread
- Tumor cells disseminate in peritoneal fluid

Peritoneal caking refers to thick tumor deposits in the omentum, giving a “cake-like” appearance.

Management Strategy

Management depends on resectability of tumor.

If disease is extensive (as in this case)- Neoadjuvant chemotherapy -> Interval debulking surgery

Advanced ovarian cancer

↓

Neoadjuvant chemotherapy

↓

Tumor size reduces

↓

Interval debulking surgery

↓

Adjuvant chemotherapy



QUESTION

| What is the dose of corticosteroids for lung maturity?

A Dexamethasone 12 mg 24 hourly 2 doses

B Dexamethasone 6 mg 12 hourly 4 doses

CORRECT

C Betamethasone 12 mg 12 hourly 2 doses

D Betamethasone 12 mg 24 hourly 4 doses

RIGHT ANSWER

OK

B. Dexamethasone 6 mg 12 hourly 4 doses

WHY THIS IS RIGHT

Antenatal corticosteroids are given to pregnant women at risk of Preterm Birth to accelerate fetal lung maturation. They significantly reduce complications like:

- Respiratory distress syndrome (RDS)
- Intraventricular hemorrhage
- Necrotizing enterocolitis
- Neonatal mortality

Corticosteroids stimulate type II pneumocytes in the fetal lungs.

Corticosteroids

↓

Type II pneumocyte stimulation

↓

↑ Surfactant production

↓

Improved lung expansion

↓

Reduced respiratory distress syndrome

Two standard regimens are used.

| Drug | Dose | Schedule |

| --- | --- | ----- |

| Dexamethasone | 6 mg IM | Every 12 hours × 4 doses |

| Betamethasone | 12 mg IM | Every 24 hours × 2 doses |

QUESTION

A patient presents at 35 weeks with chronic HTN and 3+ proteinuria. Her BP is 170/100 mmHg and she complains of headache and blurring of vision. What is the best management option?

- A** Labetalol + MgSO₄ + Expedite delivery
- B** Labetalol + MgSO₄ + Wait till 37 weeks
- C** Labetalol + Corticosteroids + wait till 37 weeks
- D** Labetalol + Corticosteroids + Expedite delivery

CORRECT

RIGHT ANSWER

- OK**
- A. Labetalol + MgSO₄ + Expedite delivery**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$21” here and does not include a written explanation for this item.

QUESTION

Early onset pre-eclampsia is defined as:

A Before 28 weeks

B Before 30 weeks

C Before 32 weeks

D Before 34 weeks

CORRECT

RIGHT ANSWER

OK **D. Before 34 weeks**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$22" here and does not include a written explanation for this item.

QUESTION

Which of the following drug is most commonly associated with neural tube defects due to its teratogenic effects?

A Sodium valproate

CORRECT

B Lamotrigine

C Levetiracetam

D Carbamazepine

RIGHT ANSWER

OK A. Sodium valproate

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$23" here and does not include a written explanation for this item.

QUESTION

A 29-year-old pregnant woman in her first trimester is found to have asymptomatic bacteriuria on routine screening, with urine culture growing *E. coli*. What is the most common complication associated with this finding?

A Chorioamnionitis

B Fetal death

C Preterm labor

CORRECT

D Miscarriage

RIGHT ANSWER

OK C. Preterm labor

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$24” here and does not include a written explanation for this item.

QUESTION

Which of the following is not a recognized clinical use of magnesium sulfate (MgSO_4)?

A Increase renal perfusion

CORRECT

B Neuroprotection

C Prevention of seizures

D Prevents abruption

RIGHT ANSWER

OK

A. Increase renal perfusion

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$25" here and does not include a written explanation for this item.

QUESTION

A pregnant patient at 36 weeks of gestation has a blood pressure of 150/105 mmHg and a +3 albuminuria. The presence of which of the following are signs of impending eclampsia?

1. Headache
2. Persistent pedal edema
3. Blurring of vision
4. Epigastric pain

A 1, 2, 3, 4

CORRECT

B 1, 3, 4

C 1, 2, 3

D 1, 2, 4

RIGHT ANSWER

OK A. 1, 2, 3, 4

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$26” here and does not include a written explanation for this item.

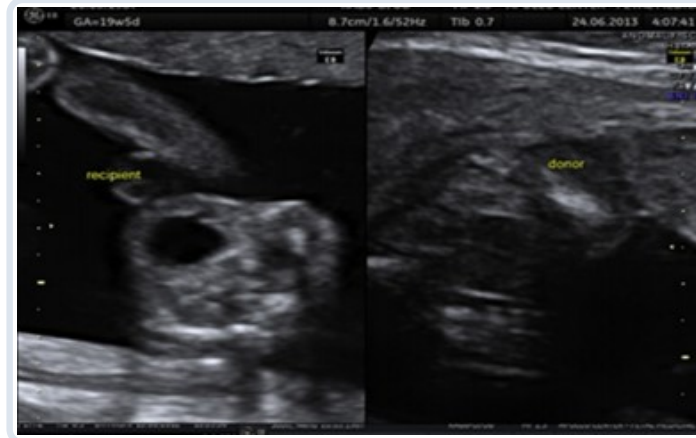
QUESTION

A 28-year-old pregnant woman at 22 weeks of gestation presents to the maternal-fetal medicine clinic for a routine prenatal check-up. She is pregnant with monochorionic diamniotic (MCDA) twins. On ultrasound examination, the following findings are noted:

Twin A: Normal amniotic fluid volume and fetal growth.

Twin B: Significant polyhydramnios (excessive amniotic fluid) and evidence of cardiomegaly

What is the likely Quintero stage for the patient?



A I

B II

CORRECT

C III

D IV

RIGHT ANSWER

OK B. II

WHY THIS IS RIGHT

Twin-to-Twin Transfusion Syndrome (TTTS) occurs in monochorionic diamniotic (MCDA) twins due to placental vascular anastomoses, causing unequal blood flow between twins.

Quintero Staging of TTTS:

- Stage I: Polyhydramnios in recipient + oligohydramnios in donor, donor bladder visible
- Stage II: Donor bladder not visible on ultrasound
- Stage III: Abnormal Doppler findings (umbilical artery, ductus venosus, or umbilical vein)
- Stage IV: Hydrops fetalis in one or both twins
- Stage V: Fetal demise

Key Concept:

- Recipient twin: Polyhydramnios, cardiomegaly, cardiac overload
- Donor twin: Oligohydramnios, growth restriction

In this case, the ultrasound findings are consistent with TTTS Stage II, characterized by absence of the donor twin bladder with fluid imbalance between twins.

QUESTION

Following delivery of an unbooked twin pregnancy, the placenta is examined and appears as shown (image). What is the most likely timing of embryonic division?



A Within 72h

B Between days 3 to 7

C After the 8th day

CORRECT

D The embryo didn't split

RIGHT ANSWER

OK C. After the 8th day

WHY THIS IS RIGHT

The placental appearance with a single placenta and two umbilical cords without a dividing membrane indicates monozygotic monoamniotic twins.

In monozygotic twinning, the timing of embryonic division determines chorionicity and amnionicity.

Timing of division	Type of twins	Placenta
Within 72 hours (day 0-3)	Dichorionic diamniotic	Two placentas
Days 4-8	Monochorionic diamniotic	One placenta, two sacs
After day 8	Monochorionic monoamniotic	One placenta, one sac
After day 13	Conjoined twins	Incomplete separation

QUESTION

A 35-year-old primigravida who conceived after in-vitro fertilization therapy came for an antenatal checkup at 38 weeks of gestation. Her obstetric history revealed that she was pregnant with DCDA twins. On examination, the first twin was found to be in a breech position and the maternal blood pressure was found to be greater than 140/90 mm Hg on two occasions with grade 1+ proteinuria. What should be done next?

A Monitor BP and terminate pregnancy if BP rises

B Immediate Caesarean section

CORRECT

C Terminate pregnancy at 40 weeks of gestation

D Induce labor with PGE2 gel

RIGHT ANSWER

OK

B. Immediate Caesarean section

WHY THIS IS RIGHT

In twin pregnancy, the presentation of the first twin determines the mode of delivery.

Key Principles:

- First twin breech -> Cesarean section indicated
- Twin pregnancy at term (≥ 37 weeks) with complications (e.g., preeclampsia) -> prompt delivery recommended
- Vaginal delivery is considered only when first twin is cephalic

QUESTION

Twin pregnancy where 1 twin is older by 1 month than the other on ultrasound. What is this known as?

- A Superfecundation
- B Superfetation**
- C Illegitimate
- D Monochorionic monoamniotic

CORRECT

RIGHT ANSWER

- OK **B. Superfetation**

WHY THIS IS RIGHT

Superfetation = twins conceived in different cycles, giving different gestational ages. Superfecundation happens in the same cycle. MCMA twins are identical and same age.

Feature	Superfetation	Superfecundation
Timing	Two different ovulation cycles	Same ovulation cycle
Gestational age	Different ages	Same age
Fathers	May be same	May be different

A) Superfecundation

- Occurs in same menstrual cycle, so fetuses have same gestational age.

C) Illegitimate

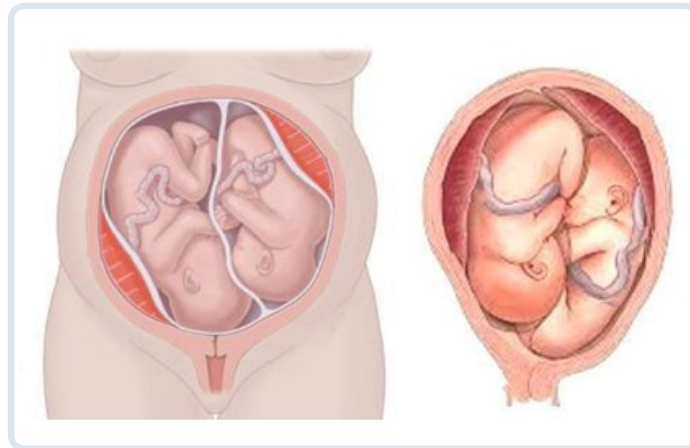
- Not a medical term.

D) Monochorionic monoamniotic

- Twins are same age, not different gestational ages.

QUESTION

What would be the mode of delivery in images 1 and 2?



- A Both caesarean
- B Both vaginal
- C Image 1: Vaginal; image 2: Caesarean
- D Image 1: Caesarean; image 2: Vaginal

CORRECT

RIGHT ANSWER

OK

C. Image 1: Vaginal; image 2: Caesarean

WHY THIS IS RIGHT

If the first twin is cephalic, vaginal delivery is safe (Image 1).

If the first twin is breech or transverse, cesarean is preferred (Image 2).

Twin A's presentation decides the mode of delivery because it is the leading fetus. Breech first twin carries risks such as cord prolapse and head entrapment.

QUESTION

| Which will you not see in twin pregnancy?

A MCMA (Monochorionic Monoamniotic)

B MCDA (Monochorionic Diamniotic)

C **MADC (Monoamniotic Dichorionic)**

CORRECT

D DADC (Dichorionic Diamniotic)

RIGHT ANSWER

OK **C. MADC (Monoamniotic Dichorionic)**

WHY THIS IS RIGHT

Twin pregnancies are classified based on:

- Chorionicity -> number of placentas
- Amnionicity -> number of amniotic sacs

| Type | Chorion | Amnion | Frequency |

| --- | ----- | ----- | ----- |

| Dichorionic diamniotic (DCDA) | 2 | 2 | Most common |

| Monochorionic diamniotic (MCDA) | 1 | 2 | Common in identical twins |

| Monochorionic monoamniotic (MCMA) | 1 | 1 | Rare |

MADC = Monoamniotic Dichorionic

This means:

- Two placentas (dichorionic)
- Only one amniotic sac (monoamniotic)

This is embryologically impossible because:

- Each chorion normally develops its own amniotic sac.
- If two chorions exist, there must be two amniotic sacs.

Thus monoamniotic dichorionic twins cannot exist.

QUESTION

After a traumatic delivery, a Kleihauer-Betke test is performed to calculate the Anti-D dose. Which statement is most accurate regarding standard Anti-D coverage?

A 300 mcg Anti-D neutralizes 30 mL fetomaternal hemorrhage

CORRECT

B 300 mcg Anti-D neutralizes 3 mL fetomaternal hemorrhage

C 150 mcg Anti-D neutralizes 30 mL fetomaternal hemorrhage

D Anti-D dose does not depend on FMH volume

RIGHT ANSWER

OK A. 300 mcg Anti-D neutralizes 30 mL fetomaternal hemorrhage

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

A 29-year-old G2P1L1, Rh negative, spouse Rh positive, had no anti-D after previous delivery. At 18 weeks, ICT titer is 1:32. Ultrasound shows no hydrops. The most appropriate next step is:

- A** Give anti-D 300 µg now and repeat at 28 weeks
- B** Repeat ICT after 4 weeks and deliver at term if titer stays stable
- C** Fetal surveillance with MCA-PSV Doppler from 20 weeks
- D** Proceed to cordocentesis immediately at 18 weeks in all cases

CORRECT

RIGHT ANSWER

- OK**
- C. Fetal surveillance with MCA-PSV Doppler from 20 weeks**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

Anti-D immunoglobulin is not given in which of the following conditions?

- A** Amniocentesis at 16 weeks
- B** Manual removal of placenta
- C** Intrauterine transfusion at 28 weeks
- D** MTP at 63 days

CORRECT

RIGHT ANSWER

- OK** **C. Intrauterine transfusion at 28 weeks**

WHY THIS IS RIGHT

Anti-D immunoglobulin is administered to Rh-negative, unsensitized pregnant women to prevent Rh isoimmunization by neutralizing Rh-positive fetal red blood cells that enter maternal circulation.

Indications for Anti-D prophylaxis include any event causing fetomaternal hemorrhage, such as:

- Amniocentesis or chorionic villus sampling
- Abortion/MTP (including early pregnancy termination)
- Manual removal of placenta
- Antepartum hemorrhage, abdominal trauma, external cephalic version
- Routine antenatal prophylaxis at 28 weeks and post-delivery if baby is Rh-positive

However, Anti-D is NOT given after intrauterine transfusion (IUT) because:

- The fetus is already Rh-sensitized and being treated for hemolytic disease of the fetus/newborn (HDFN).
- Anti-D prophylaxis is preventive, not therapeutic.

QUESTION

A 24-year-old primigravid woman at 10 weeks' gestation is brought to the emergency department with vaginal bleeding and colicky suprapubic pain radiating to the back. Her temperature is 37°C (98.7°F), blood pressure is 110/76 mm Hg, pulse is 94/min, and respirations are 18/min. Physical examination reveals a dilated cervix with visible products of conception. Suction curettage is performed, and all products of conception are evacuated. Maternal serum laboratory results are as follows:

Hematocrit: 32%

Leukocyte count: 8,000/ μ L

Blood type: AB negative

Anti-Rh antibody titer: Negative

Which of the following is the most appropriate next step in management of this patient?

A Administer anti-D immune globulin to the woman.

CORRECT

B No further workup or therapy for the woman or fetus

C Order maternal antiphospholipid antibodies

D Order maternal blood and endometrial cultures

RIGHT ANSWER

OK A. Administer anti-D immune globulin to the woman.

WHY THIS IS RIGHT

Rh-negative pregnant women exposed to Rh-positive fetal blood can develop Rh alloimmunization, leading to hemolytic disease of the fetus/newborn in future pregnancies.

Indication in This Case:

- Rh-negative mother (AB negative)
- Abortion with evacuation of products of conception
- Negative anti-Rh antibody titer -> not yet sensitized

Management:

Administer anti-D immunoglobulin (RhIg) to prevent maternal formation of anti-D antibodies.

QUESTION

Doppler assessment of which fetal vessel is most useful in detecting fetal anemia?

A Middle Cerebral Artery

CORRECT

B Umbilical artery

C Umbilical vein

D Uterine artery

RIGHT ANSWER

OK

A. Middle Cerebral Artery

WHY THIS IS RIGHT

Middle Cerebral Artery Doppler is the most sensitive non-invasive method to detect fetal anemia, especially in Rh Isoimmunization.

Middle Cerebral Artery (MCA) peak systolic velocity >1.5 multiples of median indicates fetal anemia. This non-invasive Doppler technique is the gold standard for monitoring fetal anemia, particularly in Rh isoimmunization cases. anagement if MCA PSV >1.5 MoM

Next step: Cordocentesis (PUBS) to confirm anemia.

Treatment: Intrauterine fetal blood transfusion.

QUESTION

A patient with O negative and husband B positive delivered a baby. Has received anti-D prophylaxis at 28 weeks. In which of the following conditions will you give anti-D post-delivery?

A Baby O -ve, DCT -ve

B Baby O -ve, DCT +ve

C Baby +ve, DCT +ve

D Baby +ve, DCT -ve

CORRECT

RIGHT ANSWER

OK

D. Baby +ve, DCT -ve

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1c” here and does not include a written explanation for this item.

QUESTION

A 28-year-old woman at 35 weeks and 3 days of gestation is found to have an amniotic fluid index (AFI) of 5 cm and absent end-diastolic flow (AEDF) in the umbilical artery on Doppler ultrasound. What is the most appropriate next step in her management?

A Perform daily Doppler assessments and wait for improvement

B Administer corticosteroids and delay delivery until 36 weeks

C Terminate pregnancy after 37 weeks

D Immediate delivery

CORRECT

RIGHT ANSWER

OK

D. Immediate delivery

WHY THIS IS RIGHT

Absent end-diastolic flow (AEDF) in the umbilical artery Doppler indicates severe placental insufficiency and fetal compromise, commonly seen in severe intrauterine growth restriction (IUGR). This finding is associated with a high risk of fetal hypoxia, acidosis, and intrauterine fetal demise.

Doppler Finding	Significance	Management
Increased S/D ratio	Early placental insufficiency	Close monitoring
Absent end-diastolic flow (AEDF)	Severe placental resistance	Prompt delivery if ≥ 34 weeks
Reversed end-diastolic flow (REDF)	Critical fetal compromise	Immediate delivery

Why other options are incorrect:

- Daily Doppler monitoring: Unsafe because AEDF signifies advanced compromise.
- Delay with corticosteroids: Steroids are mainly useful before 34 weeks.
- Wait until 37 weeks: Risk of fetal demise is high with AEDF.

QUESTION

A woman with obstetric score G2P1 at 14 weeks is advised uterine artery Doppler. What would it detect?

A Early-onset preeclampsia

CORRECT

B Late-onset preeclampsia

C Fetal growth restriction

D Placenta accreta

RIGHT ANSWER

OK A. Early-onset preeclampsia

WHY THIS IS RIGHT

Uterine Artery Doppler evaluates uteroplacental blood flow during pregnancy.

It is usually performed between 11-14 weeks or 18-24 weeks. The test detects impaired placental blood flow, which is associated with:

- Early Onset Preeclampsia
- Fetal Growth Restriction

However, uterine artery Doppler is primarily used to predict early-onset preeclampsia. Abnormal uterine artery Doppler predicts early-onset preeclampsia.

Normally in pregnancy:

Spiral arteries remodel

↓

Low resistance blood flow

↓

Adequate placental perfusion

In abnormal placentation:

Poor trophoblastic invasion

↓

High resistance uterine arteries

↓

Abnormal Doppler waveform

↓

Risk of early preeclampsia

| Finding | Significance |

| ----- | ----- |

| Increased pulsatility index (PI) | High resistance |

| Early diastolic notch | Poor placental perfusion |

QUESTION

| All are criteria of IUGR except?

- A** Abdominal circumference < 3rd percentile
- B** Estimated fetal weight < 3rd percentile
- C** Absent or reversal of diastolic flow in umbilical artery
- D** Uterine A PI < 95% CORRECT

RIGHT ANSWER

- OK** **D. Uterine A PI < 95%**

WHY THIS IS RIGHT

IUGR refers to failure of the fetus to achieve its genetically determined growth potential due to placental insufficiency or other causes.

Common diagnostic parameters include:

Parameter	Diagnostic finding
Estimated fetal weight (EFW)	< 3rd percentile
Abdominal circumference (AC)	< 3rd percentile
Abnormal Doppler	Umbilical artery changes
Placental insufficiency markers	Abnormal uterine artery PI

Progression of Doppler abnormalities:

Stage	Doppler Finding
Early	Increased PI
Moderate	Absent end-diastolic flow
Severe	Reversed end-diastolic flow

Uterine artery pulsatility index (PI) <95th percentile is normal, not abnormal.

For IUGR Doppler: High resistance = abnormal

So:

- Umbilical artery diastolic flow ↓
- Uterine artery PI ↑

QUESTION

A 34-year-old woman develops atonic postpartum hemorrhage after vaginal delivery. Blood pressure is 170/110 mm Hg with headache and hyperreflexia. She is a known bronchial asthma patient using inhaled steroids. Uterine atony persists after uterine massage and oxytocin infusion. The best next uterotonic choice is:

A Methylergometrine

B Carboprost

C Misoprostol

CORRECT

D Dinoprostone

RIGHT ANSWER

OK C. Misoprostol

WHY THIS IS RIGHT

Mifepristone acts as a uterotonic by blocking progesterone receptors, leading to decidual breakdown and increased uterine contractility. It sensitizes the uterus to prostaglandins and is used for medical abortion, cervical ripening, and induction of labor in obstetrics.

Other options:

- A.) Methylergometrine -> contraindicated in hypertension
- B.) Carboprost (PGF α) -> contraindicated in asthma
- C.) Misoprostol (PGE $\square$) is safe in both hypertension and asthma and effective for uterine atony
- D.) Dinoprostone is not used routinely for PPH control

QUESTION

A 25-year-old primigravida at 37 weeks' gestation presents to the emergency department with constant, excruciating abdominal pain and sudden vaginal bleeding for the past 3 hours. She is Rh negative and received Rh(D) immunoglobulin at 28 weeks.

Vital signs:

- BP: 160/100 mm Hg
- Pulse: 118/min

Physical examination shows a firm and tender uterus. Speculum exam reveals moderate bleeding from an open cervical os. Fetal heart tracing shows a baseline of 105/min with no variability.

Which of the following is the most likely cause of her bleeding?

A Attachment of the placenta onto the myometrium

B Injury to the fetal placental vessels

C Placental implantation over the cervix

D Premature placental separation

CORRECT

RIGHT ANSWER

OK

D. Premature placental separation

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

As a senior resident in the OBG department, you would consider uterine artery embolization (UAE) as a treatment option in all of the following cases except:

- A Patient with Postpartum hemorrhage
- B Prior to the removal of Placenta accreta in Multiparous woman
- C Patient diagnosed with calcified and pedunculated submucous fibroids**
- D Multiparous woman with menorrhagia

CORRECT

RIGHT ANSWER

- OK** C. Patient diagnosed with calcified and pedunculated submucous fibroids

WHY THIS IS RIGHT

Uterine artery embolization (UAE) is a minimally invasive procedure in which embolic agents are injected into the uterine arteries to block blood supply, causing ischemia and shrinkage of uterine pathology.

UAE is used in the management of:

- Postpartum hemorrhage (PPH) when bleeding is not controlled by medical or surgical methods
- Placenta accreta spectrum (as a preoperative measure to reduce blood loss)
- Symptomatic uterine fibroids causing menorrhagia or bulk symptoms, especially in women who have completed childbearing

Pedunculated submucous fibroids, particularly if calcified, are not suitable for UAE because:

- These fibroids have a narrow stalk
- Embolization can cause ischemic necrosis and detachment
- This may lead to fibroid expulsion, infection, or sepsis

Such fibroids are better treated with hysteroscopic removal (myomectomy).

QUESTION

A 34-weeks G2P1L1 pregnant woman presents with bleeding per vagina and abdominal pain for the past 4 hours. Her Hb 6 g/dL, pulse rate 120/ min, BP 80/60 mmHg. On abdominal examination, fetal heart sounds are absent and the uterus is tonically contracted. On per vaginal examination, the cervix is 2 cm dilated, 70% effaced, and the vertex is at -2 station. The patient appears distressed. What is the best management option?

- A ARM + Oxytocin
- B Steroids followed by LSCS
- C Emergency LSCS**
- D Urgent ultrasound

CORRECT

RIGHT ANSWER

- C. Emergency LSCS**

WHY THIS IS RIGHT

Placental abruption with maternal hemodynamic instability is an obstetric emergency requiring immediate delivery, regardless of fetal viability.

Key clues in the question:

- Painful vaginal bleeding
- Tonically contracted uterus
- Shock (BP 80/60, pulse 120, Hb 6 g/dL)
- Absent fetal heart sounds

These findings indicate severe placental abruption with maternal compromise.

Management principle:

- If the mother is unstable, immediate delivery (usually emergency LSCS) is required to control hemorrhage and stabilize the mother.

QUESTION

A 36-year-old woman, G4P3 presents at 34 weeks gestation for an antenatal visit. She has a history of previous cesarean deliveries. During her routine ultrasound examination, the radiologist reports findings suggestive of placenta accreta. The patient has no symptoms at present. Which of the following is the most appropriate management option for this patient?

- A** Immediate delivery via cesarean section
- B** Expectant management with close monitoring and regular ultrasounds
- C** Preoperative planning for cesarean hysterectomy CORRECT
- D** Initiation of antenatal corticosteroids and scheduled cesarean section at 37 weeks gestation

RIGHT ANSWER

- OK** **C. Preoperative planning for cesarean hysterectomy**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

Which of the following prostaglandins analogue is NOT correctly paired with its clinical use?

A Alprostadil -Closure of Ductus Arteriosus

CORRECT

B Dinoprost- Management of Postpartum hemorrhage

C Dinoprostone - Induction of Labour

D Misoprostol - Medical termination of Pregnancy

RIGHT ANSWER

OK A. Alprostadil -Closure of Ductus Arteriosus

WHY THIS IS RIGHT

Prostaglandin analogue	Type	Clinical use
Dinoprostone (PGE α)	Prostaglandin E α	Cervical ripening and induction of labor
Dinoprost (PGF α)	Prostaglandin F α	Management of postpartum hemorrhage due to uterine atony
Misoprostol (PGE α analogue)	Prostaglandin E α	Medical termination of pregnancy, cervical ripening, PPH management

Incorrect Pairing:

- Alprostadil (PGE α) is used to maintain patency of the ductus arteriosus in neonates with congenital heart disease.
- It does not cause closure of the ductus arteriosus.

Closure of the ductus arteriosus is achieved with prostaglandin synthesis inhibitors such as indomethacin or ibuprofen.

QUESTION

A primigravida at 38 completed weeks of gestation develops primary postpartum hemorrhage (PPH) due to uterine atony. The second messenger system through which the first pharmacological agent of choice act is:

A cAMP

B Phospholipase C

CORRECT

C cGMP

D Tyrosine kinase

RIGHT ANSWER

OK B. Phospholipase C

WHY THIS IS RIGHT

The first-line pharmacological agent for primary postpartum hemorrhage (PPH) due to uterine atony is oxytocin.

Mechanism of action of oxytocin:

- Oxytocin binds to Gq protein-coupled oxytocin receptors on uterine smooth muscle.
- This activates phospholipase C (PLC).
- PLC increases IP₃ and DAG, leading to increased intracellular Ca²⁺.
- Increased calcium causes strong uterine contractions, helping control bleeding.

Second messenger pathway:

Oxytocin -> Gq receptor -> Phospholipase C -> IP₃/DAG -> ↑ Ca²⁺ -> uterine contraction

QUESTION

Which of the following cannot cross the placenta?

1. Iron
2. Albumin
3. Immunoglobulin M
4. Immunoglobulin G

A 1 and 2

B Only 3

C 2 and 3

CORRECT

D 3 and 4

RIGHT ANSWER

OK C. 2 and 3

WHY THIS IS RIGHT

The placenta acts as a selective barrier between maternal and fetal circulation. Some substances cross easily, while others do not cross due to large molecular size or lack of specific transport mechanisms.

Substances that cross the placenta:

- Iron -> actively transported to support fetal hematopoiesis
- Immunoglobulin G (IgG) -> transferred via Fc receptors, providing passive immunity to the fetus

Substances that do NOT cross the placenta:

- Albumin -> large protein without an active transport mechanism
- Immunoglobulin M (IgM) -> very large pentameric molecule

QUESTION

A 36-year-old woman, gravida 3 para 2, at 35 weeks' gestation comes to the emergency department with leakage of fluid and painless vaginal bleeding. She experienced rupture of membranes 30 minutes ago; the fluid was initially clear but became bloody a few minutes later. The patient has not received prenatal care during this pregnancy, and her two previous pregnancies resulted in term cesarean deliveries. She has a history of hypertension but stopped taking her medication when she became pregnant. Speculum examination confirms rupture of membranes; the cervical os is 1 cm dilated with minimal vaginal bleeding. Doppler ultrasound is unable to detect fetal heart tones. Which of the following is the most likely cause of this patient's presentation?

A Abruptio placentae

B Intraamniotic infection

C Placenta previa

D Vasa previa

CORRECT

RIGHT ANSWER

OK D. Vasa previa

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A G2P1 woman with a previous lower segment cesarean section presents with bleeding per vaginum and is diagnosed with placenta previa. During cesarean delivery, the placenta is noted to be invading into the bladder wall. What is the most likely diagnosis?

A Placenta accreta

B Placenta increta

C Placenta percreta

CORRECT

D Abruptio placentae

RIGHT ANSWER

OK C. Placenta percreta

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1d” here and does not include a written explanation for this item.

QUESTION

A primigravida at 22 weeks of gestation presents to you with profuse vaginal bleeding. Her blood pressure and glucose levels are within normal limits. Placental implantation at which of the following sites can cause this?

A Internal os

CORRECT

B Fallopian tube

C Ovarian

D Abdominal

RIGHT ANSWER

OK

A. Internal os

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

A G2 with a previous LSCS underwent cesarean delivery. During surgery, there was excessive bleeding, and a hysterectomy had to be done. The image of the uterus is shown. What is the probable diagnosis?



A Placenta previa

B Placenta accrete syndrome

CORRECT

C Abruptio placentae

D Rupture uterus

RIGHT ANSWER

OK

B. Placenta accrete syndrome

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

A 30-week pregnant woman presents with mild bleeding. Her blood pressure is 110/70 mmHg, and fetal heart rate is 140 bpm. There were no contractions. TAS is shown below. What is the best next step in management?



- A** Induction of labour with oxytocin
- B** Hospitalisation and expectant management
- C** Immediate LSCS
- D** Amniotomy

CORRECT

RIGHT ANSWER

- OK** **B. Hospitalisation and expectant management**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$20” here and does not include a written explanation for this item.

QUESTION

A 39-year-old G6P2L1A3 presents with a history of previous 2 LSCS with PAS. What will you NOT counsel her about?

A Need for blood transfusion

B Risk of bladder injury in case of PAS

C Risk of bowel injury in case of PAS

CORRECT

D Risk of peripartum hysterectomy

RIGHT ANSWER

OK C. Risk of bowel injury in case of PAS

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$21" here and does not include a written explanation for this item.

QUESTION

A pregnant woman at 30 weeks presents with painful bleeding PV, reduced fetal movement, increased uterine tone, and absent FHR. BP is 166/98 mmHg, and the cervix is 6 cm dilated, 70% effaced with intact membranes. What is the next best step?

- A Emergency LSCS
- B Start Antihypertensives and emergency LSCS
- C Start Antihypertensives and ARM
- D Tocolysis

CORRECT

RIGHT ANSWER

- OK
- C. Start Antihypertensives and ARM

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$22” here and does not include a written explanation for this item.

QUESTION

A 30-week pregnant woman presents with mild bleeding. Her blood pressure is 110/70 mmHg, and fetal heart rate is 140 bpm. There were no contractions. TAS is shown below. What is the best next step in management?

- A. Induction of labour with oxytocin
- B. Hospitalisation and expectant management
- C. Immediate LSCS
- D. Amniotomy



A Induction of labour with oxytocin

B Hospitalisation and expectant management

CORRECT

C Immediate LSCS

D Amniotomy

RIGHT ANSWER

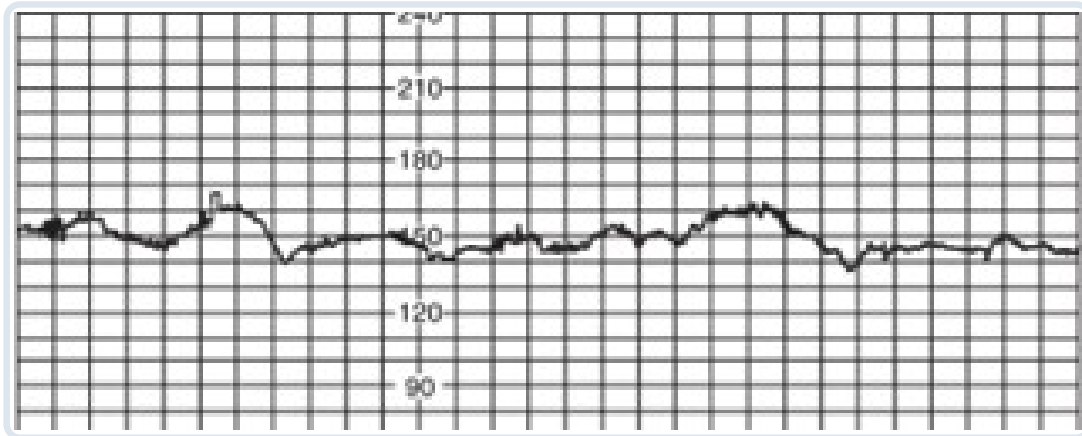
OK B. Hospitalisation and expectant management

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$23” here and does not include a written explanation for this item.

QUESTION

A 36-year-old woman, G7P3A3, at 32 weeks' gestation presents with painless vaginal bleeding. The patient awoke this morning in a pool of bright red blood and has had some irregular contractions but no constant abdominal pain or leakage of fluid; fetal movement is normal. She has had no vaginal bleeding prior to this morning and has had no prenatal care. She has used methamphetamines intermittently throughout the pregnancy. Blood pressure is 136/78 mm Hg, pulse is 95/min, and respirations are 18/min. Speculum examination reveals a small blood clot in the vagina but no active bleeding. The fetal heart rate monitoring is shown. Blood type is AB positive and hemoglobin is 9.8 g/dL. Which of the following is the best next step in management of this patient?



- A Digital cervical examination
- B Emergency caesarean delivery
- C K-B test
- D Transabdominal ultrasound

CORRECT

RIGHT ANSWER

- OK D. Transabdominal ultrasound

WHY THIS IS RIGHT

In third-trimester painless vaginal bleeding, the first investigation is transabdominal ultrasound to evaluate for placenta previa or placental location.

- Digital vaginal examination is contraindicated until placenta previa is excluded because it may cause massive hemorrhage.

Typical presentation of placenta previa:

- Painless bright red vaginal bleeding
- Normal uterine tone
- Usually stable maternal vitals and reassuring fetal status

Management approach:

1. Transabdominal ultrasound to locate placenta
2. Avoid digital cervical examination until previa ruled out
3. Further management depends on placental location and bleeding severity

QUESTION

A 28-year-old multigravida is taught fetal movement counting. She asks what “Cardiff count of 10” practically means. Which instruction is most accurate?

- A** 10 movements in 10 minutes after a meal is reassuring
- B** At rest, 10 fetal movements within 2 hours is reassuring
- C** 10 movements in 12 hours is required in all women
- D** Maximum fetal movements occur at term, so counting is most useful after 40 weeks

CORRECT

RIGHT ANSWER

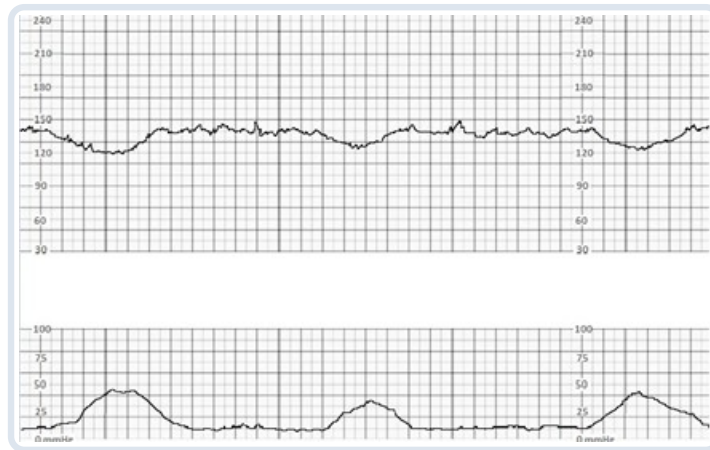
- OK** B. At rest, 10 fetal movements within 2 hours is reassuring

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$19” here and does not include a written explanation for this item.

QUESTION

A 31-year-old woman, gravida 3 para 2, at 40 weeks gestation is in active labor. The patient has had a normal prenatal course. Her first pregnancy was an uncomplicated term vaginal delivery. Her second pregnancy ended with an emergent cesarean delivery for a nonreassuring fetal heart rate pattern. Spontaneous rupture of the membranes occurred 15 minutes ago with blood-tinged amniotic fluid. Blood pressure is 124/76 mm Hg, pulse is 78/min, and respirations are 18/min. On pelvic examination, the cervix is 6 cm dilated and 80% effaced, and the fetal presenting part is at +1 station. The fetal heart rate tracing is shown. Which of the following is the next step?



A Immediate LSCS

B Intrauterine Fetal Resuscitation

C Reassure

CORRECT

D Amnioinfusion

RIGHT ANSWER

OK C. Reassure

WHY THIS IS RIGHT

This fetal heart rate (FHR) tracing represents a Category I (normal) tracing, which indicates normal fetal oxygenation and acid-base status.

- Baseline heart rate: 110-160 bpm
- Moderate variability (6-25 bpm)
- No late or variable decelerations
- Early decelerations may be present or absent

Although the amniotic fluid is blood-tinged, this can occur due to minor cervical or placental edge bleeding during labor and is not necessarily pathological.

Because the tracing is reassuring, the correct management is Reassurance and continuation of routine labor monitoring

Why Other Options Are Incorrect:

- Immediate LSCS: indicated only for non-reassuring fetal status.
- Intrauterine fetal resuscitation: used for Category II or III tracings.
- Amnioinfusion: indicated for recurrent variable decelerations due to cord compression, which are not present here.

QUESTION

Ultrasound examination shows an anterior placenta covering the cervical os and oligohydramnios, with an amniotic fluid index of 1.5 cm and a single deepest vertical pocket measuring 1.5 × 1 cm. Over a 45-minute observation period, there are 4 episodes of fetal movement, 3 flexion-extension movements, and no fetal breathing movements. The fetus is in breech presentation. Which of the following is the most likely cause of these biophysical profile findings?

A Fetal malpresentation

B Maternal hypoglycemia

C Placental insufficiency

CORRECT

D Placental location

RIGHT ANSWER

OK

C. Placental insufficiency

WHY THIS IS RIGHT

The biophysical profile (BPP) evaluates fetal well-being using five parameters:

1. Nonstress test (NST)
2. Fetal breathing movements
3. Gross body movements
4. Fetal tone
5. Amniotic fluid volume

Interpretation in this case:

- Movements present -> reassuring
- Fetal tone present -> reassuring
- No breathing movements -> abnormal
- Severe oligohydramnios (AFI 1.5 cm) -> abnormal

Reduced amniotic fluid and decreased fetal activity suggest chronic fetal hypoxia due to placental insufficiency.

Pathophysiology:

- Placental dysfunction -> reduced uteroplacental blood flow
- Decreased fetal renal perfusion -> reduced fetal urine production
- Leads to oligohydramnios

QUESTION

A 40-year-old woman, gravida 5 para 0 aborta 4, at 35 weeks' gestation presents to labor and delivery triage because she has not felt fetal movements for the past 24 hours. She has had poor oral intake due to nausea. A nonstress test shows a baseline fetal heart rate in the 130s with moderate variability, no decelerations, and no accelerations despite vibroacoustic stimulation. Tocometry shows no uterine contractions. Which of the following is the most appropriate next step in management?

A Biophysical profile

CORRECT

B Cesarean delivery

C Contraction stress test

D Umbilical artery flow velocimetry

RIGHT ANSWER

OK **A. Biophysical profile**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

A woman presents to OPD at 36 weeks of gestation and presents with complaints of breathlessness and excessive abdominal distension. On examination, fetal movements are normal, fetal parts not easily felt and muffled fetal heartbeat is heard. Symphysis fundal height came out to be 41 weeks. Per abdomen examination reveals tense abdomen but not tender. What can be the most likely diagnosis?

A Abruptio placenta

B Hydrocephalus of fetus

C Polyhydramnios

CORRECT

D Rupture uterus

RIGHT ANSWER

OK C. Polyhydramnios

WHY THIS IS RIGHT

Polyhydramnios is diagnosed by ultrasound using:

Parameter	Value
Amniotic Fluid Index (AFI)	> 24 cm
Deepest vertical pocket	> 8 cm

Causes of Polyhydramnios

Maternal causes

- Gestational Diabetes Mellitus

Fetal causes

- Anencephaly
- Esophageal Atresia

Idiopathic

- Most common (~60%).

Complications

Maternal	Fetal
Breathlessness	Preterm birth
Preterm labor	Cord prolapse
Postpartum hemorrhage	Malpresentation

Excessive distension, SFH far ahead of dates, difficulty feeling fetal parts and muffled FHR are classic of polyhydramnios. Abdomen is tense but non-tender with no bleeding or pain suggestive of abruption. Hydrocephalus alone doesn't explain this degree of maternal breathlessness and distension.

*

QUESTION

During fetal heart rate monitoring, variable decelerations are noted on the CTG trace. What is the most likely cause or mechanism of this finding?

A Head compression

B Cord compression

CORRECT

C Fetal hypoxia

D Normal finding

RIGHT ANSWER

OK B. Cord compression

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1b" here and does not include a written explanation for this item.

QUESTION

An NST shows 1 acceleration in 20 minutes with no decelerations. What is the next best step?

A Continue the NST till 40 minutes

CORRECT

B Emergency LSCS

C Biophysical profile

D Wait and watch

RIGHT ANSWER

OK A. Continue the NST till 40 minutes

WHY THIS IS RIGHT

Non Stress Test evaluates fetal well-being by monitoring fetal heart rate accelerations with fetal movements.

A reactive NST requires:

Criterion	Requirement
Accelerations	≥2 accelerations
Time	Within 20 minutes
Duration	≥15 seconds
Increase	≥15 bpm above baseline

2 accelerations in 20 minutes = reactive NST.

Sometimes the fetus is sleeping, which may reduce accelerations.

Therefore:

NST started

↓

Only 1 acceleration in 20 min

↓

Extend test to 40 minutes

↓

Reassess accelerations

Thus the correct next step is continue NST up to 40 minutes.

BPP is performed when: NST remains non-reactive after 40 minutes.

Parameter	Score
NST	2
Fetal breathing	2
Fetal movement	2
Fetal tone	2
Amniotic fluid	2

QUESTION

A woman at 26 weeks of gestation presents for routine evaluation. On examination, fundal height corresponds to 24 weeks. Ultrasonography revealed decreased amniotic fluid. Which of the following conditions would have led to this presentation?

A Renal agenesis

CORRECT

B Tracheosophageal fistula

C Cardiac abnormalities

D Ureteral stricture

RIGHT ANSWER

OK A. Renal agenesis

WHY THIS IS RIGHT

Oligohydramnios- Amniotic fluid volume depends mainly on fetal urine production after mid-pregnancy. During early pregnancy: Amniotic fluid comes from maternal plasma diffusion

After 16-20 weeks:

Fetal kidneys produce urine

↓

Urine enters amniotic sac

↓

Maintains amniotic fluid volume

If fetal kidneys are absent -> no urine -> severe oligohydramnios.

Bilateral Renal Agenesis

Consequences include:

- Severe oligohydramnios
- Potter sequence

Features include:

| Feature | Cause |

| ----- | ----- |

| Pulmonary hypoplasia | Lack of amniotic fluid |

| Flattened face | Compression |

| Limb deformities | Reduced fetal movement |

Bilateral renal agenesis -> oligohydramnios -> Potter sequence.

QUESTION

A 30-year-old gravida 2 with previous LSCS develops suprapubic pain during contractions with maternal tachycardia and fetal bradycardia at 8 cm dilation. What is the most appropriate next step?

A Immediate cesarean section

CORRECT

B Forceps delivery

C Artificial rupture of membranes

D Wait and watch

RIGHT ANSWER

OK

A. Immediate cesarean section

WHY THIS IS RIGHT

These findings strongly suggest Uterine scar dehiscence (or uterine window), a life-threatening obstetric emergency. Uterine rupture occurs when the uterine wall tears partly, often at the previous cesarean scar.

This leads to:

- Massive hemorrhage
- Fetal hypoxia
- Maternal shock

Classic Clinical Signs

Sign	Explanation
Severe abdominal/suprapubic pain	Scar tearing
Maternal tachycardia	Blood loss
Fetal bradycardia	Fetal hypoxia
Loss of fetal station	Indicates complete rupture

Fetal bradycardia is the most common early sign of uterine dehiscence/ rupture.

Suspected uterine dehiscence

↓

Immediate resuscitation

↓

Emergency laparotomy

↓

Cesarean delivery

↓

Repair uterus or hysterectomy

The goal is rapid delivery to save the fetus and prevent maternal hemorrhage.

QUESTION

Which of the following conditions is least likely to be associated with fetal bradycardia?

- A Abruption
- B Fetal head compression
- C Congenital heart disease

D Maternal fever

CORRECT

RIGHT ANSWER

D. Maternal fever

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

Which of the following conditions is least likely to be associated with fetal bradycardia?

- A Abruption
- B Fetal head compression
- C Congenital heart disease

D Maternal fever

CORRECT

RIGHT ANSWER

D. Maternal fever

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

On doing a per-vaginal examination of a woman in labor, you were able to palpate the mouth with hard alveolar margins, nose, malar eminence, and supraorbital ridges of the fetus. Which of the following would have been the engaging diameter for this presentation?

A Suboccipitofrontal

B Occipitofrontal

C Mentovertical

D Submentovertical

CORRECT

RIGHT ANSWER

OK

D. Submentovertical

WHY THIS IS RIGHT

Palpation of mouth, nose, malar eminence, and supraorbital ridges on vaginal examination indicates a face presentation of the fetus.

Engaging Diameter:

- In face presentation, the fetal head is fully extended.
- The engaging diameter is submentovertical (~11.5 cm).

Diameter	Attitude of the head	Presentation
Suboccipitobregmatic 9.5 cm	Complete flexion	Vertex
Suboccipitofrontal 10 cm	Incomplete flexion	Vertex
Occipitofrontal 11.5cm	Marked deflexion	Vertex
Mentovertical 14 cm	Partial extension	Brow
Submentobregmatic 9.5 cm	Complete extension	Face
MC in Anencephaly		

QUESTION

Identify the correct statements about the most common fetal head positions associated with different pelvic types:

1. Persistent occiput posterior (OP) -> Anthropoid pelvis
2. Face presentation to pubis -> Android pelvis
3. Right occiput posterior (ROP) -> Platypelloid pelvis
4. Left occiput transverse (LOT) -> Gynecoid pelvis

A 1, 2, 3, 4

B 1, 4

CORRECT

C 2, 3

D 1, 2, 4

RIGHT ANSWER

OK B. 1, 4

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$19" here and does not include a written explanation for this item.

QUESTION

A multiparous woman is in labor at 38 weeks of gestation. On examination, the uterus appears asymmetrical. In fundal grip, the fetal pole is not palpable, and on pelvic grip, the lower pole of the uterus is empty. All of the following are true about the given presentation except:

- A** Placenta previa should be ruled out
- B** Uterine diadelphys is likely in the patient
- C** There are high chances of cord prolapse in the patient
- D** Elective LSCS should be performed

CORRECT

RIGHT ANSWER

- OK** **B. Uterine diadelphys is likely in the patient**

WHY THIS IS RIGHT

The findings of asymmetrical uterus, empty lower pole on pelvic grip, and inability to palpate the fetal pole on fundal grip suggest an oblique/transverse lie.

Key points about transverse/oblique lie:

- Lower uterine segment is empty because no fetal presenting part occupies the pelvis.
- Cord prolapse risk is high since the presenting part does not occlude the cervix.
- Placenta previa should be ruled out because it can cause abnormal lie.
- Delivery is usually by cesarean section if the lie persists in labor.

Incorrect statement: Uterus didelphys is likely - uterine malformations are not the typical cause of this presentation.

QUESTION

Identify the fetal position shown in the image below:



A Right occipito-posterior

B Left occipito-anterior

CORRECT

C Left occipito-posterior

D Right occipito-anterior

RIGHT ANSWER

OK

B. Left occipito-anterior

WHY THIS IS RIGHT

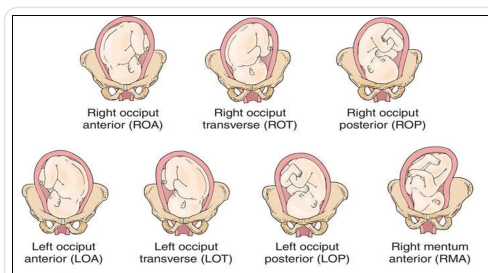
In cephalic presentation, the fetal position is determined by the relationship of the occiput (posterior fontanelle) to the maternal pelvis.

In the image, the occiput is directed toward the left anterior quadrant of the maternal pelvis, indicating Left Occipito-Anterior (LOA) position.

- LOA is the most common and most favorable fetal position for vaginal delivery.
- The occiput faces the maternal left anterior pelvis, while the fetal face is toward the right posterior side.
- During normal labor, the fetal head undergoes flexion → internal rotation → extension, allowing delivery with the occiput under the pubic symphysis.

Clinical significance:

- Occipito-anterior positions (LOA/ROA) facilitate easier labor and delivery compared with occipito-posterior positions, which may cause prolonged labor.



QUESTION

Identify the correct pair of malformations:

- A** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM7J4GXFDYJANJS0J4PA5Z94.jpg
- B** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM7J4H0DZNVCS1P0WBVFNPKEH.jpg
- C** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM7J4H2PKGZJZBPX4DF8ZRB7.jpg **CORRECT**
- D** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM7J4H5MHSZMB9F7X7QV39HZ.jpg

RIGHT ANSWER

- OK** **C.** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM7J4H2PKGZJZBPX4DF8ZRB7.jpg

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1a” here and does not include a written explanation for this item.

QUESTION

The type of pelvis commonly associated with occipitoposterior and “face to pubis” is:

- A** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YFHFHZGD97K4MYWPV9D.jpg
- B** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YJPS9ZW34HE7EE899S5.jpg
- C** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YN6Z4B51AW9NZQV2RZ0.jpg CORRECT
- D** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YQDAXK3YBTF05FESCZX.jpg

RIGHT ANSWER

- OK** **C.** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YN6Z4B51AW9NZQV2RZ0.jpg

WHY THIS IS RIGHT

The anthropoid pelvis has a long anteroposterior diameter and narrow transverse diameter. This shape favors persistent occipitoposterior positioning and sometimes face-to-pubis delivery. The fetal head rotates posteriorly due to pelvic anatomy.

QUESTION

During labor, a fetus is found to be in face presentation. Which fetal skull diameter presents to the maternal pelvis in this position?

A Mento-bregmatic

B Submento-bregmatic

CORRECT

C Vertico-mental

D Suboccipito-bregmatic

RIGHT ANSWER

OK

B. Submento-bregmatic

WHY THIS IS RIGHT

Face presentation is characterized by complete extension of the fetal head, and the presenting diameter is the submentobregmatic diameter, which measures 9.5 cm. This extends from: Submentum (junction of neck and chin) to Bregma (anterior fontanelle)

Diameter	Attitude of the head	Presentation
Suboccipitobregmatic 9.5 cm	Complete flexion	Vertex
Suboccipitofrontal		
10 cm	Incomplete flexion	Vertex
Occipitofrontal 11.5cm	Marked deflexion	Vertex
Mentovertical		
14 cm	Partial extension	Brow
Submentobregmatic 9.5 cm	Complete extension	Face
MC in Anencephaly |

While vertex presentation (complete flexion) has sub-occipitobregmatic (9.5 cm), and brow presentation (partial extension) has Mento-vertical (14 cm) diameter.

QUESTION

I All of the following statements are true except:

- A** The shortest anteroposterior (AP) diameter of the pelvic inlet is the obstetric conjugate
- B** The diagonal conjugate is measured from tip of the sacral promontory to the lower margin of the pubic symphysis
- C** The obstetric conjugate is calculated by subtracting 1.5 cm from the diagonal conjugate
- D** A contracted pelvis is defined as s transverse diameter <10cm and an AP diameter <12cm CORRECT

RIGHT ANSWER

- OK** **D. A contracted pelvis is defined as s transverse diameter <10cm and an AP diameter <12cm**

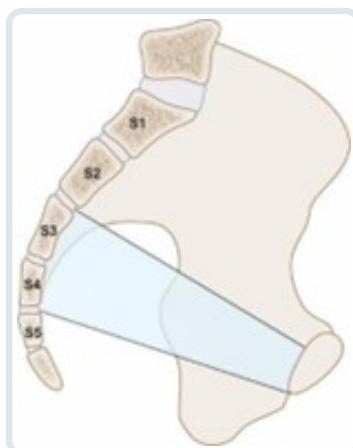
WHY THIS IS RIGHT

Pelvic adequacy is assessed using multiple pelvic diameters and overall obstetric assessment. Although the obstetric conjugate is important, a contracted pelvis cannot be defined by a single measurement alone. Clinical pelvimetry and labor outcome are also essential considerations.

- A) True - The obstetric conjugate is the shortest AP diameter of the pelvic inlet.
- B) True - Diagonal conjugate is measured from the sacral promontory to the lower margin of the pubic symphysis on per vaginum exam.
- C) True - Obstetric conjugate $\approx$ diagonal conjugate - 1.5 cm.
- D) False - A contracted pelvis is defined when any pelvic diameter is reduced below normal size

QUESTION

Identify the blue-colored area shown in the image.



A Obstetric outlet

B Anatomical outlet

C Pelvic inlet

D Mid-pelvis

CORRECT

RIGHT ANSWER

OK D. Mid-pelvis

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1b" here and does not include a written explanation for this item.

QUESTION

Shortest anterior posterior diameter of the pelvic inlet is represented by which of the following conjugates?

A Anatomical conjugate

B Diagonal conjugate

C Obstetric conjugate

CORRECT

D True conjugate

RIGHT ANSWER

OK C. Obstetric conjugate

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A pregnant woman with a history of bronchial asthma in third stage of labor. Which of the following drugs should be avoided in the management of postpartum hemorrhage in this patient?

A Carboprost

CORRECT

B Oxytocin

C Dinoprostone

D Methyl ergometrine

RIGHT ANSWER

OK

A. Carboprost

WHY THIS IS RIGHT

In an asthmatic patient:

Bronchoconstriction

☐

Airway narrowing

☐

Acute bronchospasm

☐

Life-threatening respiratory distress

Carboprost is a prostaglandin F2 α analogue that can precipitate bronchospasm and is contraindicated in patients with asthma. In postpartum hemorrhage, it may trigger severe airway constriction. Oxytocin and ergometrine do not cause bronchospasm. Hence carboprost must be avoided in asthmatic patients.

B. Oxytocin

- First-line drug for PPH

- Safe in asthma

C. Dinoprostone (PGE2)

- Causes less bronchoconstriction

- Not strictly contraindicated

D. Methylethergometrine

Causes:

Vasoconstriction

☐

Raises BP

QUESTION

A primigravida came to the labor room at 40 weeks +5 days gestation for induction of labor. On per vaginal examination, the cervix is 1 cm dilated and 30% effaced. The vertex is at -1 station and the cervix is soft and posterior. What will be the modified Bishop score for this lady?

A 3

B 4

C 5

CORRECT

D 8

RIGHT ANSWER

OK C. 5

WHY THIS IS RIGHT

The Modified Bishop score is used to assess cervical favorability before induction of labor and predicts the likelihood of successful vaginal delivery.

Cervical Feature	0	1	2	3
Cervical dilatation	< 1cm	1-2 cm	2-4 cm	> 4cm
Cervical length	4 cm	2-4 cm	1-2 cm	< 1 cm
Effacement* (%)	30	40-50	60-70	>80
Station of presenting part	-3 cm	-2 cm	-1/0 cm	+1/+2 cm
Consistency of cervix	Firm	Average	Soft	
Position of cervix	Posterior	Mid position	Anterior	

Scoring in this patient:

- Dilation: 1 cm -> 1 point
- Effacement: 30% -> 1 point
- Station: -1 -> 2 points
- Consistency: Soft -> 1 point
- Position: Posterior -> 0 points

Total = 5

Interpretation:

- Score ≥6-8: Favorable cervix (successful induction likely)
- Score <6: Unfavorable cervix -> cervical ripening needed (e.g., prostaglandins or Foley catheter)

QUESTION

A pregnant woman presents with obstructed labor and is grossly dehydrated. Investigations reveal fetal demise. What will be the management?

A Craniotomy

B Decapitation

C Cesarean section

CORRECT

D Forceps extraction

RIGHT ANSWER

OK C. Cesarean section

WHY THIS IS RIGHT

In obstructed labor with fetal demise, the choice of delivery depends on the maternal condition and feasibility of vaginal delivery.

Key management principle:

- If the mother is severely compromised (e.g., gross dehydration, exhaustion, shock, or sepsis risk), immediate cesarean section is preferred to rapidly terminate labor and stabilize the mother.

Other options:

- Craniotomy or decapitation: destructive procedures used only when vaginal delivery is feasible and the mother is stable.
- Forceps extraction: requires fully dilated cervix and engaged fetal head.

QUESTION

A 29-year-old primipara undergoes vaginal delivery. Active management of the third stage is planned, Oxytocin is available. The staff nurse prepares oxytocin in a dextrose 5% bottle because normal saline is out of stock. After starting the infusion, the patient develops headache, nausea, confusion, and a generalized tonic clonic seizure. What is the most likely mechanism?

- A** Acute hyperglycemia triggering ketoacidosis
- B** Water intoxication due to hypotonic free water load CORRECT
- C** Pulmonary edema due to oxytocin-induced myocardial depression
- D** Anaphylaxis to oxytocin preservative

RIGHT ANSWER

- B. Water intoxication due to hypotonic free water load**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1a” here and does not include a written explanation for this item.

QUESTION

A patient with uterine inversion is taken for laparotomy after failed manual methods. On traction on the round ligaments, the inverted fundus begins to rise through the cervical ring and the uterus is restored without incising the ring. What is the indicated operative method called as?

A Huntington method

CORRECT

B Haultain method

C B-Lynch suture

D Hayman suture

RIGHT ANSWER

OK

A. Huntington method

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

| Which statement is false regarding the active phase of labor?

A Prolonged latent phase in a multipara is when it is over 12hrs.

CORRECT

B Arrest of descent means no descent for over 1 hour

C Minimum cervical dilation rate in nullipara is 1.2 cm/hr

D Arrest of active phase means no dilation of 4hrs with adequate uterine contractions

RIGHT ANSWER

OK

A. Prolonged latent phase in a multipara is when it is over 12hrs.

WHY THIS IS RIGHT

The active phase of labor begins when cervical dilation reaches ~6 cm and is characterized by rapid cervical dilation and fetal descent.

- Minimum cervical dilation rate:
- Nullipara: ~1.2 cm/hour
- Arrest of active phase:
- No cervical dilation for ≥4 hours with adequate uterine contractions
- Arrest of descent:
- No fetal descent for ≥1 hour in second stage

The prolonged latent phase occurs before the active phase and in multipara it is >8 hours, not 12 hours.

QUESTION

A 34-year-old nulliparous woman in active labor has been pushing for the past 2 hours without progress and feels extremely fatigued. CTG is normal. On examination, the fetal head is 1 cm above the ischial spines (station -1) in the occipitoanterior position. What is the most appropriate next step in management?

A Observe for spontaneous progress

B Trial of forceps in theater

C **Emergency cesarean section**

CORRECT

D Perform fetal blood sampling

RIGHT ANSWER

OK **C. Emergency cesarean section**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A 35-year-old woman, gravida 1 para 0, at 40 weeks gestation has a protracted labor course for which a cesarean delivery is performed under epidural anesthesia. Shortly after delivery, the patient has chest pain and difficulty breathing. She becomes hypotensive, bradycardic, hypoxic, and unresponsive, and undergoes emergency intubation. The surgical incisions begin to bleed profusely and the patient goes into cardiorespiratory arrest. She is declared dead after 30 minutes of cardiopulmonary resuscitation. The family agrees to an autopsy. Which of the following is the most likely finding during histologic evaluation of her lungs?

- A** Alveolar ducts lined with hyaline membranes
- B** Giant cell foreign body response in the lower lobe of the right lung
- C** Pulmonary arterioles with lipid globules
- D** Pulmonary artery branch with swirls of fetal squamous cells

CORRECT

RIGHT ANSWER

- OK** **D. Pulmonary artery branch with swirls of fetal squamous cells**

WHY THIS IS RIGHT

This presentation is classic for amniotic fluid embolism (AFE) - a rare but catastrophic obstetric emergency.

- Sudden respiratory distress
- Hypotension and cardiovascular collapse
- Disseminated intravascular coagulation (DIC) with severe bleeding
- Occurs during labor, cesarean delivery, or shortly after delivery

Pathophysiology:

- Amniotic fluid enters the maternal circulation
- Causes pulmonary vascular obstruction and an anaphylactoid inflammatory response
- Leads to acute respiratory failure and DIC

Histologic finding:

- Fetal squamous cells, lanugo hair, and mucin within maternal pulmonary arteries

QUESTION

Identify the true statements:

1. Flexion point in ventouse delivery is 3 cm posterior to the anterior fontanelle
2. Carcinoma cervix causing hydronephrosis is Stage IIIb
3. When the first twin has a non-vertex presentation, the preferred method of delivery is a cesarean section.
4. Post-partum IUCD can be inserted after 24 hours, for one week after delivery

A 1, 2, 3, 4

B 1, 2, 3

C 1, 4

D 2, 3

CORRECT

RIGHT ANSWER

OK

D. 2, 3

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

A 32-year-old primigravida presents at 28 weeks' gestation with painful uterine contractions for the past 2 hours, occurring every 5 minutes. She reports frequent fetal movements and denies leakage of fluid or vaginal bleeding. Her temperature is 37°C (98.7°F), blood pressure 125/60 mm Hg, and pulse 80/min. On digital examination, the cervix is 3 cm dilated and 90% effaced with a bulging bag of membranes. Ultrasound confirms vertex presentation. Fetal heart rate tracing is normal, and the tocometer shows contractions every 5 minutes. Betamethasone and indomethacin are administered. Which of the following is the most appropriate next step in management?

A Administer magnesium sulfate

CORRECT

B Administer nifedipine

C Administer progesterone

D Observe and reexamine the cervix in 2 hours

RIGHT ANSWER

OK **A. Administer magnesium sulfate**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1e" here and does not include a written explanation for this item.

QUESTION

A 31-year-old woman, gravida 1 para 1, is evaluated on postoperative day 2 for lower abdominal pain, chills, and pain with sitting. She presented to the hospital one day after spontaneous rupture of membranes without the onset of contractions. After a 26-hour induction of labor, she underwent a primary cesarean delivery for arrest of descent.

Breast examination shows fullness without erythema or fluctuance. The uterine fundus is firm and tender to palpation. There is scant serosanguineous drainage from the inferior aspect of the incision. Pelvic examination reveals a small amount of blood on the perineal pad with mildly foul-smelling discharge.

- A Ceftriaxone
- B Ceftriaxone plus azithromycin
- C Clindamycin plus gentamicin
- D Dicloxacillin

CORRECT

RIGHT ANSWER

- OK C. Clindamycin plus gentamicin

WHY THIS IS RIGHT

Postpartum endometritis is the most common cause of postpartum fever after cesarean delivery, especially in women with prolonged rupture of membranes and prolonged labor.

Risk factors:

- Cesarean delivery (most important risk factor)
- Prolonged rupture of membranes (>18 hours)
- Prolonged labor or multiple vaginal examinations
- Internal fetal monitoring

Clinical features:

- Fever, chills
- Lower abdominal pain
- Uterine fundal tenderness
- Foul-smelling lochia
- Tachycardia or malaise

The infection is polymicrobial, involving anaerobes, gram-negative rods, and streptococci from vaginal flora.

Treatment (first-line): IV clindamycin + gentamicin

This combination provides broad coverage against anaerobes and gram-negative organisms, which are the most common pathogens.

QUESTION

Which of the following instruments are used in the cesarean section?

1. Bard-Parker blade
2. Doyen's retractor
3. Cusco's speculum
4. Allis forceps
5. Shirodkar's uterine clamp
6. Green Armytage forceps

A 1, 2, 5, 6

B 1, 2, 3, 5

C 1, 2, 4, 6

CORRECT

D 1, 2, 3, 6

RIGHT ANSWER

OK C. 1, 2, 4, 6

WHY THIS IS RIGHT

A cesarean section (LSCS) requires instruments for incision, tissue retraction, hemostasis, and handling tissues during abdominal and uterine surgery.

Instruments commonly used in cesarean section:

- Bard-Parker blade -> Used to make the skin and uterine incision.
- Doyen's retractor -> Used to retract the abdominal wall and bladder, improving surgical exposure.
- Allis forceps -> Used to grasp fascia, peritoneum, or tissue edges during dissection and closure.
- Green-Armytage forceps -> Used to clamp bleeding edges of the uterine incision for hemostasis.

Instruments not used in cesarean section:

- Cusco's speculum -> Used for vaginal examination or procedures, not abdominal surgery.
- Shirodkar's uterine clamp -> Used in cervical cerclage procedures, not LSCS.

QUESTION

A 29-year-old woman, gravida 2 para 1, at 38 weeks' gestation comes to the emergency department due to severe abdominal pain and vaginal bleeding. The patient had an ultrasound at 8 weeks gestation for vaginal spotting but has not otherwise received prenatal care this pregnancy. Her prior pregnancy two and a half years ago ended in a classical cesarean delivery at 24 weeks gestation for placental abruption. The patient smokes a pack of cigarettes daily and uses cocaine multiple times a week. Blood pressure is 90/60 mm Hg and pulse is 130/min. The abdomen is tender and has an irregular mass; no contractions are palpated. Bright red blood is noted on the perineal pad. Fetal heart tracing shows multiple prolonged decelerations to 100/min. Which of the following risk factors most likely contributed to this patient's presentation?

A First-trimester bleeding

B Illicit substance use

C Interpregnancy interval

D Prior uterine surgery

CORRECT

RIGHT ANSWER

OK

D. Prior uterine surgery

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

You are an intern conducting the delivery of a 24-year-old G2P1 woman. After delivery of the head, restitution and external rotation occur. On attempting to deliver the anterior shoulder, you notice two tight loops of umbilical cord around the neck. What is the next best step?

- A** Attempt to slip the cords over the fetal head
- B** Deliver the anterior shoulder immediately
- C** Clamp the cord, cut it and unwind it from around the fetal neck
- D** Immediately call for help

CORRECT

RIGHT ANSWER

- OK** **C. Clamp the cord, cut it and unwind it from around the fetal neck**

WHY THIS IS RIGHT

A nuchal cord occurs when the umbilical cord is wrapped around the fetal neck. It is a common finding during delivery.

Management depends on whether the cord is loose or tight:

- 1\ Loose nuchal cord
 - Slip the cord over the fetal head before delivery of the shoulders.
- 2\ Tight nuchal cord (cannot be slipped over the head)
 - Clamp the cord in two places and cut it
 - Then unwind the cord from around the neck
 - Proceed with delivery of the shoulders

A tight nuchal cord may compress the cord, impairing fetal blood flow and preventing further descent if not released.

QUESTION

A 49-year-old woman, gravida 5 para 5, presents to the OPD with involuntary, intermittent leakage of urine for the past 5 months. She leaks a small amount of urine when asked to cough. She has no dysuria, urgency, or hematuria and she usually awakens once at night to void. Her postvoid residual urine volume is 40 mL. What is the most likely cause of her symptoms?

A Bladder outlet obstruction

B Detrusor overactivity

C Urethral hypermobility

CORRECT

D Vesicovaginal fistula

RIGHT ANSWER

OK C. Urethral hypermobility

WHY THIS IS RIGHT

Stress urinary incontinence (SUI) is characterized by involuntary leakage of urine during activities that increase intra-abdominal pressure, such as coughing, sneezing, or laughing, without urgency.

Most common mechanism:

- Urethral hypermobility due to weakening of pelvic floor support (pubourethral ligaments and endopelvic fascia).
- Common in multiparous women because repeated childbirth stretches pelvic support structures.

Supporting features in this case:

- Leakage only on coughing
- No urgency or dysuria
- Normal postvoid residual (40 mL)
- History of multiple vaginal deliveries

Why other options are incorrect:

- Detrusor overactivity: causes urgency and urge incontinence.
- Bladder outlet obstruction: usually causes high postvoid residual urine.
- Vesicovaginal fistula: causes continuous leakage, not intermittent.

*

QUESTION

A 32-year-old woman, gravida 3 para 2, at 38 weeks' gestation comes to the hospital due to contractions. She had a cesarean delivery for breech presentation at 39 weeks' gestation in her second pregnancy. Her blood pressure is 100/60 mm Hg, pulse is 100/min, and respirations are 22/min. Fetal heart rate tracing shows moderate variability, multiple accelerations, and no decelerations. Uterine contractions are regular and occur every 4 minutes. The cervix is 6 cm dilated and 60% effaced, and the fetal vertex is at 0 station. After 2 hours, the patient suddenly becomes restless and develops intense lower abdominal pain. Fetal heart rate monitoring now shows recurrent late decelerations. On pelvic examination, there is moderate vaginal bleeding, the cervix remains 6 cm dilated and 60% effaced, and the fetal vertex is now at -3 station. Which of the following is the most likely diagnosis in this patient?

A Fetal nuchal cord

B Normal labor

C Uterine rupture

CORRECT

D Vasa previa

RIGHT ANSWER

OK C. Uterine rupture

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$20" here and does not include a written explanation for this item.

QUESTION

I All of the following are true except:

- A** The cardinal movements in the mechanism of labor are Engagement -> Crowning -> Flexion -> Restitution -> Internal rotation **CORRECT**
- B** COCPS have no role in protection against HIV and STDs
- C** Warning bleeds are a feature of placenta previa
- D** An upper segment cesarean section is done in case of perimortem cesarean section if there is no return of spontaneous circulation in 5 minutes in a pregnant woman who has experienced total cardiopulmonary arrest

RIGHT ANSWER

- OK** **A. The cardinal movements in the mechanism of labor are Engagement -> Crowning -> Flexion -> Restitution -> Internal rotation**

WHY THIS IS RIGHT

The cardinal movements of labor describe the sequence of fetal head movements that allow passage through the maternal pelvis during vaginal delivery.

Correct order of cardinal movements:

1. Engagement
2. Descent
3. Flexion
4. Internal rotation
5. Extension
6. Restitution
7. External rotation
8. Expulsion

Option A is incorrect because it gives the wrong sequence (crowning occurs late and internal rotation occurs before restitution).

Other statements:

- COCs do not protect against HIV/STDs -> only barrier methods (condoms) provide protection.
- Warning bleeds are characteristic of placenta previa (painless recurrent bleeding).
- Perimortem cesarean section is performed within 5 minutes of maternal cardiac arrest if there is no ROSC, often via classical/upper segment incision for rapid delivery.

QUESTION

You are attending a patient in labor. The biparietal diameter of the fetal head is seen stretching the vulval outlet. After the contraction subsides, the fetal head does not recede. What is the next event expected to occur?

A Extension

CORRECT

B Restitution

C External rotation

D Expulsion

RIGHT ANSWER

OK

A. Extension

WHY THIS IS RIGHT

When the fetal head becomes visible at the vulval outlet and does not recede after a contraction, it is called crowning. Crowning indicates that the biparietal diameter has passed through the vulval ring, and the next step in the mechanism of labor is extension of the fetal head.

Sequence of cardinal movements of labor:

1. Engagement
2. Descent
3. Flexion
4. Internal rotation
5. Extension (delivery of head at the vulva)
6. Restitution
7. External rotation
8. Expulsion

Why extension occurs next:

- As the fetal head reaches the pelvic outlet, it extends around the pubic symphysis.
- This allows sequential delivery of the occiput -> vertex -> brow -> face -> chin.

QUESTION

Modified Robson's classification - Group 2 includes which of the following?

A Nulliparous, singleton, cephalic pregnancy, induced labour

CORRECT

B Nulliparous, singleton, cephalic pregnancy, spontaneous labour

C Multiparous without previous cesarean section, spontaneous labour

D Multiparous without previous cesarean section, induced labour or cesarean section before labour

RIGHT ANSWER

OK

A. Nulliparous, singleton, cephalic pregnancy, induced labour

WHY THIS IS RIGHT

Robson Group 2 includes nulliparous women with a singleton cephalic pregnancy who undergo induction of labor or prelabor cesarean section. This group is analyzed separately to assess cesarean rates related to induction.

The 10 Robson Groups

1. Nulliparous, single, cephalic, ≥ 37 weeks, spontaneous labor
2. Nulliparous, single, cephalic, ≥ 37 weeks, induced or CS before labor
3. Multiparous (no previous CS), single, cephalic, ≥ 37 weeks, spontaneous labor
4. Multiparous (no previous CS), single, cephalic, ≥ 37 weeks, induced or CS before labor
5. Previous CS, single, cephalic, ≥ 37 weeks
6. Nulliparous breech
7. Multiparous breech (including previous CS)
8. Multiple pregnancy
9. Transverse/oblique lie (including previous CS)
10. Single cephalic, < 37 weeks (including previous CS)

QUESTION

Following delivery at a PHC, a patient was referred with the following image. On examination, there is a tear extending to the rectum. Identify the type of tear.

A 1st degree

B 2nd degree

C 3rd degree

D 4th degree

CORRECT

RIGHT ANSWER

OK D. 4th degree

WHY THIS IS RIGHT

Degree	Extent of Damage	Key Features
1st	Vaginal mucosa or perineal skin only	Superficial tear, no muscle involvement
2nd	Perineal muscles (not anal sphincter)	Similar to episiotomy, deeper than 1st degree
3a	<50% of external anal sphincter torn	Partial external sphincter involvement
3b	>50% of external anal sphincter torn	Major external sphincter involvement
3c	External + internal anal sphincter torn	Complete sphincter disruption
4th	Extends through rectal mucosa	Most severe, involves perineum, sphincters, rectal lining

QUESTION

A G3P2L1 presents at 37 weeks with previous 2 LSCS with primary active HSV. What is the next best step?

A LSCS

CORRECT

B Classical cesarean

C VBAC

D IOL

RIGHT ANSWER

OK
A. LSCS

WHY THIS IS RIGHT

Active herpes simplex virus infection during labor is an indication for a cesarean section to prevent neonatal transmission. Possible complications include:

Complication	Effect
Encephalitis	Brain infection
Disseminated disease	Multi-organ failure
Skin lesions	Vesicular rash

Mortality can be very high if untreated.

B) Classical Cesarean Section

- Reserved for special situations (placenta previa, transverse lie).

C) VBAC

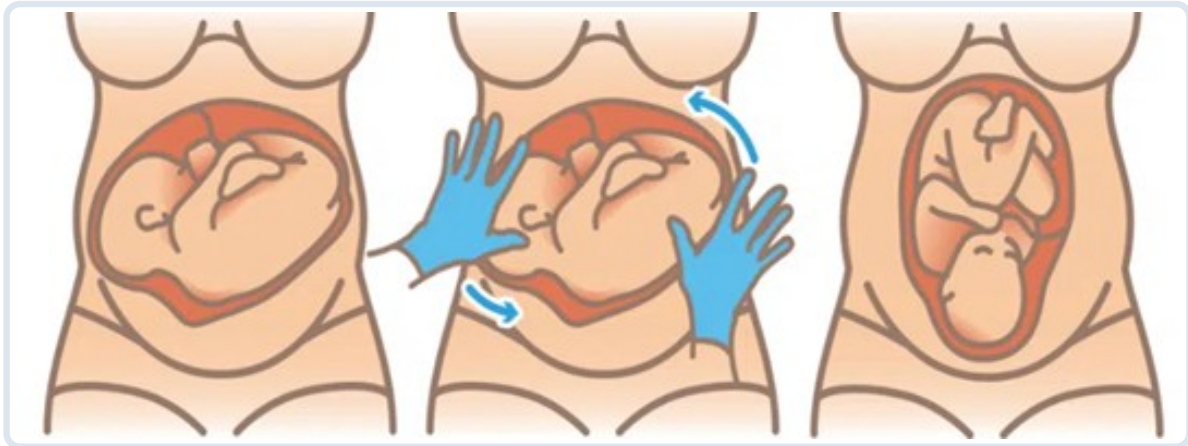
- Contraindicated with active genital HSV infection.

D) IOL

- Vaginal delivery should not be attempted with active HSV lesions.

QUESTION

Which of the following is not a contraindication to the procedure shown?



A Placenta previa

B Primigravida

CORRECT

C Multiple pregnancy

D Ruptured membranes

RIGHT ANSWER

OK B. Primigravida

WHY THIS IS RIGHT

The procedure shown is an External Cephalic Version (ECV), a technique used to turn a breech fetus to a cephalic (head-down) position before labor to facilitate a vaginal delivery. Primigravida is not a contraindication for ECV, though it may be technically more challenging compared to multiparous women.

However:

- Success rate is higher in multiparous women
- But the procedure can still be performed in primigravida

Key contraindications to ECV include placenta previa, multiple pregnancy, and ruptured membranes.

INDICATIONS of ECV: >36wks, singleton with breech/transverse (not in knee or footling), adequate liquor, membranes intact, normal FHR, no placenta previa (OPD based)

Success Rate of ECV

Factor	Effect
Multiparity	Higher success
Adequate liquor	Easier rotation
Unengaged fetal head	Better outcome

Success rate ≈ 50-60%.

QUESTION

Identify this instrument used in the delivery of the after-coming head in breech.



A Wrigley forceps

B Piper forceps

CORRECT

C Kielland forceps

D Dass forceps

RIGHT ANSWER

OK B. Piper forceps

WHY THIS IS RIGHT

Piper forceps have long, curved shanks specifically designed to assist the after-coming head in breech.

Wrigley = outlet forceps

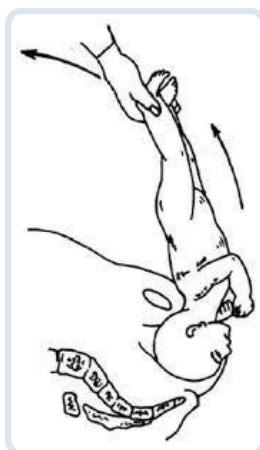
Kielland = rotational forceps;

Dass = low forceps



QUESTION

Identify the maneuver?



A Burn Marshall

CORRECT

B Wigand

C Mauriceau Smellie Viet

D Prague

RIGHT ANSWER

OK A. Burn Marshall

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$21" here and does not include a written explanation for this item.

QUESTION

| Drug contraindicated in asthma in PPH (Postpartum Hemorrhage) case?

A Methyl ergometrine

B Carboprost

CORRECT

C Misoprostol

D Oxytocin

RIGHT ANSWER

OK **B. Carboprost**

WHY THIS IS RIGHT

Carboprost (PGF₂α) causes bronchoconstriction and is contraindicated in asthma. Oxytocin, misoprostol, and methylergometrine do not trigger bronchospasm and are safe alternatives for PPH management in asthmatics.

Drug	Mechanism	Contraindication
---	-----	-----
Oxytocin	First-line uterotonic	None major
Methylergometrine	Potent uterotonic	Hypertension
Misoprostol	Alternative uterotonic	Few contraindications
Carboprost	PGF ₂ α analogue	Asthma

QUESTION

A 28-year-old pregnant G3P2L2 woman presented to OBG department at 36 weeks of amenorrhea. Ultrasound shows that the fetus is in a transverse lie. The liquor is adequate, the placenta is normal, and she has no gross anomaly. Both her previous deliveries were normal vaginal deliveries. How will you manage this patient?

- A Cesarean section
- B External cephalic version**
- C Expectant management
- D Induction of labor

CORRECT

RIGHT ANSWER

- B. External cephalic version**

WHY THIS IS RIGHT

External Cephalic Version

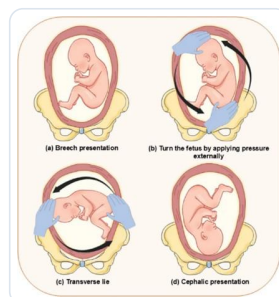
This procedure is usually performed at 36-37 weeks.

Conditions favorable in this patient:

Factor	Interpretation
Multiparous woman	Higher success rate
Adequate liquor	Easier fetal movement
No fetal anomaly	Safe to attempt
36 weeks gestation	Ideal time

Success rate is 50-60%.

ECV is performed at 36-37 weeks for breech or transverse lie.



QUESTION

A woman is planned for a laparoscopic hysterectomy. She asks the surgeon for any disadvantages of this procedure. What is the disadvantage of laparoscopic over open surgery?

A Prolonged recovery time

B More risk of thermal burns

CORRECT

C Increased bleeding

D Increased pain

RIGHT ANSWER

OK

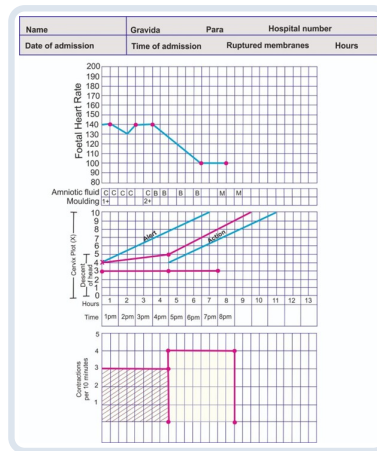
B. More risk of thermal burns

WHY THIS IS RIGHT

No explanation was provided in the source quiz.

QUESTION

A partogram of a woman in labor is shown below. Oxytocin infusion has been administered. Mark the best management for the patient?



A Forceps-assisted delivery

B Vacuum-assisted delivery

C Oxytocin infusion

D Cesarean section

CORRECT

RIGHT ANSWER

OK

D. Cesarean section

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$22" here and does not include a written explanation for this item.

QUESTION

Following a vaginal delivery, a patient develops postpartum hemorrhage (PPH) after delivery of the placenta. The uterus is atonic. Oxytocin and other uterotonics have already been administered, but bleeding continues. What is the next best step in management?

- A Uterine artery ligation
- B Internal iliac artery ligation
- C Intrauterine balloon tamponade**
- D Uterine compression sutures

CORRECT

RIGHT ANSWER

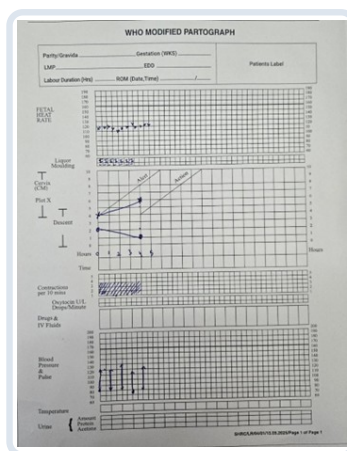
- OK**
C. Intrauterine balloon tamponade

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$23” here and does not include a written explanation for this item.

QUESTION

A 23-year-old primigravida presents in labor. Her partograph is shown below. Based on the findings, what should be the next step in management?



A ARM

CORRECT

B Cesarean section

C Wait and reassess after 4 hr

D Vacuum assisted delivery

RIGHT ANSWER

OK

A. ARM

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$24” here and does not include a written explanation for this item.

QUESTION

A 26-year-old primigravida at 41+3 weeks gestation is brought to the emergency department after prolonged labor (18 hours) at home. She is dehydrated, with pulse 126/min, BP 90/58 mmHg, and temperature 100°F. On examination, the uterus is tense and contracted, and a transverse ridge is seen and felt across the lower abdomen. Fetal heart rate is 100 bpm with late decelerations. What is the transverse band seen in this patient?

A Retraction ring

CORRECT

B Contraction ring

C Shirodkar ring

D Transverse ring

RIGHT ANSWER

OK A. Retraction ring

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$25" here and does not include a written explanation for this item.

QUESTION

Following the delivery of a macrosomic baby, the shoulders become impacted. What is the first maneuver that should be attempted to release the shoulders?

A McRoberts maneuver

CORRECT

B Rubin maneuver

C Suprapubic pressure

D Zavanelli maneuver

RIGHT ANSWER

OK A. McRoberts maneuver

WHY THIS IS RIGHT

McRoberts Maneuver involves hyperflexion of the maternal hips toward the abdomen.

Mechanism

Hyperflex maternal hips

↓

Straightens lumbosacral angle

↓

Increases pelvic outlet diameter

↓

Releases impacted shoulder

| Risk factor | Reason |

| ----- | ----- |

| Fetal macrosomia | Large shoulders |

| Diabetes in pregnancy | Macrosomia |

| Prolonged second stage | Difficult delivery |

| Operative vaginal delivery | Instrumental delivery |

Stepwise Management of Shoulder Dystocia

1\ McRoberts maneuver

2\ Suprapubic pressure

3\ Rubin maneuver

4\ Woods corkscrew maneuver

5\ Gaskin maneuver

6\ Zavanelli maneuver

QUESTION

The maneuver shown in the image is being performed during delivery. What is the primary purpose of this maneuver?



A Prevent perineal trauma

CORRECT

B Hasten the process of delivery

C Prevent fetal distress

D Prevent fetal trauma

RIGHT ANSWER

OK **A. Prevent perineal trauma**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$26" here and does not include a written explanation for this item.

QUESTION

A woman delivers before reaching the hospital. Soon after delivery, she develops abdominal pain, breathlessness, hypotension, and tachycardia. The degree of shock is out of proportion to visible bleeding. On examination, a large, boggy mass is seen at the introitus. What is the most likely diagnosis?



A Disseminated intravascular coagulation (DIC)

B Postpartum hemorrhage (PPH)

C Uterine inversion

CORRECT

D Amniotic fluid embolism

RIGHT ANSWER

OK C. Uterine inversion

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$27” here and does not include a written explanation for this item.

QUESTION

Which of the following are indications for lower segment cesarean section (LSCS)?

1. Brow presentation
2. Mentoposterior position
3. Breech presentation
4. Occipitoposterior position
5. Mentoanterior position

A 1, 2

CORRECT

B 3, 4

C 1, 2, 3

D 2, 5

RIGHT ANSWER

OK A. 1, 2

WHY THIS IS RIGHT

Certain malpresentations and malpositions during labor can make vaginal delivery difficult or impossible, requiring lower segment cesarean section (LSCS).

- Brow presentation -> Indication for LSCS

o The presenting diameter (mentoverical ~13.5 cm) is too large to pass through the pelvis.

- Mentoposterior position (face presentation) -> Indication for LSCS

o In mentoposterior, the chin cannot rotate anteriorly, making vaginal delivery impossible.

- Breech presentation -> Not an absolute indication

o Vaginal delivery may be possible depending on case selection.

- Occipitoposterior position -> Usually rotates spontaneously; vaginal delivery often possible.
- Mentoanterior position -> Vaginal delivery possible because the chin rotates anteriorly.

QUESTION

A primigravida is scheduled for induction of labor. On vaginal examination, the cervix is soft, in a mid-position, 2 cm dilated, and 50% effaced. The fetal head is at -1 station. What is the Bishop score in this case?

A 3; unfavorable

B 5; unfavorable

C 7; favourable

CORRECT

D 8; favourable

RIGHT ANSWER

OK

C. 7; favourable

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$28” here and does not include a written explanation for this item.

QUESTION

A woman undergoes vaginal delivery. After the baby is delivered, a perineal tear is observed that involves the perineal muscles and less than 50% of the external anal sphincter, while the rectal mucosa remains intact. What is the degree of perineal tear?

A 3A

CORRECT

B 3B

C 3C

D 4

RIGHT ANSWER

OK
A. 3A

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$29” here and does not include a written explanation for this item.

QUESTION

A 34-year-old woman, gravida 2 para 1, at 26 weeks' gestation presents to the emergency department with intermittent leakage of fluid for the past 6 hours. She has no vaginal bleeding or contractions. Her previous pregnancy was complicated by preterm prelabor rupture of membranes (PPM) at 29 weeks' gestation, and she delivered at 34 weeks after inpatient management with corticosteroids and latency antibiotics. On examination, her temperature is 39.4 °C (103 °F), blood pressure is 100/70 mm Hg, and pulse is 114/min. The fetal heart rate is 170/min. The cervix is 2cm dilated. In addition to antibiotics and corticosteroids, which of the following is the best next step in management?

A Fetal fibronectin testing and fetal lung maturity assessment

B Immediate induction of labor

CORRECT

C Tocolysis

D Serial fetal-ultrasounds and amnioinfusion

RIGHT ANSWER

OK B. Immediate induction of labor

WHY THIS IS RIGHT

This patient has preterm premature rupture of membranes (PPROM) complicated by chorioamnionitis.

- High fever (39.4°C)
- Maternal tachycardia (114/min)
- Fetal tachycardia (170/min)
- Leakage of amniotic fluid
- Cervical dilation

These findings indicate intra-amniotic infection (chorioamnionitis).

Management principle:

- Chorioamnionitis is an indication for immediate delivery regardless of gestational age.
- Management includes:
 - Broad-spectrum IV antibiotics
 - Prompt induction of labor

Why other options are incorrect:

- Tocolysis: contraindicated in infection.
- Fetal fibronectin or lung maturity testing: unnecessary once infection is present.
- Expectant management (serial ultrasounds): dangerous because infection can worsen maternal and fetal outcomes.

*

QUESTION

A primigravida presents to the emergency room in the early stage of labor with adequate uterine contractions. On per vaginal examination, a gynecoid pelvis is felt, the membranes are ruptured, and the vertex is felt in the right occipito-posterior position. How will you manage this patient?

A Vacuum-assisted delivery

B Cesarean section

C Normal vaginal delivery

CORRECT

D Forceps delivery

RIGHT ANSWER

OK

C. Normal vaginal delivery

WHY THIS IS RIGHT

Occipito Posterior Position occurs when the back of the fetal head (occiput) faces the maternal sacrum.

Position	Description
Occipito-anterior (OA)	Occiput toward maternal symphysis pubis
Occipito-posterior (OP)	Occiput toward maternal sacrum
Occipito-transverse (OT)	Occiput toward lateral pelvis

In most cases of OP position:

Occipito-posterior position

↓

Internal rotation during labor

↓

Conversion to occipito-anterior

↓

Normal vaginal delivery

Approximately 90% of OP fetuses rotate spontaneously to OA.

In this patient:

Finding	Interpretation
Adequate contractions	Labor progressing
Gynecoid pelvis	Favorable pelvis
Vertex presentation	Normal presentation
Early labor	Rotation likely

Thus expectant management with vaginal delivery is recommended.

QUESTION

A 27-year-old woman, gravida 1 para 0, at 40 weeks' gestation presents to the hospital with painful contractions for the past few hours. She has no leakage of fluid or vaginal bleeding, and fetal movements have been normal. On admission, the cervix is 5 cm dilated and 90% effaced with the fetal head at -1 station. She received epidural analgesia. On repeat cervical examination, the cervix is 6 cm dilated and 100% effaced, with the fetal head still at -1 station. Two hours later, the cervix examination is unchanged. Fetal heart rate monitoring shows a baseline of 130/min, moderate variability, accelerations, and occasional early decelerations. The tocodynamometer shows contractions occurring every 5-7 minutes. Which of the best next step is management?

- A Cesarean delivery
- B Continue expectant management
- C Oxytocin infusion
- D Vaginal misoprostol

CORRECT

RIGHT ANSWER

- OK
- C. Oxytocin infusion

WHY THIS IS RIGHT

This patient is in the active phase of labor (≥ 6 cm cervical dilation) but shows no cervical change for 2 hours, indicating protracted or arrested labor due to inadequate uterine contractions.

- Cervix: 6 cm dilated, 100% effaced
- No progress for 2 hours
- Contractions every 5-7 minutes $\rightarrow$ inadequate frequency
- Reassuring fetal heart tracing (baseline 130, moderate variability, accelerations)

Management:

- Augment labor with oxytocin infusion to increase uterine contraction frequency and strength.

Why not other options:

- Cesarean delivery: reserved for failed augmentation or non-reassuring fetal status.
- Expectant management: inappropriate because contractions are inadequate and labor is not progressing.
- Vaginal misoprostol: used for cervical ripening/induction, not augmentation in active labor.

*

QUESTION

A 34y G2P1 presents at 35 weeks. She has no complaints and is appreciating fetal movements well. She had a previous classical cesarean at 25 weeks for eclampsia and severe FGR. She is currently on low dose aspirin and prenatal vitamins. On examination, the uterus is SFH is 38 cm and FHR is 140 bpm. An ultrasound reveals a single live fetus in breech presentation, placenta posterior and amniotic fluid normal. The patient desires a vaginal delivery. What is the best management?

- A** Review USG after 2 weeks
- B** Schedule elective LSCS at 37 weeks
- C** ECV at 36 weeks
- D** Await labor and do internal podalic version

CORRECT

RIGHT ANSWER

- OK** **B. Schedule elective LSCS at 37 weeks**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2a” here and does not include a written explanation for this item.

QUESTION

| Where will be the level of the uterus on the second-day post-delivery?

A One finger breadth below umbilicus

B Two finger breadths below umbilicus

CORRECT

C Three finger breadths below umbilicus

D Four finger breadths below umbilicus

RIGHT ANSWER

OK

B. Two finger breadths below umbilicus

WHY THIS IS RIGHT

Uterus is at the umbilicus after delivery and involutes ~1 fingerbreadth per day. Therefore, on day 2 it lies 2 fingerbreadths below.

Postpartum Day	Fundal Position
Immediately after delivery	At the level of the umbilicus
Day 1	1 finger breadth below umbilicus
Day 2	2 finger breadths below umbilicus
Each subsequent day	Descends ~1 cm/day
10-14 days	Not palpable abdominally

Monitoring postpartum fundal level helps detect:

Condition	Sign
Postpartum Hemorrhage	Boggy uterus
Subinvolution	Fundus higher than expected
Infection	Tender uterus

QUESTION

A primigravida presents to the labor room at 40 weeks of gestation with lower abdominal pain. She has been in labor for 3 hours. Which of the following will determine if she is in active labor?

- A Fetal head 5/5 palpable
- B Two contractions of 10 sec in 10 min
- C More than 5 cm dilation with complete effacement**
- D Rupture of membranes

CORRECT

RIGHT ANSWER

- OK C. More than 5 cm dilation with complete effacement**

WHY THIS IS RIGHT

Labor is divided into three stages.

Stage	Description
-----	-----
First stage	Cervical dilatation from 0 -> 10 cm
Second stage	Full dilatation -> delivery of baby
Third stage	Delivery of placenta

The first stage is further divided into latent and active phases.

WHO defines active labor onset at >5 cm dilation. Contractions, head station, or membrane status do not alone define active labor.

Characteristics of active labor:

Feature	Finding
-----	-----
Cervical dilation	≥5 cm
Effacement	Nearly complete
Contractions	Strong and regular

Active labor begins at 5 cm cervical dilation.

QUESTION

You are examining a multigravida in the second stage of labor for the past two hours. On examination, contractions are adequate, the cervix is fully dilated with the head at station 0 with molding 2+ and caput 2+. The sagittal suture is in the right occipito-transverse position. The fetal heart rate is 140 beats/minute. Which of the following is carried out for the management of this patient?

- A** Mid pelvic forceps
- B** Vacuum-assisted delivery
- C** Wait for an hour
- D** Lower segment cesarean section

CORRECT

RIGHT ANSWER

- OK** **D. Lower segment cesarean section**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2b” here and does not include a written explanation for this item.

QUESTION

You are applying a vacuum to deliver a baby in a patient with prolonged 2nd stage. The point at which the vacuum is applied is:

- A** 3 cm anterior to the posterior fontanelle
- B** 6 cm anterior to the posterior fontanelle
- C** 4 cm anterior to the posterior fontanelle
- D** Midway between the anterior and posterior fontanelle

CORRECT

RIGHT ANSWER

- OK** A. 3 cm anterior to the posterior fontanelle

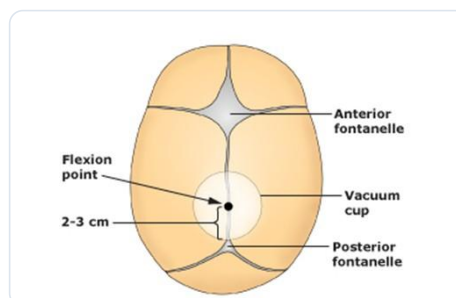
WHY THIS IS RIGHT

Vacuum Extraction is used in the second stage of labor to assist delivery.

Common indications:

Indication	Explanation
-----	-----
Prolonged second stage	Maternal exhaustion
Fetal distress	Need for rapid delivery
Medical conditions	Avoid maternal pushing

The optimal cup placement is the flexion point, located 3 cm anterior to the posterior fontanelle. This ensures maximum flexion of the fetal head and presents the smallest diameter through the pelvis.



QUESTION

Collapse in a patient during labor/ delivery followed by bleeding and DIC in the absence of coexisting conditions is most likely due to?

A Amniotic fluid embolism

CORRECT

B Postpartum haemorrhage

C Eclampsia

D Peripartum cardiomyopathy

RIGHT ANSWER

OK **A. Amniotic fluid embolism**

WHY THIS IS RIGHT

Amniotic Fluid Embolism is a rare but catastrophic complication of pregnancy.

It occurs when amniotic fluid, fetal cells, or debris enter the maternal bloodstream, triggering a massive inflammatory and coagulation response.

Amniotic fluid enters maternal circulation

↓

Pulmonary vasospasm

↓

Acute respiratory failure

↓

Massive inflammatory reaction

↓

DIC and severe bleeding

AFE = sudden collapse + respiratory distress + DIC during labor.

Management is supportive and emergency-based.

Steps include:

- Immediate resuscitation
- Oxygen and ventilation
- Blood products for DIC
- Intensive care support

| Feature | Explanation |

| ----- | ----- |

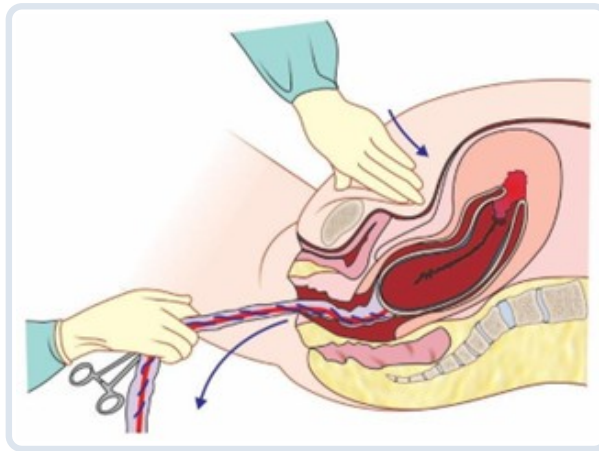
| Sudden cardiovascular collapse | Hypotension, shock |

| Respiratory distress | Acute hypoxia |

| DIC | Severe bleeding |

QUESTION

Following delivery, the placenta is being removed by traction; the cord snaps and there is bleeding. What is the next step in management?



- A Oxytocin
- B Uterine massage
- C Arrange blood and Crede's method

D Manual removal of placenta

CORRECT

RIGHT ANSWER

D. Manual removal of placenta

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2c" here and does not include a written explanation for this item.

QUESTION

A woman with GDM is in labor. After head delivery, shoulders are impacted. What is the correct sequence of maneuvers?

A McRobert's -> Rubin -> Gaskin -> Zavanelli

CORRECT

B Rubin -> McRobert's -> Gaskin -> Zavanelli

C Gaskin -> McRobert's -> Rubin -> Zavanelli

D McRobert's -> Gaskin -> Rubin -> Zavanelli

RIGHT ANSWER

OK A. McRobert's -> Rubin -> Gaskin -> Zavanelli

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2d" here and does not include a written explanation for this item.

QUESTION

In a case of atonic postpartum hemorrhage (PPH), all primary medical management measures have failed. What is the next step to be performed in the labor room?

A Intrauterine balloon tamponade

CORRECT

B Uterine devascularization

C Compression sutures

D Hysterectomy

RIGHT ANSWER

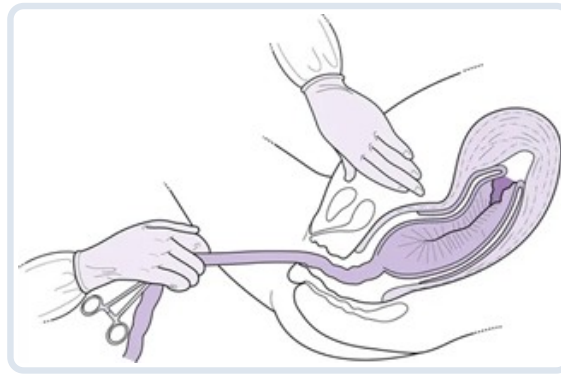
OK A. Intrauterine balloon tamponade

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2e” here and does not include a written explanation for this item.

QUESTION

Identify the maneuver shown in the image below:



A Controlled cord traction

CORRECT

B Manual removal of placenta

C Ritgen maneuver

D Perineal massage

RIGHT ANSWER

OK

A. Controlled cord traction

WHY THIS IS RIGHT

The maneuver shown corresponds to Controlled Cord Traction, a key step in active management of the third stage of labour (AMTSL).

Controlled cord traction is used to assist delivery of the placenta after the baby is born.

Principle

- Gentle traction on the umbilical cord
- Simultaneous counter-pressure on the uterus

This prevents uterine inversion.

Steps of Controlled Cord Traction

Placenta separates

↓

One hand stabilizes uterus above symphysis

↓

Other hand applies gentle cord traction

↓

Placenta delivered safely

Active Management of Third Stage of Labour

| Step | Purpose |

| --- | ----- |

| Oxytocin administration | Prevent uterine atony |

| Controlled cord traction | Deliver placenta |

| Delayed cord clamping | Improve neonatal iron stores |

QUESTION

While performing a repair following delivery, what is the appropriate sequence of layer closure in a mediolateral episiotomy?

A Mucosa -> muscle -> skin

CORRECT

B Muscle -> mucosa -> skin

C Skin -> muscle -> mucosa

D Mucosa -> skin -> muscle

RIGHT ANSWER

OK A. Mucosa -> muscle -> skin

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

A primigravida in labor at 5 cm cervical dilatation suddenly develops severe fetal bradycardia. On vaginal examination, cord prolapse is detected and the cord is still pulsating. What should be the immediate next step in management?

A Trendelenburg, push the head up

CORRECT

B Fill the bladder and put back the cord

C ARM and oxytocin

D Wait and watch

RIGHT ANSWER

OK

A. Trendelenburg, push the head up

WHY THIS IS RIGHT

Cord prolapse occurs when the umbilical cord descends before the fetal presenting part, leading to cord compression and fetal hypoxia. Immediate Action Is Needed. Cord compression leads to:

Cord compression

↓

Reduced fetal oxygen supply

↓

Fetal bradycardia

↓

Fetal hypoxia

↓

Risk of fetal death

Therefore immediate decompression of the cord is essential.

Initial emergency measures include:

| Step | Purpose |

| --- | ----- |

| Trendelenburg or knee-chest position | Reduce cord compression |

| Manual elevation of presenting part | Relieve pressure on cord |

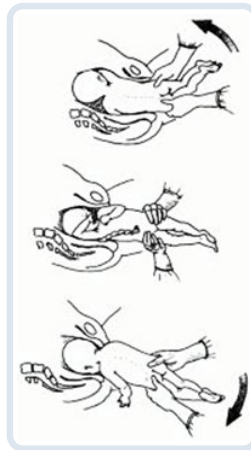
| Avoid handling the cord | Prevent vasospasm |

| Oxygen to mother | Improve fetal oxygenation |

After stabilization: Emergency cesarean section is performed.

QUESTION

Identify the obstetric maneuver shown in the image below:



A Lovset maneuver

CORRECT

B Pinnard maneuver

C Burn-Marshall maneuver

D Mauriceau-Smellie-Veit (MSV) maneuver

RIGHT ANSWER

OK A. Lovset maneuver

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1b" here and does not include a written explanation for this item.

QUESTION

A woman who has just delivered a full-term baby vaginally suddenly develops profuse postpartum hemorrhage associated with severe lower abdominal pain. She becomes hypotensive and tachycardic. On examination, the uterine fundus is not palpable abdominally, and a fleshy mass is felt protruding through the vagina with the placenta still attached. What is the immediate next step?

A Remove placenta and reposition the uterus

B Put uterus inside without removing the placenta

CORRECT

C Shift to OT and insert the uterus back

D Start Oxytocin

RIGHT ANSWER

OK B. Put uterus inside without removing the placenta

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1c” here and does not include a written explanation for this item.

QUESTION

Which of the following uterotonic agents is contraindicated in the management of postpartum hemorrhage?

- A Oxytocin
- B Misoprostol
- C **Dinoprostone**
- D 15 methyl analogue of PGF 2 α

CORRECT

RIGHT ANSWER

- OK **C. Dinoprostone**

WHY THIS IS RIGHT

Postpartum hemorrhage is defined as:

- ≥ 500 mL blood loss after vaginal delivery
- ≥ 1000 mL after cesarean section

The most common cause is uterine atony, where the uterus fails to contract after delivery.

Uterotonic drugs are given to stimulate uterine contraction and reduce bleeding.

Uterotonic Drugs Used in PPH

Drug	Mechanism	Use in PPH
Oxytocin	Stimulates uterine smooth muscle contraction	Class- Hormone ☐ First-line drug
Misoprostol (PGE1)	Causes uterine contraction	PGE1 analogue ☐ Used in PPH
15-methyl PGF α (Carboprost)	Strong uterine contraction	PGF α analogue ☐ Used in refractory PPH
Dinoprostone (PGE2)	Cervical ripening	☐ Not used in PPH

QUESTION

A primigravida with a normal vaginal delivery develops intractable postpartum haemorrhage, not responding to uterine massage and uterotonics. What is the next best step in management?

A Uterine artery embolization

B Balloon tamponade

CORRECT

C Peripartum hysterectomy

D Systematic pelvic devascularisation

RIGHT ANSWER

OK

B. Balloon tamponade

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

Which of the following are used in a Caesarean section?

1. Doyen Retractor
2. Bard Parker handle with blade
3. Karman's cannula
4. Shirodkar clamp
5. Cusco's speculum
6. Allis forceps
7. Green Armytage forceps

A 1,2, 6, and 7

CORRECT

B 1,2, 4, and 5

C 1,2, 3, and 7

D 1,2, 4, and 7

RIGHT ANSWER

OK A. 1,2, 6, and 7

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

A 24-year-old woman is in labor. The cervix is 3 cm dilated and 70% effaced. A "bag of worms" is felt. What is the next best step?

A Rupture membranes and confirm cord prolapse

B Emergency LSCS

CORRECT

C Put the cord above the vertex

D Wait for spontaneous delivery

RIGHT ANSWER

OK B. Emergency LSCS

WHY THIS IS RIGHT

During vaginal examination:

- The examiner feels the soft, pulsating loops of the cord.
- These loops resemble a "bag of worms."

This description is classic for Umbilical Cord Prolapse. Umbilical cord prolapse occurs when the umbilical cord descends below the presenting part of the fetus.

This leads to compression of the cord, causing acute fetal hypoxia.

In this case:

Finding	Significance
Cervix only 3 cm dilated	Vaginal delivery not imminent
Cord prolapse suspected	High risk of fetal hypoxia

While preparing for surgery:

Step	Purpose
Elevate presenting part	Relieve cord compression
Knee-chest / Trendelenburg position	Reduce pressure on cord
Avoid handling the cord	Prevent vasospasm
Oxygen to mother	Improve fetal oxygenation

QUESTION

A woman who has just delivered a full-term baby vaginally suddenly develops profuse postpartum hemorrhage associated with severe lower abdominal pain. She becomes hypotensive and tachycardic. On examination, the uterine fundus is not palpable abdominally, and a fleshy mass is felt protruding through the vagina with the placenta still attached. What is the immediate next step?

A Remove placenta and reposition the uterus

B Put uterus inside without removing the placenta

CORRECT

C Shift to OT and insert the uterus back

D Start Oxytocin

RIGHT ANSWER

OK B. Put uterus inside without removing the placenta

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

A primigravida is in the 2nd stage of labor for 2 hours. The head is at +3 station with caput present and the fetal heart rate (FHR) is dropping to 90 bpm. What is the next best step?

A LSCS

B Low forceps

C Outlet forceps

CORRECT

D Ventouse

RIGHT ANSWER

OK C. Outlet forceps

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$20” here and does not include a written explanation for this item.

QUESTION

Which drug is contraindicated in a patient with atonic PPH with a history of hypertension?

A Misoprostol

B Oxytocin

C Ergotamine

CORRECT

D PGF2 alpha

RIGHT ANSWER

OK C. Ergotamine

WHY THIS IS RIGHT

Postpartum Hemorrhage is defined as:

- ≥ 500 mL blood loss after vaginal delivery
- ≥ 1000 mL after cesarean section

The most common cause (~70-80%) is uterine atony.

Uterotonic Drugs Used in Atonic PPH

Drug	Class	Important Note
Oxytocin	First-line uterotonic	Safe in hypertension
Misoprostol	PGE $\square$ analogue	Safe
Carboprost (PGF $\square$ α)	Prostaglandin	Avoid in asthma
Ergometrine / Ergotamine	Ergot alkaloid	☐ Avoid in hypertension

Why Ergotamine is Contraindicated-

Ergot derivatives (ergometrine/ergotamine):

- Cause powerful uterine contraction
- Also cause systemic vasoconstriction

This can lead to:

- Severe hypertension
- Stroke
- Coronary vasospasm

Therefore they are contraindicated in hypertensive patients and preeclampsia.

QUESTION

| When is delayed cord clamping done?

- A** Only Vigorous term babies not requiring resuscitation
- B** All preterm babies irrespective of birth weight
- C** Vigorous term and preterm babies not requiring resuscitation
- D** All term babies irrespective of birth weight

CORRECT

RIGHT ANSWER

- OK** C. Vigorous term and preterm babies not requiring resuscitation

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$21” here and does not include a written explanation for this item.

QUESTION

| Which is not an indication of instrumental vaginal delivery?

- A** CPD CORRECT
- B** Fetal distress
- C** Maternal exhaustion
- D** Prolonged 2nd stage labour

RIGHT ANSWER

OK A. CPD

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$22" here and does not include a written explanation for this item.

QUESTION

| Which step is not included in active management of third stage of labor (AMTSL)?

A Bimanual compression

CORRECT

B Delayed cord clamp

C Brandt Andrews manouever

D Administration of oxytocics

RIGHT ANSWER

OK A. Bimanual compression

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$23” here and does not include a written explanation for this item.

QUESTION

| What is restitution in the events of labour?

- A** Head rotated by 1/8th of a circle
- B** Head rotating due to untwisting of the neck CORRECT
- C** The shoulder undergoing rotation by 1/8th of circle
- D** The movement by which the head is born

RIGHT ANSWER

- OK** **B. Head rotating due to untwisting of the neck**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$24" here and does not include a written explanation for this item.

QUESTION

Which of the following uterotonic agents is contraindicated in the management of postpartum hemorrhage?

- A Oxytocin
- B Misoprostol
- C **Dinoprostone**
- D 15 methyl analogue of PGF 2 α

CORRECT

RIGHT ANSWER

- OK
- C. Dinoprostone

WHY THIS IS RIGHT

Postpartum hemorrhage is defined as:

- ≥ 500 mL blood loss after vaginal delivery
- ≥ 1000 mL after cesarean section

The most common cause is uterine atony, where the uterus fails to contract after delivery.

Uterotonic drugs are given to stimulate uterine contraction and reduce bleeding.

Uterotonic Drugs Used in PPH

Drug	Mechanism	Use in PPH
Oxytocin	Stimulates uterine smooth muscle contraction	Class- Hormone ☐ First-line drug
Misoprostol (PGE1)	Causes uterine contraction	PGE1 analogue ☐ Used in PPH
15-methyl PGF α (Carboprost)	Strong uterine contraction	PGF α analogue ☐ Used in refractory PPH
Dinoprostone (PGE2)	Cervical ripening	☐ Not used in PPH

QUESTION

A primigravida with a normal vaginal delivery develops intractable postpartum haemorrhage, not responding to uterine massage and uterotonics. What is the next best step in management?

A Uterine artery embolization

B Balloon tamponade

CORRECT

C Peripartum hysterectomy

D Systematic pelvic devascularisation

RIGHT ANSWER

OK B. Balloon tamponade

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$25” here and does not include a written explanation for this item.

QUESTION

Which of the following are used in a Caesarean section?

1. Doyen Retractor
2. Bard Parker handle with blade
3. Karman's cannula
4. Shirodkar clamp
5. Cusco's speculum
6. Allis forceps
7. Green Armytage forceps

A 1, 2, 6, and 7

CORRECT

B 1, 2, 4, and 5

C 1, 2, 3, and 7

D 1, 2, 4, and 7

RIGHT ANSWER

OK A. 1, 2, 6, and 7

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$26” here and does not include a written explanation for this item.

QUESTION

A pregnant woman with a history of bronchial asthma in third stage of labor. Which of the following drugs should be avoided in the management of postpartum hemorrhage in this patient?

A Carboprost

CORRECT

B Oxytocin

C Dinoprostone

D Methyl ergometrine

RIGHT ANSWER

OK

A. Carboprost

WHY THIS IS RIGHT

In an asthmatic patient:

Bronchoconstriction

☐

Airway narrowing

☐

Acute bronchospasm

☐

Life-threatening respiratory distress

Carboprost is a prostaglandin F2 α analogue that can precipitate bronchospasm and is contraindicated in patients with asthma. In postpartum hemorrhage, it may trigger severe airway constriction. Oxytocin and ergometrine do not cause bronchospasm. Hence carboprost must be avoided in asthmatic patients.

B. Oxytocin

- First-line drug for PPH

- Safe in asthma

C. Dinoprostone (PGE2)

- Causes less bronchoconstriction

- Not strictly contraindicated

D. Methylethergometrine

Causes:

Vasoconstriction

☐

Raises BP

QUESTION

Following delivery at a PHC, a patient was referred with the following image. On examination, there is a tear extending to the rectum. Identify the type of tear.

A 1st degree

B 2nd degree

C 3rd degree

D 4th degree

CORRECT

RIGHT ANSWER

OK

D. 4th degree

WHY THIS IS RIGHT

Degree	Extent of Damage	Key Features
1st	Vaginal mucosa or perineal skin only	Superficial tear, no muscle involvement
2nd	Perineal muscles (not anal sphincter)	Similar to episiotomy, deeper than 1st degree
3a	<50% of external anal sphincter torn	Partial external sphincter involvement
3b	>50% of external anal sphincter torn	Major external sphincter involvement
3c	External + internal anal sphincter torn	Complete sphincter disruption
4th	Extends through rectal mucosa	Most severe, involves perineum, sphincters, rectal lining

QUESTION

A G3P2L1 presents at 37 weeks with previous 2 LSCS with primary active HSV. What is the next best step?

A LSCS

CORRECT

B Classical cesarean

C VBAC

D IOL

RIGHT ANSWER

OK
A. LSCS

WHY THIS IS RIGHT

Active herpes simplex virus infection during labor is an indication for a cesarean section to prevent neonatal transmission. Possible complications include:

Complication	Effect
Encephalitis	Brain infection
Disseminated disease	Multi-organ failure
Skin lesions	Vesicular rash

Mortality can be very high if untreated.

B) Classical Cesarean Section

- Reserved for special situations (placenta previa, transverse lie).

C) VBAC

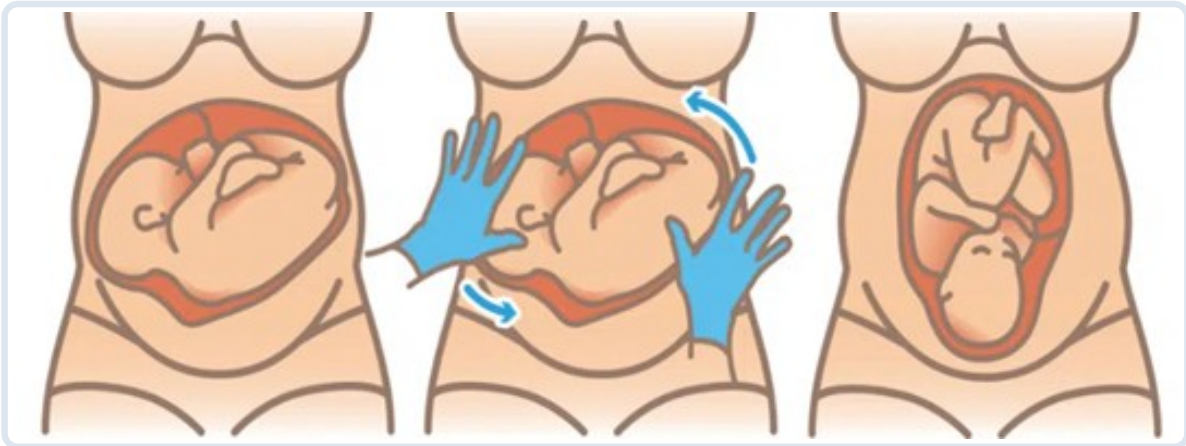
- Contraindicated with active genital HSV infection.

D) IOL

- Vaginal delivery should not be attempted with active HSV lesions.

QUESTION

Which of the following is not a contraindication to the procedure shown?



A Placenta previa

B Primigravida

CORRECT

C Multiple pregnancy

D Ruptured membranes

RIGHT ANSWER

OK

B. Primigravida

WHY THIS IS RIGHT

The procedure shown is an External Cephalic Version (ECV), a technique used to turn a breech fetus to a cephalic (head-down) position before labor to facilitate a vaginal delivery. Primigravida is not a contraindication for ECV, though it may be technically more challenging compared to multiparous women.

However:

- Success rate is higher in multiparous women
- But the procedure can still be performed in primigravida

Key contraindications to ECV include placenta previa, multiple pregnancy, and ruptured membranes.

INDICATIONS of ECV: >36wks, singleton with breech/transverse (not in knee or footling), adequate liquor, membranes intact, normal FHR, no placenta previa (OPD based)

Success Rate of ECV

Factor	Effect
Multiparity	Higher success
Adequate liquor	Easier rotation
Unengaged fetal head	Better outcome

Success rate ≈ 50-60%.

QUESTION

Identify this instrument used in the delivery of the after-coming head in breech.



A Wrigley forceps

B Piper forceps

CORRECT

C Kielland forceps

D Dass forceps

RIGHT ANSWER

OK B. Piper forceps

WHY THIS IS RIGHT

Piper forceps have long, curved shanks specifically designed to assist the after-coming head in breech.

Wrigley = outlet forceps

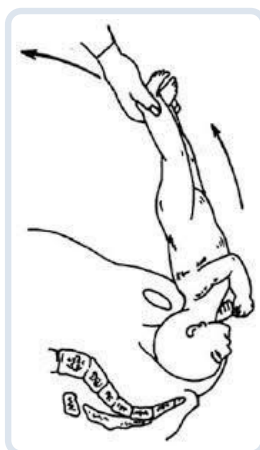
Kielland = rotational forceps;

Dass = low forceps



QUESTION

Identify the maneuver?



A Burn Marshall

CORRECT

B Wigand

C Mauriceau Smellie Viet

D Prague

RIGHT ANSWER

OK

A. Burn Marshall

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$19" here and does not include a written explanation for this item.

QUESTION

| Drug contraindicated in asthma in PPH (Postpartum Hemorrhage) case?

A Methyl ergometrine

B Carboprost

CORRECT

C Misoprostol

D Oxytocin

RIGHT ANSWER

OK B. Carboprost

WHY THIS IS RIGHT

Carboprost (PGF₂α) causes bronchoconstriction and is contraindicated in asthma. Oxytocin, misoprostol, and methylergometrine do not trigger bronchospasm and are safe alternatives for PPH management in asthmatics.

| Drug | Mechanism | Contraindication |

| --- | --- | --- |

| Oxytocin | First-line uterotonic | None major |

| Methylergometrine | Potent uterotonic | Hypertension |

| Misoprostol | Alternative uterotonic | Few contraindications |

| Carboprost | PGF₂α analogue | Asthma |

QUESTION

A 28-year-old pregnant G3P2L2 woman presented to OBG department at 36 weeks of amenorrhea. Ultrasound shows that the fetus is in a transverse lie. The liquor is adequate, the placenta is normal, and she has no gross anomaly. Both her previous deliveries were normal vaginal deliveries. How will you manage this patient?

- A Cesarean section
- B External cephalic version**
- C Expectant management
- D Induction of labor

CORRECT

RIGHT ANSWER

- B. External cephalic version**

WHY THIS IS RIGHT

External Cephalic Version

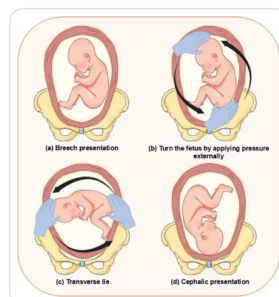
This procedure is usually performed at 36-37 weeks.

Conditions favorable in this patient:

Factor	Interpretation
Multiparous woman	Higher success rate
Adequate liquor	Easier fetal movement
No fetal anomaly	Safe to attempt
36 weeks gestation	Ideal time

Success rate is 50-60%.

ECV is performed at 36-37 weeks for breech or transverse lie.



QUESTION

A woman is planned for a laparoscopic hysterectomy. She asks the surgeon for any disadvantages of this procedure. What is the disadvantage of laparoscopic over open surgery?

A Prolonged recovery time

B More risk of thermal burns

CORRECT

C Increased bleeding

D Increased pain

RIGHT ANSWER

OK

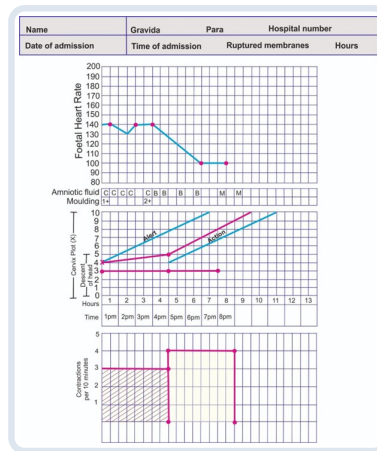
B. More risk of thermal burns

WHY THIS IS RIGHT

No explanation was provided in the source quiz.

QUESTION

A partogram of a woman in labor is shown below. Oxytocin infusion has been administered. Mark the best management for the patient?



A Forceps-assisted delivery

B Vacuum-assisted delivery

C Oxytocin infusion

D Cesarean section

CORRECT

RIGHT ANSWER

OK

D. Cesarean section

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

Following a vaginal delivery, a patient develops postpartum hemorrhage (PPH) after delivery of the placenta. The uterus is atonic. Oxytocin and other uterotonics have already been administered, but bleeding continues. What is the next best step in management?

- A Uterine artery ligation
- B Internal iliac artery ligation
- C Intrauterine balloon tamponade**
- D Uterine compression sutures

CORRECT

RIGHT ANSWER

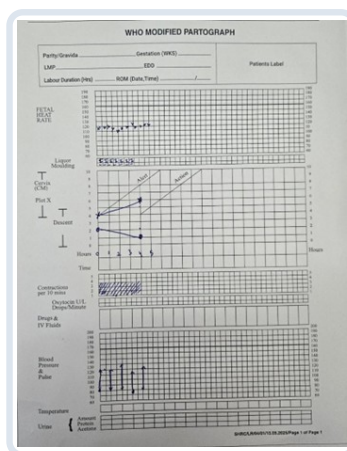
- OK**
C. Intrauterine balloon tamponade

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

A 23-year-old primigravida presents in labor. Her partograph is shown below. Based on the findings, what should be the next step in management?



A ARM

CORRECT

B Cesarean section

C Wait and reassess after 4 hr

D Vacuum assisted delivery

RIGHT ANSWER

OK

A. ARM

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A 26-year-old primigravida at 41+3 weeks gestation is brought to the emergency department after prolonged labor (18 hours) at home. She is dehydrated, with pulse 126/min, BP 90/58 mmHg, and temperature 100°F. On examination, the uterus is tense and contracted, and a transverse ridge is seen and felt across the lower abdomen. Fetal heart rate is 100 bpm with late decelerations. What is the transverse band seen in this patient?

A Retraction ring

CORRECT

B Contraction ring

C Shirodkar ring

D Transverse ring

RIGHT ANSWER

OK A. Retraction ring

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1d" here and does not include a written explanation for this item.

QUESTION

Following the delivery of a macrosomic baby, the shoulders become impacted. What is the first maneuver that should be attempted to release the shoulders?

A McRoberts maneuver

CORRECT

B Rubin maneuver

C Suprapubic pressure

D Zavanelli maneuver

RIGHT ANSWER

OK A. McRoberts maneuver

WHY THIS IS RIGHT

McRoberts Maneuver involves hyperflexion of the maternal hips toward the abdomen.

Mechanism

Hyperflex maternal hips

↓

Straightens lumbosacral angle

↓

Increases pelvic outlet diameter

↓

Releases impacted shoulder

| Risk factor | Reason |

| ----- | ----- |

| Fetal macrosomia | Large shoulders |

| Diabetes in pregnancy | Macrosomia |

| Prolonged second stage | Difficult delivery |

| Operative vaginal delivery | Instrumental delivery |

Stepwise Management of Shoulder Dystocia

1\ McRoberts maneuver

2\ Suprapubic pressure

3\ Rubin maneuver

4\ Woods corkscrew maneuver

5\ Gaskin maneuver

6\ Zavanelli maneuver

QUESTION

The maneuver shown in the image is being performed during delivery. What is the primary purpose of this maneuver?



CORRECT

- A** Prevent perineal trauma
- B** Hasten the process of delivery
- C** Prevent fetal distress
- D** Prevent fetal trauma

RIGHT ANSWER

- OK** **A. Prevent perineal trauma**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1e" here and does not include a written explanation for this item.

QUESTION

A woman delivers before reaching the hospital. Soon after delivery, she develops abdominal pain, breathlessness, hypotension, and tachycardia. The degree of shock is out of proportion to visible bleeding. On examination, a large, boggy mass is seen at the introitus. What is the most likely diagnosis?



A Disseminated intravascular coagulation (DIC)

B Postpartum hemorrhage (PPH)

C Uterine inversion

CORRECT

D Amniotic fluid embolism

RIGHT ANSWER

OK C. Uterine inversion

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1f” here and does not include a written explanation for this item.

QUESTION

A primigravida is scheduled for induction of labor. On vaginal examination, the cervix is soft, in a mid-position, 2 cm dilated, and 50% effaced. The fetal head is at -1 station. What is the Bishop score in this case?

A 3; unfavorable

B 5; unfavorable

C 7; favourable

CORRECT

D 8; favourable

RIGHT ANSWER

OK

C. 7; favourable

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$20" here and does not include a written explanation for this item.

QUESTION

A woman undergoes vaginal delivery. After the baby is delivered, a perineal tear is observed that involves the perineal muscles and less than 50% of the external anal sphincter, while the rectal mucosa remains intact. What is the degree of perineal tear?

A 3A

CORRECT

B 3B

C 3C

D 4

RIGHT ANSWER

OK

A. 3A

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$21” here and does not include a written explanation for this item.

QUESTION

A primigravida presents to the emergency room in the early stage of labor with adequate uterine contractions. On per vaginal examination, a gynecoid pelvis is felt, the membranes are ruptured, and the vertex is felt in the right occipito-posterior position. How will you manage this patient?

A Vacuum-assisted delivery

B Cesarean section

C Normal vaginal delivery

CORRECT

D Forceps delivery

RIGHT ANSWER

OK C. Normal vaginal delivery

WHY THIS IS RIGHT

Occipito Posterior Position occurs when the back of the fetal head (occiput) faces the maternal sacrum.

Position	Description
Occipito-anterior (OA)	Occiput toward maternal symphysis pubis
Occipito-posterior (OP)	Occiput toward maternal sacrum
Occipito-transverse (OT)	Occiput toward lateral pelvis

In most cases of OP position:

Occipito-posterior position

↓

Internal rotation during labor

↓

Conversion to occipito-anterior

↓

Normal vaginal delivery

Approximately 90% of OP fetuses rotate spontaneously to OA.

In this patient:

Finding	Interpretation
Adequate contractions	Labor progressing
Gynecoid pelvis	Favorable pelvis
Vertex presentation	Normal presentation
Early labor	Rotation likely

Thus expectant management with vaginal delivery is recommended.

QUESTION

A 34y G2P1 presents at 35 weeks. She has no complaints and is appreciating fetal movements well. She had a previous classical cesarean at 25 weeks for eclampsia and severe FGR. She is currently on low dose aspirin and prenatal vitamins. On examination, the uterus is SFH is 38 cm and FHR is 140 bpm. An ultrasound reveals a single live fetus in breech presentation, placenta posterior and amniotic fluid normal. The patient desires a vaginal delivery. What is the best management?

- A** Review USG after 2 weeks
- B** Schedule elective LSCS at 37 weeks
- C** ECV at 36 weeks
- D** Await labor and do internal podalic version

CORRECT

RIGHT ANSWER

- OK** **B. Schedule elective LSCS at 37 weeks**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$22” here and does not include a written explanation for this item.

QUESTION

| Where will be the level of the uterus on the second-day post-delivery?

A One finger breadth below umbilicus

B Two finger breadths below umbilicus

CORRECT

C Three finger breadths below umbilicus

D Four finger breadths below umbilicus

RIGHT ANSWER

OK

B. Two finger breadths below umbilicus

WHY THIS IS RIGHT

Uterus is at the umbilicus after delivery and involutes ~1 fingerbreadth per day. Therefore, on day 2 it lies 2 fingerbreadths below.

Postpartum Day	Fundal Position
Immediately after delivery	At the level of the umbilicus
Day 1	1 finger breadth below umbilicus
Day 2	2 finger breadths below umbilicus
Each subsequent day	Descends ~1 cm/day
10-14 days	Not palpable abdominally

Monitoring postpartum fundal level helps detect:

Condition	Sign
Postpartum Hemorrhage	Boggy uterus
Subinvolution	Fundus higher than expected
Infection	Tender uterus

QUESTION

A primigravida presents to the labor room at 40 weeks of gestation with lower abdominal pain. She has been in labor for 3 hours. Which of the following will determine if she is in active labor?

- A Fetal head 5/5 palpable
- B Two contractions of 10 sec in 10 min
- C More than 5 cm dilation with complete effacement**
- D Rupture of membranes

CORRECT

RIGHT ANSWER

- OK C. More than 5 cm dilation with complete effacement**

WHY THIS IS RIGHT

Labor is divided into three stages.

Stage	Description
First stage	Cervical dilatation from 0 -> 10 cm
Second stage	Full dilatation -> delivery of baby
Third stage	Delivery of placenta

The first stage is further divided into latent and active phases.

WHO defines active labor onset at >5 cm dilation. Contractions, head station, or membrane status do not alone define active labor.

Characteristics of active labor:

Feature	Finding
Cervical dilation	≥5 cm
Effacement	Nearly complete
Contractions	Strong and regular

Active labor begins at 5 cm cervical dilation.

QUESTION

You are examining a multigravida in the second stage of labor for the past two hours. On examination, contractions are adequate, the cervix is fully dilated with the head at station 0 with molding 2+ and caput 2+. The sagittal suture is in the right occipito-transverse position. The fetal heart rate is 140 beats/minute. Which of the following is carried out for the management of this patient?

- A** Mid pelvic forceps
- B** Vacuum-assisted delivery
- C** Wait for an hour
- D** Lower segment cesarean section

CORRECT

RIGHT ANSWER

- OK** **D. Lower segment cesarean section**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$23” here and does not include a written explanation for this item.

QUESTION

You are applying a vacuum to deliver a baby in a patient with prolonged 2nd stage. The point at which the vacuum is applied is:

- A** 3 cm anterior to the posterior fontanelle
- B** 6 cm anterior to the posterior fontanelle
- C** 4 cm anterior to the posterior fontanelle
- D** Midway between the anterior and posterior fontanelle

CORRECT

RIGHT ANSWER

- OK** **A. 3 cm anterior to the posterior fontanelle**

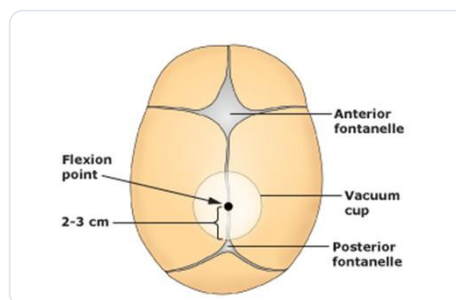
WHY THIS IS RIGHT

Vacuum Extraction is used in the second stage of labor to assist delivery.

Common indications:

Indication	Explanation
-----	-----
Prolonged second stage	Maternal exhaustion
Fetal distress	Need for rapid delivery
Medical conditions	Avoid maternal pushing

The optimal cup placement is the flexion point, located 3 cm anterior to the posterior fontanelle. This ensures maximum flexion of the fetal head and presents the smallest diameter through the pelvis.



QUESTION

Collapse in a patient during labor/ delivery followed by bleeding and DIC in the absence of coexisting conditions is most likely due to?

A Amniotic fluid embolism

CORRECT

B Postpartum haemorrhage

C Eclampsia

D Peripartum cardiomyopathy

RIGHT ANSWER

OK **A. Amniotic fluid embolism**

WHY THIS IS RIGHT

Amniotic Fluid Embolism is a rare but catastrophic complication of pregnancy.

It occurs when amniotic fluid, fetal cells, or debris enter the maternal bloodstream, triggering a massive inflammatory and coagulation response.

Amniotic fluid enters maternal circulation

↓

Pulmonary vasospasm

↓

Acute respiratory failure

↓

Massive inflammatory reaction

↓

DIC and severe bleeding

AFE = sudden collapse + respiratory distress + DIC during labor.

Management is supportive and emergency-based.

Steps include:

- Immediate resuscitation
- Oxygen and ventilation
- Blood products for DIC
- Intensive care support

| Feature | Explanation |

| ----- | ----- |

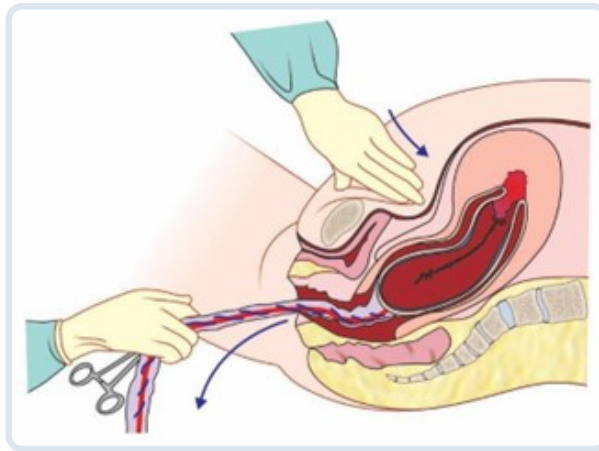
| Sudden cardiovascular collapse | Hypotension, shock |

| Respiratory distress | Acute hypoxia |

| DIC | Severe bleeding |

QUESTION

Following delivery, the placenta is being removed by traction; the cord snaps and there is bleeding. What is the next step in management?



- A Oxytocin
- B Uterine massage
- C Arrange blood and Crede's method

D Manual removal of placenta

CORRECT

RIGHT ANSWER

D. Manual removal of placenta

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$24" here and does not include a written explanation for this item.

QUESTION

A woman with GDM is in labor. After head delivery, shoulders are impacted. What is the correct sequence of maneuvers?

CORRECT

A McRobert's -> Rubin -> Gaskin -> Zavanelli

B Rubin -> McRobert's -> Gaskin -> Zavanelli

C Gaskin -> McRobert's -> Rubin -> Zavanelli

D McRobert's -> Gaskin -> Rubin -> Zavanelli

RIGHT ANSWER

OK

A. McRobert's -> Rubin -> Gaskin -> Zavanelli

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$25" here and does not include a written explanation for this item.

QUESTION

In a case of atonic postpartum hemorrhage (PPH), all primary medical management measures have failed. What is the next step to be performed in the labor room?

A Intrauterine balloon tamponade

CORRECT

B Uterine devascularization

C Compression sutures

D Hysterectomy

RIGHT ANSWER

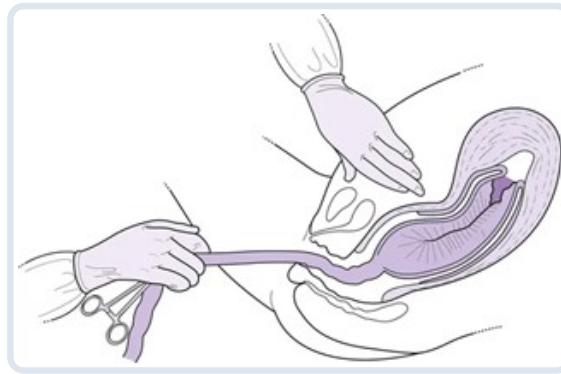
OK A. Intrauterine balloon tamponade

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$26" here and does not include a written explanation for this item.

QUESTION

Identify the maneuver shown in the image below:



A Controlled cord traction

CORRECT

B Manual removal of placenta

C Ritgen maneuver

D Perineal massage

RIGHT ANSWER

OK

A. Controlled cord traction

WHY THIS IS RIGHT

The maneuver shown corresponds to Controlled Cord Traction, a key step in active management of the third stage of labour (AMTSL).

Controlled cord traction is used to assist delivery of the placenta after the baby is born.

Principle

- Gentle traction on the umbilical cord
- Simultaneous counter-pressure on the uterus

This prevents uterine inversion.

Steps of Controlled Cord Traction

Placenta separates

↓

One hand stabilizes uterus above symphysis

↓

Other hand applies gentle cord traction

↓

Placenta delivered safely

Active Management of Third Stage of Labour

| Step | Purpose |

| --- | ----- |

| Oxytocin administration | Prevent uterine atony |

| Controlled cord traction | Deliver placenta |

| Delayed cord clamping | Improve neonatal iron stores |

QUESTION

While performing a repair following delivery, what is the appropriate sequence of layer closure in a mediolateral episiotomy?

A Mucosa -> muscle -> skin

CORRECT

B Muscle -> mucosa -> skin

C Skin -> muscle -> mucosa

D Mucosa -> skin -> muscle

RIGHT ANSWER

OK A. Mucosa -> muscle -> skin

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$27" here and does not include a written explanation for this item.

QUESTION

A primigravida in labor at 5 cm cervical dilatation suddenly develops severe fetal bradycardia. On vaginal examination, cord prolapse is detected and the cord is still pulsating. What should be the immediate next step in management?

A Trendelenburg, push the head up

CORRECT

B Fill the bladder and put back the cord

C ARM and oxytocin

D Wait and watch

RIGHT ANSWER

OK

A. Trendelenburg, push the head up

WHY THIS IS RIGHT

Cord prolapse occurs when the umbilical cord descends before the fetal presenting part, leading to cord compression and fetal hypoxia. Immediate Action Is Needed. Cord compression leads to:

Cord compression

↓

Reduced fetal oxygen supply

↓

Fetal bradycardia

↓

Fetal hypoxia

↓

Risk of fetal death

Therefore immediate decompression of the cord is essential.

Initial emergency measures include:

| Step | Purpose |

| --- | ----- |

| Trendelenburg or knee-chest position | Reduce cord compression |

| Manual elevation of presenting part | Relieve pressure on cord |

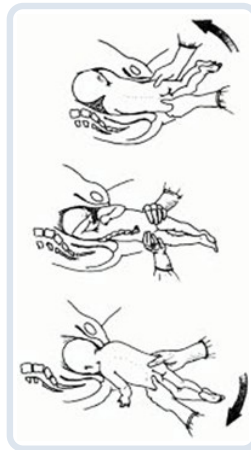
| Avoid handling the cord | Prevent vasospasm |

| Oxygen to mother | Improve fetal oxygenation |

After stabilization: Emergency cesarean section is performed.

QUESTION

Identify the obstetric maneuver shown in the image below:



CORRECT

A

Lovset maneuver

B

Pinnard maneuver

C

Burn-Marshall maneuver

D

Mauriceau-Smellie-Veit (MSV) maneuver

RIGHT ANSWER

OK

A. Lovset maneuver

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$28" here and does not include a written explanation for this item.

QUESTION

A woman who has just delivered a full-term baby vaginally suddenly develops profuse postpartum hemorrhage associated with severe lower abdominal pain. She becomes hypotensive and tachycardic. On examination, the uterine fundus is not palpable abdominally, and a fleshy mass is felt protruding through the vagina with the placenta still attached. What is the immediate next step?

A Remove placenta and reposition the uterus

B Put uterus inside without removing the placenta

CORRECT

C Shift to OT and insert the uterus back

D Start Oxytocin

RIGHT ANSWER

OK **B. Put uterus inside without removing the placenta**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$29” here and does not include a written explanation for this item.

QUESTION

Which of the following uterotonic agents is contraindicated in the management of postpartum hemorrhage?

- A Oxytocin
- B Misoprostol
- C **Dinoprostone**
- D 15 methyl analogue of PGF 2 α

CORRECT

RIGHT ANSWER

OK **C. Dinoprostone**

WHY THIS IS RIGHT

Postpartum hemorrhage is defined as:

- ≥ 500 mL blood loss after vaginal delivery
- ≥ 1000 mL after cesarean section

The most common cause is uterine atony, where the uterus fails to contract after delivery.

Uterotonic drugs are given to stimulate uterine contraction and reduce bleeding.

Uterotonic Drugs Used in PPH

Drug	Mechanism	Use in PPH
Oxytocin	Stimulates uterine smooth muscle contraction	Class- Hormone ☐ First-line drug
Misoprostol (PGE1)	Causes uterine contraction	PGE1 analogue ☐ Used in PPH
15-methyl PGF α (Carboprost)	Strong uterine contraction	PGF α analogue ☐ Used in refractory PPH
Dinoprostone (PGE2)	Cervical ripening	☐ Not used in PPH

QUESTION

A primigravida with a normal vaginal delivery develops intractable postpartum haemorrhage, not responding to uterine massage and uterotonics. What is the next best step in management?

A Uterine artery embolization

B Balloon tamponade

CORRECT

C Peripartum hysterectomy

D Systematic pelvic devascularisation

RIGHT ANSWER

OK

B. Balloon tamponade

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2a” here and does not include a written explanation for this item.

QUESTION

Which of the following are used in a Caesarean section?

1. Doyen Retractor
2. Bard Parker handle with blade
3. Karman's cannula
4. Shirodkar clamp
5. Cusco's speculum
6. Allis forceps
7. Green Armytage forceps

A 1,2, 6, and 7

CORRECT

B 1,2, 4, and 5

C 1,2, 3, and 7

D 1,2, 4, and 7

RIGHT ANSWER

OK A. 1,2, 6, and 7

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2b” here and does not include a written explanation for this item.

QUESTION

A 24-year-old woman is in labor. The cervix is 3 cm dilated and 70% effaced. A "bag of worms" is felt. What is the next best step?

A Rupture membranes and confirm cord prolapse

B Emergency LSCS

CORRECT

C Put the cord above the vertex

D Wait for spontaneous delivery

RIGHT ANSWER

OK B. Emergency LSCS

WHY THIS IS RIGHT

During vaginal examination:

- The examiner feels the soft, pulsating loops of the cord.
- These loops resemble a "bag of worms."

This description is classic for Umbilical Cord Prolapse. Umbilical cord prolapse occurs when the umbilical cord descends below the presenting part of the fetus.

This leads to compression of the cord, causing acute fetal hypoxia.

In this case:

Finding	Significance
Cervix only 3 cm dilated	Vaginal delivery not imminent
Cord prolapse suspected	High risk of fetal hypoxia

While preparing for surgery:

Step	Purpose
Elevate presenting part	Relieve cord compression
Knee-chest / Trendelenburg position	Reduce pressure on cord
Avoid handling the cord	Prevent vasospasm
Oxygen to mother	Improve fetal oxygenation

QUESTION

A woman who has just delivered a full-term baby vaginally suddenly develops profuse postpartum hemorrhage associated with severe lower abdominal pain. She becomes hypotensive and tachycardic. On examination, the uterine fundus is not palpable abdominally, and a fleshy mass is felt protruding through the vagina with the placenta still attached. What is the immediate next step?

A Remove placenta and reposition the uterus

B Put uterus inside without removing the placenta

CORRECT

C Shift to OT and insert the uterus back

D Start Oxytocin

RIGHT ANSWER

OK

B. Put uterus inside without removing the placenta

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2c” here and does not include a written explanation for this item.

QUESTION

A primigravida is in the 2nd stage of labor for 2 hours. The head is at +3 station with caput present and the fetal heart rate (FHR) is dropping to 90 bpm. What is the next best step?

A LSCS

B Low forceps

C Outlet forceps

CORRECT

D Ventouse

RIGHT ANSWER

OK C. Outlet forceps

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2d" here and does not include a written explanation for this item.

QUESTION

Which drug is contraindicated in a patient with atonic PPH with a history of hypertension?

A Misoprostol

B Oxytocin

C Ergotamine

CORRECT

D PGF2 alpha

RIGHT ANSWER

OK C. Ergotamine

WHY THIS IS RIGHT

Postpartum Hemorrhage is defined as:

- ≥ 500 mL blood loss after vaginal delivery
- ≥ 1000 mL after cesarean section

The most common cause (~70-80%) is uterine atony.

Uterotonic Drugs Used in Atonic PPH

Drug	Class	Important Note
Oxytocin	First-line uterotonic	Safe in hypertension
Misoprostol	PGE $\square$ analogue	Safe
Carboprost (PGF $\square$ α)	Prostaglandin	Avoid in asthma
Ergometrine / Ergotamine	Ergot alkaloid	☐ Avoid in hypertension

Why Ergotamine is Contraindicated-

Ergot derivatives (ergometrine/ergotamine):

- Cause powerful uterine contraction
- Also cause systemic vasoconstriction

This can lead to:

- Severe hypertension
- Stroke
- Coronary vasospasm

Therefore they are contraindicated in hypertensive patients and preeclampsia.

QUESTION

| When is delayed cord clamping done?

- A** Only Vigorous term babies not requiring resuscitation
- B** All preterm babies irrespective of birth weight
- C** Vigorous term and preterm babies not requiring resuscitation
- D** All term babies irrespective of birth weight

CORRECT

RIGHT ANSWER

- OK** C. Vigorous term and preterm babies not requiring resuscitation

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2e” here and does not include a written explanation for this item.

QUESTION

| Which is not an indication of instrumental vaginal delivery?

A CPD

CORRECT

B Fetal distress

C Maternal exhaustion

D Prolonged 2nd stage labour

RIGHT ANSWER

OK
A. CPD

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2f" here and does not include a written explanation for this item.

QUESTION

| Which step is not included in active management of third stage of labor (AMTSL)?

A Bimanual compression

CORRECT

B Delayed cord clamp

C Brandt Andrews manouever

D Administration of oxytocics

RIGHT ANSWER

OK A. Bimanual compression

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$30" here and does not include a written explanation for this item.

QUESTION

| What is restitution in the events of labour?

- A** Head rotated by 1/8th of a circle
- B** Head rotating due to untwisting of the neck CORRECT
- C** The shoulder undergoing rotation by 1/8th of circle
- D** The movement by which the head is born

RIGHT ANSWER

- OK** **B. Head rotating due to untwisting of the neck**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$31” here and does not include a written explanation for this item.

QUESTION

Which of the following uterotonic agents is contraindicated in the management of postpartum hemorrhage?

- A Oxytocin
- B Misoprostol
- C **Dinoprostone**
- D 15 methyl analogue of PGF 2 α

CORRECT

RIGHT ANSWER

OK C. Dinoprostone

WHY THIS IS RIGHT

Postpartum hemorrhage is defined as:

- ≥ 500 mL blood loss after vaginal delivery
- ≥ 1000 mL after cesarean section

The most common cause is uterine atony, where the uterus fails to contract after delivery.

Uterotonic drugs are given to stimulate uterine contraction and reduce bleeding.

Uterotonic Drugs Used in PPH

Drug	Mechanism	Use in PPH
Oxytocin	Stimulates uterine smooth muscle contraction	Class- Hormone ☐ First-line drug
Misoprostol (PGE1)	Causes uterine contraction	PGE1 analogue ☐ Used in PPH
15-methyl PGF α (Carboprost)	Strong uterine contraction	PGF α analogue ☐ Used in refractory PPH
Dinoprostone (PGE2)	Cervical ripening	☐ Not used in PPH

QUESTION

A primigravida with a normal vaginal delivery develops intractable postpartum haemorrhage, not responding to uterine massage and uterotonics. What is the next best step in management?

A Uterine artery embolization

B Balloon tamponade

CORRECT

C Peripartum hysterectomy

D Systematic pelvic devascularisation

RIGHT ANSWER

OK B. Balloon tamponade

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$32” here and does not include a written explanation for this item.

QUESTION

Which of the following are used in a Caesarean section?

1. Doyen Retractor
2. Bard Parker handle with blade
3. Karman's cannula
4. Shirodkar clamp
5. Cusco's speculum
6. Allis forceps
7. Green Armytage forceps

A 1, 2, 6, and 7

CORRECT

B 1, 2, 4, and 5

C 1, 2, 3, and 7

D 1, 2, 4, and 7

RIGHT ANSWER

OK **A. 1, 2, 6, and 7**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$33" here and does not include a written explanation for this item.

QUESTION

A young woman presents with vault prolapse. It is being fixed to a bony point with a mesh. Where is this mesh fixed to?



A Ischial spine

B Ischial tuberosity

C Sacral promontory

CORRECT

D Pubic symphysis

RIGHT ANSWER

OK

C. Sacral promontory

WHY THIS IS RIGHT

In sacrohysteropexy, the mesh is attached from the cervix/uterus to the sacral promontory, providing strong apical support. Ischial structures are not used for mesh fixation. Gold standard surgery for vault prolapse = sacrocolpopexy.

The Sacral Promontory provides:

Advantage	Reason
Strong fixation	Firm bony landmark
Restores vaginal axis	Anatomical alignment
Durable repair	Low recurrence rate

QUESTION

A 30-year-old P2L2 woman presents with cervical elongation. Her family is complete. What is the preferred surgery advised?

A Fothergill repair

CORRECT

B McCall Culdoplasty

C Le Fort procedure

D Shirodkar sling

RIGHT ANSWER

OK A. Fothergill repair

WHY THIS IS RIGHT

For cervical elongation in women with completed family, the preferred procedure is Fothergill (Manchester repair). Sling procedures are fertility-preserving; Le Fort is for very elderly non-sexually active women.

Cervical amputation



Shortening of elongated cervix



Reattachment of cardinal (Mackenrodt) ligaments



Restoration of uterine support

Fothergill repair is the operation of choice for cervical elongation.

B) McCall Culdoplasty

- Used during hysterectomy to prevent vault prolapse.

C) Le Fort procedure

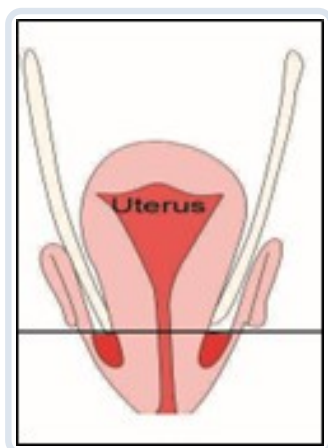
- Done for elderly women who do not desire intercourse.

D) Shirodkar sling

- Used mainly for uterine prolapse, not isolated cervical elongation.

QUESTION

Identify the grade of prolapse?



A Grade 3 prolapse

CORRECT

B Grade 2 prolapse

C Grade 1 prolapse

D Procidentia

RIGHT ANSWER

OK A. Grade 3 prolapse

WHY THIS IS RIGHT

First-degree prolapse:-

- Cervix descends into the vagina
- Does not reach the introitus
- Often asymptomatic or mild symptoms

Second-degree prolapse:-

- Cervix reaches the level of the introitus
- May be seen at the vaginal opening on straining

Third-degree prolapse:-

- Cervix protrudes outside the introitus
- Body of uterus remains inside the vagina

Procidentia (Complete prolapse):-

- Entire uterus lies outside the introitus
- Severe form, often associated with ulceration and discharge

QUESTION

The classification shown is for?

Anterior wall Aa	Anterior wall Ba	Cervix or cuff C
Genital hiatus gh	Perineal body pb	Total vaginal length tvL
Posterior wall Ap	Posterior wall Bp	Posterior fornix D

A Cervical cancer

B Pelvic organ prolapse

CORRECT

C Vulvar cancer

D Uterine anomalies

RIGHT ANSWER

OK

B. Pelvic organ prolapse

WHY THIS IS RIGHT

This diagram represents the POP-Q (Pelvic Organ Prolapse Quantification) system, used to objectively measure pelvic organ prolapse.

Key Points

- Uses specific vaginal reference points measured in cm relative to the hymen.
- Negative values = above hymen; positive values = below hymen (prolapse).
- Anterior vaginal wall: Aa, Ba
- Posterior vaginal wall: Ap, Bp
- Cervix/vaginal cuff: C
- Posterior fornix: D (only if cervix present)

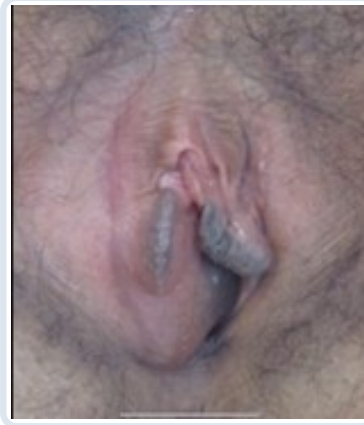
Additional measurements

- GH (Genital hiatus) - distance from urethral meatus to posterior hymen
- PB (Perineal body) - posterior hymen to anus
- TVL (Total vaginal length) - vaginal depth when prolapse reduced

Purpose: Standardized assessment and staging of pelvic organ prolapse (POP).

QUESTION

A woman comes with complaints of pain and swelling in the perineal area, difficulty in walking and sitting. She has a history of multiple sexual partners. On examination, a tender swelling is seen with redness on the labia, as shown in the image given below. What is the most likely diagnosis?



A Skene duct abscess

B Bartholin abscess

CORRECT

C Genital Tuberculosis

D Gartner duct cyst

RIGHT ANSWER

OK

B. Bartholin abscess

WHY THIS IS RIGHT

It develops when the Bartholin duct becomes obstructed and infected.

- A unilateral, very painful, erythematous, fluctuant swelling at the posterior vulva (4-8 o'clock position) is typical of Bartholin abscess.
- Skene duct cyst will be para-urethral whereas Gartner duct cyst --> present in the anterior vaginal wall.
- Management is Incision and drainage followed by catheter insertion.

Common Causative Organisms

Organism	Source
Neisseria gonorrhoeae	STI
Escherichia coli	Enteric flora
Staphylococcus	Skin flora

A) Skene Duct abscess:

- Swelling occurs near urethral meatus, not labia.

C) Genital tuberculosis

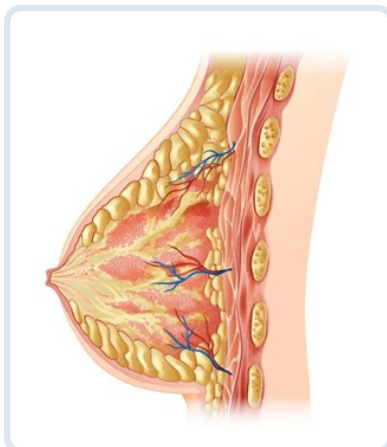
- Usually causes infertility, not painful vulvar swelling.

D) Gartner duct cyst

- Usually painless cyst in lateral vaginal wall.

QUESTION

| Which hormone is primarily responsible for the growth of breast tissue?



A Oxytocin

B Estrogen

C Prolactin

D Progesterone

CORRECT

RIGHT ANSWER

OK

D. Progesterone

WHY THIS IS RIGHT

The growth and development of mammary alveoli (as shown in the diagram) is primarily stimulated by progesterone. Progesterone is the primary hormone responsible for mammary alveolar growth and development, while estrogen primarily stimulates ductal growth. This hormonal distinction is crucial for understanding mammary gland development and the cyclical changes that occur during the menstrual cycle.

Hormone	Function
Estrogen	Ductal growth of breast
Progesterone	Lobuloalveolar development
Prolactin	Milk production
Oxytocin	Milk ejection (let-down reflex)

QUESTION

A 25-year-old woman presents soon after home delivery by an untrained Dai with a vaginal mass. On examination, the finding is shown below. This condition occurs due to weakening of which ligament?



A Mackenrodt ligaments

CORRECT

B Sacroiliac ligaments

C Round ligament

D Ovarian ligament

RIGHT ANSWER

OK A. Mackenrodt ligaments

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$19" here and does not include a written explanation for this item.

QUESTION

In a regular 28-day menstrual cycle, which of the following hormonal patterns is typically seen between days 21 and 25 of the cycle?

- A** Estrogen and progesterone high, FSH and LH low
- B** Estrogen increase progesterone low, FSH increase LH low
- C** Estrogen decreases progesterone high, FSH decrease and LH high
- D** Estrogen increases and progesterone low, LH and FSH low

CORRECT

RIGHT ANSWER

- OK** A. Estrogen and progesterone high, FSH and LH low

WHY THIS IS RIGHT

This is the luteal phase (secretory phase)

□ Dominant structure: Corpus luteum

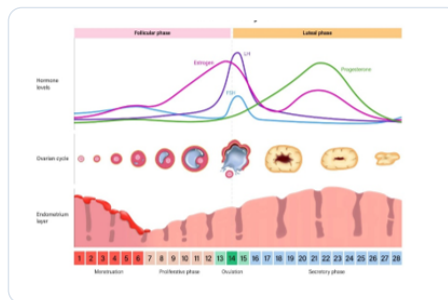
□ Hormonal environment:

- Progesterone ↑↑ (peak)
- Estrogen ↑ (moderate)
- FSH ↓
- LH ↓

Days 21-25 correspond to the mid-luteal phase dominated by the corpus luteum. Progesterone is high and estrogen is moderately elevated due to luteal secretion.

These steroids exert negative feedback on the pituitary--> suppressing FSH and LH.

This pattern maintains luteal support while preventing another ovulatory surge.



QUESTION

| What hormone levels are typical during days 21-25 of a 28-day cycle?

A Estrogen ↑, Progesterone ↑ ; FSH ↓, LH ↓

CORRECT

B Estrogen ↓, Progesterone ↓ ; FSH ↓, LH ↓

C Estrogen ↓, Progesterone ↑ ; FSH ↑, LH ↑

D Estrogen ↓, Progesterone ↓ ; FSH ↓, LH ↑

RIGHT ANSWER

OK

A. Estrogen ↑, Progesterone ↑ ; FSH ↓, LH ↓

WHY THIS IS RIGHT

Days 21-25 correspond to the mid-luteal phase, when the corpus luteum is fully functional. Progesterone peaks, and estrogen remains moderately elevated. High steroid levels exert negative feedback on the pituitary, suppressing FSH and LH, matching option A.

QUESTION

| The most potent natural estrogen is?

- A Estrone
- B Estradiol**
- C Estriol
- D Conjugated equine estrogen

CORRECT

RIGHT ANSWER

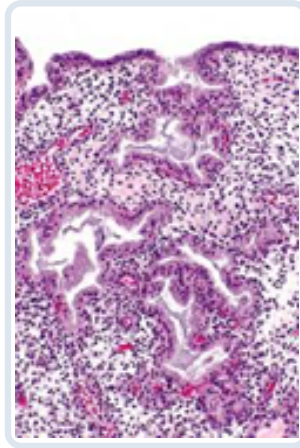
- B. Estradiol**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1a” here and does not include a written explanation for this item.

QUESTION

An HPE image of the endometrium is shown. The hormone responsible is secreted by?



A Corpus luteum

CORRECT

B Primary follicle

C Granulosa cell

D Theca interna

RIGHT ANSWER

OK A. Corpus luteum

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1b" here and does not include a written explanation for this item.

QUESTION

| What is the likely diagnosis?



A Hydrosalpinx

CORRECT

B Ovarian cancer

C Endometriosis

D Dermoid cyst

RIGHT ANSWER

OK A. Hydrosalpinx

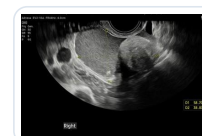
WHY THIS IS RIGHT

Cogwheel sign is due to longitudinal folds seen in a dilated fallopian tube filled with fluid.

- It is characteristic of chronic hydrosalpinx.

Ovarian carcinoma: A cyst with suspicious features

- Dermoid cyst: Heterogenous/ Dot-dash, Rokitansky nodule
- Endometrioma: Ground glass appearance with dense echoes



QUESTION

A 25-year-old woman with primary infertility is found to have bilateral tubal block on HSG. The next best step is?

A Laparoscopy with chromopertubation

CORRECT

B IVF

C IUI

D Letrozole

RIGHT ANSWER

OK

A. Laparoscopy with chromopertubation

WHY THIS IS RIGHT

HSG is a screening test for tubal patency.

- HSG findings must be confirmed --> by laparoscopy with chromopertubation.
- This allows direct visualization and dye testing for tubal patency.

> IVF is considered only after confirmation, IUI and Letrozole are ineffective with bilateral block.

>

- Methylene blue dye injected through cervix

↓

Dye passes through uterus

↓

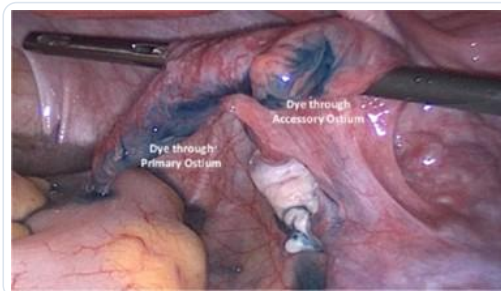
Spillage from fimbrial end

↓

Confirms tubal patency

If no dye spill is seen, tubal obstruction is confirmed.

*



QUESTION

LSCS (Lower Segment Cesarean Section) for breech was done. Intraoperatively, finding is shown. What is the diagnosis?



- A Arcuate uterus
- B Bicornuate uterus
- C Unicornuate uterus
- D Uterine didelphys**

CORRECT

RIGHT ANSWER

- OK D. Uterine didelphys**

WHY THIS IS RIGHT

Presence of two separate uterine cavities indicates uterine didelphys. --> results from failure of Müllerian duct fusion.

> Arcuate uterus shows only mild indentation, bicornuate has one cervix, and unicornuate has a single horn.

The female reproductive tract develops from Müllerian ducts.

Two Müllerian ducts develop

↓

Fusion normally occurs

↓

Single uterus formed

• In uterine didelphys:

Complete failure of fusion

↓

Two separate uterine cavities

↓

Two cervices (sometimes double vagina)

*

QUESTION

A 28-year-old woman with a history of multiple sexual partners presents with lower abdominal pain for 1 month. She experiences minimal discharge and complaints of intermenstrual bleeding. What is the most likely cause?

A Herpes simplex

B Genital tuberculosis

C Candida

D **Neisseria gonorrhoea**

CORRECT

RIGHT ANSWER

OK

D. Neisseria gonorrhoea

WHY THIS IS RIGHT

History of *multiple partners*, *chronic lower abdominal pain*, *abnormal bleeding* and *per vaginal discharge* are *suggestive of pelvic inflammatory disease.*

- Among the given options, N. gonorrhoea is a classic sexually transmitted pathogen causing PID.

Common causative organisms:

Organism	Type
Neisseria gonorrhoeae	STI
Chlamydia trachomatis	STI
Mixed anaerobes	Secondary infection

- Mechanism of upstream infection:-

Sexually transmitted infection

↓

Cervicitis

↓

Ascending infection

↓

Endometritis and salpingitis

↓

Pelvic inflammatory disease

This leads to pelvic pain and abnormal bleeding.

*

QUESTION

A 23-year-old woman accompanied by her mother-in-law comes to the infertility clinic. She has been having regular intercourse for 6 months but is not able to conceive. What is the next best step?

A Semen analysis for husband

B Reassure and review the couple after 6 months

CORRECT

C Hysterolaparoscopy

D Diagnostic hysteroscopy

RIGHT ANSWER

OK

B. Reassure and review the couple after 6 months

WHY THIS IS RIGHT

Infertility is defined as failure to conceive after 12 months of unprotected intercourse in women <35 years.

- She has tried only for 6 months--> so no investigation is indicated yet.
- Reassurance and review after another 6 months is appropriate. If >35yrs, evaluation can start at 6months.
- With regular intercourse : The chance of conception per cycle $\approx$ 20-25%

Cumulative probability:

Duration	Chance of conception
3 months	$\sim$ 50%
6 months	$\sim$ 75%
12 months	$\sim$ 85%

Infertility is diagnosed only after 12 months of trying (<35 years).

- Situation | Action |
- | Young (<35), <12 months trying | ☐ Reassure |
- | $\geq$ 12 months trying | Start workup |
- | Red flags (amenorrhea, PID, etc.) | Early workup |

QUESTION

| In which of the following conditions, hysteroscopy can be done?

A Tubal ligation

B Asherman syndrome

CORRECT

C Endocervical polyp

D Subserosal fibroid

RIGHT ANSWER

OK

B. Asherman syndrome

WHY THIS IS RIGHT

It is characterized by fibrous adhesions inside the uterine cavity--> Causes of Asherman Syndrome

Common causes include:

Cause	Example
----	- - - - -
Post-curettage trauma	After abortion
Postpartum curettage	Retained placenta
Uterine surgery	Myomectomy

Asherman syndrome consists of intrauterine adhesions and hysteroscopy is the investigation and treatment of choice (hysteroscopic adhesiolysis).

- Hysteroscopy is both diagnostic and therapeutic.

Direct visualization of uterine cavity

↓

Identify intrauterine adhesions

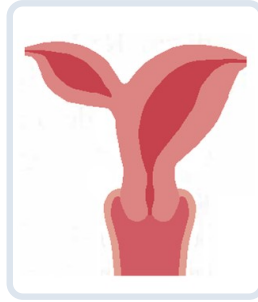
↓

Hysteroscopic adhesiolysis

- Tubal ligation is laparoscopic, subserosal fibroids are extrauterine, and endocervical polyps are usually removed by simple excision.

QUESTION

The following image shows an uterine anomaly. This anomaly occurs due to which of the following developmental defects?



- A** Mesonephric duct; complete non-fusion
- B** Para mesonephric duct; complete non-fusion
- C** Mesonephric duct; partial fusion
- D** Para mesonephric duct; partial fusion

CORRECT

RIGHT ANSWER

- OK** D. Para mesonephric duct; partial fusion

WHY THIS IS RIGHT

The female reproductive tract develops from the Paramesonephric Duct, also known as the Müllerian duct.

These ducts form:

Structure formed	Organ
Fallopian tubes	From upper duct
Uterus	Fusion of both ducts
Cervix	From fused ducts
Upper vagina	From fused ducts

Mechanism of the Anomaly

Two paramesonephric ducts develop

↓

They normally fuse in midline

↓

Uterus and cervix formed

If fusion is incomplete or partial: Müllerian duct anomaly develops

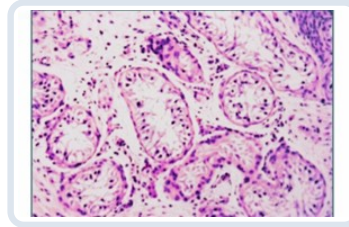
In this case: Partial fusion defect of paramesonephric ducts

Common uterine anomalies arise due to fusion or resorption defects-

Defect	Resulting anomaly
Complete non-fusion	Uterus didelphys
Partial fusion	Bicornuate uterus
Failure of septal resorption	Septate uterus
Complete agenesis	MRKH syndrome

QUESTION

A 25-year-old male patient is evaluated for primary infertility. Semen analysis shows azoospermia. A testicular biopsy is done and the image is shown below. The shown finding is consistent with?



A Sertoli cell only syndrome

CORRECT

B Testicular atrophy

C Benign testicular neoplasm

D Orchitis

RIGHT ANSWER

OK

A. Sertoli cell only syndrome

WHY THIS IS RIGHT

Sertoli Cell Only Syndrome is a cause of non-obstructive azoospermia. Normal seminiferous tubules contain:

- Spermatogonia
- Spermatocytes
- Spermatids
- Sertoli cells

In Sertoli cell only syndrome:

Seminiferous tubules

↓

Germ cells absent

↓

Only Sertoli cells remain

↓

No spermatogenesis

↓

Azoospermia

| Type | Cause |

| --- | ---- |

| Obstructive | Vas deferens obstruction |

| Non-obstructive | Spermatogenic failure |

B) Testicular atrophy

Shows shrunken seminiferous tubules, not selective germ cell absence.

C) Benign testicular neoplasm

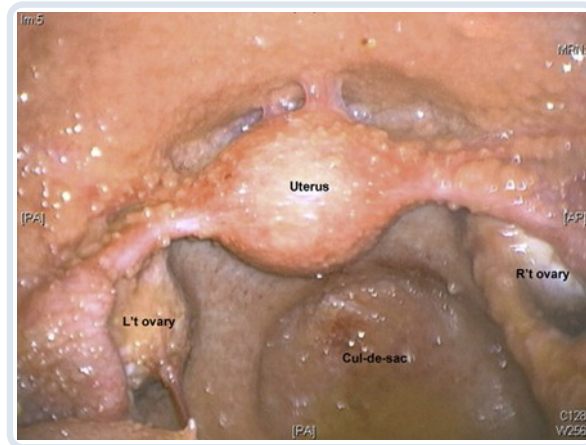
Shows tumor cells, not normal Sertoli cells.

D) Orchitis

Shows inflammatory infiltrates and edema.

QUESTION

A 25-year-old woman whose last delivery was 5 years back presents with secondary amenorrhea of 2 years. She does not bleed on giving estrogen and progesterone. A laparoscopy shows the following. What is the diagnosis?



A Endometriosis

B Fibroids

C Sarcoidosis

D Genital TB

CORRECT

RIGHT ANSWER

OK

D. Genital TB

WHY THIS IS RIGHT

Absence of withdrawal bleeding after estrogen-progesterone challenge indicates endometrial damage. Laparoscopic caseous nodules and tubercles are classic for genital tuberculosis, which destroys the endometrium and causes amenorrhea.

QUESTION

A 20-year-old woman is evaluated for primary infertility. Hysterosalpingography reveals the given finding. What is the anomaly seen?



A Septate uterus

B Uterine didelphys

C Bicornuate uterus

CORRECT

D Unicornuate uterus

RIGHT ANSWER

OK

C. Bicornuate uterus

WHY THIS IS RIGHT

HSG showing two closely placed cavities with a narrow angle ($<75^\circ$) suggests a septate uterus. Widely divergent horns ($>105^\circ$) indicate bicornuate, and didelphys shows two completely separate cavities. It occurs due to partial failure of fusion of the paramesonephric (Müllerian) ducts during embryonic development. Characteristic feature: Two uterine horns giving a “heart-shaped” or “rabbit-ear” appearance.

During development:

Two Müllerian ducts

↓

Fusion in midline

↓

Formation of uterus

If fusion fails partially:

Partial fusion defect

↓

Two uterine horns

↓

Bicornuate uterus

Bicornuate uterus = partial fusion defect of Müllerian ducts.

QUESTION

Based on this laparoscopic image showing free spillage on chromotubation in an infertility patient, what is the most likely diagnosis?



A Endometriosis

B Ovarian cyst

C PCOS

CORRECT

D Tubo ovarian mass

RIGHT ANSWER

OK

C. PCOS

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

| Which of these is not a test for the measurement of ovarian reserve?

A Serum FSH in the early follicular phase

B Antral follicular count

C Anti mullerian hormone

D Serum Estradiol in the early follicular phase

CORRECT

RIGHT ANSWER

OK D. Serum Estradiol in the early follicular phase

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1d” here and does not include a written explanation for this item.

QUESTION

A 14-year-old girl presents with primary amenorrhea. On examination, a bluish hue is seen in vagina. What is the most likely cause?

A Imperforate Hymen

CORRECT

B Transverse vaginal septum

C Mayer-Rokitansky-Küster-Hauser syndrome

D OHVIRA syndrome

RIGHT ANSWER

OK A. Imperforate Hymen

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

A couple has been attempting to conceive for the past two years with unprotected intercourse yet without success. What percentage of infertile women have unexplained infertility?

A 5%

B 10%

C 15%

CORRECT

D 20%

RIGHT ANSWER

OK
C. 15%

WHY THIS IS RIGHT

Infertility is defined as:

- Failure to conceive after 12 months of regular unprotected intercourse.

Evaluation usually includes assessment of:

- Ovulation
- Tubal patency
- Uterine cavity
- Male factor

If all tests are normal but pregnancy still does not occur, the condition is called unexplained infertility.

Unexplained infertility occurs when:

- Ovulation is normal
- Tubes are patent
- Semen analysis is normal
- No uterine pathology is detected

Yet the couple is unable to conceive.

Prevalence- Approximately 10-20% of infertile couples have unexplained infertility.

Major steps in infertility evaluation:

Investigation Purpose
----- -----
Semen analysis Male factor
Ovulation assessment (progesterone, LH) Ovulatory function
Hysterosalpingography (HSG) Tubal patency
Ultrasound pelvis Ovarian and uterine structure
Laparoscopy Endometriosis or adhesions

QUESTION

Based on this laparoscopic image showing free spillage on chromopertubation in an infertility patient, what is the most likely diagnosis?



A Endometriosis

B Ovarian cyst

C PCOS

CORRECT

D Tubo ovarian mass

RIGHT ANSWER

OK

C. PCOS

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

| Which of these is not a test for the measurement of ovarian reserve?

A Serum FSH in the early follicular phase

B Antral follicular count

C Anti mullerian hormone

D Serum Estradiol in the early follicular phase

CORRECT

RIGHT ANSWER

OK D. Serum Estradiol in the early follicular phase

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$20" here and does not include a written explanation for this item.

QUESTION

A 16-year-old girl presents in OPD with complaints of cyclical pain in abdomen. On examination, a suprapubic bulge can be seen in the pelvic area. PR examination reveals a swelling in the anterior aspect. What is the most likely diagnosis?

A Transverse vaginal septum above the vagina

B Vaginal atresia

C Imperforate hymen

CORRECT

D Cervical agenesis

RIGHT ANSWER

OK C. Imperforate hymen

WHY THIS IS RIGHT

Cyclical pain with outflow obstruction and suprapubic bulge plus PR swelling along the anterior wall indicate hematocolpos due to imperforate hymen (cryptomenorrhea). Transverse septum and vaginal atresia present differently and do not show a tense bulging hymen. It is the most common obstructive anomaly of the female genital tract. Normally the hymen perforates before birth.

In imperforate hymen:

Hymenal membrane fails to perforate

↓

Menstrual blood cannot exit

↓

Blood accumulates in vagina

↓

Hematocolpos

| Feature | Reason |

| ----- | ----- |

| Primary amenorrhea | Menstrual blood cannot exit |

| Cyclical abdominal pain | Uterine contractions during menses |

| Suprapubic mass | Accumulated blood |

| Bluish bulging hymen | Blood behind hymen |

QUESTION

A 16-year-old girl is seen for primary amenorrhea. She has not development of breasts or hair in the pubic or axillary region. Her height is 155cm and her weight is 48 kg. She has bilateral inguinal masses. On USG examination, the uterus, fallopian tube, and ovary are absent. What is the most likely diagnosis?

A Complete androgen insensitivity syndrome

B Hypergonadotropic hypogonadism

CORRECT

C Turner syndrome

D Polycystic ovary syndrome

RIGHT ANSWER

OK B. Hypergonadotropic hypogonadism

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$21” here and does not include a written explanation for this item.

QUESTION

A 16-year-old girl presents with primary amenorrhea. On examination, breast development is present but pubic and axillary hair are absent. Ultrasound shows an absent uterus. Karyotype is 46,XY. What is the most likely diagnosis?

A Androgen insensitivity syndrome

CORRECT

B Mullerian agenesis

C 46XY gonadal dysgenesis

D Turner syndrome

RIGHT ANSWER

OK **A. Androgen insensitivity syndrome**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$22” here and does not include a written explanation for this item.

QUESTION

A patient develops secondary amenorrhea for 9 months following a dilatation and curettage (D&C). Both the progesterone challenge test and the estrogen + progesterone challenge test are negative. What is the most probable diagnosis?

A Asherman syndrome

CORRECT

B Premature ovarian failure

C PCOS

D Sheehan syndrome

RIGHT ANSWER

OK

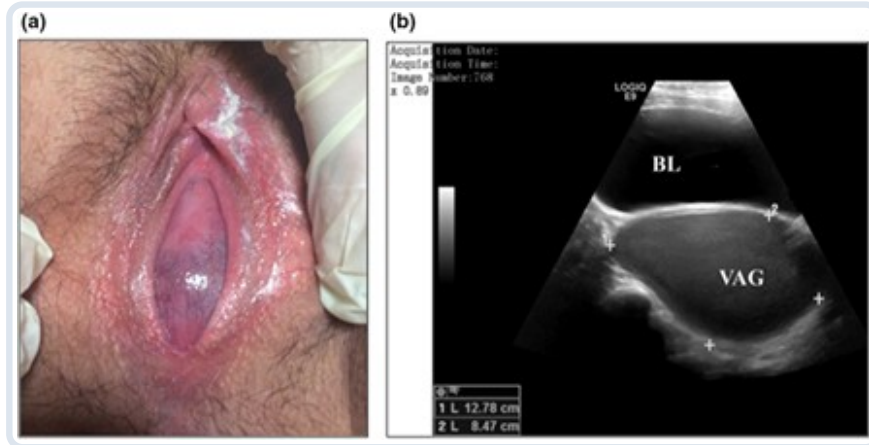
A. Asherman syndrome

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$23” here and does not include a written explanation for this item.

QUESTION

A 16 year old girl with primary amenorrhea with secondary sexual characters present, uterus and ovaries present with an image as shown. What is the likely karyotype?



A 45 XO

B 46 XX

CORRECT

C 47 XXY

D 46 XY

RIGHT ANSWER

OK

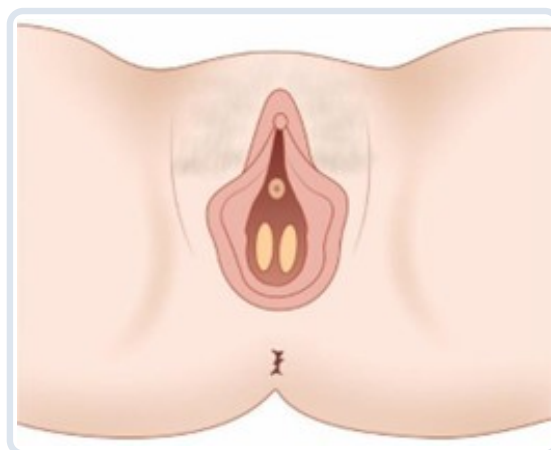
B. 46 XX

WHY THIS IS RIGHT

Primary amenorrhea with secondary sexual characteristics and normal uterus + ovaries and bluish bulge with USG suggesting blood accumulation in the vagina suggests imperforate hymen, which has a 46 XX karyotype, since internal structures are normal.

QUESTION

Identify the type of hymen shown in the image.



A Imperforate hymen

B Semilunar hymen

C Septate hymen

CORRECT

D Annular hymen

RIGHT ANSWER

OK C. Septate hymen

WHY THIS IS RIGHT

Septate Hymen

In this condition, a fibrous band runs across the hymenal opening, dividing it into two openings. The hymen forms from the junction of the Müllerian ducts and urogenital sinus.

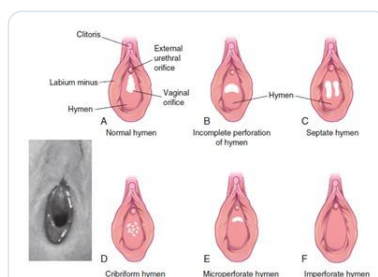
Incomplete degeneration of hymenal membrane

↓
Persistence of central septum

↓
Septate hymen

Treatment is simple:

- Minor surgical excision of the septum
- Done under local anesthesia



QUESTION

A 35-year-old woman with secondary amenorrhea shows high FSH/LH and AMH 0.05. What is the most likely diagnosis?

A PCOD

B Premature ovarian failure

CORRECT

C Hyperprolactinemia

D Sheehan syndrome

RIGHT ANSWER

OK

B. Premature ovarian failure

WHY THIS IS RIGHT

Primary Ovarian Insufficiency is defined as: Loss of ovarian function before 40 years of age

It results in amenorrhea, estrogen deficiency, and elevated gonadotropins.

Hormone	Level
FSH	↑ High
LH	↑ High
Estrogen	↓ Low
AMH	↓ Very low

AMH reflects ovarian reserve. Very low AMH suggests depleted follicles.

Clinical Features

Feature	Explanation
Secondary amenorrhea	Loss of ovulation
Infertility	No follicular development
Hot flashes	Estrogen deficiency
Vaginal dryness	Hypoestrogenism

Causes of Premature Ovarian Failure

Cause	Example
Genetic	Turner syndrome
Autoimmune	Autoimmune oophoritis
Iatrogenic	Chemotherapy / radiotherapy
Idiopathic	Most common

QUESTION

A young girl presents with retention of urine and cyclical abdominal pain. On examination, there is a tense bluish bulge seen at the introitus. The diagnosis is?

A Imperforate hymen

CORRECT

B Transverse vaginal septum

C Vertical vaginal septum

D Mullerian agenesis

RIGHT ANSWER

OK A. Imperforate hymen

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$24" here and does not include a written explanation for this item.

QUESTION

An 18-year-old girl with primary amenorrhea presents to the OPD. She has Tanner stage IV secondary sexual characters. Her karyotype is 46XX. FSH is 5 and LH is 13. What is the likely diagnosis?

A Gonadal dysgenesis

B Mullerian agenesis

CORRECT

C Kallmann syndrome

D Androgen insensitivity syndrome

RIGHT ANSWER

OK

B. Mullerian agenesis

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$25” here and does not include a written explanation for this item.

QUESTION

A 24-year-old athlete woman with secondary amenorrhea. Biochemical evaluation reveals LH=0.3, FSH=2, BMI 17.5. She likely suffers from which of the following conditions?

- A** Primary ovarian insufficiency
- B** Hypogonadotropic hypogonadism
- C** Hypergonadotropic hypogonadism
- D** Normogonadotropic normogonadism

CORRECT

RIGHT ANSWER

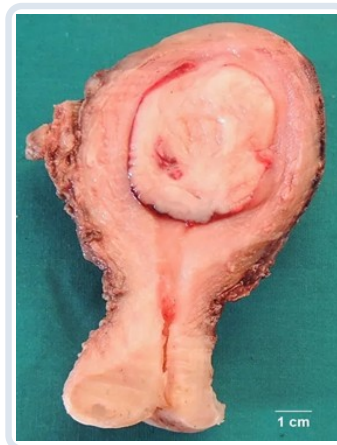
- OK** **B. Hypogonadotropic hypogonadism**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$26” here and does not include a written explanation for this item.

QUESTION

Identify the image.



CORRECT

A Fibroid

B Adenomyosis

C Endometrial polyp

D Endometrial cancer

RIGHT ANSWER

OK A. Fibroid

WHY THIS IS RIGHT

A well-circumscribed whitish lesion in uterine cavity is a submucosal fibroid. Fibroids are benign smooth muscle tumors, distinct from adenomyosis (diffuse thickening), polyps (soft mucosal growths), or cancer (irregular invasive mass). Depending on location:

Type	Location
---	-----
Intramural	Within uterine wall
Submucosal	Beneath endometrium
Subserosal	Beneath serosa

Submucosal fibroids are most associated with abnormal uterine bleeding (AUB).

QUESTION

A 40-year-old woman presents with heavy menstrual bleeding and something coming out of the vagina. Her last childbirth was 10 years back. On bimanual palpation, the uterus is palpable. On examination, the cervix admits 1 finger, and the following is seen. What is the probable diagnosis?



A Adenomyoma

B **Leiomyomatous polyp**

CORRECT

C Intramural fibroid

D Inversion

RIGHT ANSWER

OK **B. Leiomyomatous polyp**

WHY THIS IS RIGHT

Heavy bleeding with a mass protruding through cervix suggests a Leiomyomatous polyp.

Leiomyomatous Polyp-It is a type of submucosal fibroid that grows inside the uterine cavity and may prolapse through the cervical os.

It is a submucosal fibroid extending into uterine cavity and vagina. Adenomyoma is intramural, inversion presents with absent uterine fundus in the context of shock during labour. Mass through cervix + uterus palpable -> prolapsed fibroid polyp.

Management usually includes:

- Vaginal myomectomy (polypectomy)

If multiple fibroids are present:

- Hysterectomy may be considered.

QUESTION

A 49-year-old well-off businesswoman presents with irregular, heavy bleeding. Her mother tells her this is normal at her age, but she seeks medical advice. What is the next best step?

A Start her on HRT

B Reassure

C Endometrial ablation

D TVS

CORRECT

RIGHT ANSWER

OK

D. TVS

WHY THIS IS RIGHT

Abnormal Uterine Bleeding is common in perimenopausal women due to hormonal imbalance but must always be evaluated to rule out pathology.

Common causes are classified using the PALM-COEIN system.

Structural causes	Non-structural causes
P - Polyp	C - Coagulopathy
A - Adenomyosis	O - Ovulatory dysfunction
L - Leiomyoma	E - Endometrial
M - Malignancy	I - Iatrogenic
	N - Not classified

In perimenopausal women (40+ years) with heavy bleeding: irregular cycles may be normal but heavy bleeding always requires evaluation with endometrial sampling to exclude malignancy, hyperplasia, and structural lesions before considering any treatment options. TVS is needed to see any structural cause and endometrial thickness.

QUESTION

| Which of the following statements is true regarding endometrial hyperplasia?

A Diagnosed by a hysteroscopic guided biopsy or a D & C

CORRECT

B After biopsy, no other follow-up is required

C Hysterectomy should be done in all cases

D Majority will regress without any treatment

RIGHT ANSWER

OK **A. Diagnosed by a hysteroscopic guided biopsy or a D & C**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$27" here and does not include a written explanation for this item.

QUESTION

A 40-year-old woman presents with a history of abdominal discomfort and abdominal pain. What is the most likely diagnosis?

A Adenomyosis

CORRECT

B Fibroid

C Endometriosis

D Endometrial hyperplasia

RIGHT ANSWER

OK A. Adenomyosis

WHY THIS IS RIGHT

Adenomyosis is a condition where *endometrial tissue grows inside the uterine muscle (myometrium)*. This leads to:

- Diffuse uterine enlargement
- Painful menstruation
- Heavy menstrual bleeding

Imaging Findings (TVS)

- Heterogeneous myometrium
- Myometrial cysts
- Globular uterus

MRI *may show junctional zone thickening (>12 mm).*

QUESTION

A 46-year-old nulliparous woman is found to have an endometrial thickness of 16 mm on TVS. What is the most appropriate next step in management?

A Endometrial biopsy

CORRECT

B Hysterectomy

C Reassure

D Repeat TVS after 1 month

RIGHT ANSWER

OK A. Endometrial biopsy

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$28" here and does not include a written explanation for this item.

QUESTION

A 45-year-old woman with irregular bleeding is found to have an endometrial thickness of 15 mm. What is the most appropriate next step in management?

A Endometrial biopsy

CORRECT

B Hysterectomy

C MRI Pelvis

D Hysteroscopy and fractional curettage

RIGHT ANSWER

OK A. Endometrial biopsy

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$29" here and does not include a written explanation for this item.

QUESTION

A 45-year-old woman with irregular bleeding is found to have an endometrial thickness of 15 mm. What is the most appropriate next step in management?

A Endometrial biopsy

CORRECT

B Hysterectomy

C MRI Pelvis

D Hysteroscopy and fractional curettage

RIGHT ANSWER

OK A. Endometrial biopsy

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2a” here and does not include a written explanation for this item.

QUESTION

A patient comes after 6 months of vaginal delivery with an episiotomy repair with pain at the site of episiotomy which increases during her periods. On palpation, a nodular lesion is felt. The probable diagnosis is?

A Endometriosis

CORRECT

B Retained suture

C Inclusion cyst

D Melanoma

RIGHT ANSWER

OK

A. Endometriosis

WHY THIS IS RIGHT

Endometrial tissue implanted in surgical scar

↓

Hormonal stimulation during menstrual cycle

↓

Bleeding within scar tissue

↓

Painful nodular swelling

Cyclical pain in surgical scar = scar endometriosis

Cyclic pain at scar site with nodular lesion is classic for scar endometriosis.

Ectopic endometrial tissue responds to hormones, causing swelling and pain during menses.

Definitive treatment is: Wide Local Excision--> Hormonal therapy has limited benefit.

- B) Retained suture
- Causes localized discomfort, but not cyclical pain.

C) Inclusion cyst

- Usually painless cystic swelling, not menstrual pain.

D) Melanoma

- Presents as pigmented lesion, unrelated to menstrual cycle.

*

QUESTION

A 36-year-old woman (P2L2) who previously underwent tubectomy and surgical management of endometriosis (adhesiolysis and excision of lesions), now presents with recurrence of the symptoms. What is the definitive treatment for this patient?

- A Hysterectomy alone
- B Hysterectomy with bilateral salpingo-oophorectomy**
- C LNG-IUS
- D Resection of endometriotic nodules

CORRECT

RIGHT ANSWER

- B. Hysterectomy with bilateral salpingo-oophorectomy**

WHY THIS IS RIGHT

Endometriosis is a chronic estrogen-dependent condition.

Common sites:

- Ovary
- Uterosacral ligaments
- Pelvic peritoneum
- Rectovaginal septum

Definitive Treatment : Total Hysterectomy with Bilateral Salpingo-Oophorectomy (TAH + BSO)

Removes uterus ; Removes ovaries -> eliminates estrogen source

- A) Hysterectomy alone
- Ovaries remain -> estrogen production continues -> recurrence possible.

C) LNG-IUS

Used for symptom control, not definitive treatment.

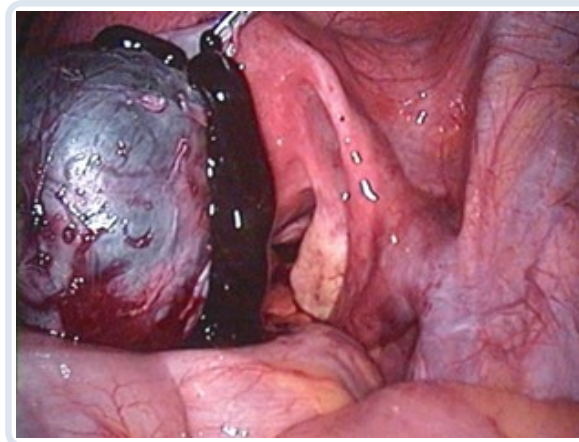
D) Resection of nodules

Conservative surgery may lead to recurrence.

*

QUESTION

A 34-year-old woman presents with dysmenorrhea. Laparoscopic finding is as shown. What is the diagnosis?



A Endometriosis

CORRECT

B Dermoid cyst

C PID

D Fibroid

RIGHT ANSWER

OK A. Endometriosis

WHY THIS IS RIGHT

A cyst filled with dark brown “chocolate” fluid is an endometrioma, a hallmark of endometriosis.

Ectopic endometrial tissue bleeds cyclically, forming old blood-filled cysts, and dysmenorrhea is the most common presenting symptom.

QUESTION

What are the diagnostic criteria for Polycystic Ovary Syndrome (PCOS) as defined by the Modified Rotterdam Criteria?

1. Obesity
2. Delayed menstruation
3. Hirsutism
4. Insulin resistance

A 1, 2 and 3

B 1 and 2

C 2 and 3

CORRECT

D 1 and 4

RIGHT ANSWER

OK

C. 2 and 3

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2b” here and does not include a written explanation for this item.

QUESTION

A young girl presents with menstrual irregularity, acne, increased hair growth with a Ferriman Gallway score of 8, and a BMI of 29. Her mother has diabetes. Which is not a management option?

- A** OCP
- B** OCP + Anti androgen CORRECT
- C** Yoga + Exercise
- D** Counsel for metabolic syndrome

RIGHT ANSWER

- OK** **B. OCP + Anti androgen**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2c” here and does not include a written explanation for this item.

QUESTION

What are the diagnostic criteria for Polycystic Ovary Syndrome (PCOS) as defined by the Modified Rotterdam Criteria?

1. Obesity
2. Delayed menstruation
3. Hirsutism
4. Insulin resistance

A 1, 2 and 3

B 1 and 2

C 2 and 3

CORRECT

D 1 and 4

RIGHT ANSWER

OK

C. 2 and 3

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2d” here and does not include a written explanation for this item.

QUESTION

While discharging a patient who underwent a vesicovaginal fistula repair, which of the following would you recommend?

A Sexual abstinence for 3 months and avoid pregnancy for a year

CORRECT

B Sexual abstinence for 3 weeks and avoid pregnancy for 6 months

C Sexual abstinence for 6 weeks and avoid pregnancy for a year

D Sexual abstinence for 6 months and avoid pregnancy for 6 years

RIGHT ANSWER

OK

A. Sexual abstinence for 3 months and avoid pregnancy for a year

WHY THIS IS RIGHT

Vesicovaginal Fistula

This condition results in continuous leakage of urine through the vagina.

| Cause | Example |

| ---- | ----- |

| Obstructed labor | Most common in developing countries |

| Gynecologic surgery | Post-hysterectomy |

| Radiation therapy | Pelvic cancers |

| Trauma | Difficult instrumental delivery |

Most common cause worldwide -> obstructed labor.

Postoperative Care After VVF Repair

Key recommendations after surgery:

| Advice | Reason |

| ----- | ----- |

| Sexual abstinence for 3 months | Allow complete tissue healing |

| Avoid pregnancy for 1 year | Prevent stress on repair site |

| Continuous bladder drainage | Prevent pressure on suture line |

QUESTION

A 45-year-old woman undergoes a Pap smear as part of a cervical cancer screening program. To preserve the cellular morphology for cytological examination, the smear must be immediately fixed. Which concentration of ethanol is most appropriate for fixation in this case?

A 50% ethanol

B 70% ethanol

C 95% ethanol

CORRECT

D 100% ethanol

RIGHT ANSWER

OK C. 95% ethanol

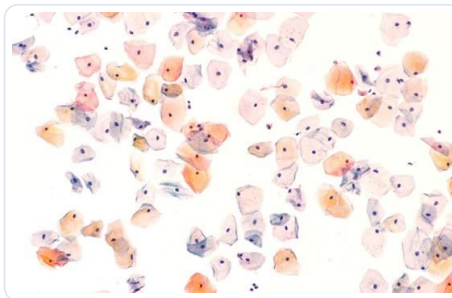
WHY THIS IS RIGHT

Pap smear cytology requires immediate wet fixation to preserve nuclear and cytoplasmic details. 95% ethanol is the standard fixative used to prevent air-drying artifacts.

Normal Pap Smear

Lower concentrations cause cellular swelling, while absolute alcohol leads to excessive dehydration. Thus, 95% ethanol best preserves cellular morphology for cytological evaluation.

Concentration	Use
95% ethanol	Pap smear (best)
70% ethanol	General fixation
100% ethanol	Too harsh
50% ethanol	Inadequate



QUESTION

| All of the following are features of granulosa cell tumor of the ovary except:

- A Presence of Call Exner body
- B Expression of inhibin A
- C Coffee bean nucleus
- D Increased CA 125 levels**

CORRECT

RIGHT ANSWER

- OK D. Increased CA 125 levels**

WHY THIS IS RIGHT

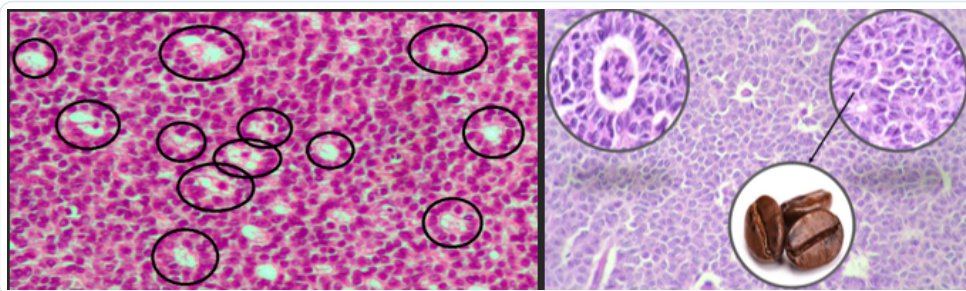
Granulosa cell tumors characteristically show Call-Exner bodies and “coffee-bean” nuclei due to nuclear grooves. They secrete estrogen and express inhibin A, which serves as a useful tumor marker. These tumors are sex-cord stromal in origin, not epithelial.

Call-Exner bodies marked with black circles micrograph of a [granulosa cell tumour](https://en.wikipedia.org/wiki/Granulosa_cell_tumour "Granulosa cell tumour"), a type of sex cord stromal tumour. Think of granulosa tumor as a tiny ovary trying to act like a full endocrine gland

-> making estrogen

-> forming mini follicles (Call-Exner bodies)

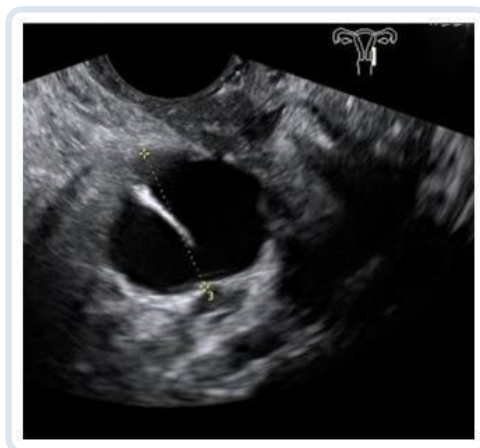
CA-125 is typically elevated in epithelial ovarian cancers, not granulosa cell tumors.



QUESTION

Which are the tumor markers for the ultrasound image shown below?

1. CA 125
2. LDH
3. AFP
4. hCG
5. CA 19-9



A 1,2,4

B 2,3,5

C 1,2,3

D 1,2,3,4,5

CORRECT

RIGHT ANSWER

OK

D. 1,2,3,4,5

WHY THIS IS RIGHT

Tumor Marker	Associated Ovarian Tumor
CA-125	Epithelial ovarian cancer (especially serous carcinoma)
LDH	Dysgerminoma
AFP	Yolk sac tumor (Endodermal sinus tumor)
β-hCG	Choriocarcinoma, Embryonal carcinoma
CA 19-9	Mucinous ovarian tumors

QUESTION

A 45-year-old woman with a history of cervical erosion and spotting since 2 months. What is the next best step?

A LBC + HPV + cervical biopsy

CORRECT

B Pap smear + HCV

C Pap smear + HBV

D VDRL + Liquid cytology

RIGHT ANSWER

OK **A. LBC + HPV + cervical biopsy**

WHY THIS IS RIGHT

Liquid Based Cytology

Advantages:

- Better sample preservation
- Reduced false negatives
- Allows HPV testing from same sample

Human Papillomavirus

High-risk types:

- HPV 16
- HPV 18

These cause ~70% of cervical cancers.

Cervical Biopsy

This confirms the definitive diagnosis.

Suspicious cervix

↓

Screening test (LBC)

↓

HPV testing

↓

Biopsy for confirmation

In a 45-year-old with persistent spotting and cervical erosion, cervical cancer must be ruled out. Liquid-Based-Cytology + HPV testing is the recommended screening combination. Biopsy is mandatory when symptoms persist or lesion appears suspicious.

QUESTION

A 52-year-old woman came to the OPD with a diagnosis of advanced cervical cancer. She has a 14-year-old daughter. What advice would you give for her daughter?

A Advise HPV vaccine

CORRECT

B Screen for BRCA mutation

C Screen for PTEN mutation

D Perform pap smear

RIGHT ANSWER

OK A. Advise HPV vaccine

WHY THIS IS RIGHT

Most cases of cervical cancer are caused by Human Papillomavirus infection.

High-risk oncogenic types include:

- HPV 16
- HPV 18

These account for ~70% of cervical cancers.

| Age group | Schedule |

| ----- | ----- |

| 9-14 years | 2 doses (0 and 6 months) |

| ≥15 years | 3 doses |

Best time for HPV vaccination is before sexual debut.

Since the daughter is 14 years old, she falls into the ideal vaccination age group.

At 14 years, the best preventive strategy is HPV vaccination (primary prevention). Screening with Pap/HPV testing starts later (usually ≥25 years). BRCA/PTEN mutations are linked to other cancers, not typical cervical carcinoma.

QUESTION

A 52-year-old woman presents with foul-smelling bloody discharge per vagina mixed with mucous discharge. On examination, a necrotizing growth is seen in the cervix with lateral parametrium involvement. What will be the management for this patient?

A Chemotherapy

B Brachytherapy

C Chemoradiation

CORRECT

D Surgery

RIGHT ANSWER

OK C. Chemoradiation

WHY THIS IS RIGHT

Lateral parametrium involvement = FIGO Stage IIB carcinoma cervix. Standard of care from Stage IIB onwards is concurrent chemoradiation (external beam + brachytherapy). Surgery is reserved for earlier stages (up to 2A1). For Stage IIB cervical cancer, the treatment of choice is: Concurrent chemoradiation

This involves:

Treatment	Purpose
External beam radiotherapy	Destroy tumor
Cisplatin	Enhances radiation effect
Brachytherapy	Internal radiation

Once parametrium is involved, surgical removal becomes difficult because:

Tumor extends into parametrium

↓

Cannot obtain clear surgical margins

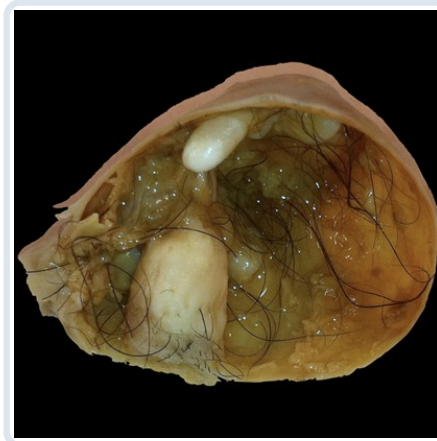
↓

Higher recurrence risk

Thus chemoradiation is preferred.

QUESTION

A female patient undergoes surgery for an abdominal mass associated with pain. The excised specimen appears as shown in the image below. What is the most likely diagnosis?



A Mucinous cystadenoma

B Serous cystadenoma

C Teratoma

CORRECT

D Chocolate cyst

RIGHT ANSWER

OK

C. Teratoma

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$19” here and does not include a written explanation for this item.

QUESTION

In a Pap smear, which fixative agent is commonly used to fix the slides immediately after sample collection?

A 95% ethanol

CORRECT

B Air fixation

C Mathanol

D 25% ethanol

RIGHT ANSWER

OK A. 95% ethanol

WHY THIS IS RIGHT

Pap Smear is used to detect precancerous and cancerous changes in cervical cells. After collecting the sample, immediate fixation is essential to preserve cellular morphology.

The smear must be fixed immediately after spreading the cells on the slide.

Standard fixative: 95% ethanol

Purpose:

Function	Explanation
Prevent drying artifact	Maintains cell morphology
Preserve nuclear details	Important for detecting dysplasia
Improve staining quality	Essential for Pap stain

Delayed fixation causes:

- Nuclear distortion
- Poor staining
- Diagnostic errors.

The smear is stained using the Papanicolaou Stain.

It helps identify:

- Dysplasia
- Carcinoma in situ
- Cervical cancer.

QUESTION

In the context of cervical cancer screening protocols, co-testing refers to performing which of the following diagnostic tests together?

A HPV testing + Pap smear

CORRECT

B VIA + Pap smear

C Antibody testing + Pap smear

D HPV testing + VIA

RIGHT ANSWER

OK A. HPV testing + Pap smear

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

A 30-year-old woman undergoes surgery for an ovarian cyst. The specimen image is shown below. Based on the appearance, identify the type of cyst?



A Mature cystic teratoma

CORRECT

B Dysgerminoma

C Serous cystadenoma

D D. Mucinous cystadenoma

RIGHT ANSWER

OK

A. Mature cystic teratoma

WHY THIS IS RIGHT

Mature Cystic Teratoma is the most common benign ovarian tumor in reproductive-age women. It arises from totipotent germ cells, which can differentiate into multiple tissue types.

Typical gross findings:

- Sebaceous material
- Hair
- Teeth or bone
- Thick cyst wall

Characteristic structure: Rokitansky Protuberance

- Dysgerminoma :Features-
- Solid tumor
- Occurs in younger women
- No hair/teeth components.
- Serous Cystadenoma
- Thin-walled cyst
- Clear serous fluid.
- Mucinous Cystadenoma
- Multiloculated cyst
- Thick mucinous fluid.



QUESTION

A patient presented to the OPD as a known case of cervical cancer. On further evaluation, the pelvic side wall was found to be involved, and hydronephrosis was also seen. Identify the stage of cervical cancer.

A 2B

B 3A

C 3B

CORRECT

D 3C

RIGHT ANSWER

OK C. 3B

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

A postmenopausal woman with ovarian mass and CA-125 = 1000 U/mL. What is the most probable diagnosis?



A Serous cystadenocarcinoma

CORRECT

B Immature teratoma

C Sertoli cell tumor

D Granulosa cell tumor

RIGHT ANSWER

OK A. Serous cystadenocarcinoma

WHY THIS IS RIGHT

Serous Cystadenocarcinoma is the most common ovarian malignancy, especially in postmenopausal women.

Feature	Explanation
Age	Postmenopausal women
Tumor marker	CA-125 ↑
Laterality	Often bilateral
Gross appearance	Papillary cystic masses

CA-125 is commonly elevated in epithelial ovarian tumors, particularly serous carcinoma.

Interpretation:

CA-125 Level	Significance
<35 U/mL	Normal
Mild elevation	Benign conditions
Very high (>500)	Suggests malignancy

Spread of Serous Ovarian Cancer

Common spread:

- Transcoelomic spread in peritoneal cavity
- Omental metastasis (omental cake)
- Ascites formation

QUESTION

A 54-year-old woman with cervical cancer shows parametrial involvement and bilateral hydroureteronephrosis. What is the FIGO stage?

A Stage IIIA

B Stage IIIB

CORRECT

C Stage IIIC

D Stage IV

RIGHT ANSWER

OK B. Stage IIIB

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A 65-year-old postmenopausal woman presents with blood-stained vaginal discharge. On examination, her BP is 160/100 mmHg. What is the most appropriate next step in management?

A Urgent cardiology opinion

B TVS

CORRECT

C CECT pelvis

D MRI pelvis

RIGHT ANSWER

OK

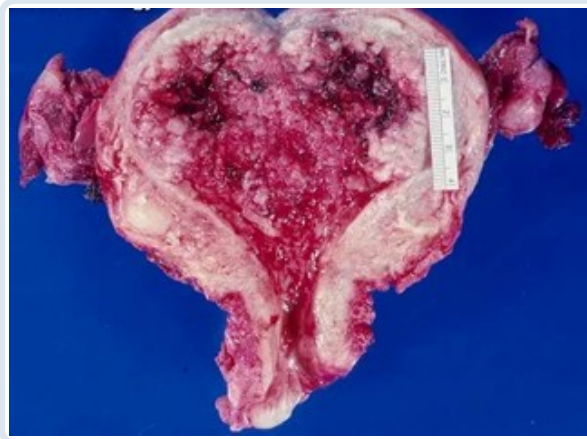
B. TVS

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1d” here and does not include a written explanation for this item.

QUESTION

A hysterectomy specimen was obtained from a woman with postmenopausal bleeding. The cut section of the uterus is examined and shown below. What is the most likely diagnosis?



- A** Fibroid
- B** Adenomyosis
- C** Endometriosis
- D** Endometrial cancer

CORRECT

RIGHT ANSWER

- OK** D. Endometrial cancer

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

Which of the following represents the correct sequence of steps for performing a Pap smear?

1. Lithotomy position
2. Per speculum examination
3. Per vaginal examination
4. Take sample with Ayre's spatula

A 1, 2, 3, 4

B 1, 3, 4

C 1, 2, 4

CORRECT

D 1, 3, 2, 4

RIGHT ANSWER

OK C. 1, 2, 4

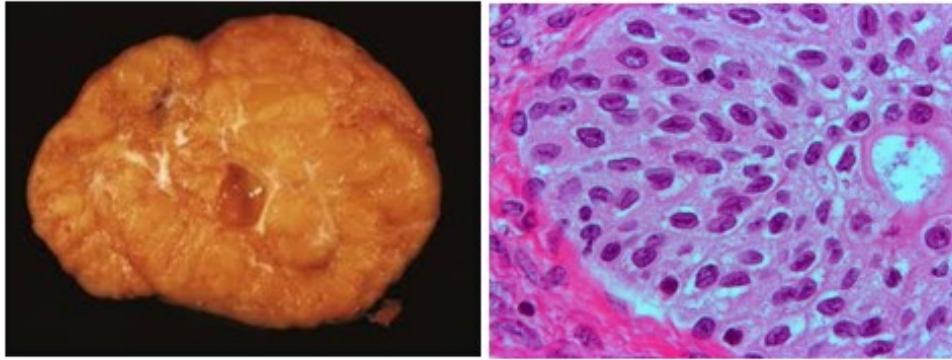
WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

Based on the gross pathology and histopathology images shown, which of the following statements are correct?

1. It is a sex cord stromal tumor
2. Inhibin-B is increased
3. Ca 125 is raised
4. Call Exner bodies are seen on HPE



A 1, 2, 3 and 4

B 1, 2, 4

C 1 and 4

CORRECT

D 2, 3 and 4

RIGHT ANSWER

OK C. 1 and 4

WHY THIS IS RIGHT

Granulosa cell tumor belongs to sex cord-stromal tumors of the ovary.

Key features

- Usually unilateral
- Yellowish solid tumor (due to lipid content)
- Produces estrogen

Hormonal effect

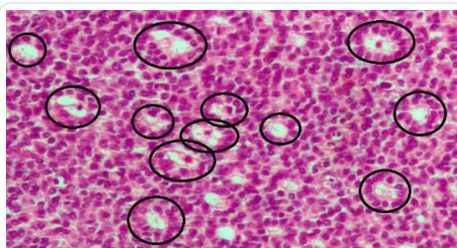
Excess estrogen causes:

- Precocious puberty in children
- Menorrhagia / irregular bleeding in reproductive age
- Postmenopausal bleeding in elderly women

Call-Exner bodies are small follicle-like structures filled with eosinophilic material.

They resemble immature ovarian follicles and are considered the histologic hallmark of granulosa cell tumors.

Granulosa cell tumor = Coffee-bean nuclei + Call-Exner bodies



Tumor	Marker	Key Histology
Granulosa cell tumor	Inhibin	Call-Exner bodies
Dysgerminoma	LDH	Clear cells
Yolk sac tumor	AFP	Schiller-Duval bodies
Choriocarcinoma	β -hCG	Cytotrophoblast + syncytiotrophoblast
Serous carcinoma	CA-125	Psammoma bodies

QUESTION

A 65-year-old postmenopausal woman presents with abdominal distension and discomfort. Imaging reveals an ovarian mass with solid components, ascites, and omental caking. Her serum CA-125 level is markedly elevated at 990 U/mL. What is the most likely diagnosis?

A Mucinous cystadenocarcinoma

B Serous cystadenocarcinoma

CORRECT

C Endometrioid tumor

D Granulosa cell tumor

RIGHT ANSWER

OK B. Serous cystadenocarcinoma

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$20” here and does not include a written explanation for this item.

QUESTION

A 35-year-old woman presents with intermenstrual bleeding. Atypical glandular cells are seen on a pap smear. What is the most appropriate next step in management?

A Repeat Pap smear after 6 months

B Colposcopy and endometrial sampling

CORRECT

C Punch biopsy from cervix

D Conisation

RIGHT ANSWER

OK B. Colposcopy and endometrial sampling

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$21” here and does not include a written explanation for this item.

QUESTION

I Reinke crystals are seen in which of the following gonadal tumours:

A Seminoma

B Yolk sac tumor

C Leydig cell tumor

CORRECT

D Sertoli cell tumor

RIGHT ANSWER

OK C. Leydig cell tumor

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$22" here and does not include a written explanation for this item.

QUESTION

| Which of the following is a risk factor for progression to borderline ovarian tumor?

- A OCP
- B Functional ovarian cyst
- C Nulliparity**
- D PCOS

CORRECT

RIGHT ANSWER

- OK C. Nulliparity**

WHY THIS IS RIGHT

Borderline Ovarian Tumor are epithelial tumors that show cellular proliferation and atypia but no stromal invasion. They are also called tumors of low malignant potential (LMP).

Several reproductive factors increase the risk of epithelial ovarian tumors and borderline tumors.

Risk factor	Reason
Nulliparity	More ovulatory cycles
Early menarche	Increased ovulation
Late menopause	Prolonged estrogen exposure
Infertility	Hormonal imbalance

Protective factor	Mechanism
OCP use	Suppresses ovulation
Pregnancy	Anovulation
Breastfeeding	Reduced ovulatory cycles

QUESTION

| What is the antigen present in the recombinant HPV vaccine?

A E1 + E2

B E6 + E7

C L1

CORRECT

D L2

RIGHT ANSWER

OK C. L1

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$23" here and does not include a written explanation for this item.

QUESTION

| Which of the following is a virilizing ovarian tumor?

- A** Brenner tumor
- B** Arrhenoblastoma
- C** Carcinoid tumor of the ovary
- D** Theca cell tumor

CORRECT

RIGHT ANSWER

- OK** **B. Arrhenoblastoma**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$24" here and does not include a written explanation for this item.

QUESTION

| Which of the following is not classified as a germ cell tumor of the ovary?

A Yolk sac tumor

B Dysgerminoma

C Choriocarcinoma

D Granulosa cell tumor

CORRECT

RIGHT ANSWER

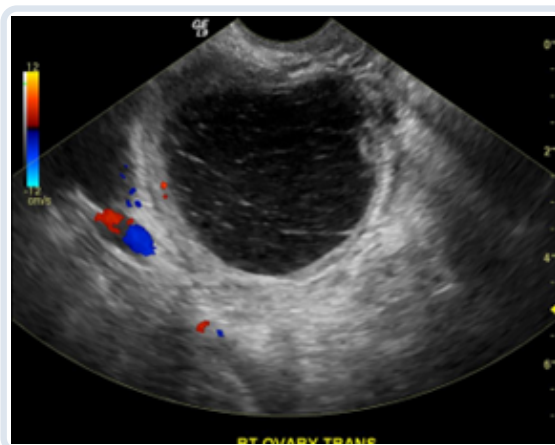
OK D. Granulosa cell tumor

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$25" here and does not include a written explanation for this item.

QUESTION

A 24-year-old P1L1 woman with acute abdominal pain undergoes a USG revealing 6×8 cm ovarian cyst with reticular markings as shown below. She is currently on warfarin. Which of the following is the next best step?



A MRI

B Surgical exploration

C Follow up after 6-8 weeks

CORRECT

D Measure Ca-125

RIGHT ANSWER

OK

C. Follow up after 6-8 weeks

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$26” here and does not include a written explanation for this item.

QUESTION

Dr. Savita is training her interns who are being posted for rural posting. Which is appropriate for cervical cancer screening?

- A Pap smear alone every 5 yearly
- B Pap smear + HPV DNA every 5 yearly
- C Pap smear alone every 3 yearly**
- D Pap smear in high-risk individuals

CORRECT

RIGHT ANSWER

- OK C. Pap smear alone every 3 yearly**

WHY THIS IS RIGHT

Cervical Cancer Screening- The most widely used screening test is the Pap smear (cervical cytology). The Pap smear detects precancerous lesions (CIN) before they progress to invasive cancer. It samples cells from the transformation zone of the cervix, where most cervical cancers originate.

For low-resource settings (such as rural areas), the recommended approach is:

Age Group	Screening Method	Interval
21-29 years	Pap smear alone	Every 3 years
30-65 years	Pap smear every 3 years OR HPV testing	Depending on resources

Because HPV testing may not be widely available in rural setups, Pap smear every 3 years is considered practical and effective.

QUESTION

Which of the following represents the correct sequence of steps for performing a Pap smear?

1. Lithotomy position
2. Per speculum examination
3. Per vaginal examination
4. Take sample with Ayre's spatula

A 1, 2, 3, 4

B 1, 3, 4

C 1, 2, 4

CORRECT

D 1, 3, 2, 4

RIGHT ANSWER

OK C. 1, 2, 4

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$27” here and does not include a written explanation for this item.

QUESTION

Which strain of Human Papillomavirus (HPV) is most commonly linked to the development of cervical cancer?

A 41, 42

B 6, 11

C 16, 18

CORRECT

D 31, 33

RIGHT ANSWER

OK C. 16, 18

WHY THIS IS RIGHT

Persistent infection with high-risk HPV types leads to cervical intraepithelial neoplasia (CIN) and eventually cervical carcinoma.

The two most important oncogenic strains are:

- HPV 16
- HPV 18

Together they cause ~70% of cervical cancers worldwide.

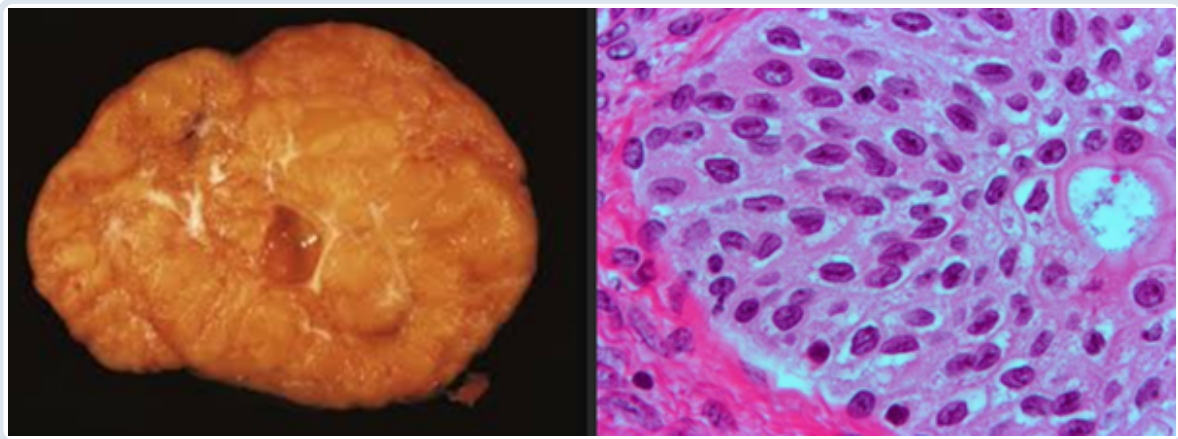
High-risk HPV strains produce two key oncogenic proteins:

Viral Protein	Target	Effect
E6	p53 tumor suppressor	Inhibits apoptosis
E7	Rb tumor suppressor	Uncontrolled cell cycle

QUESTION

Based on the gross pathology and histopathology images shown, which of the following statements are correct?

1. It is a sex cord stromal tumor
2. Inhibin-B is increased
3. Ca 125 is raised
4. Call Exner bodies are seen on HPE



A 1, 2, 3 and 4

B 1, 2, 4

C 1 and 4

CORRECT

D 2, 3 and 4

RIGHT ANSWER

OK

C. 1 and 4

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$28" here and does not include a written explanation for this item.

QUESTION

A 65-year-old postmenopausal woman presents with abdominal distension and discomfort. Imaging reveals an ovarian mass with solid components, ascites, and omental caking. Her serum CA-125 level is markedly elevated at 990 U/mL. What is the most likely diagnosis?

A Mucinous cystadenocarcinoma

B Serous cystadenocarcinoma

CORRECT

C Endometrioid tumor

D Granulosa cell tumor

RIGHT ANSWER

OK

B. Serous cystadenocarcinoma

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$29” here and does not include a written explanation for this item.

QUESTION

A 35-year-old woman presents with intermenstrual bleeding. Atypical glandular cells are seen on a pap smear. What is the most appropriate next step in management?

A Repeat Pap smear after 6 months

B Colposcopy and endometrial sampling

CORRECT

C Punch biopsy from cervix

D Conisation

RIGHT ANSWER

OK B. Colposcopy and endometrial sampling

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2a" here and does not include a written explanation for this item.

QUESTION

| The most common site of tubal ligation and the reason for ligation at this site is?

- A** Isthmus because of more uniform muscle thickness CORRECT
- B** Isthmus because of narrowest area
- C** Ampulla because of more circular muscles than longitudinal muscles
- D** Ampulla because of narrowest area

RIGHT ANSWER

- OK** **A. Isthmus because of more uniform muscle thickness**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2b” here and does not include a written explanation for this item.

QUESTION

A 26-year-old conceives on the IUCD. She wants to continue pregnancy. The IUCD threads are visible. What would be the next best step?

A Remove the IUCD gently

CORRECT

B Leave the IUCD in situ

C MTP for medical indication

D Remove with Shirodkar hook

RIGHT ANSWER

OK A. Remove the IUCD gently

WHY THIS IS RIGHT

If pregnancy occurs with an IUCD and threads are visible, removal is recommended because the device increases risk of:

Complication	Reason
Miscarriage	Intrauterine irritation
Infection	Foreign body
Preterm labor	Inflammation

If pregnancy continues with an IUCD in situ, the safest approach is gentle removal if strings are visible. Leaving it increases risks of preterm labor, infection, and miscarriage. Removal slightly increases miscarriage risk but is still preferred.

Removal with Shirodkar hook indicated for CuT when threads are not visible.

Situation	Management
Threads visible	Remove IUCD
Threads not visible	Leave IUCD in situ

Attempting blind removal may cause abortion.

QUESTION

Which of the following is a contraindication to the use of a long-acting subcutaneous contraceptive implant?

A HTN

B DM

C PID

D Undiagnosed genital bleeding

CORRECT

RIGHT ANSWER

OK

D. Undiagnosed genital bleeding

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2c" here and does not include a written explanation for this item.

QUESTION

According to the WHO Medical Eligibility Criteria (MEC-1), in which of the following conditions can combined oral contraceptives (OCPs) be safely used?

A Diabetes Mellitus

B Hypertension

C Hyperlipidemia

D HIV

CORRECT

RIGHT ANSWER

OK

D. HIV

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2d" here and does not include a written explanation for this item.

QUESTION

Combined oral contraceptive pills (OCPs) provide protection against several cancers. Which of the following cancers is not protected against by their use?

A Colorectal cancer

B Cervical cancer

CORRECT

C Endometrial cancer

D Ovarian cancer

RIGHT ANSWER

OK B. Cervical cancer

WHY THIS IS RIGHT

Combined Oral Contraceptive Pills are widely used for contraception and also provide non-contraceptive health benefits. They work by:

- Suppressing ovulation
- Thickening cervical mucus
- Altering endometrium

Long-term use of OCPs reduces the risk of several cancers.

Cancer	Effect
Endometrial Cancer	↓ Risk
Ovarian Cancer	↓ Risk
Colorectal Cancer	↓ Risk

Mechanisms include suppression of ovulation and reduced endometrial proliferation.

Cervical Cancer is not protected against by OCP use.

In fact:

- Long-term OCP use may slightly increase cervical cancer risk in women with persistent HPV infection.

Reason:

HPV infection

↓

Persistent viral replication

↓

Cervical intraepithelial neoplasia

↓

Cervical cancer

Hormonal exposure may enhance HPV persistence.

OCP protects -> Ovarian + Endometrial + Colon

OCP does NOT protect -> Cervical cancer

QUESTION

A 24-year-old lactating female with an 18-month-old child comes with a history of irregular, heavy bleeding seeking contraceptive advice. Which is the contraceptive of choice?

A Progestasert

B Copper-T 380A

C Mala N

CORRECT

D Norethisterone enanthate - depot

RIGHT ANSWER

OK

C. Mala N

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2e” here and does not include a written explanation for this item.

QUESTION

IUCD can be inserted after delivery till?

CORRECT

A 48 hrs

B 48 hrs - 6 weeks

C 24 hrs

D 12 hrs

RIGHT ANSWER

OK

A. 48 hrs

WHY THIS IS RIGHT

Postpartum IUCD insertion is safe within 10 minutes up to 48 hours after delivery. The period between 48 hours-6 weeks should be avoided due to highest expulsion risk. Insertion after 6 weeks is classified as interval IUCD placement.

QUESTION

Which of the following is an absolute contraindication for the insertion of the device shown in the image?



- A Menstruation
- B Trophoblastic disease**
- C Immediately after delivery
- D Ruptured condom during intercourse

CORRECT

RIGHT ANSWER

- OK
- B. Trophoblastic disease**

WHY THIS IS RIGHT

Gestational Trophoblastic Disease

Examples include:

- Hydatidiform mole
- Choriocarcinoma

In this condition:

Abnormal trophoblastic proliferation

↓

High β -hCG levels

↓

Risk of bleeding and malignancy

Insertion of an IUCD can:

- Increase risk of infection
- Cause uterine bleeding
- Delay diagnosis of complications

IUCD is contraindicated in gestational trophoblastic disease.

IUCD Indications

| Situation | Use |

| ----- | --- |

| Long-term contraception | 5-10 years |

| Emergency contraception | Within 5 days of intercourse |

| Spacing method | Reversible |

QUESTION

Which of the following timings for intrauterine device (IUD) insertion is recommended?

1. Immediate postpartum
2. Within 48 hr of delivery
3. Within 5-7 days of menses
4. Within 5-7 days of next menstrual cycle

A 1, 2, 3

CORRECT

B 1, 2, 4

C 2, 3, 4

D 1, 3, 4

RIGHT ANSWER

OK
A. 1, 2, 3

WHY THIS IS RIGHT

Postpartum IUD Timing
Mechanism of Action of Copper IUD
Copper ions released
↓
Local inflammatory reaction
↓
Toxic to sperm
↓
Prevents fertilization

1) IUD can be inserted within 10 minutes after placental delivery.

Advantages:

- Woman already in hospital
- High motivation for contraception
- Immediate protection

2) Insertion during the first 48 hours postpartum is also recommended.

However:

- If >48 hours and <6 weeks postpartum, insertion is not recommended because of increased expulsion risk.

3) Within 5-7 Days of Menses

This timing is preferred because:

- Cervix is slightly dilated
- Pregnancy is ruled out
- Insertion is easier and safer

Timing	Recommendation
Within 10 min of placental delivery	✓ <u>Postplacental</u> insertion
Within 48 hours of delivery	✓ Allowed
48 hours – 6 weeks postpartum	✗ Not recommended
After 6 weeks postpartum	✓ Safe

QUESTION

A female patient taking DMPA came 14 days late. What should be advised to her?

A Do UPT and then give DMPA

B DMPA + 7 days backup

C DMPA from next cycle

D Give DMPA, no backup required

CORRECT

RIGHT ANSWER

OK

D. Give DMPA, no backup required

WHY THIS IS RIGHT

Depot Medroxyprogesterone Acetate is a progestin-only injectable contraceptive.

It is commonly given as:

- 150 mg intramuscular injection
- Every 3 months (12 weeks)

The WHO and CDC guidelines allow a grace period of up to 2 weeks after the scheduled injection.

| Timing | Recommendation |

| ----- | ----- |

| On time (12 weeks) | Give injection |

| ≤2 weeks late (up to 14 weeks) | Give injection immediately, no backup needed |

| >2 weeks late | Pregnancy test + backup contraception |

Since this patient is 14 days late, she is within the grace period.

Advantages of DMPA

| Benefit | Explanation |

| ----- | ----- |

| Highly effective | <1% failure |

| Long acting | 3 months protection |

| Safe in breastfeeding | Progestin-only |

| Decreases menstrual bleeding | Amenorrhea common |

QUESTION

Which of the following timings for intrauterine device (IUD) insertion is recommended?

1. Immediate postpartum
2. Within 48 hr of delivery
3. Within 5-7 days of menses
4. Within 5-7 days of next menstrual cycle

A 1, 2, 3

CORRECT

B 1, 2, 4

C 2, 3, 4

D 1, 3, 4

RIGHT ANSWER

OK
A. 1, 2, 3

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2f” here and does not include a written explanation for this item.

QUESTION

Patient experiences softening of the cervix in early pregnancy. This sign is called as?

A Osiander

B Chadwick

C Goodell

CORRECT

D Hegar

RIGHT ANSWER

OK C. Goodell

WHY THIS IS RIGHT

Goodell's sign refers to the softening of the cervix, which is observed during early pregnancy. This sign occurs due to increased vascularization and changes in the connective tissue of the cervix, making it feel softer compared to the non-pregnant state, where the cervix feels firm like the tip of the nose.

| Probable Signs | Description |

| ----- | ----- |

| Goodell's sign | Soft cervix |

| Jacquemier's

Chadwick's sign | Bluish hue of ant vaginal wall |

| Osiander's sign | Increased pulsation felt through the lateral fornices |

| Piscacek's sign | Asymmetrical uterine enlargement in lateral implantation |

| Hegar's sign | On bimanual exam, the abdominal and vaginal finger appose below the body of the uterus |

| Palmer's sign | Rhythmic uterine contractions elicited on bimanual exam |

QUESTION

Identify the anomaly seen on the ultrasound.



A Anencephaly

CORRECT

B Encephalocele

C Lissencephaly

D Holoprosencephaly

RIGHT ANSWER

OK A. Anencephaly

WHY THIS IS RIGHT

Anencephaly shows the classic “frog-eye” appearance, with absence of cranial vault and cerebral hemispheres. Encephalocele presents as a sac; lissencephaly shows smooth brain; holoprosencephaly has midline defects, not frog-face.

QUESTION

A pregnant woman at 36 weeks of gestation presents to you with complaints of feeling light-headedness and dizziness when she lies on her back and feels relieved if she lies on her side or when walks. What is the most likely reason behind this?

A Increased intracranial pressure

B IVC compression

CORRECT

C Heavy meals

D Excessive venous pooling at the feet

RIGHT ANSWER

OK B. IVC compression

WHY THIS IS RIGHT

This condition is known as Supine Hypotensive Syndrome. In late pregnancy, the enlarged uterus compresses the inferior vena cava when the woman lies on her back.

Gravid uterus compresses IVC

↓

Reduced venous return to heart

↓

Decreased cardiac output

↓

Maternal hypotension

↓

Dizziness and light-headedness

Common features include:

Symptom	Reason
Dizziness	Reduced cerebral perfusion
Nausea	Hypotension
Pallor	Decreased cardiac output
Tachycardia	Compensatory response

It may also reduce uteroplacental blood flow.

Best management:

- Left lateral position

This shifts the uterus away from the vena cava.

Supine position -> IVC compression

Left lateral position -> venous return restored

QUESTION

A pregnant woman comes to the clinic. She already has twins by normal delivery. Which of the following is the correct representation of her obstetric score?

A G3P2

B G3P1

C G2P1

CORRECT

D G2P2

RIGHT ANSWER

OK C. G2P1

WHY THIS IS RIGHT

Each pregnancy counts once for gravida and parity, irrespective of number of fetuses. One prior twin pregnancy delivered at viability = G1P1, and current pregnancy makes her G2P1.

| Situation | Gravida | Para |

| ----- | ----- | ---- |

| One pregnancy with twins | G1 | P1 |

| Two pregnancies, one twin delivery | G2 | P1 |

| Three pregnancies, two singleton births | G3 | P2 |

Twin delivery counts as one parity event. Parity counts pregnancies, not number of babies.

QUESTION

| Testosterone helps in development of fetal organs. Which stimulates its production?

A LH from maternal pituitary

B HCG from placenta

CORRECT

C Inhibin from corpus luteum

D GnRH from fetal hypothalamus

RIGHT ANSWER

OK

B. HCG from placenta

WHY THIS IS RIGHT

Testosterone is produced by fetal Leydig cells in the testes and is essential for male genital differentiation. Human Chorionic Gonadotropin is secreted by the placenta during early pregnancy.

Mechanism:

Placenta releases hCG

↓

hCG acts like LH

↓

Stimulates fetal Leydig cells

↓

Testosterone production

Thus hCG acts as a substitute for LH in early fetal life.

Testosterone helps form:

| Structure | Development |

| ----- | ----- |

| Internal genitalia | Epididymis, vas deferens |

| External genitalia | Penis, scrotum |

| Secondary sexual differentiation | Later in puberty |

QUESTION

A primigravida woman at 12 weeks comes for nutritional advice. Which is recommended?

- A** Additional 300 kcal in 2nd trimester
- B** Additional 300 kcal in 1st trimester
- C** Additional 400 kcal in 3rd trimester
- D** Additional 300 kcal throughout pregnancy

CORRECT

RIGHT ANSWER

- OK** A. Additional 300 kcal in 2nd trimester

WHY THIS IS RIGHT

Pregnancy requires additional calories to support:

- Fetal growth
- Placental development
- Maternal metabolic changes

According to nutritional guidelines, extra calories are mainly required from the second trimester onwards. No extra calories are needed in 1st trimester. Second trimester requires ~300-340 kcal extra; third trimester ~450 kcal. Hence option A matches recommendations. Some sources say Additional 300 kcal throughout pregnancy but the above information is more accurate.

Nutrient	Requirement
Protein	~60 g/day
Iron	27 mg/day
Folic acid	400-600 µg/day
Calcium	1000-1200 mg/day

BMI Category	Weight gain
Normal BMI	11-16 kg
Underweight	12-18 kg
Overweight	7-11 kg

QUESTION

A 28-year-old G5L4 with all 4-girl children presents at 18 weeks and asks for the sex of the child on ultrasound. This is her first antenatal visit. What should be done?

- A** Do ultrasound for gestational age, check for abnormalities, check sex, and tell the mother
- B** Do ultrasound for gestational age, check for abnormalities, check sex but don't tell the mother
- C** Do ultrasound for gestational age, check for abnormalities, don't check the sex or reveal to the mother CORRECT
- D** Don't do ultrasound, do ANC only

RIGHT ANSWER

- OK** **C. Do ultrasound for gestational age, check for abnormalities, don't check the sex or reveal to the mother**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$30" here and does not include a written explanation for this item.

QUESTION

| During examination of a normal umbilical cord, which structures are expected?

A 2 umbilical veins and 2 arteries

B 2 umbilical arteries and 1 umbilical vein

CORRECT

C Single umbilical artery and vein

D 2 umbilical arteries and 2 veins

RIGHT ANSWER

OK

B. 2 umbilical arteries and 1 umbilical vein

WHY THIS IS RIGHT

The Umbilical Cord normally contains three vessels embedded in Wharton's jelly. Normal cord = 3 vessels: two arteries carrying deoxygenated blood from fetus to placenta, one vein carrying oxygenated blood back.

Structure	Function
1 Umbilical vein	Carries oxygenated blood from placenta to fetus
2 Umbilical arteries	Carry deoxygenated blood from fetus to placenta
Wharton's jelly	Protects vessels

Sometimes one artery is absent, called Single Umbilical Artery.

Associated anomalies:

System	Examples
Renal	Renal agenesis
Cardiac	Congenital heart disease
Gastrointestinal	Atresia

SUA is commonly associated with congenital anomalies and IUGR.

QUESTION

A pregnant woman doesn't recall LMP. What is the best method to calculate period of gestation?

A Crown-rump length (CRL)

CORRECT

B Biparietal diameter (BPD)

C Abdominal circumference (AC)

D Femur length (FL)

RIGHT ANSWER

OK A. Crown-rump length (CRL)

WHY THIS IS RIGHT

Crown-Rump Length is the most accurate ultrasound parameter for determining gestational age in early pregnancy.

Feature	Explanation
Used in	First trimester (7-13 weeks)
Accuracy	$\pm 3-5$ days
Purpose	Dating pregnancy

These measurements are used later in pregnancy.

Parameter	Best Use
BPD (Biparietal diameter)	Second trimester dating
AC (Abdominal circumference)	Fetal growth assessment
FL (Femur length)	Growth evaluation in third trimester



QUESTION

A pregnant woman in her first trimester presents with lymphadenopathy and past history of toxoplasmosis. Current serology shows IgG Toxoplasma positive. What is the most appropriate advice?

A Advise MTP

B Advise fetal testing

C Safe to continue pregnancy

CORRECT

D Initiate pyrimethamine

RIGHT ANSWER

OK

C. Safe to continue pregnancy

WHY THIS IS RIGHT

Toxoplasmosis is a parasitic infection that can cause congenital infection if acquired during pregnancy. Transmission usually occurs via:

- Undercooked meat
- Cat feces
- Contaminated food or soil

Serology Result	Meaning
IgG positive, IgM negative	Past infection
IgM positive	Recent infection
IgG negative	No immunity

In this case: IgG positive = past infection

This means the mother already developed protective immunity.

Therefore fetal infection risk is extremely low.

Classic triad:

Feature	Explanation
Hydrocephalus	CSF obstruction
Intracranial calcifications	Brain damage
Chorioretinitis	Eye involvement

However, this occurs only if infection is acquired during pregnancy.

QUESTION

| Which infection contracted in pregnancy won't be teratogenic?

A Rubella

B CMV

C HSV 2

CORRECT

D Chicken pox

RIGHT ANSWER

OK

C. HSV 2

WHY THIS IS RIGHT

Herpes simplex virus type 2 usually causes neonatal infection during delivery, not congenital malformations. Herpes Simplex Virus Type 2 mainly causes neonatal herpes infection during delivery through contact with infected genital lesions. Certain infections during pregnancy can cross the placenta and cause congenital anomalies in the fetus. These are classically remembered under TORCH Infections. Common teratogenic infections

| Infection | Fetal effects |

| ----- | ----- |

| Rubella | Cataracts, PDA, deafness

Classic triad:

- Cataracts
- Patent ductus arteriosus
- Sensorineural deafness

|

| CMV | Microcephaly, periventricular calcification, Hearing loss |

| Varicella (Chickenpox) | Limb hypoplasia, skin scarring, Neurological defects |

| Toxoplasmosis | Hydrocephalus, chorioretinitis |

*

QUESTION

A patient presents at 18 weeks with raised AFP, low Estrol, low HCG, low Inhibin-A.
What is the next best step?

A Anomaly scan

CORRECT

B Amniocentesis

C Chorionic villous sampling

D NIPT

RIGHT ANSWER

OK
A. Anomaly scan

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$19" here and does not include a written explanation for this item.

QUESTION

Which of the following statements regarding physiological changes in pregnancy is incorrect?

A Fasting Hypoglycemia and Postprandial Hyperglycemia

B Increase SBP and DBP at 6 weeks

CORRECT

C Increase in RBC mass

D Peripheral Insulin Resistance

RIGHT ANSWER

OK

B. Increase SBP and DBP at 6 weeks

WHY THIS IS RIGHT

Cardiovascular Changes in Pregnancy-

During pregnancy:

- Systemic vascular resistance decreases
- Cardiac output increases
- Blood pressure falls in early pregnancy

Trimester	Blood Pressure
Early pregnancy	↓ BP
Mid pregnancy	Lowest BP
Late pregnancy	Returns toward baseline

Glucose Metabolism in Pregnancy- Pregnancy is considered a diabetogenic state.

Hormones responsible include:

- Human placental lactogen (hPL)
- Progesterone
- Cortisol
- Estrogen

These hormones cause peripheral insulin resistance.

Hematological changes during pregnancy:

- RBC mass increases by ~20-30%
- Plasma volume increases by ~40-50%

This leads to physiological anemia of pregnancy.

Parameter	Change
RBC mass	↑
Plasma volume	↑↑
Hemoglobin concentration	↓

QUESTION

A 16 weeks pregnant woman is evaluated using Quadruple test. Which of the following is not part of it?

A Inhibin B

CORRECT

B Beta hCG

C AFP

D Unconjugated Estriol

RIGHT ANSWER

OK

A. Inhibin B

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1a” here and does not include a written explanation for this item.

QUESTION

Which of the following investigative modalities is generally considered unsafe for use during pregnancy?

A Ultrasound

B CT scan

CORRECT

C Doppler

D MRI

RIGHT ANSWER

OK B. CT scan

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1b" here and does not include a written explanation for this item.

QUESTION

A patient present at 9 weeks pregnancy. She asks for medical method of abortion. What will you advise her?

A Hyperosmolar saline

B Mifepristone and misoprostol

CORRECT

C Oxytocin

D Dinoprostone

RIGHT ANSWER

OK

B. Mifepristone and misoprostol

WHY THIS IS RIGHT

Medical termination of pregnancy (MTP) using mifepristone and misoprostol is recommended for up to 9 weeks of gestation.

Mifepristone 200 mg orally

Action:

Blocks progesterone

↓

Breakdown of endometrium

↓

Detachment of gestational sac

After 48 hours:

Misoprostol 800 µg

-> Vaginal / Buccal / Sublingual

Action:

Uterine contractions

↓

Expulsion of products of conception

Action:

Uterine contractions

↓

Expulsion of products of conception

QUESTION

| All are members of the medical board in MTP > 24 weeks, except?

A Radiologist

B Gynecologist

C Legal advisor

CORRECT

D Pediatrician

RIGHT ANSWER

OK C. Legal advisor

WHY THIS IS RIGHT

For MTP >24 weeks (special categories), the medical board includes gynecologist, radiologist, pediatrician, and a relevant specialist. A legal advisor is NOT part of the board, as decisions are medical, not legal.

QUESTION

A patient was undergoing a hysteroscopic removal of a submucosal fibroid, in which a fluid deficit of 2000 mL is estimated in a patient. What is the immediate complication of this?

A Acute tubular necrosis

B DIC

C Pulmonary edema

CORRECT

D Thromboembolism

RIGHT ANSWER

OK C. Pulmonary edema

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1c” here and does not include a written explanation for this item.

QUESTION

A 26-year-old woman who is being treated for infertility with human menopausal gonadotropin presented with complaints of sudden abdominal pain, nausea, vomiting, and breathlessness. The finding of the ultrasound is shown below. What is the most likely diagnosis?

A Ovarian hyperstimulation syndrome

CORRECT

B Polycystic ovarian syndrome

C Theca lutein cysts

D Granulosa cell tumor

RIGHT ANSWER

OK

A. Ovarian hyperstimulation syndrome

WHY THIS IS RIGHT

Ovarian Hyperstimulation Syndrome- It occurs most commonly after ovulation induction therapy.
Drugs That Cause OHSS

Commonly associated with:

Drug	Use
Human Menopausal Gonadotropin	Ovulation induction
hCG trigger	Final oocyte maturation
Clomiphene (rarely)	Ovulation induction

Excess ovarian stimulation

↓
High estrogen levels
↓
Release of VEGF
↓
Increased vascular permeability
↓
Fluid shifts to third spaces

This leads to:

- Ascites
- Pleural effusion
- Hemoconcentration

Ultrasound Findings

Typical findings:

- Enlarged multicystic ovaries
- Ascites

These features strongly suggest OHSS.

Severity	Features
Mild	Ovarian enlargement
Moderate	Ascites
Severe	Hemoconcentration, pleural effusion
Critical	Thrombosis, renal failure

QUESTION

A female presents to OPD with 6 weeks of amenorrhea complaints of bleeding per vagina and mild abdominal pain. The urine pregnancy test is positive and hCG level is 2800 IU/L. On investigation, mass is seen on the left adnexa measuring 3 x 2 cm. She is hemodynamically stable. How will you manage this patient?

- A** Oral methotrexate
- B** Single-dose methotrexate injection
- C** Serial methotrexate injections + leucovorin rescue
- D** Salpingectomy

CORRECT

RIGHT ANSWER

- OK** **B. Single-dose methotrexate injection**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1d” here and does not include a written explanation for this item.

QUESTION

A patient in early pregnancy presents to the emergency department with vaginal spotting. On ultrasound, which of the following findings is diagnostic of a missed abortion?

CORRECT

A No cardiac activity at a CRL > 7mm

B No cardiac activity at a CRL < 7mm

C No cardiac activity at a CRL > 25mm

D No cardiac activity at a CRL < 12mm

RIGHT ANSWER

OK

A. No cardiac activity at a CRL > 7mm

WHY THIS IS RIGHT

Missed abortion is diagnosed when there is no cardiac activity detected on ultrasound at CRL $\geq$ 7mm. Typical presentation:

- Vaginal spotting
- Loss of pregnancy symptoms
- Closed cervical os

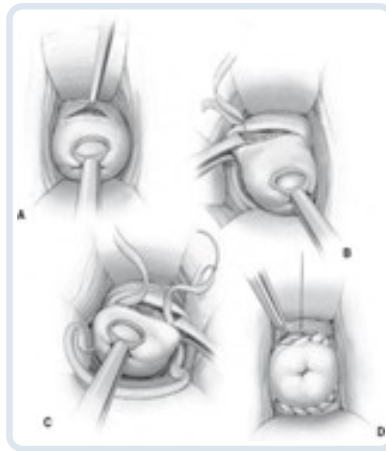
This threshold distinguishes between normal early development (cardiac activity not yet detectable) and embryonic demise (cardiac activity absent when it should be present).

Ultrasound finding	Diagnosis
CRL $\geq$ 7 mm with no cardiac activity	Diagnostic of missed abortion
Gestational sac $\geq$ 25 mm with no embryo	Anembryonic pregnancy

Finding	Interpretation
Gestational sac $\geq$ 25 mm with no embryo	Blighted ovum
No embryo after 2 weeks of sac seen	Pregnancy failure

QUESTION

An image shows a cervical cerclage being applied in a patient with cervical insufficiency. Identify the type of cerclage procedure?



A McDonald

B Modified McDonald

C Shirodkar

D Modified Shirodkar

CORRECT

RIGHT ANSWER

OK

D. Modified Shirodkar

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1e" here and does not include a written explanation for this item.

QUESTION

Identify the clinical sign demonstrated in the image below?



A Chadwick sign

B Goodell sign

C Hegar sign

CORRECT

D Osiander sign

RIGHT ANSWER

OK

C. Hegar sign

WHY THIS IS RIGHT

Hegar sign is softening of the lower uterine segment, allowing fingers to approximate on bimanual exam in early pregnancy (6-10 weeks). Other signs relate to cervical softening or vascular changes.

During early pregnancy:

Hormonal changes (progesterone, estrogen)

↓

Increased uterine vascularity

↓

Softening of uterine isthmus

↓

Lower uterine segment becomes compressible

During examination:

- The cervix and uterine body feel separate
- Because the isthmus becomes very soft

During bimanual examination:

- One hand in vagina
- Other hand on abdomen

The uterine body and cervix feel disconnected due to soft isthmus.

Other Early Pregnancy Signs

| Sign | Finding |

| --- | ----- |

| Chadwick Sign | Bluish cervix |

| Goodell Sign | Soft cervix |

| Osiander Sign | Pulsation felt in lateral fornix |

| Hegar sign | Soft uterine isthmus |

QUESTION

A 20-year-old woman presented at 7 weeks of gestation, unwilling to continue the pregnancy. What are the drugs used for medical termination of pregnancy in this patient?

A Misoprostol + Medroxyprogesterone

B Misoprostol + Mifepristone

CORRECT

C Mifepristone + Methotrexate

D Mifepristone + Medroxyprogesterone

RIGHT ANSWER

OK

B. Misoprostol + Mifepristone

WHY THIS IS RIGHT

Medical Termination of Pregnancy is commonly performed in early pregnancy (≤ 9 weeks) using a combination of two drugs.

Mifepristone

Mechanism:

- Blocks progesterone receptors
- Causes decidual breakdown
- Detaches the gestational sac

Misoprostol

Mechanism:

- Causes uterine contractions
- Leads to expulsion of products of conception

| Drug | Function |

| --- | ----- |

| Mifepristone | Sensitizes uterus to prostaglandins |

| Misoprostol | Induces uterine contractions |

Day 1 -> Mifepristone 200 mg orally

↓

24-48 hours later

↓

Misoprostol 800 µg vaginal / buccal

↓

Expulsion of pregnancy

QUESTION

A 22y primigravida is overdue by 2 weeks. She visits the OPD with complaints of vaginal bleeding and abdominal pain on the right side. On Examination, her vitals are stable. Abdomen examination is unremarkable. A bimanual examination reveals a bulky, soft uterus with no tenderness and no adnexal mass. Mild bleeding +. Beta hCG is 1400 IU. An ultrasound reveals a trilaminar endometrium, and both the adnexa are normal. The next best step is?

A Repeat serum beta HCG after 48h

CORRECT

B Diagnostic laparoscopy

C Repeat USG after 3 days

D Wait and watch

RIGHT ANSWER

OK A. Repeat serum beta HCG after 48h

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1f” here and does not include a written explanation for this item.

QUESTION

A 39y G2P1 presents at 18 weeks 5 days for her routine targeted fetal anomaly ultrasound. The fetal anatomy appears normal, but the cervical length is 15mm. Despite being counselled that there is no clear proven benefit for the same; the patient insisted on a cervical cerclage. Which of the following is a complete contra-indication to cerclage?

A Positive fetal fibronectin test

B Membranes bulging into vagina

C Ruptured membranes

CORRECT

D Advanced maternal age

RIGHT ANSWER

OK

C. Ruptured membranes

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$20" here and does not include a written explanation for this item.

QUESTION

A 14-year-old girl, a victim of rape, presents at 22 weeks for abortion. What advice will you give her?

- A MTP cannot be done as she has crossed 20 weeks
- B MTP can be done till 24 weeks**
- C MTP can be done only if the mother's life is at risk
- D MTP can only be done if there is a substantial fetal anomaly

CORRECT

RIGHT ANSWER

- B. MTP can be done till 24 weeks**

WHY THIS IS RIGHT

Termination of pregnancy in India is governed by the Medical Termination of Pregnancy Act.

The 2021 amendment expanded the upper gestational limit for certain categories.

Gestational Age	Requirement
Up to 20 weeks	Opinion of 1 registered medical practitioner
20-24 weeks	Opinion of 2 registered medical practitioners
>24 weeks	Allowed only for major fetal anomalies (medical board approval)

Special Categories Eligible for 20-24 Week Termination

The law specifically includes rape survivors.

Eligible groups:

Category
Survivors of rape or incest
Minors
Differently-abled women
Change in marital status (widow/divorce)
Severe fetal anomalies

QUESTION

According to the MTP Act Amendment of 2021, at what gestational age range is the opinion of two registered medical practitioners required for termination of pregnancy?

A < 12 weeks

B 12-20 weeks

C 20-24 weeks

CORRECT

D > 24 weeks

RIGHT ANSWER

OK C. 20-24 weeks

WHY THIS IS RIGHT

Medical Termination of Pregnancy (MTP) Act 2021

The 2021 amendment expanded access to abortion and modified the doctor approval requirements depending on gestational age.

| Gestational Age | Doctor Requirement |

| ----- | ----- |

| ≤20 weeks | Opinion of 1 Registered Medical Practitioner |

| 20-24 weeks | Opinion of 2 Registered Medical Practitioners |

| >24 weeks | Allowed only for fetal abnormalities with approval of a State Medical Board |

Thus, two doctors are specifically required for termination between 20 and 24 weeks.

QUESTION

A woman presents with bleeding for 2 days and abdominal pain. Her LMP was 6 weeks back. An ultrasound shows fluid in the pouch of Douglas. What is the diagnosis?

A Abruptio placentae

B Placenta previa

C Missed abortion

D Ruptured ectopic pregnancy

CORRECT

RIGHT ANSWER

OK

D. Ruptured ectopic pregnancy

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$21” here and does not include a written explanation for this item.

QUESTION

A 26-year woman presents with six weeks amenorrhea. Obstetrician notices right adnexal tenderness on cervical motion during examination. Which of the following is an incorrect statement?

A Abdominal pain is the commonest presentation

B Oral methotrexate is treatment of choice

CORRECT

C Chances of ectopic increase in PID

D Low progesterone is not diagnostic

RIGHT ANSWER

OK **B. Oral methotrexate is treatment of choice**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$22” here and does not include a written explanation for this item.

QUESTION

According to the MTP Act Amendment of 2021, at what gestational age range is the opinion of two registered medical practitioners required for termination of pregnancy?

A < 12 weeks

B 12-20 weeks

C 20-24 weeks

CORRECT

D > 24 weeks

RIGHT ANSWER

OK C. 20-24 weeks

WHY THIS IS RIGHT

Medical Termination of Pregnancy (MTP) Act 2021

The 2021 amendment expanded access to abortion and modified the doctor approval requirements depending on gestational age.

| Gestational Age | Doctor Requirement |

| ----- | ----- |

| ≤20 weeks | Opinion of 1 Registered Medical Practitioner |

| 20-24 weeks | Opinion of 2 Registered Medical Practitioners |

| >24 weeks | Allowed only for fetal abnormalities with approval of a State Medical Board |

Thus, two doctors are specifically required for termination between 20 and 24 weeks.

QUESTION

In a case of MgSO_4 toxicity, all of the following parameters are monitored except?

- A RR (Respiratory Rate)
- B Urine output
- C DTR (Deep Tendon Reflexes)
- D Serum Mg level**

CORRECT

RIGHT ANSWER

- OK
- D. Serum Mg level**

WHY THIS IS RIGHT

Magnesium toxicity is monitored clinically by RR, urine output, and DTR. Loss of patellar reflex is the earliest sign of MgSO_4 toxicity. Routine serum Mg levels are not required unless toxicity is suspected. Magnesium is cleared through the kidneys.

Reduced urine output

↓

Magnesium accumulation

↓

Risk of toxicity

Therefore: Urine output should be $>25\text{-}30$ mL/hour.

Clinical monitoring is more reliable and practical in obstetric practice.

| Serum Mg Level | Effect |

| ----- | ----- |

| 4-7 mEq/L | Therapeutic level |

| 7-10 mEq/L | Loss of DTR |

| 10-12 mEq/L | Respiratory depression |

| >15 mEq/L | Cardiac arrest |

Serum Mg Level Is Not Monitored Routinely

Although it can be measured, routine monitoring relies on clinical parameters because they are:

- Rapid
- Bedside accessible
- Clinically reliable

Antidote for Magnesium Toxicity- Calcium Gluconate

Dose:

- 10 mL of 10% calcium gluconate IV slowly

QUESTION

A primigravida presents at 37 weeks. She is a known case of heart disease with a prosthetic valve on warfarin. What is the next best step?

A Continue warfarin

B Switch to LMWH

CORRECT

C Immediate caesarean

D Immediate IOL

RIGHT ANSWER

OK B. Switch to LMWH

WHY THIS IS RIGHT

Warfarin is unsafe near term due to fetal and maternal bleeding risk. Near delivery, warfarin increases the risk of:

Complication	Reason
Fetal intracranial hemorrhage	Placental transfer
Maternal bleeding during labor	Anticoagulation
Neonatal bleeding	Long half-life

Therefore, warfarin is replaced by heparin near term.

At 36-37 weeks, anticoagulation is switched to LMWH, which does not cross the placenta. Delivery is planned only after stopping LMWH for an appropriate interval.

QUESTION

A 26-year-old G2P1 at 8 weeks diagnosed to have hyperthyroidism. What is the drug of choice?

A Methimazole

B Carbimazole

C Iodine 131

D Propylthiouracil

CORRECT

RIGHT ANSWER

OK

D. Propylthiouracil

WHY THIS IS RIGHT

PTU is preferred in the 1st trimester because methimazole/carbimazole are linked to congenital anomalies (e.g., aplasia cutis). Radioactive iodine is absolutely contraindicated. After 1st trimester, therapy is usually switched to methimazole. This switch reduces PTU-related hepatotoxicity later in pregnancy.

QUESTION

| A 32-year-old G2P1 is diagnosed to have DVT at 30 weeks. The drug of choice is?

- A** Warfarin
- B** LMWH (Low Molecular Weight Heparin) CORRECT
- C** Fondaparinux
- D** Apixaban

RIGHT ANSWER

- OK** **B. LMWH (Low Molecular Weight Heparin)**

WHY THIS IS RIGHT

LMWH is the treatment of choice for DVT in pregnancy because it does not cross the placenta and has a predictable safety profile. Warfarin and DOACs (e.g., apixaban) cross the placenta and are unsafe. Fondaparinux is reserved for HIT.

QUESTION

A primigravida presents to you in her early pregnancy with anemia. She is 7 weeks pregnant as seen on ultrasound. Her haemoglobin level is 9 g/dL. When should the iron supplements be started for her?

A 10 to 12 weeks

B 8 to 10 weeks

CORRECT

C After 14 weeks

D After 20 weeks

RIGHT ANSWER

OK B. 8 to 10 weeks

WHY THIS IS RIGHT

Iron supplementation is usually started after early organogenesis begins because:

Early pregnancy

↓

Organogenesis occurring

↓

Iron started after early weeks

↓

Better tolerance and absorption

Starting at 8-10 weeks ensures that:

- The fetus has begun significant hematopoiesis
- Maternal iron stores can be replenished early

Hb 9 g/dL denotes moderate anemia, which needs therapeutic iron without delay. Prophylactic iron starts at 14 weeks, but treatment of established anemia must begin earlier. Among options, 8-10 weeks is the earliest and therefore correct.

| Requirement | Approximate amount |

| ----- | ----- |

| Fetal development | ~300 mg |

| Placenta | ~50 mg |

| Maternal RBC expansion | ~500 mg |

Daily supplementation usually includes:

| Nutrient | Dose |

| ----- | ---- |

| Iron | 60 mg elemental iron |

| Folic acid | 400-500 µg |

QUESTION

A 23-year-old woman with eclampsia is on a maintenance dose of MgSO_4 . When will you stop MgSO_4 ?

A Knee jerk present

B RR 18/min

C Visual disturbance

D Urine output 60 ml in 4 hr

CORRECT

RIGHT ANSWER

OK D. Urine output 60 ml in 4 hr

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$23” here and does not include a written explanation for this item.

QUESTION

A pregnant woman with no other comorbid conditions develops preeclampsia. She enquires about the cause. The doctor explains that it is due to the failure of the invasion of?

- A** Spiral artery by villous trophoblasts
- B** Radial artery by cytotrophoblasts
- C** Spiral artery by extravillous trophoblasts
- D** Arcuate artery by extravillous trophoblasts

CORRECT

RIGHT ANSWER

- OK** **C. Spiral artery by extravillous trophoblasts**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$24” here and does not include a written explanation for this item.

QUESTION

A 22y type 1 DM is in the post operative ward following a cesarean done for failed induction (for preeclampsia with severe features). She complains of drowsiness and altered sensorium. She is on maintenance MgSO₄ infusion and on IV infusion of insulin. On examination, her PR is 70/ min. BP is 140/ 98 mmHg. RR is 10/min. Auscultation of lungs reveals bilateral normal air entry. Abdominal examination reveals a firm uterus with normal tenderness. Pfannenstiel scar is intact and there is no significant vaginal bleeding. B/I patellar reflexes are absent. A urine dipstick for protein and sugar is negative and a capillary glucose sample is 270 mg%. The suspected diagnosis is?

A Magnesium sulphate toxicity

CORRECT

B Diabetic ketoacidosis

C Postpartum eclampsia

D Peripartum cardiomyopathy

RIGHT ANSWER

OK A. Magnesium sulphate toxicity

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$25" here and does not include a written explanation for this item.

QUESTION

A pregnant lady with 34 weeks of amenorrhea has the following findings: LDH - 700 IU/L, platelets - 75,000/ mm³, serum bilirubin - 1.5 mg/dL, SGOT - 200 U/L, SGPT - 150 U/L, and BP - 140/96 mm Hg. Her coagulation profile and renal function tests are normal. What is the diagnosis?

A HELLP syndrome

CORRECT

B Acute fatty liver of pregnancy

C Viral hepatitis

D Intrahepatic cholestasis

RIGHT ANSWER

OK A. HELLP syndrome

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$26” here and does not include a written explanation for this item.

QUESTION

A woman post-emergency LSCS for preeclampsia with fetal distress. Which is the best drug for thromboprophylaxis postpartum?

A Warfarin

B Aspirin

C Clopidogrel

D LMWH

CORRECT

RIGHT ANSWER

OK
D. LMWH

WHY THIS IS RIGHT

Pregnancy and postpartum are hypercoagulable states due to physiological changes that prepare the body to prevent bleeding.

Risk factors present in this case:

Risk Factor Reason
----- -----
Cesarean section Surgical trauma
Preeclampsia Endothelial injury
Postpartum state Hypercoagulability

This increases risk of Deep Vein Thrombosis and Pulmonary Embolism.

Low Molecular Weight Heparin- Inhibits Factor Xa

Examples:

- Enoxaparin
- Dalteparin

Advantage Reason
----- -----
Safe in breastfeeding Minimal secretion in milk
Predictable pharmacokinetics Less monitoring
Lower bleeding risk Compared with UFH
Once daily dosing Convenient

Duration of Postpartum Thromboprophylaxis

Risk level Duration
----- -----
Moderate risk 7-10 days
High risk Up to 6 weeks

QUESTION

What is the total loading dose of magnesium sulfate (MgSO_4) in the Pritchard regimen?

A 4 g

B 10 g

C 14 g

CORRECT

D 15 g

RIGHT ANSWER

OK C. 14 g

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$27" here and does not include a written explanation for this item.

QUESTION

A pregnant patient at 36 weeks of gestation has a blood pressure of 150/105 mmHg and a +3 albuminuria. The presence of which of the following are signs of impending eclampsia?

1. Headache
2. Persistent pedal edema
3. Blurring of vision
4. Epigastric pain

A 1, 2, 3, 4

CORRECT

B 1, 3, 4

C 1, 2, 3

D 1, 2, 4

RIGHT ANSWER

OK A. 1, 2, 3, 4

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$28” here and does not include a written explanation for this item.

QUESTION

A 65-year-old woman with epithelial ovarian cancer has peritoneal caking as shown in the CECT and ascites. What is the management?



A Debulking followed by radiotherapy

B Debulking followed by chemotherapy

C Chemotherapy followed by debulking

CORRECT

D Staging laparotomy

RIGHT ANSWER

OK C. Chemotherapy followed by debulking

WHY THIS IS RIGHT

Clinical clues

- 65-year-old woman
- Epithelial ovarian cancer
- Ascites
- Peritoneal / omental caking on CECT

These findings indicate advanced-stage disease.

Ovarian cancer commonly spreads by:

- Transcoelomic spread
- Tumor cells disseminate in peritoneal fluid

Peritoneal caking refers to thick tumor deposits in the omentum, giving a “cake-like” appearance.

Management Strategy

Management depends on resectability of tumor.

If disease is extensive (as in this case)- Neoadjuvant chemotherapy -> Interval debulking surgery

Advanced ovarian cancer

↓

Neoadjuvant chemotherapy

↓

Tumor size reduces

↓

Interval debulking surgery

↓

Adjuvant chemotherapy



QUESTION

| What is the dose of corticosteroids for lung maturity?

A Dexamethasone 12 mg 24 hourly 2 doses

B Dexamethasone 6 mg 12 hourly 4 doses

CORRECT

C Betamethasone 12 mg 12 hourly 2 doses

D Betamethasone 12 mg 24 hourly 4 doses

RIGHT ANSWER

OK

B. Dexamethasone 6 mg 12 hourly 4 doses

WHY THIS IS RIGHT

Antenatal corticosteroids are given to pregnant women at risk of Preterm Birth to accelerate fetal lung maturation. They significantly reduce complications like:

- Respiratory distress syndrome (RDS)
- Intraventricular hemorrhage
- Necrotizing enterocolitis
- Neonatal mortality

Corticosteroids stimulate type II pneumocytes in the fetal lungs.

Corticosteroids

↓

Type II pneumocyte stimulation

↓

↑ Surfactant production

↓

Improved lung expansion

↓

Reduced respiratory distress syndrome

Two standard regimens are used.

| Drug | Dose | Schedule |

| --- | --- | ----- |

| Dexamethasone | 6 mg IM | Every 12 hours × 4 doses |

| Betamethasone | 12 mg IM | Every 24 hours × 2 doses |

QUESTION

A patient presents at 35 weeks with chronic HTN and 3+ proteinuria. Her BP is 170/100 mmHg and she complains of headache and blurring of vision. What is the best management option?

- A** Labetalol + MgSO₄ + Expedite delivery
- B** Labetalol + MgSO₄ + Wait till 37 weeks
- C** Labetalol + Corticosteroids + wait till 37 weeks
- D** Labetalol + Corticosteroids + Expedite delivery

CORRECT

RIGHT ANSWER

- OK**
- A. Labetalol + MgSO₄ + Expedite delivery**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$29” here and does not include a written explanation for this item.

QUESTION

Early onset pre-eclampsia is defined as:

A Before 28 weeks

B Before 30 weeks

C Before 32 weeks

D Before 34 weeks

CORRECT

RIGHT ANSWER

OK **D. Before 34 weeks**

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2a" here and does not include a written explanation for this item.

QUESTION

Which of the following drug is most commonly associated with neural tube defects due to its teratogenic effects?

A Sodium valproate

CORRECT

B Lamotrigine

C Levetiracetam

D Carbamazepine

RIGHT ANSWER

OK A. Sodium valproate

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$2b" here and does not include a written explanation for this item.

QUESTION

A 29-year-old pregnant woman in her first trimester is found to have asymptomatic bacteriuria on routine screening, with urine culture growing *E. coli*. What is the most common complication associated with this finding?

A Chorioamnionitis

B Fetal death

C Preterm labor

CORRECT

D Miscarriage

RIGHT ANSWER

OK C. Preterm labor

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2c” here and does not include a written explanation for this item.

QUESTION

Which of the following is not a recognized clinical use of magnesium sulfate (MgSO_4)?

A Increase renal perfusion

CORRECT

B Neuroprotection

C Prevention of seizures

D Prevents abruption

RIGHT ANSWER

OK

A. Increase renal perfusion

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2d” here and does not include a written explanation for this item.

QUESTION

A pregnant patient at 36 weeks of gestation has a blood pressure of 150/105 mmHg and a +3 albuminuria. The presence of which of the following are signs of impending eclampsia?

1. Headache
2. Persistent pedal edema
3. Blurring of vision
4. Epigastric pain

A 1, 2, 3, 4

CORRECT

B 1, 3, 4

C 1, 2, 3

D 1, 2, 4

RIGHT ANSWER

OK A. 1, 2, 3, 4

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2e” here and does not include a written explanation for this item.

QUESTION

Twin pregnancy where 1 twin is older by 1 month than the other on ultrasound. What is this known as?

- A Superfecundation
- B Superfetation**
- C Illegitimate
- D Monochorionic monoamniotic

CORRECT

RIGHT ANSWER

B. Superfetation

WHY THIS IS RIGHT

Superfetation = twins conceived in different cycles, giving different gestational ages. Superfecundation happens in the same cycle. MCMA twins are identical and same age.

Feature	Superfetation	Superfecundation
Timing	Two different ovulation cycles	Same ovulation cycle
Gestational age	Different ages	Same age
Fathers	May be same	May be different

A) Superfecundation

- Occurs in same menstrual cycle, so fetuses have same gestational age.

C) Illegitimate

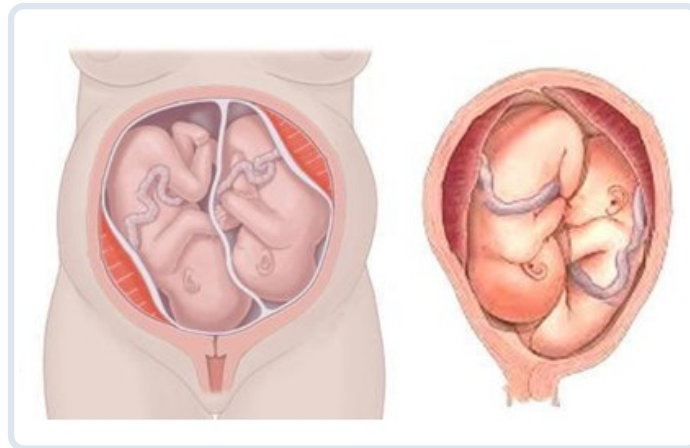
- Not a medical term.

D) Monochorionic monoamniotic

- Twins are same age, not different gestational ages.

QUESTION

What would be the mode of delivery in images 1 and 2?



- A Both caesarean
- B Both vaginal
- C Image 1: Vaginal; image 2: Caesarean
- D Image 1: Caesarean; image 2: Vaginal

CORRECT

RIGHT ANSWER

OK

C. Image 1: Vaginal; image 2: Caesarean

WHY THIS IS RIGHT

If the first twin is cephalic, vaginal delivery is safe (Image 1).

If the first twin is breech or transverse, cesarean is preferred (Image 2).

Twin A's presentation decides the mode of delivery because it is the leading fetus. Breech first twin carries risks such as cord prolapse and head entrapment.

QUESTION

| Which will you not see in twin pregnancy?

A MCMA (Monochorionic Monoamniotic)

B MCDA (Monochorionic Diamniotic)

C **MADC (Monoamniotic Dichorionic)**

CORRECT

D DADC (Dichorionic Diamniotic)

RIGHT ANSWER

OK

C. MADC (Monoamniotic Dichorionic)

WHY THIS IS RIGHT

Twin pregnancies are classified based on:

- Chorionicity -> number of placentas
- Amnionicity -> number of amniotic sacs

| Type | Chorion | Amnion | Frequency |

| --- | ----- | ----- | ----- |

| Dichorionic diamniotic (DCDA) | 2 | 2 | Most common |

| Monochorionic diamniotic (MCDA) | 1 | 2 | Common in identical twins |

| Monochorionic monoamniotic (MCMA) | 1 | 1 | Rare |

MADC = Monoamniotic Dichorionic

This means:

- Two placentas (dichorionic)
- Only one amniotic sac (monoamniotic)

This is embryologically impossible because:

- Each chorion normally develops its own amniotic sac.
- If two chorions exist, there must be two amniotic sacs.

Thus monoamniotic dichorionic twins cannot exist.

QUESTION

Doppler assessment of which fetal vessel is most useful in detecting fetal anemia?

A Middle Cerebral Artery

CORRECT

B Umbilical artery

C Umbilical vein

D Uterine artery

RIGHT ANSWER

OK

A. Middle Cerebral Artery

WHY THIS IS RIGHT

Middle Cerebral Artery Doppler is the most sensitive non-invasive method to detect fetal anemia, especially in Rh Isoimmunization.

Middle Cerebral Artery (MCA) peak systolic velocity >1.5 multiples of median indicates fetal anemia. This non-invasive Doppler technique is the gold standard for monitoring fetal anemia, particularly in Rh isoimmunization cases. anagement if MCA PSV >1.5 MoM

Next step: Cordocentesis (PUBS) to confirm anemia.

Treatment: Intrauterine fetal blood transfusion.

QUESTION

A patient with O negative and husband B positive delivered a baby. Has received anti-D prophylaxis at 28 weeks. In which of the following conditions will you give anti-D post-delivery?

A Baby O -ve, DCT -ve

B Baby O -ve, DCT +ve

C Baby +ve, DCT +ve

D Baby +ve, DCT -ve

CORRECT

RIGHT ANSWER

OK

D. Baby +ve, DCT -ve

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$2f” here and does not include a written explanation for this item.

QUESTION

A woman with obstetric score G2P1 at 14 weeks is advised uterine artery Doppler. What would it detect?

A Early-onset preeclampsia

CORRECT

B Late-onset preeclampsia

C Fetal growth restriction

D Placenta accreta

RIGHT ANSWER

OK A. Early-onset preeclampsia

WHY THIS IS RIGHT

Uterine Artery Doppler evaluates uteroplacental blood flow during pregnancy.

It is usually performed between 11-14 weeks or 18-24 weeks. The test detects impaired placental blood flow, which is associated with:

- Early Onset Preeclampsia
- Fetal Growth Restriction

However, uterine artery Doppler is primarily used to predict early-onset preeclampsia. Abnormal uterine artery Doppler predicts early-onset preeclampsia.

Normally in pregnancy:

Spiral arteries remodel

↓

Low resistance blood flow

↓

Adequate placental perfusion

In abnormal placentation:

Poor trophoblastic invasion

↓

High resistance uterine arteries

↓

Abnormal Doppler waveform

↓

Risk of early preeclampsia

| Finding | Significance |

| ----- | ----- |

| Increased pulsatility index (PI) | High resistance |

| Early diastolic notch | Poor placental perfusion |

QUESTION

| All are criteria of IUGR except?

- A** Abdominal circumference < 3rd percentile
- B** Estimated fetal weight < 3rd percentile
- C** Absent or reversal of diastolic flow in umbilical artery
- D** Uterine A PI < 95%

CORRECT

RIGHT ANSWER

- OK** D. Uterine A PI < 95%

WHY THIS IS RIGHT

IUGR refers to failure of the fetus to achieve its genetically determined growth potential due to placental insufficiency or other causes.

Common diagnostic parameters include:

Parameter	Diagnostic finding
Estimated fetal weight (EFW)	< 3rd percentile
Abdominal circumference (AC)	< 3rd percentile
Abnormal Doppler	Umbilical artery changes
Placental insufficiency markers	Abnormal uterine artery PI

Progression of Doppler abnormalities:

Stage	Doppler Finding
Early	Increased PI
Moderate	Absent end-diastolic flow
Severe	Reversed end-diastolic flow

Uterine artery pulsatility index (PI) <95th percentile is normal, not abnormal.

For IUGR Doppler: High resistance = abnormal

So:

- Umbilical artery diastolic flow ↓
- Uterine artery PI ↑

QUESTION

A G2P1 woman with a previous lower segment cesarean section presents with bleeding per vaginum and is diagnosed with placenta previa. During cesarean delivery, the placenta is noted to be invading into the bladder wall. What is the most likely diagnosis?

A Placenta accreta

B Placenta increta

C Placenta percreta

CORRECT

D Abruptio placentae

RIGHT ANSWER

OK

C. Placenta percreta

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$30" here and does not include a written explanation for this item.

QUESTION

A primigravida at 22 weeks of gestation presents to you with profuse vaginal bleeding. Her blood pressure and glucose levels are within normal limits. Placental implantation at which of the following sites can cause this?

A Internal os

CORRECT

B Fallopian tube

C Ovarian

D Abdominal

RIGHT ANSWER

OK

A. Internal os

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$19” here and does not include a written explanation for this item.

QUESTION

A G2 with a previous LSCS underwent cesarean delivery. During surgery, there was excessive bleeding, and a hysterectomy had to be done. The image of the uterus is shown. What is the probable diagnosis?



A Placenta previa

B Placenta accrete syndrome

CORRECT

C Abruptio placentae

D Rupture uterus

RIGHT ANSWER

OK

B. Placenta accrete syndrome

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1a" here and does not include a written explanation for this item.

QUESTION

A 30-week pregnant woman presents with mild bleeding. Her blood pressure is 110/70 mmHg, and fetal heart rate is 140 bpm. There were no contractions. TAS is shown below. What is the best next step in management?



- A** Induction of labour with oxytocin
- B** Hospitalisation and expectant management
- C** Immediate LSCS
- D** Amniotomy

CORRECT

RIGHT ANSWER

- OK** **B. Hospitalisation and expectant management**

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1b” here and does not include a written explanation for this item.

QUESTION

A 39-year-old G6P2L1A3 presents with a history of previous 2 LSCS with PAS. What will you NOT counsel her about?

A Need for blood transfusion

B Risk of bladder injury in case of PAS

C Risk of bowel injury in case of PAS

CORRECT

D Risk of peripartum hysterectomy

RIGHT ANSWER

OK C. Risk of bowel injury in case of PAS

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1c" here and does not include a written explanation for this item.

QUESTION

A pregnant woman at 30 weeks presents with painful bleeding PV, reduced fetal movement, increased uterine tone, and absent FHR. BP is 166/98 mmHg, and the cervix is 6 cm dilated, 70% effaced with intact membranes. What is the next best step?

- A** Emergency LSCS
- B** Start Antihypertensives and emergency LSCS
- C** Start Antihypertensives and ARM
- D** Tocolysis

CORRECT

RIGHT ANSWER

- OK** C. Start Antihypertensives and ARM

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1d” here and does not include a written explanation for this item.

QUESTION

A 30-week pregnant woman presents with mild bleeding. Her blood pressure is 110/70 mmHg, and fetal heart rate is 140 bpm. There were no contractions. TAS is shown below. What is the best next step in management?

- A. Induction of labour with oxytocin
- B. Hospitalisation and expectant management
- C. Immediate LSCS
- D. Amniotomy



A Induction of labour with oxytocin

B Hospitalisation and expectant management

CORRECT

C Immediate LSCS

D Amniotomy

RIGHT ANSWER

OK B. Hospitalisation and expectant management

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$1e” here and does not include a written explanation for this item.

QUESTION

A woman presents to OPD at 36 weeks of gestation and presents with complaints of breathlessness and excessive abdominal distension. On examination, fetal movements are normal, fetal parts not easily felt and muffled fetal heartbeat is heard. Symphysis fundal height came out to be 41 weeks. Per abdomen examination reveals tense abdomen but not tender. What can be the most likely diagnosis?

A Abruptio placenta

B Hydrocephalus of fetus

C Polyhydramnios

CORRECT

D Rupture uterus

RIGHT ANSWER

OK C. Polyhydramnios

WHY THIS IS RIGHT

Polyhydramnios is diagnosed by ultrasound using:

Parameter	Value
Amniotic Fluid Index (AFI)	> 24 cm
Deepest vertical pocket	> 8 cm

Causes of Polyhydramnios

Maternal causes

- Gestational Diabetes Mellitus

Fetal causes

- Anencephaly
- Esophageal Atresia

Idiopathic

- Most common (~60%).

Complications

Maternal	Fetal
Breathlessness	Preterm birth
Preterm labor	Cord prolapse
Postpartum hemorrhage	Malpresentation

Excessive distension, SFH far ahead of dates, difficulty feeling fetal parts and muffled FHR are classic of polyhydramnios. Abdomen is tense but non-tender with no bleeding or pain suggestive of abruption. Hydrocephalus alone doesn't explain this degree of maternal breathlessness and distension.

*

QUESTION

During fetal heart rate monitoring, variable decelerations are noted on the CTG trace. What is the most likely cause or mechanism of this finding?

A Head compression

B Cord compression

CORRECT

C Fetal hypoxia

D Normal finding

RIGHT ANSWER

OK B. Cord compression

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$1f" here and does not include a written explanation for this item.

QUESTION

An NST shows 1 acceleration in 20 minutes with no decelerations. What is the next best step?

A Continue the NST till 40 minutes

CORRECT

B Emergency LSCS

C Biophysical profile

D Wait and watch

RIGHT ANSWER

OK A. Continue the NST till 40 minutes

WHY THIS IS RIGHT

Non Stress Test evaluates fetal well-being by monitoring fetal heart rate accelerations with fetal movements.

A reactive NST requires:

Criterion	Requirement
Accelerations	≥2 accelerations
Time	Within 20 minutes
Duration	≥15 seconds
Increase	≥15 bpm above baseline

2 accelerations in 20 minutes = reactive NST.

Sometimes the fetus is sleeping, which may reduce accelerations.

Therefore:

NST started

↓

Only 1 acceleration in 20 min

↓

Extend test to 40 minutes

↓

Reassess accelerations

Thus the correct next step is continue NST up to 40 minutes.

BPP is performed when: NST remains non-reactive after 40 minutes.

Parameter	Score
NST	2
Fetal breathing	2
Fetal movement	2
Fetal tone	2
Amniotic fluid	2

QUESTION

A woman at 26 weeks of gestation presents for routine evaluation. On examination, fundal height corresponds to 24 weeks. Ultrasonography revealed decreased amniotic fluid. Which of the following conditions would have led to this presentation?

A Renal agenesis

CORRECT

B Tracheosophageal fistula

C Cardiac abnormalities

D Ureteral stricture

RIGHT ANSWER

OK

A. Renal agenesis

WHY THIS IS RIGHT

Oligohydramnios- Amniotic fluid volume depends mainly on fetal urine production after mid-pregnancy. During early pregnancy: Amniotic fluid comes from maternal plasma diffusion

After 16-20 weeks:

Fetal kidneys produce urine

↓

Urine enters amniotic sac

↓

Maintains amniotic fluid volume

If fetal kidneys are absent -> no urine -> severe oligohydramnios.

Bilateral Renal Agenesis

Consequences include:

- Severe oligohydramnios
- Potter sequence

Features include:

| Feature | Cause |

| ----- | ----- |

| Pulmonary hypoplasia | Lack of amniotic fluid |

| Flattened face | Compression |

| Limb deformities | Reduced fetal movement |

Bilateral renal agenesis -> oligohydramnios -> Potter sequence.

QUESTION

A 30-year-old gravida 2 with previous LSCS develops suprapubic pain during contractions with maternal tachycardia and fetal bradycardia at 8 cm dilation. What is the most appropriate next step?

A Immediate cesarean section

CORRECT

B Forceps delivery

C Artificial rupture of membranes

D Wait and watch

RIGHT ANSWER

OK

A. Immediate cesarean section

WHY THIS IS RIGHT

These findings strongly suggest Uterine scar dehiscence (or uterine window), a life-threatening obstetric emergency. Uterine rupture occurs when the uterine wall tears partly, often at the previous cesarean scar.

This leads to:

- Massive hemorrhage
- Fetal hypoxia
- Maternal shock

Classic Clinical Signs

Sign	Explanation
Severe abdominal/suprapubic pain	Scar tearing
Maternal tachycardia	Blood loss
Fetal bradycardia	Fetal hypoxia
Loss of fetal station	Indicates complete rupture

Fetal bradycardia is the most common early sign of uterine dehiscence/ rupture.

Suspected uterine dehiscence

↓

Immediate resuscitation

↓

Emergency laparotomy

↓

Cesarean delivery

↓

Repair uterus or hysterectomy

The goal is rapid delivery to save the fetus and prevent maternal hemorrhage.

QUESTION

Which of the following conditions is least likely to be associated with fetal bradycardia?

- A Abruption
- B Fetal head compression
- C Congenital heart disease

D Maternal fever

CORRECT

RIGHT ANSWER

D. Maternal fever

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$20" here and does not include a written explanation for this item.

QUESTION

Which of the following conditions is least likely to be associated with fetal bradycardia?

- A Abruption
- B Fetal head compression
- C Congenital heart disease

D Maternal fever

CORRECT

RIGHT ANSWER

D. Maternal fever

WHY THIS IS RIGHT

The source quiz contains the placeholder “\$21” here and does not include a written explanation for this item.

QUESTION

The type of pelvis commonly associated with occipitoposterior and “face to pubis” is:

- A** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YFHFHZGD97K4MYWPV9D.jpg
- B** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YJPS9ZW34HE7EE899S5.jpg
- C** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YN6Z4B51AW9NZQV2RZ0.jpg CORRECT
- D** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YQDAXK3YBTF05FESCZX.jpg

RIGHT ANSWER

- OK** **C.** https://corebtr-assets-production.s3.ap-south-1.amazonaws.com/questions_image/option/01KM530YN6Z4B51AW9NZQV2RZ0.jpg

WHY THIS IS RIGHT

The anthropoid pelvis has a long anteroposterior diameter and narrow transverse diameter. This shape favors persistent occipitoposterior positioning and sometimes face-to-pubis delivery. The fetal head rotates posteriorly due to pelvic anatomy.

QUESTION

During labor, a fetus is found to be in face presentation. Which fetal skull diameter presents to the maternal pelvis in this position?

A Mento-bregmatic

B Submento-bregmatic

CORRECT

C Vertico-mental

D Suboccipito-bregmatic

RIGHT ANSWER

OK

B. Submento-bregmatic

WHY THIS IS RIGHT

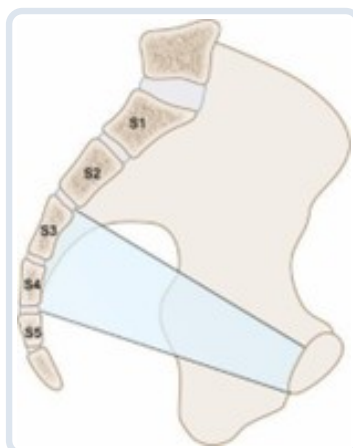
Face presentation is characterized by complete extension of the fetal head, and the presenting diameter is the submentobregmatic diameter, which measures 9.5 cm. This extends from: Submentum (junction of neck and chin) to Bregma (anterior fontanelle)

Diameter	Attitude of the head	Presentation
Suboccipitobregmatic 9.5 cm	Complete flexion	Vertex
Suboccipitofrontal		
10 cm	Incomplete flexion	Vertex
Occipitofrontal 11.5cm	Marked deflexion	Vertex
Mentovertical		
14 cm	Partial extension	Brow
Submentobregmatic 9.5 cm	Complete extension	Face
MC in Anencephaly |

While vertex presentation (complete flexion) has sub-occipitobregmatic (9.5 cm), and brow presentation (partial extension) has Mento-vertical (14 cm) diameter.

QUESTION

Identify the blue-colored area shown in the image.



A Obstetric outlet

B Anatomical outlet

C Pelvic inlet

D Mid-pelvis

CORRECT

RIGHT ANSWER

OK D. Mid-pelvis

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$22" here and does not include a written explanation for this item.

QUESTION

Shortest anterior posterior diameter of the pelvic inlet is represented by which of the following conjugates?

A Anatomical conjugate

B Diagonal conjugate

C Obstetric conjugate

CORRECT

D True conjugate

RIGHT ANSWER

OK C. Obstetric conjugate

WHY THIS IS RIGHT

The source quiz contains the placeholder "\$23" here and does not include a written explanation for this item.