1. Which of the following is correct regarding vaginal bleeding
    a) Hypothyroidism may be associated with heavy uterine bleeding
    b) Anovulatory uterine bleeding in adolescence is usually heavy and painful and often requires dilatation and curettage (D+C)
    c) The most common coagulopathy causing heavy uterine bleeds is immune thrombocytopaenia
    d) 10% of women taking the oral contraceptive pill will experience abnormal bleeding in the initial 4 to 6 months

2. Which is **not** a typical adverse effect of ovarian hyperstimulation syndrome
    a) Acute kidney injury
    b) Sagittal sinus thrombosis
    c) Massive uterine bleeding
    d) Ascites

3. Which is correct regarding ovarian torsion
    a) 70% of cases occur on the left side
    b) Nausea and vomiting are rare symptoms
    c) 30% of patients may have bilateral adnexal tenderness on bimanual examination
    d) A positive Doppler ultrasound for poor blood flow only has a 60% positive predictive value

4. Regarding ectopic pregnancies which is correct
    a) 80% occur in the isthmus of the fallopian tube
    b) No missed menses are reported in 15% of ectopic pregnancies
    c) Heterotopic pregnancies occur in 1:3,000 pregnancies for naturally conceived
    d) B-hcG can remain positive up to 1 week after surgery for ectopic pregnancy

5. Which is the typically quoted discrimination zone for identifying a viable intra-uterine pregnancy on transvaginal ultrasound
    a) BhcG > 500 mIU/mL
    b) BhcG > 1,500
    c) BhcG > 4,000
    d) BhcG > 6,000

6. When can Anti-D not be offered in first trimester in a Rh –ve woman
    a) Complete miscarriage
    b) Termination of pregnancy medically
    c) Ectopic pregnancy
    d) Threatened Miscarriage

7. Regarding PV bleeding before 3rd trimester which is **incorrect**
    a) Spontaneous miscarriage occurs in 20 to 40% of pregnancies
    b) 75% of miscarriages occur before 8 weeks gestation
    c) Hyperemesis is more common in Gestational Trophoblastic disease (molar pregnancies) than PV bleeding
    d) Pregnancy induced hypertension before 24 weeks gestation are associated with Gestational Trophoblastic disease (molar pregnancies)

8. In the pregnant woman which change in comorbidity disorder is correct
    a) Women with type I diabetes have a 3 to 5 times higher risk of hypoglycaemic episodes compared to prior to pregnancy
    b) DKA is very common in diet controlled gestational diabetes
    c) Transient hyperthyroidism of hyperemesis gravidarum can have a goiter and be positive for thyroid antibodies
    d) In women with known type I diabetes who later get pregnant, DKA most commonly affect them in the first trimester

9. Regarding thromboembolism in pregnancy which is correct
    a) Pregnancy up to and including 3rd trimester increases risk of DVT and PE Sixty-fold
    b) Highest daily risk of thromboembolism is during the post-partum period
    c) Right sided leg DVTs are more common than left (approximately 90% of cases)
    d) Isolated iliac vein thrombosis is less common in pregnancy compared to general population

10. Which radiological investigation has a higher radiation exposure to the foetus (in mGy or mSv or x0.1 rads) than normal background radiation over 9 months
    a) VQ (ventilation – perfusion scan)
    b) Head CT
    c) AP Pelvis xray
    d) Chest CT or CTPA

11. Which parameter is absolutely required for diagnosis of preeclampsia
    a) Systolic BP ≥ 140 mmHg
    b) Diastolic BP ≥ 90 mmHg
    c) Proteinuria
    d) > 20 weeks gestation

12. Regarding “MAGPIE TRIAL” Magnesium v placebo in the treatment of preeclampsia & eclampsia
    a) Magnesium does not help prevent eclampsia if given to women with preeclampsia
    b) There was a statistically significant reduction in maternal mortality at discharge in the Magnesium group compared to placebo
    c) Magnesium did not appear to have substantive harmful effects on mother or baby in the short term
    d) There was a statistically significant greater risk of baby dying in the placebo group compared to Magnesium group

13. Regarding Abruptio placentae which is correct
    a) Hypertension is not a risk factor for placental abruption
    b) Ultrasound is more useful than CTG in identifying abruption diagnosis and risk of adverse outcomes from it
    c) Majority of Abruptio placentae cases have heavy PV bleeding
    d) Spontaneous abruption is highest between 24 and 28 weeks gestation

14. Regarding pre-term birth which is true
    a) Steroids should be given routinely before 38 weeks gestation
    b) If at risk of group B Strep infection post premature rupture of membranes, amoxicillin-clavulanate should be the first choice antibiotic
    c) Do not clamp the umbilical cord of preterm infants for at least 1 to 3 minutes after birth
    d) Tocolysis should routinely be given if there is premature rupture of membranes

15. Which is **not** a typical risk factor of post-partum hemorrhage in the first 24 hours
    a) Primiparity
    b) Fetal birth weight > 3.5g
    c) Grand multiparity
    d) Labor augmentation

16. Which of the following indicates fetal distress during labor
    a) Little variability in fetal heart tracing
    b) Fetal heart rate of 120
    c) Brief Decelerations in fetal heart rate only during contraction
    d) Brief Accelerations in fetal heart rate

17. What is the most common first step in a birth complicated by shoulder dystocia
    a) Apply suprapubic pressure
    b) Mother to flex thighs and keep knees apart

c) Move mother to all fours position
d) Episiotomy

18. Which variability in fetal presentation during delivery is considered safe to proceed without urgent C.Section
    a) Frank breech position
    b) Footling breech position
    c) Umbilical cord prolapse
    d) Transverse lie position

19. Regarding Vaginitis which of the following is **not** true
    a) Trichomonas vaginalis is the most common non-viral STI
    b) Bacterial vaginitis is usually polymicrobial
    c) Vaginitis increases likelihood of HIV acquisition and spread
    d) Candida vaginitis is the most common cause of infectious vaginitis

20. Which is **not** true of pelvic inflammatory disease
    a) IUD insitu increases risk for PID
    b) Pregnancy increases risk for PID
    c) Ectopic pregnancy risk increases in women who have PID
    d) Silent PID is associated with infertility

21. Which is a **not** clinical sign of a prolactinoma
    a) Homonymous hemianopia
    b) Galactorrhea
    c) Infertility
    d) Osteopenia

22. Which is a feature of "critical" or life threatening Ovarian Hyperstimulation syndrome
    a) Presence of ascites
    b) Hypoalbuminemia
    c) WCC > 25
    d) Very enlarged ovary

Answers

1. A (Anovulatory uterine bleeding in adolescence is usually minimal and painless and D&C are rarely required, the most common coagulopathy causing uterine bleeding is von Willebrand's,

40% of women receiving OCP will have abnormal bleeding in the initial 4-6 months. Tintinalli 8th edition)

2. C (Iatrogenic condition in women undergoing ovulation induction, exaggerated response to FSH and HCG, severe form massive transudation of albumin and fluid out of vascular compartment, can cause: thromboembolisms, renal impairment, hyperkalaemia, pulmonary effusions, ascites, hypovolaemic shock. Ovarian Hyperstimulation Syndrome DUNN RJ emergencymedicinemanual.com 2016)
3. C (50 to 70% of cases occur on the right side, risk factors include pregnancy, ovarian hyperstimulation syndrome and large ovarian cysts. N+V present in 70% of cases, up to 60% of cases can be missed on arterial Doppler alone but a positive Doppler has 100% positive predictive value. Tintinalli 8th edition)
4. B (80% occur in the ampulla of fallopian tube with 10% in the isthmus, BhcG can remain elevated for 2-3 weeks after surgery for ectopic, heterotopic pregnancies occur 1:30,000 in naturally conceived and 1:100 to 3:100 in assisted reproduction and overall is 1:3,000. Heterotopic pregnancy radiopedia.org AND Ectopic pregnancy DUNN RJ emergencymedicinemanual.com 2016)
5. B
6. D (Indications for Anti-D: miscarriage, Chorionic Villus Sampling, termination of pregnancy medically or surgically, ectopic pregnancy. No evidence for threatened miscarriage before 12 weeks gestation. RANZCOG Guidelines for the use of RhD Immunoglobulin Anti-D in obstetrics in Australia reviewed Nov 2015 section 4.2 product use)
7. C (Molar pregnancy: vaginal bleeding in 75% to 95% of cases and hyperemesis in 26% of cases)
8. A (DKA rarely develops in gestational diet controlled diabetes, Transient hyperthyroidism of hyperemesis gravidarum have no palpable goiter and no thyroid antibodies, DKA commonly affects type I diabetics in 2nd and 3rd trimester or newly diagnosed type I DM who are pregnant. Tintinalli 8th edition)
9. B (Pregnancy increases thromboembolism risk five-fold and in 3 months post-partum period risk of thromboembolism increases by sixty-fold, left sided DVTs are higher proportioned at 90% due to the crossing right iliac artery over the left iliac vein, isolated iliac vein thrombus is more common in pregnancy)
10. A (Foetus exposure to normal background radiation over 9 months is 1 mSv or 0.1 rads. Radiation dose in mSv: CXR <0.001 mSv, Chest CT or CTPA = 0.2, AP pelvis xray = 0.4, head CT < 0.5, abdo xray series = 2, VQ scan = 2.1, Lumbosacral spine = 1.6-3.5, CTKUB = 10, Abdo CT = 25-35, safe in pregnancy = 50, threshold for teratogenesis = 100 mSv)
11. D (Definition of pre-eclampsia: gestation >20 weeks, SBP ≥ 140 OR DBP ≥ 90, AND the coexistence of one or more: proteinuria, maternal organ dysfunction, uteroplacental dysfunction. Note: Tintinalli states that proteinuria must be part of diagnosis but maternal organ dysfunction is not necessary for diagnosis, DUNN however states that proteinuria is part of the diagnosis and at least one maternal organ dysfunction. The International Society for the Study of Hypertension in Pregnancy [ISSHP] 2014 defined pre-eclampsia: Hypertension developing after 20 weeks gestation and coexistence of one or more of proteinuria, maternal organ dysfunction, uteroplacental dysfunction. Paper found in ranzcog.edu.au College statements & Guidelines)
12. C (Magpie trial showed: 58% reduced risk of eclampsia if pre-eclampsia women were given Mg, no statistically significant reduction in maternal or child mortalities and no substantive harmful

effects of Mg on mother or baby in the short term. The Magpie Trial Lancet Volume 359, No 9321, pg1877-1890, 1 June 2002)

13. D (HT is the commonest risk factor for abruption [45%], CTG has 100% negative predictive value for adverse outcomes whilst ultrasound has high specificity but poor sensitivity, PV bleeding is common [80%] but often mild. Tintinalli 8th edition AND Abruptio placentae DUNN RJ emergencymedicinemanual.com 2016)
14. C (Delayed cord clamping increases neonatal iron stores, steroids are not administered after 34 weeks, augmentin should be avoided in PROM as it is associated with necrotizing enterocolitis instead first line is penicillin G or ampicillin or cefazolin, tocolysis is relatively contraindicated in pre-term PROM)
15. B (Fetal birth weight >4.5g, other risk factors: preeclampsia, prolonged 3rd stage labor, fetal age <32 weeks, placental previa, transverse fetal lie, cervical trauma, previous PPH, coagulopathy)
16. A (Normal birth should have good variability of fetal heart rate between 120 to 160, bradycardia is defined as <110, brief accelerations can be normal, Late decelerations in fetal heart rate indicates fetal distress: persistent drops in fetal heart rate both during and more than 30s after a contraction, poor variability of fetal heart tracing may be due to fetal hypoxia)
17. B (McRoberts maneuver = flex thighs and keep knees apart, Suprapubic pressure next in McRoberts position, move patient to all fours = Gaskin maneuver, internal manual manipulation and rotation of fetus to oblique position = Corkscrew maneuver + episiotomy last)
18. A (Frank and complete breech where buttocks present first can proceed to normal vaginal birth)
19. D (Bacterial vaginitis accounts for up to 50% of cases in symptomatic women)
20. B (Pregnancy decreases risk for PID)
21. A (Pituitary tumour causes bitemporal hemianopia, others: amenorrhea, dyspareunia, headache, hypothyroid, in men hypogonadism)
22. C (Features of critical OHSS: Tense ascites, large hydrothorax, Hct > 0.55, WCC > 25, anuria, thromboembolism, ARDS. Ovarian size may not correlate with severity of OHSS. Guideline from royal college of OG in UK.
https://www.rcog.org.uk/globalassets/documents/guidelines/green-top-guidelines/gtg_5_ohss.pdf)