Gynecology Mini OSCE

تنويه مهم

- هذا التجميع يحتوي على جميع سنوات امتحانات النسائية (الميني أوسكي) في الجامعة الهاشمية لكل من السنة الخامسة والسادسة, موزعين حسب المواضيع.

- نود التنبيه على أن هذه الأسئلة واجاباتها هي تجميع طلاب وقد تحتمل الصواب والخطأ, تم محاولة تدقيق جميع الأسئلة قدر الامكان لكن من الممكن وجود بعض الأخطاء المتبقية.
- في حال اكتشاف خطأ في إجابة أي سؤال يرجى التواصل مع أحد أعضاء الفريق الأكاديمي في دفعتك ليقوم بإيصال الملاحظة لنا وتعديلها.

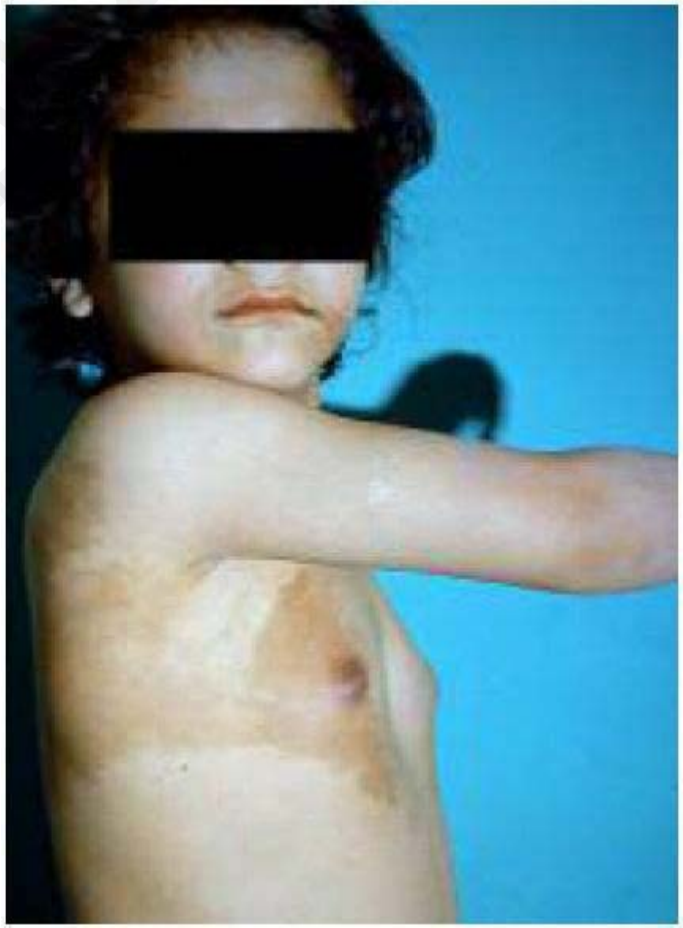
- شكر جزيل لكل من ساهم في جمع هذه الأسئلة, لم يكن ليتم هذا العمل لولاكم, وشكر خاص للزميل **يزن علاونة** من دفعة إحسان على جهوده الكبيرة في جمع وتنسيق هذا الملف.

Puberty

Q1: 8 y/o, her mother is complaining that her baby girl is showing early signs of puberty:

1. Define Precocious Puberty?

- onset of pubertal development before the age 8 in girls & 9 in boys



2. Classification/Types with examples?

A. *Central, gonadotrophin dependent, or true PP*:
e.g. brain tumors, or CNS malformation, 75% idiopathic

B. *Peripheral precocious puberty, Pseudopuberty*:
e.g. hormone producing ovarian tumors, exogenous estrogen administration, McCune Albright
Note: Central is the majority (80%!), & peripheral is always pathological

3. Investigations to do?

- FSH/LH (high in central, low in peripheral)
- Brain imaging
- Pelvic and abdominal imaging

4. How will you manage and why?

- Surgical resection if it's a lesion
- GnRH analogues to suppress pubertal development.
- cause: to slow down the growth velocity and avoid early skeletal maturation. Furthermore, early development of sexual characteristic is distressing to a young girl.

5. If patient have brown lesions on her skin and bone abnormalities, what syndrome you may consider?

McCune Albright Syndrome (Polyostotic fibrous dysplasia, Café au lait, & precocious puberty)

Q2: 15 y/o brought by her mother who is concerned that her daughter has not menstruated yet, she is an athlete:

1. What physical findings you search for?

- Stature, BMI, Breast development, Hair (Pubic and axillary), Inguinal masses, hirsutism, virilization

2. What investigations you would order?

- Peripheral blood karyotyping: to differentiate syndromes
- Pelvic US/MRI: to R/O pelvic tumors
- FSH/LH: to differentiate between central and peripheral causes
- Estradiol level: related to breast development and ovarian function

3. What is your management for Turner?

- GH and HRT
- Induction of Puberty
-(childbearing possible with ovum donation

4. What is the DDx if:

A: High FSH: Turner's, POF (so if no breast, and high FSH, *do karyotyping*!)

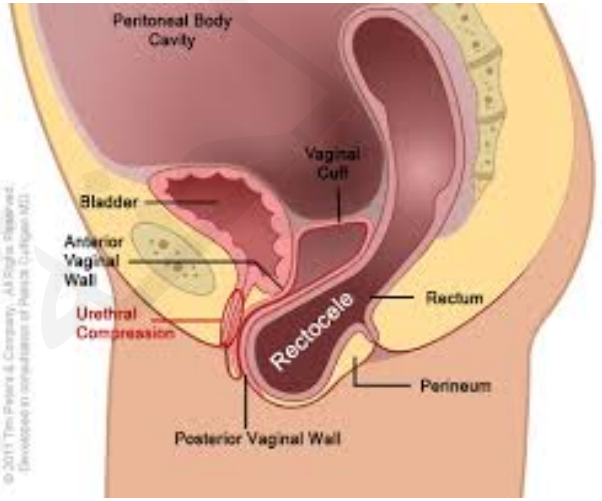
B: Low FSH: Central causes: hypogonadotropic hypogonadism or constitutional

C: Normal FSH: Mullerian agenesis, anatomical outflow obstruction, MRKH

D: Normal breast, and FSH 86 (High): Premature ovarian failure, CAIS

UTI & Prolapse

Q3:



1. What is your Dx?

- Rectocele

2. Prolapse is best assessed when?

- Under general anesthesia

3. Name four risk factors?

- Parity (strongest RF)
- Maximum birth weight
- Age, menopause
- Constipation, straining
- Heavy lifting
- Obesity
- Previous pelvic surgeries

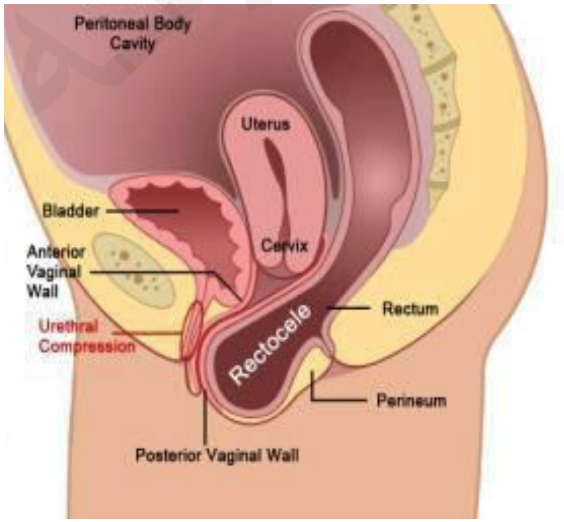
4. Name four symptoms?

- Incomplete bowel empty
- Obstructed defecation
- Constipation
- Fecal incontinence
- Inability to empty the rectum without reducing the prolapse.

Q4: 55 years old patient presented to the clinic with the presentation shown in the picture:

1. Dx?

- Posterior vaginal wall prolapse (rectocele)



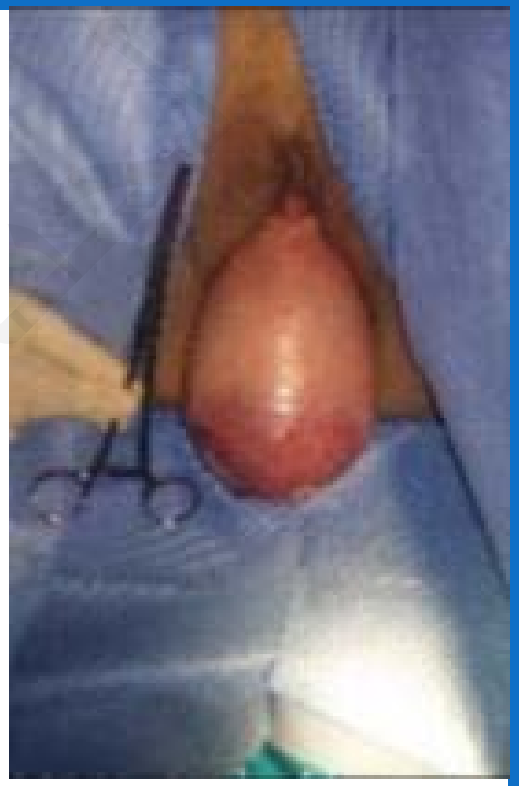
2. Mention 4 risk factors?

1. straining and constipation
2. heavy lifting
3. increasing parity and maximum birth weight
4. chronic pulmonary Disease

3. Other Symptoms the pt may present by?

1. fecal incontinence
2. incomplete bowel emptying
3. constipation
4. obstructed defecation

Q5:



1. Mention 3 RF?

- Multiparity, Menopause, Pelvic surgeries

2. Mention the structures supporting the uterus?

1) Uterosacral, Cardinal ligaments
2) Arcus Tendineus
3) Perineal body and membranes

for vagina.

3. The patient had a recent stroke and she is not fit for surgery, what are the non-surgical Mx that are possible for her (mention 2)?

- Pelvic floor exercise (physiotherapy), Pessaries

4. When the patient becomes fit for surgery .what are the possible surgeries (mention 2)?

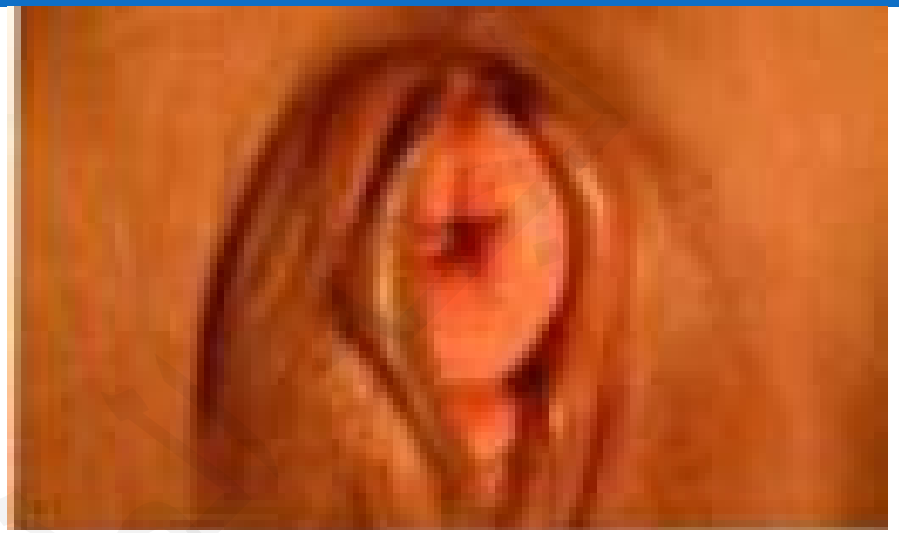
1) Vaginal hysterectomy with anterior and posterior repair
2) Trans-vaginal tape (TVT), Trans-obturator tape (TOT)

para vaginal repair / hysteropexy.

Q6:

1.Mention 4 RF?

1. Straining and constipation
2. Heavy lifting
3. Chronic pulmonary Disease
4. Collagen abnormalities
5. Parity, age and menopause



2. What can you do if the patient isn't fit for surgery?

1. Pelvic floor exercise (Kegel's)
2. Physiotherapy
3. Pessary

3. What are the type of surgeries?

- Vaginal
- Abdominal
- Laparoscopic

Classification of prolapse surgery

Vaginal	Abdominal	Laparoscopic
Primary Vaginal hysterectomy Anterior/Posterior repair Secondary Sacrospinous fixation Iliococcygeus fixation Uterosacral fixation Recurrent+/- reinforcement Synthetic mesh/autologous/ donor/Xenograft	Primary Paravaginal repair Hysteropexy Secondary +- reinforcement Sacrocolpopexy Uterosacral/Sacrospinous fixation	All of the Abdominal procedures +/- reinforcement

Q7:

-1	0	-5
4	3	9
+1	+4	-8

1. What does number 4, 3, 9, -1 stand for?

4: Genital Hiatus

3: Perineal Body

9: Total vaginal length

-1: Point A on the anterior vaginal wall

2. What is your Dx?

- Grade 2 Cystocele
- Grade 1 Uterine Prolapse
- Grade 3 Rectocele

POP-Q System

Aa "point A on the anterior wall" 3 cm above the hymen	**Ba** "point B on the anterior wall" 6 cm above the hymen	**C** "Cervix" normally: 7 cm above the hymen ring
gh "Genital hiatus" - normally: 3 – 4.5 - <3 narrow vagina - >4.5 wide vagina	**Pb** "Perineal Body" - normally: 2 – 3.5 - <2 deficient perineum	**Tvl** "Total vaginal length" - normally: 8 – 10 - <8 short - >10 long
Ap "point B on the posterior wall	**Bp** "point B on the posterior wall"	**D** "Posterior fornix"

For anterior wall prolapse: check Aa, Ba
For posterior wall prolapse: Check Ap, Bp
For uterine prolapse: C value

For anterior/posterior wall:
1st degree: (-3) – (-1)
2nd degree: (-1) – (+1)
3rd degree: > (+1)
For uterine prolapse: 1st degree (-6) – (-1),
2nd and 3rd degree's are the same

Q8: Patient X is 65-year-old lady. She presented to the clinic c/o leaking urine when she coughs and sneezes. She cannot always make it to the toilet when she needs to void. In addition she mentioned that she voids 10 times during a day and must rise at least twice at night to void. Her symptoms started 2 months ago.

1. What is your clinical diagnosis?

- Mixed urinary incontinence

2. What investigations will you request?

- Bladder diary
- Urine analysis
- Urine culture
- Urodynamic study
- Spermicides

3. What are the treatment options you would discuss with the lady?

-Fluid manipulation, pelvic floor muscle training, bladder training, antimuscarinics, surgery

4. Define urgency

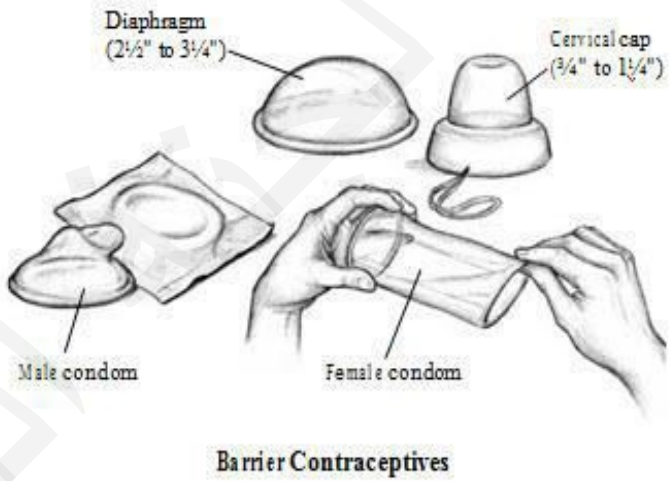
Sudden and compelling desire to pass urine, which is difficult to defer

Contraception

Q9:

1. What Is this contraceptive method?

- Barrier method of Contraceptives



Barrier Contraceptives

2. Give Examples of this type:

- Female condoms
- Male condoms
- Occlusive caps
- Vaginal sponges
- Spermicides

3. Advantages & Disadvantages?

Advantages	Disadvantages
- Widely available - Condoms protect from STI - No systemic SE - No effect on lactation - Decrease risk of cervical malignancy	- High FR - Not acceptable in some relationships - Diaphragms require fitting at clinics - Diaphragm size need to be change according to weight change

4. Explain the FR (Failure Rate)

4 - 20 !

- FR of condoms depends on the way of use, correct insertion, use at right time, shouldn't be used with oil-based creams (use water based creams)

Q10: 23 y/o lactating asking about OCPs, she is 18 d postpartum

1. What are the types of OCPs:

- Monophasic (fixed dose): Estrogen + Progesteron
- Variable dose (Phasic)

2. what type you would prescribe for her? Why? And how would you teach her how to use it?

- We give her Progesterone only pills, because other types suppress lactation, she takes 21 tablets (1st 7 to inhibit ovulation which are the most important ones & 14 to maintain anovulation, the remaining 7 days of the month are PFI, also warn her of major SE, and recommend her to wear a condom for STI protection

take a pill every day at the same time, without pill free interval

3. Mention non-contraceptive benefits of OCPs?

- Decrease Menstrual disorders
- Decrease Benign ovarian tumors, and functional ovarian cysts
- Decrease Benign breast disease
- Decrease PID
- Decrease endometrial and ovarian and colon cancer
- Protective against RA, thyroid disease and duodenal ulcer

4. What is the most feared SE by new bills users?

- VTE

Q11: 69-year-old lady takes HRT pills:

1. Name 3 advantages and 3 SE?

Advantages	Side Effects
- Improve Vasomotor Sx - Reduce risk of osteoporosis - Reduce risk of urogenital Sx and improve sexuality - Reduce risk of colorectal cancer	- More risk of breast and endometrial cancer - More risk of VTE - More risk of gallbladder disease

↓ mood or sleep disturbances

2. Describe the relation between HRT and endometrial Carcinoma?

- while estrogen only pills do increase the risk of endometrial cancer the estrogen and progesterone pills don't, because of the protective effect of the progesterone

3. If Hysterectomy was done in this patient, what is the drug of choice for her?

- Estrogen only

Q12: A women less than 40, nonsmoker, no chronic medical illnesses, she complains of HMB (heavy menstrual bleeding), and she ask you for a contraceptive method with long duration (>5y)

1. Mention 3 long duration methods for this patient?

- Hormonal: Mirena, Progesterone injections, implants
- Non-hormonal: Cupper IUD

2. What is your 1st choice and why?

- Mirena, because it works on both HMB and Contraception, and easily reversible with very low failure rate

3. Mention four risk factors for this choice?

- Expulsion, Perforation, PID, Vasovagal syncope, Ectopic pregnancy, Pregnancy (if failed), Lost thread

Q13:

1. Name the two methods?

A. IUCD-Cu

B. IUS Mirena

2. When to insert it for:

a. Menstruating lady: after the end of menses (day 5-6)

b. After C/S: after 4-6 weeks

3. When to tell the lady to come back for follow up?

4-6 weeks after insertion

4. How would you follow up (2 points)?

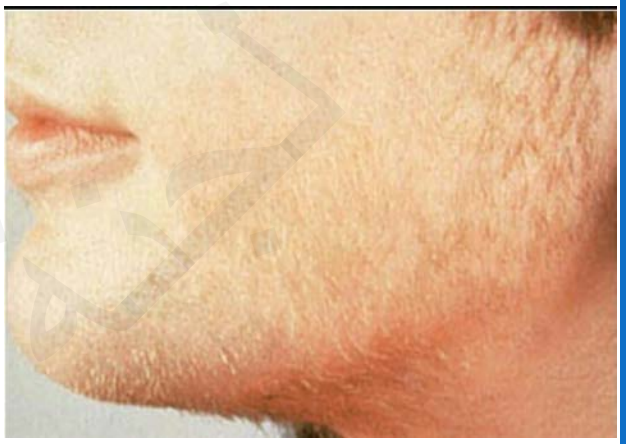
- Check if the lady has any problems since its insertion "pregnancy, perforation, expulsion, missed thread", if it was expulsed after menses then check the thread by speculum , if not seen then do US … if not seen also :do abdominal x-ray for copper , CT for Mirena.

5. Mention 1 contraindication?

- Breast Ca
- Undiagnosed vaginal bleeding
- Pelvic TB

Infertility

Q14:



1. Diagnosis Criteria of PCOS:

requires 2 of the following + exclude other causes

- Oligo/Anovulation
- Hyperandrogenemia/Hyperandrogenism
- PCO on US >12 follicle in each ovary or
  increase ovarian volume >10ml

2. Write the WHO Criteria for ovulation disorders with examples?

Group I: hypothalamic pituitary failure: Stress (by diet and exercise)
Group II: hypothalamic-pituitary-ovarian dysfunction: PCOS
Group III: ovarian failure.

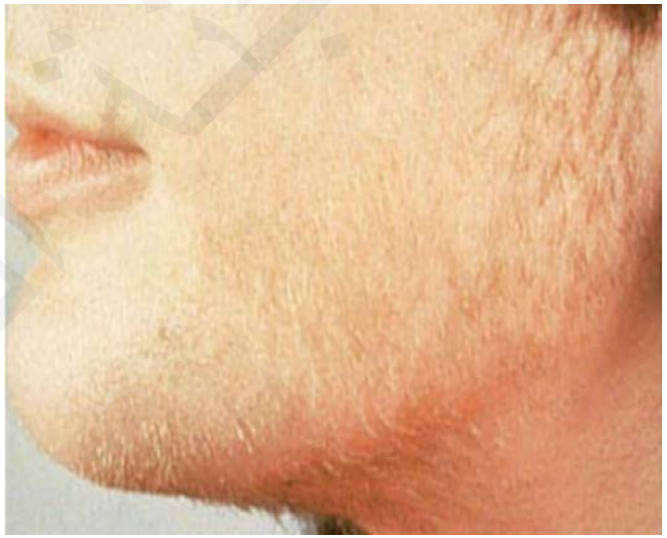
3. PCOS Treatment?

-Treat obesity

-Ovulation induction: by this chronological order:

1) Wt. reduction and lifestyle changes to reach optimal BMI (19-30)
2) Metformin: 8% rate of success.
3) Clomiphene: 6 consecutive cycles with 75% ovulation rate.
4) Letrozole aromatase inhibitor.
5) Either FSH&LH injections or LOD with preference of the latter.
6) IVF as a last resort

Q15:Huda, a 28 y/o obese lady , she complained of irregular menstrual bleeding .



1.What is shown in the pic?

- Hirsutism

2.Most likely Dx?

- PCOS

3. 3 Investigations for infertility?

- Testosterone concentration
- FSH & Estradiol
- TSH

4. 3 advices for fertility (to Induce Ovulation)?

1) Wt. reduction
2) Metformin
3) Clomiphene
4) Letrozole aromatase inhibitor.
5) FSH & LH injections or LOD
6) IVF as a last resort.

5. Mention2 causes of Hirsutism?

1) PCOS
2) Ovarian tumors (sertoli leydig tumor)

6. if medical Mx failed, mention 2 other options?

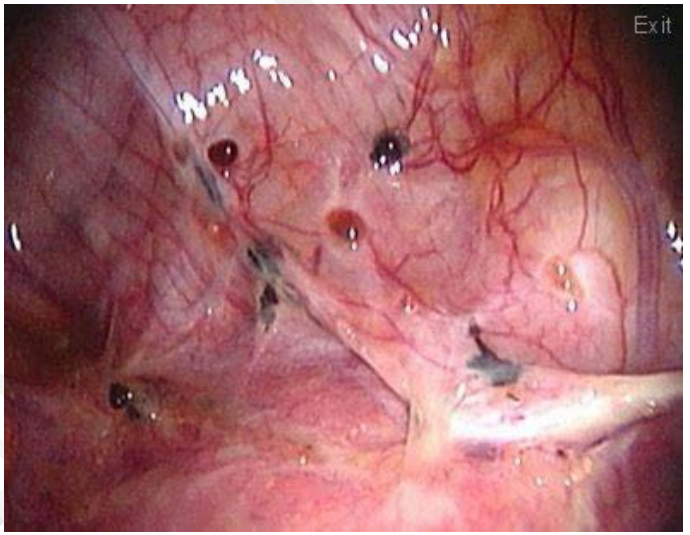
- Laparoscopic ovarian drilling (LOD)
- IVF

7. On physical examination give 2 signs you will look for?

1) Acne and signs of verilization
2) Acanthosis nigricans

(3) pelvic exam.

Q16: 24 y/o married female, Go, presents to your clinic with chronic pain for 3 years, according to the image below, answer the following questions:



1. What is your Dx?

- Endometriosis

2. Give other causes of pelvic pain?

- PID
- Adenomyosis
- Pelvic adhesions

3.Mention different approaches to Mx this patient?

1) Conservative: simple analgesia, patient support groups

2) Medical: COCP, Progestogen, GnRH agonist, aim is to produce atrophy of ectopic endometrium

3) Surgical

4. Name the types of surgeries you may do for her?

1) Laparoscopic ablation (Laser or bipolar) and excision

2) TAH + BSO

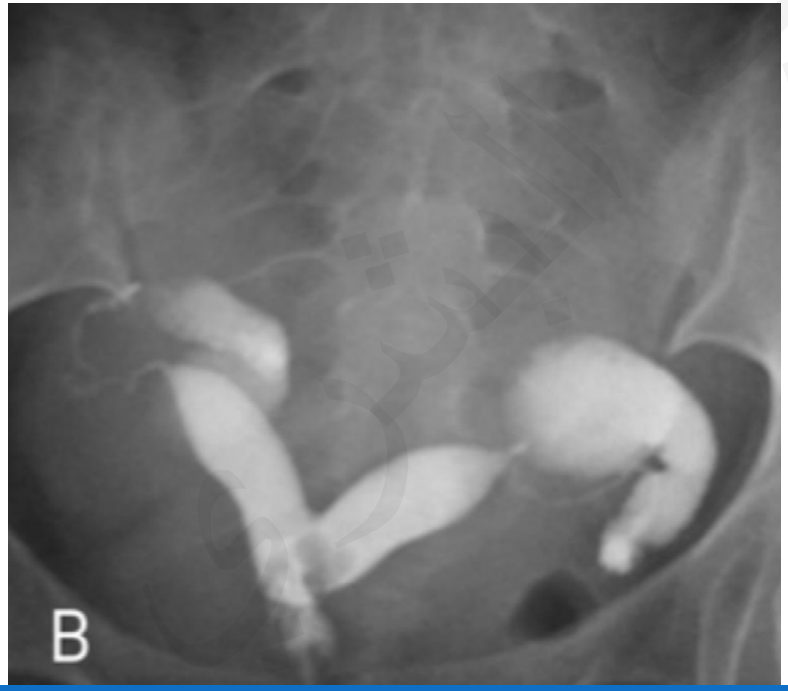
Q17:

1. Mention two abnormalities?

- Bicornuate uterus
- Distal obstruction of both tubes with dilatation (Hydrosalpinges, some said only the left tube)

2. Mention two other investigations to use?

- Laproscopy
- Hysteroscopy
- Hysterosalpingo-contrast sonography (Hy-Co-Sy)



3. if pregnancy occured naturally, mention two complications that might occur?

- Miscarriage (50%)
- Pre-term delivery
- ~~IUGR~~
- Malpresentation

+0 for bicornuate uterus

4. How you would know that the patient has ovulated (two points)?

1) Serum progesterone in mid luteal phase of the cycle
2) Serum FSH-LH on day 2-3

5. How you can treat this patient (two points)?

- Laproscopic Salpingectomy or disconnection of both tubes
- then IVF or ICSI

Q18:

1. Name of this procedure?

- Hysterosalpingogram

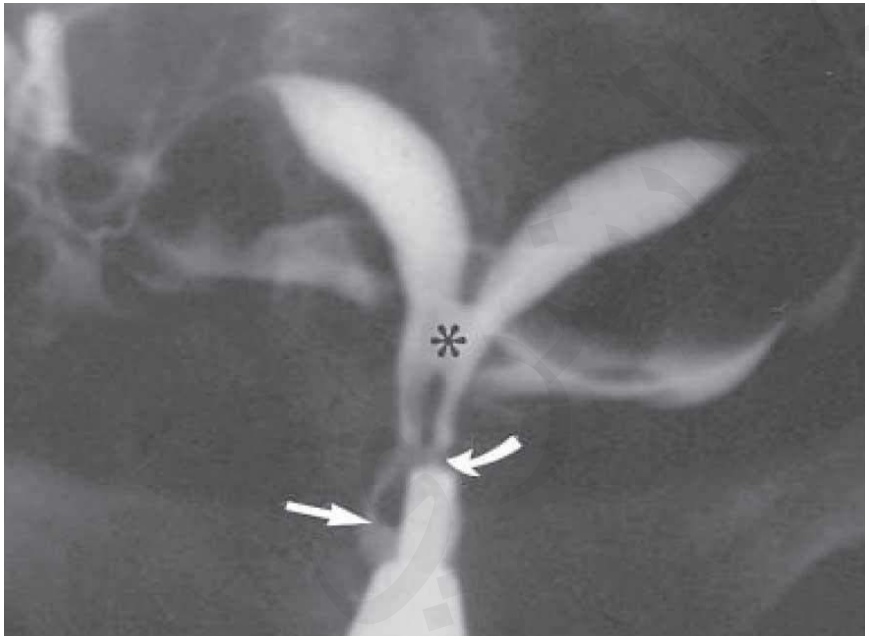
2. What is the indication for use?

- Tubal patency test, and the shape of uterine cavity

3.Mention the abnormality?

- Bicornuate uterus

Uterine Septum.



4.What advice you give the couple in order to conceive?

- Stop smoking
- Semen analysis workup
- IVF

① have a regular unprotected intercourse (at least twice a week)
② stop smoking

5. mention the normal levels of the three primary parameters for sperm analysis (semen analysis)?

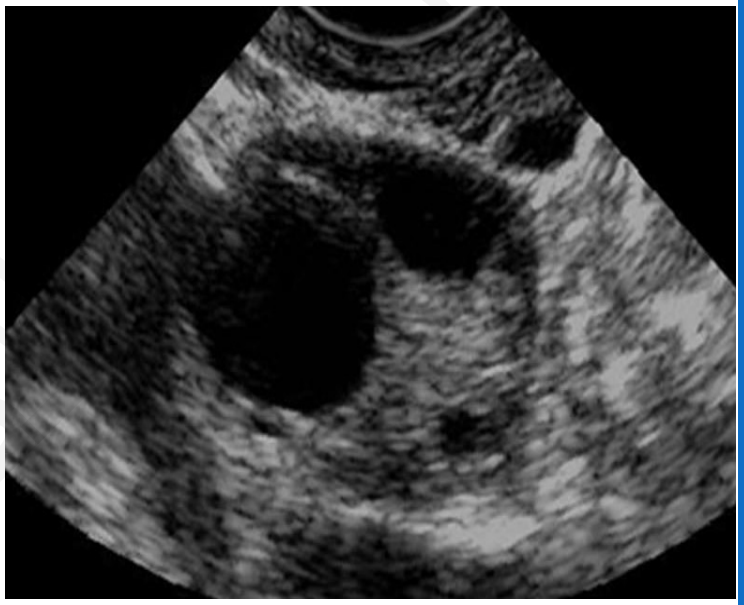
- Concentration: >15 million
- Motility: >40%
- Morphology: >4%

6. According to group 2 WHO disorders, what are the non surgical Mx for ovulation induction? Group 2 is PCOS

- Reduce weight
- GnRH administration
- Clomiphene Citrate/Metformin

Oncology & Masses

Q19: 50 y/o Pt complains of Rt lower abd pain, you did US



1.Suppose this is a malignant tumor what signs you would see on US?

Benign	Malignant
• Unilateral • Unilocular • Thin wall • No papillae • No solid areas	• Bilateral • Multilocular • Thick wall • present Papillae • Mixed echogenicity (due to solid areas) • Greater vascularity (angiogenesis and blood flow)

2.Most common ovarian malignancy?

- Dysgerminoma

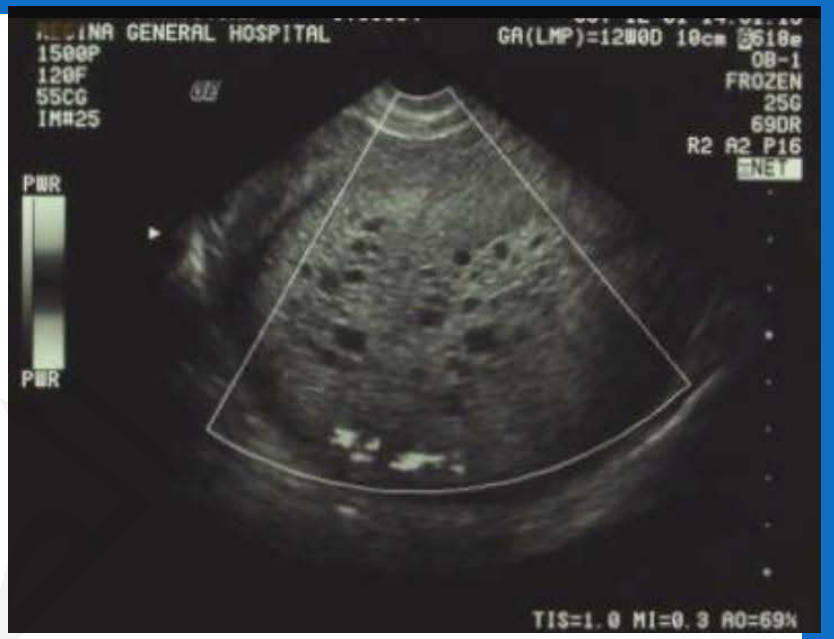
3. possible complications of ovarian cysts?

- Rupture
- Torsion
- Hemorrhage
- Infection

4. Mention 4 types of germ cell tumors of the ovaries:

- Dysgerminoma
- Endodermal Sinus T
- Choriocarcinoma
- Gonadoblastoma
- Teratomas

Q20: 26 y/o complains of vaginal bleeding one week after vaginal delivery:



1. What is your Dx?

- Partial Hydatiform Molar pregnancy

2. Mention 4 points to ask in the Hx?

1) Recurrent vomiting
2) Hyperthyroidism Sx
3) Vaginal Passage of Vesicle
4) Pelvic pain

3. What investigation you should do to confirm your Dx?

- B-HCG
- Histological examination of the tissue

4. Mention 4 findings in PE?

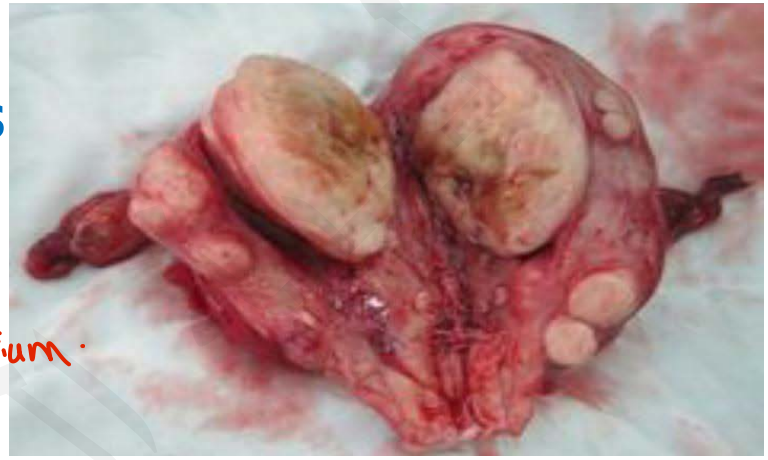
1) Gravid uterus
2) Signs of hyperthyroidism
3) Signs of anemia
4) Blood pressure

- Large fundus = ↑ BP

5. What is your Mx?

- Surgical Evacuation by Suction and Curettage

Q21 : 47 y/o lady complains of painful vaginal bleeding, and hysterectomy was done before one week, for that reason:



1. What is your Dx?

- Multiple Uterine Fibroid

① stretching of endometrium.
② ↑ blood flow

2. How does it cause AUB?

1) Increase surface area
2) Increase in blood flow
3) Increase in muscle contraction
4) Endometrial Hyperplasia
(due to increase in estrogen level)

③ interfer with uterin contractionc
④ endo metrial hyperplasia

3. How does it cause infertility?

1) Decrease in implantation
2) Decrease in Tubal motility
3) Blockage of the fallopian tubes
4) Changes the shape of the cervix

4. Mention other option than hysterectomy for Mx?

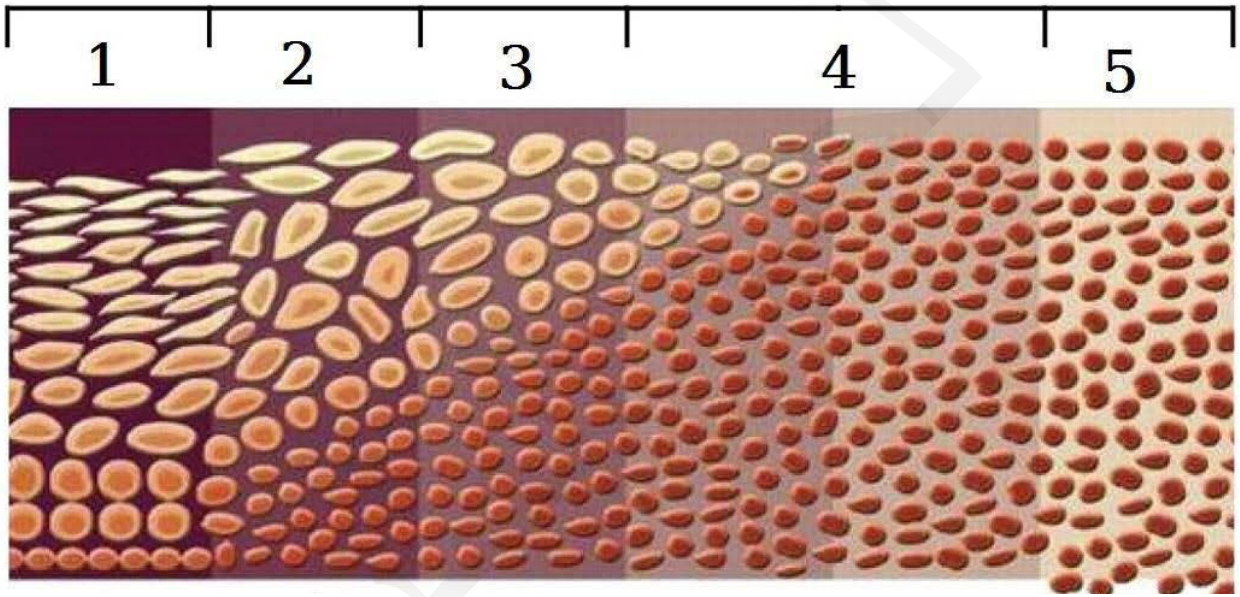
1) Mirena IUS
2) GnRH Analogues
3) Myomectomy
4) Observe till menopause, the fibroids will shrink alone

5. Mention Fibroids RF?

1) Nulliparus
2) Estrogen producing tumors
3) Obesity

early menarch

Q22:



1. Name of the test?

- Pap Smear

2. Indication?

- Screening tool for pre-malignant cervical changes

3. At what age do we start doing it, and at what age do we stop?

- **Start:** start at 21 years, or after the first sexual contact
- **Stop:** stop at 65 years if all tests were (-) for the last 10 years

4. What are the numbers 1 – 5?

1: Normal
2: Mild Dysplasia or CIN (1)
3: Moderate Dysplasia or CIN (2)
4: Severe Dysplasia of CIN (3)
5: Invasive Carcinoma

Obstetrics

Metabolic Diseases (HTN, DM)

Q23: Pregnant 28 weeks, having BP 140/90:

1. Mention 3 RF of PET?

- FHx
- 1st pregnancy (null parity)
- Extremes of maternal age
- Obesity
- Medical (DM, renal disease, pre-existing HTN)
- Obstetric factors (multiple pregnancy, PET Hx, triploidy)

2. What is your Mx?

follow up after 1-2 weeks

This is mild hypertension. Mild hypertension doesn't require medical therapy and only lifestyle modifications + regular follow ups. Medical management starts at severe hypertension (systolic 160 or higher, diastolic 110 or higher). If you want to give medical management, it would be as follows:

- Methyldopa, slow release nifidipine, labetalol
- AVOID: Diuretics, atenolol, ACEI, ARBS

3. Give 3 investigations?

- Renal function test
- Liver function test
- CBC, Albumin-creatinine ratio

- Urine analysis
- CBC
- Renal function test

Q24: Gestational Hypertension

1. Severe PET Dx:

- Systolic BP >160 or diastolic >110 on 2 occasions of 6 hrs apart
- Proteinuria ≥ 5 g/24 hrs
- Oliguria < 500 cc /24 hrs
- Cerebral or visual symptoms
- Epigastric or Rt upper quadrant pain
- Pulmonary edema or cyanosis
- Low PLt
- ↑↑ liver enzymes
- IUGR

1. cerebral symptoms
2. epigastric or RUQ pain
3. pulmonary edema
4. elevated Liver
5. ↑ creatinine
6. PLt < 150

2. Hypertensive medications?

- Avoid: Diretics, Atenolol, ACEIs, ARABs
- Methyldopa (slow releasing Nifedipine or Labetalol may be added)
- If BP >170/110: Labetalol or Hydralize or Nifedipine

3. Management?

- Lifestyle
- Fetal Assessment
- Fluid management
- Medications

Q24: Gestational Hypertension

1. Severe PET Dx:

- Systolic BP >160 or diastolic >110 on 2 occasions of 6 hrs apart
- Proteinuria ≥ 5 g/24 hrs
- Oliguria < 500 cc /24 hrs
- Cerebral or visual symptoms
- Epigastric or Rt upper quadrant pain
- Pulmonary edema or cyanosis
- Low PLt
- ↑↑ liver enzymes
- IUGR

2. Anti-hypertensive medications?

- Avoid: Diretics, Atenolol, ACEIs, ARABs
- Methyldopa (slow releasing Nifedipine or Labetalol may be added)
- If BP >170/110: Check blood pressure every 15 minutes until stable + Labetalol 50 mg I.V. repeated at 10 minutes PRN **or** Hydralazine 10 mg I.M. or I.V. **or** Nifedipine 10 mg orally repeated at 30 minutes PRN

3. Management?

- Lifestyle
- Fetal Assessment
- Fluid management
- Medications

Q25: Pregnant lady came with high blood sugar reading:

1. What are the complications on: mother, fetus, neonate:

Mother	Fetus	Neonate
- Risk of miscarriage - Risk of PET - Risk of infection - Risk of LSCS rate	- Congenital Anomalies - Macrosomia - Stillbirth - IUFD/IUGR - Polycythemia	- RDS - Hypoglycemia - 2ry Polycythemia - Jaundice - Hyper-viscosity syndrome

2. What are the effect of pregnancy on Diabetes:

1) Increase requirement of insulin
2) More risk of nephropathy, or worse deterioration
3) Progression of diabetic retinopathy
4) Hypoglycemia
5) DKA

Anti hypertensive treatment

Mild PET

- There is no benefit of antihypertensive therapy

Severe PET

Antihypertensive therapy is used to prevent maternal stroke i.e acute HTN complications

Anti hypertensive treatment

- **Methyldopa** 500 mg P.O. loading followed by 250-750 mg q.d.s
- Slow-release **nifidipine** or **labetalol** may be added to this regimen
- Antihypertensive medications that should be avoided;
  - *Diuretics*
  - *Atenolol*
  - *Angiotensin converting enzyme inhibitors (ACE)*
  - *Angiotensin receptor-blocking drugs (ARB)*

Anti hypertensive treatment

- If BP > 170/110 mmHg;

PRN
- **Labetalol** 50 mg I.V. repeated at 10 minutes

OR

- **Hydralazine** 10 mg I.M. or I.V.

OR

PRN
- **Nifedipine** 10 mg orally, repeated at 30 minutes

❑ Check blood pressure every 15 minutes until stable

PREVENTION /CONTROL OF CONVULSIONS

- Magnesium sulfate IV infusion ➡ 4 gm loading dose in 100 ml of IV fluid over 20 min ➡ 2 gm /hr maintenance
- Measure serum MG level at 4-6hrs maintain at 4-7 mEq /L
- D/C 24 hrs after delivery➡25% of seiz occur post partum
- Avoid toxicity by :
  - -monitoring patellar reflexes
  - -respiratory rate
  - -urine output
- Antidote ➡calcium gluconate 1gm IV
- Compared to phenytoin or diazepam ➡50% ↓ in maternal mortality ,67% ↓ in convulsions

Labor & Presentation

Definitions

- Engagement: the widest diameter of the presenting part is below the pelvic brim.

- Descent: passage of the presenting part of the fetus through the birth canal, this occurs as a result of the active forces of labor.

- Position: the relationship of the denominator (occiput/sacrum) of the presenting part to the quadrants of pelvis.

- **Station**: the relationship in cm of the presenting part (head/buttocks/feet) to the ischial spines.

- **Lie**: relationship of the long axis of fetus to the long axis of the uterus e.g. longitudinal, transverse, oblique.

- **Presentation**: the presenting part of the fetus which is occupying the lower pole of the uterus i.e. cephalic (vertex), breech, face, brow or shoulder.

Q26: What are the cardinal movements?

1. Engagement
2. Descent
3. Flexion
4. Internal rotation
5. Extension
6. External rotation
7. Expulsion

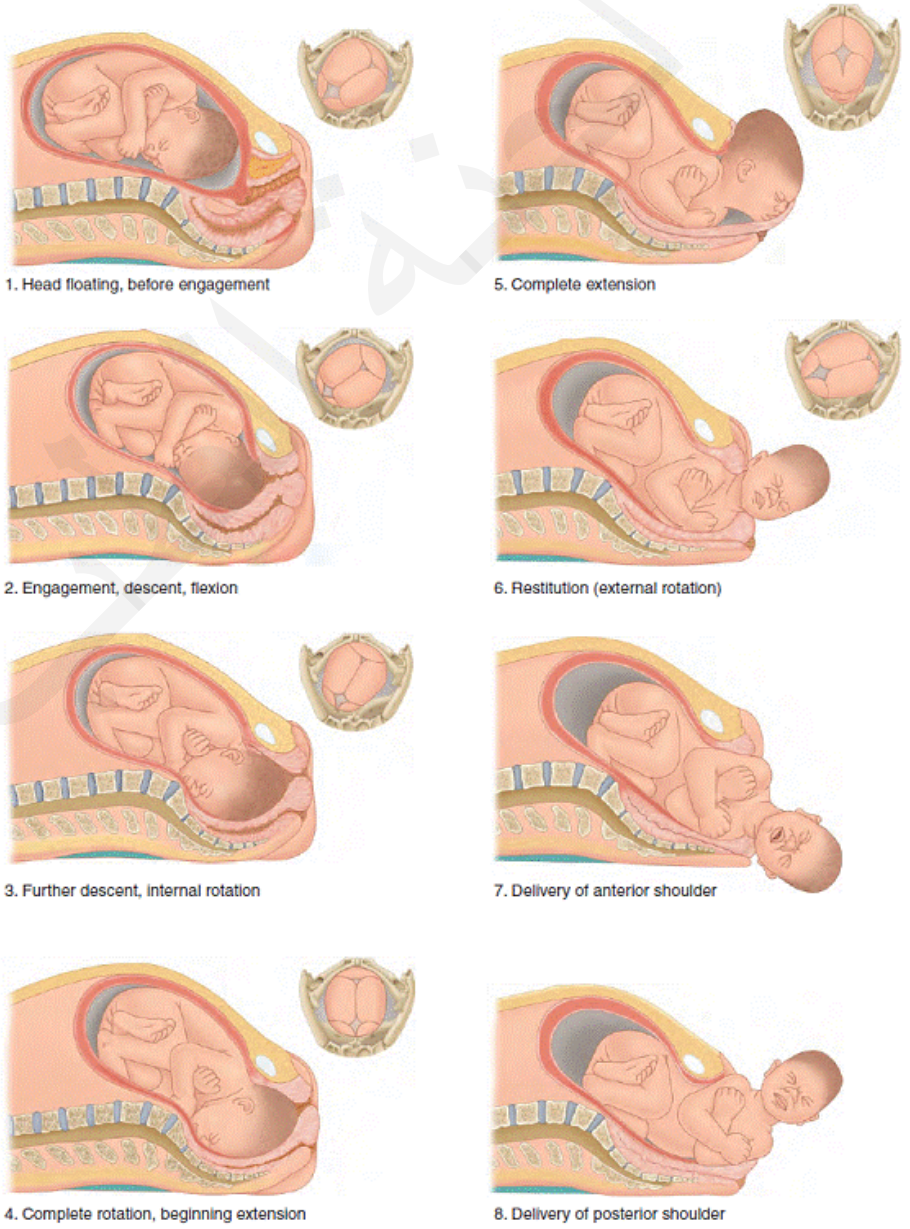


FIGURE 17-11 Cardinal movements of labor and delivery from a left occiput anterior position.

Q27:

1. Mention three signs of obstructed labor?

1. Arrested cervical dilatation and descent
2. Large caput
3. Extensive molding
4. Edematous cervix and vulva
5. Maternal or Fetal distress
6. Ballooning of LUS and formation of a retraction ring

2. Mention the characteristics of effective uterine contractions?

1. Frequency: 3-5/10 min
2. Intensity: >50 mmHg
3. Duration: 40-60 seconds

Q28:

1. Name the presentations?

2. What's the diameter of the presenting part in Face/Brow?

- **Face:** Submento-bregmatic
- **Brow:** Occipito-mental

3. Which of the four presentations is delivered normally (vaginal)?

- Face presentation.

Also the brow presentation might flex to become vertex or extends to become face. If so, then also brow.

Q29: Picture of breech and scenario of PPROM at 30 weeks:

1. Name this presentation:

- Complete Breech

2. Name three risk factors:

- Placenta Previa, Uterine Anomalies, Large Fibroids, Macrosomia

3. Name the procedure you do for this patient, and mention 3 pre-requisite for it?

- External Cephalic Version (ECV)
- GA more than 36, US, CTG, Check BP and pulse

4. Mention benefits for speculum for this patient (4 Points):

- Check the cord
- Presentation
- R/O Local causes
- R/O PROM

5. Mention benefits for US (4 points):

- R/O Placenta previa
- Check presentation, check the amniotic fluid

Q30: P1,Go Came to the ANC with this presentation:

1. What's the lie?

- Longitudinal lie

2. Give four causes of this presentation?

1) Extending legs preventing spontaneous version
2) Conditions preventing the presenting part from entering the pelvic cavity (masses, fibroids, ovarian masses, hydrocephalus)
3) Uterine Anomalies
4) Cornual placenta, Placenta previa
5) Preterm delivery

3. Give 2 complications of ECV?

- Preterm labor
- Abruptio placenta, Uterine rupture
- Cord accident

Q31:

1. What type of breech is this?

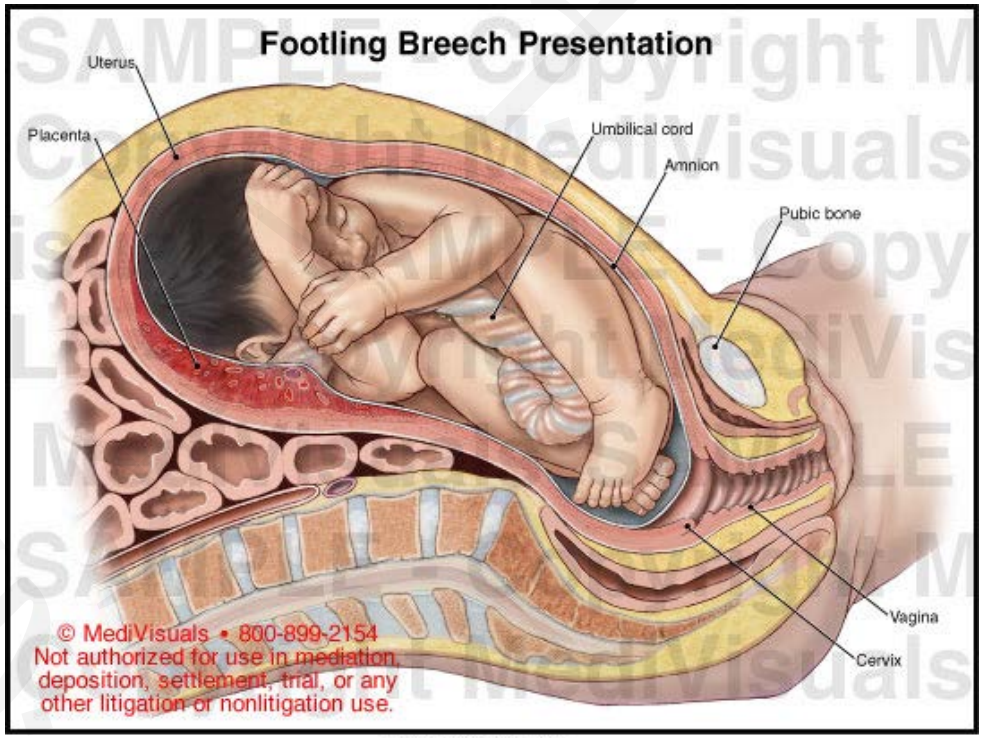
- Footling Breech

2. What maneuver can you do to deliver with without CS?

- External cephalic version

3. When can you do this maneuver and why?

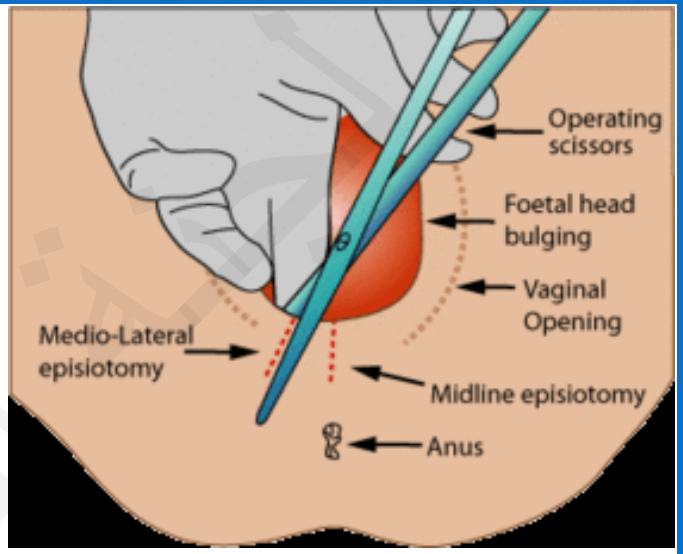
Only if breech is diagnosed before onset of labor and the GA is >=37 (term)
+Pt should be NPO in case maneuver failed and CS is the solution



Q32:

1. What is the name of the procedure?

- Episiotomy



2. Indications for it?

- To quickly enlarge the opening for the baby to pass
- Instrumental Delivery
- Shoulder Dystocia
- Narrow birth canal

3. Mandatory-prerequisite for it?

- Local anesthesia

4. What are the types?

- Midline and Mediolateral

5. What are the advantages/disadvantages of each?

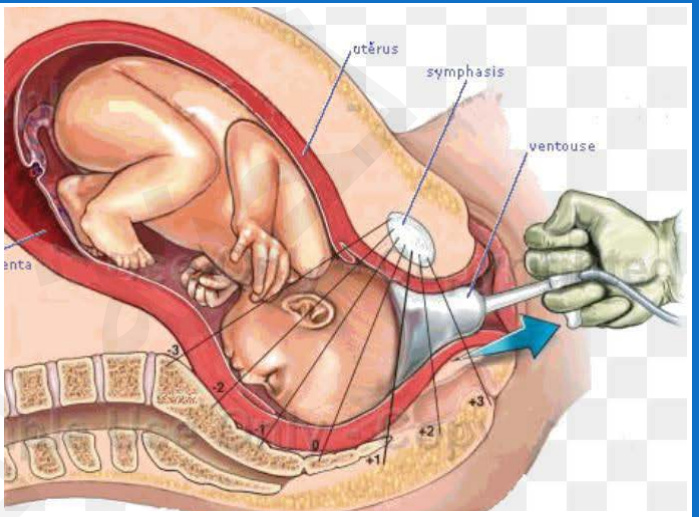
- Mentioned in the next slide

	Median	Medio-lateral
Merits	- Muscles are not cut - Less blood loss - Easy repair - Post-op comfort is maximum - Better Healing - Wound disruption is rare - Dyspareunia is rare	- Less rectal involvement - Incision can be extended
Demerits	- Extension involve rectum - Not suitable for manipulative delivery or abnormal presentation or position (in these cases it is selective)	- Extend to tissues/muscles - More blood loss - Post-op discomfort is more - More wound disruption - More Dyspareunia

Q33:

1. Mention 2 indications?

1) Failure of progression in the 2nd stage of labor
2) Fetal or mother distress in the 2nd stage of labor



2. Mention 2 presentations CI?

1) Face presentation
2) Breech presentation

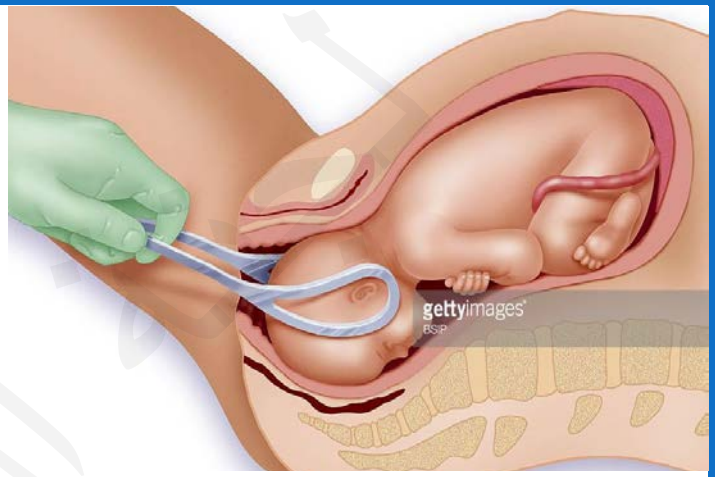
3. Mention 1 maternal and 1 fetal complication?

- Maternal: perineal and genital laceration
- Fetal: scalp abrasion, retinal hemorrhage

Q4: What would you do before using it (4 points)?

1) Empty bladder
2) Uterine contractions present
3) Full cervix dilation
4) Known head position

Q34:



1. Name this procedure?

- Instrumental delivery via forceps

2. What are the types of such delivery?

1) Forceps (Simpson, Kieland)
2) Ventouse (Vacuum extractor)

3. Mention 1 maternal complication?

- Vaginal tears and lacerations
- Perineal tears including 3rd and 4th degree

4. Give 3 Indications?

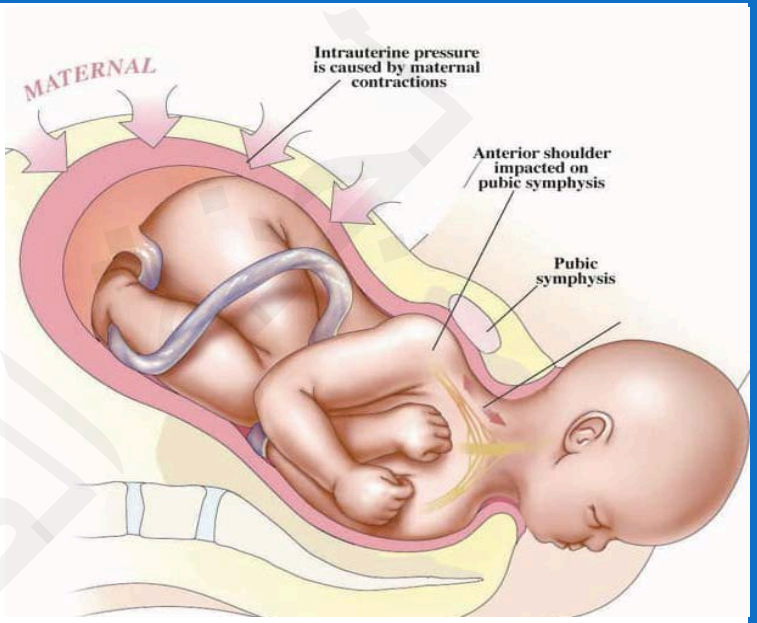
1) Failure to advance in the 2nd stage
2) Fetal distress in the 2nd stage
3) Cord prolapse in the 2nd stage

5. What are the pre-requests needed for this?

1) Cervix must be fully dilated
2) Uterus must be contracted
3) Head must be engaged

Q35:

1.What is the name of the condition in this image?



Shoulder dystocia

2. What is the incidence?

0.2-3% (other books say 1%)

3. Mention 3 risk factors?

Maternal DM, obesity, post date pregnancies,
fetal macrosomia, prolonged 1st or 2nd stage of labor, Hx of shoulder dystocia

4. Mention 3 fetal complications that can occur?

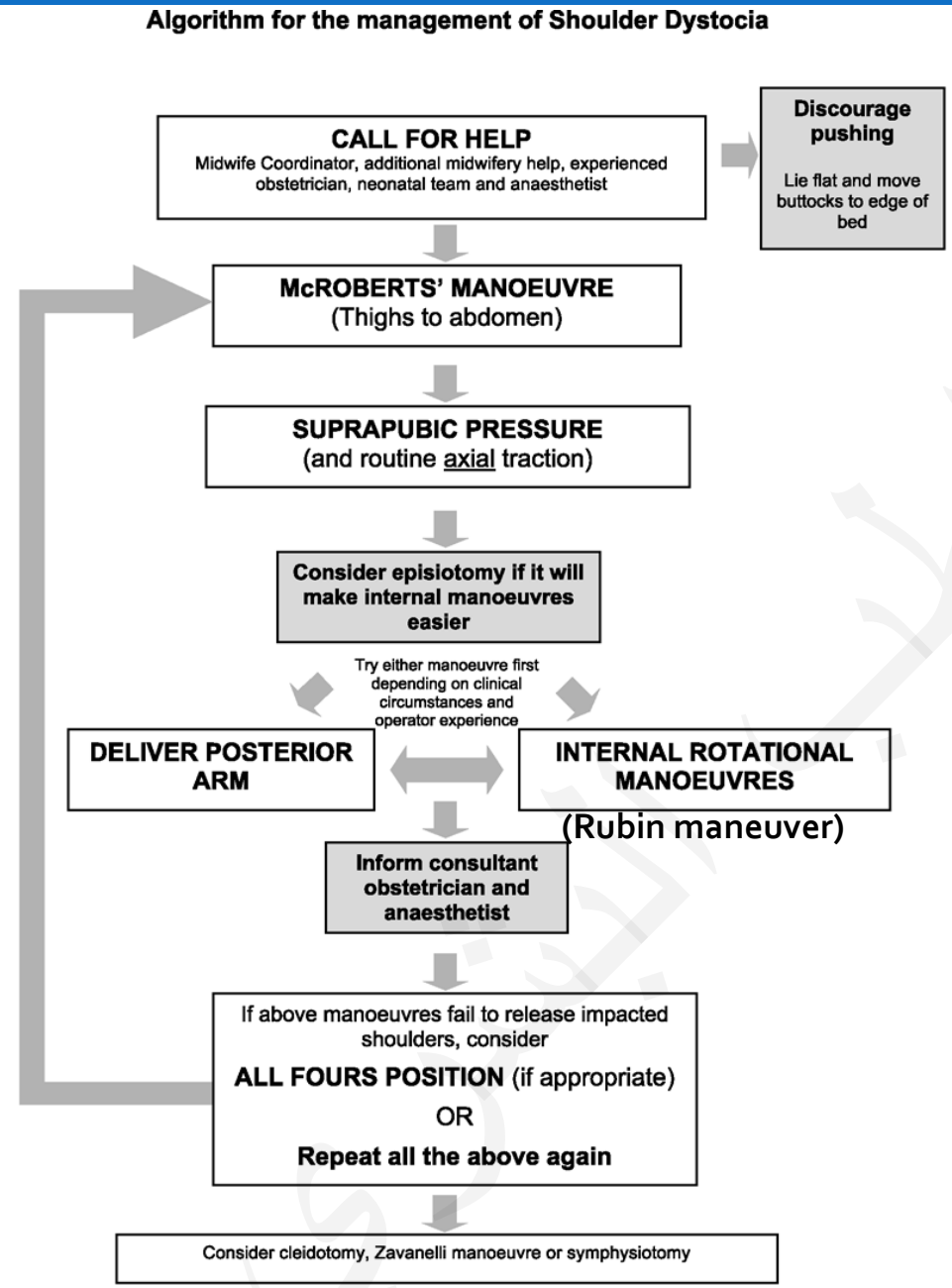
Brachial plexus nerve injuries, Erb's palsy, fetal humeral/clavicular fractures, hypoxia/death, permanent neonatal neurological damage

Q5: Mention 4 maneuvers to deliver the baby?

- McRoberts Maneuver
- Suprapubic pressure
-Zavanelli maneuver
- Woods screw maneuver
- Rubin maneuver
- Manual delivery of the posterior arm

Management of shoulder dystocia

- The steps to treating a shoulder dystocia are outlined by the mnemonic **ALARMER**:
- **A**sk for help. This involves asking for the help of an obstetrician, anesthesia, and for pediatrics for subsequent resuscitation of the infant that may be needed if the methods below fail.
- **L**eg hyperflexion and abduction at the hips (**McRoberts' maneuver**)
- **A**nterior shoulder disimpaction (**suprapubic pressure**)
- **R**otation of the shoulder (**Rubin maneuver**)
- **M**anual delivery of posterior arm
- **E**pisiotomy
- **R**oll over on all fours
- Typically the procedures are performed in the order listed and the sequence ends whenever a technique is successful.
- Intentional fracturing of the clavicle is another possibility at nonoperative vaginal delivery prior to Zavanelli's maneuver or symphysiotomy, both of which are considered extraordinary treatment measures.
- Pushing on the fundus is not recommended.



RCOG ALGORITHM FOR SHOULDER DYSTOCIA

PTL, PROM & Post-Date

Q36: 24 y/o lady,28 GA, came complaining of regular uterine contractions 3/10 min. & on PV the cervix was 2 cm dilated.

1. What's the Dx?
- PTL (preterm labor)

2. Give 2 causes?
- previous PTL
- Polyhydramnios
- Twin Gestation
- Smoking, alcohol, drugs

3. 2 Investigations to do?
- Fetal fibronectin
- Cervical length TVS
- Ultrasound

4. 2 lines of Mx?
- Bed rest & hydration
- Maternal steroids
- Tocolytics
- Antibiotics (Erythromycin)
- Fetal assessment

5. 3 maternal complications:
- Tocolytic risk
- Postnatal Depression
- Prolonged labor
- Infections risk
- C/S

6. 3 fetal outcomes:
- RDS
- NEC
- PDA
- Jaundice
- Retinopathy
- Feeding difficulty
- Hypothermia

Q37: 35 GA pt with vaginal leakage of fluid:

1. Give DDx:

- Seminal fluid collection: sexual intercourse
- Amniotic fluid: PROM
- Infections: UTI, vaginal
- Urinary Incontinence
- Leucorrhea
- Abruption of the placenta

2. History of PROM?

- Gush of watery fluid from the vagina followed by continuous dribbling (we care for timing, amount, color, odor)

3. How will you manage?

- Admission
- Stabilize
- Give antibiotics
- Induction of labor

Management depends on GA; this patient is 35 weeks

Q38: 22 y/o lady ,33 weeks gestation came complaining of gush of fluid per vagina for 2 hours.

1. most common cause:

- PROM

2. What do you look for in Speculum?

- Pool of fluid post vagina
- Positive Cough Sign
- Cervix for dilatation
- Cord?

3. Investigations Done?

- Nitrazine test
- Ferning pattern
- Genital tract swabs
- Maternal wellbeing (vital signs/ WBC/CRP → early markers for infection)
- Fetal wellbeing (Serial NST)
- Ultrasound
- Speculum
- AmniSure test

4. Mention 3 lines of Mx:

- Admission
- Antibiotics (Eryhromycin)
- Corticosteroids

5. Mention 3 Complications:

- Fetal Distress
- PTD
- Cord prolapse
- Operative Delivery
- Hyaline membrane disease
- Abruption
- Chorioamnionitis

MANAGEMENT OF PROM

24-34 weeks

- Confirmation of diagnosis and presentation.
- Baseline FBC, CRP, swabs and MSU
- Ultrasound assessment of fetal wellbeing
- Steroids
- Oral erythromycin for 10 days
- MOD

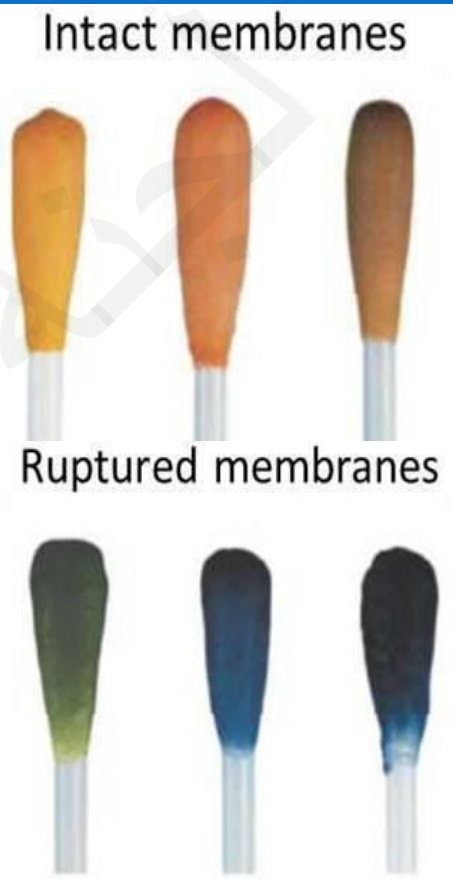
34-37 weeks

- Controversial
- Immediate IOL
  - less hospitalisation
  - less perinatal infection
  - less NN morbidity

Q39:

1. What is the name of the test?

- Nitrazine test



2. Other tests to confirm?

- Ferning pattern
- AmniSure ROM test

3. Name a Complication?

- Fetal Distress/deformities
- PTD
- Cord prolapse
- Operative surgery

4. When to consider delivery?

- Individualized, in general if there was complications for either the mother or the fetus, we might tend for delivery

Q40: 30w GA with painful regular (3/10min) uterine contractions, the cervix is 2 cm dilated, and the presentation is extended breech

1. What is your Dx:

- Pre-term labor

2. Mention 2 maternal complications?

- Post-natal depression
- Post-partum hemorrhage

3. Mention 3 causes for this?

- Uterine ascending infection
- Extra-uterine infection: Pyelonephritis
- Social causes: smoking, alcohol

4. Mention 2 ways to confirm the Dx:

- Fetal fibronectin
- Cervical length
- PV every 4 hours

5. What is you Mx (2 points):

- Steroids
- Vaginal Delivery

Q41: 42 weeks pregnant, you want to induce labor.

1. Why would you induce labor:

- This lady is 42 weeks pregnant (post term), we want to do IOL because maintenance of pregnancy will increase maternal & fetal complications
(fetal death, post maturity syndrome, dismaturity, meconium aspiration)

*Post term: 42 weeks and more

*Post date: between 40 weeks and 42 weeks

2. What are the components of Bishop Score?

a. Dilation

b. Effacement (%)

c. Station

d. Consistency

e. Position of the cervix

3. If Bishop score if 5, how will you induce labor?

- By Prostaglandins (IV Pitocin can also be used)

Bishop scoring system:

Score	Dilation (cm)	Position of cervix	Effacement (%)	Station (-3 to +3)	Cervical Consistency
0	Closed	Posterior	0-30	-3	Firm
1	1-2	Mid position	40-50	-2	Medium
2	3-4	Anterior	60-70	-1, 0	Soft
3	5-6	--	80	+1, +2	--

The modified Bishop score replaced cervical effacement with cervical length in cm, and its score is calculated as follows:

Score 0: cervical length >4 cm

Score 1: cervical length 3-4 cm

Score 2: cervical length 1-2 cm

Score 3: cervical length <1 cm

APH & PPH

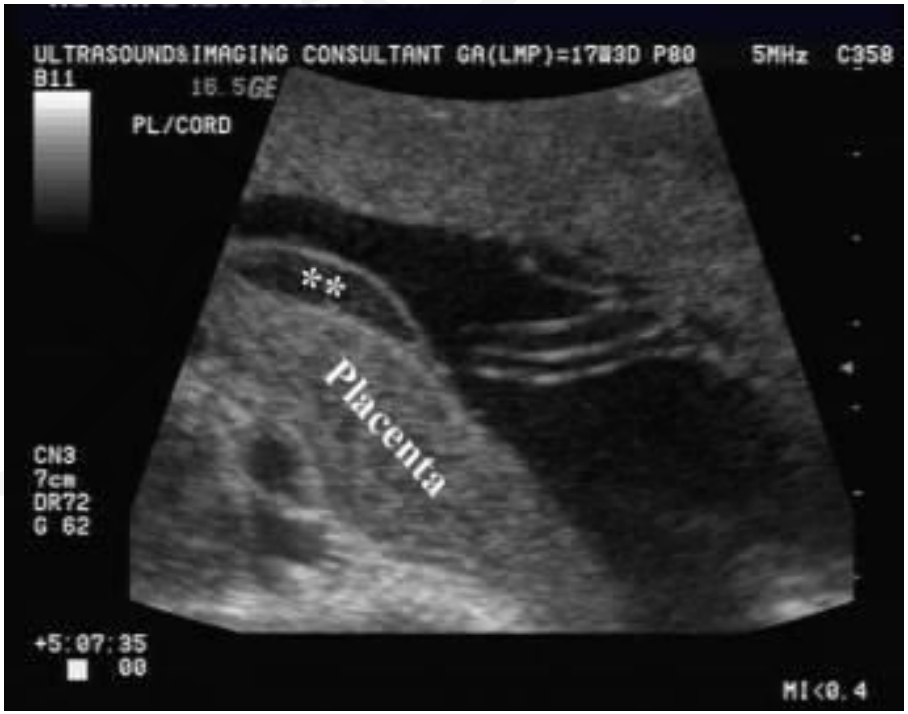
Q42:

1. What is the Dx:

- Placental Abruption

2. Causes, & which is the most common?

- Hypertension (most common cause)
- Previous abruption
- Trauma
- Chorioamnionitis
- Abnormal placentation
- Increasing maternal age
- Increasing parity
- Smoking
- Drug misuse (cocaine)
- Anemia
- Prolonged ROM >24 hours

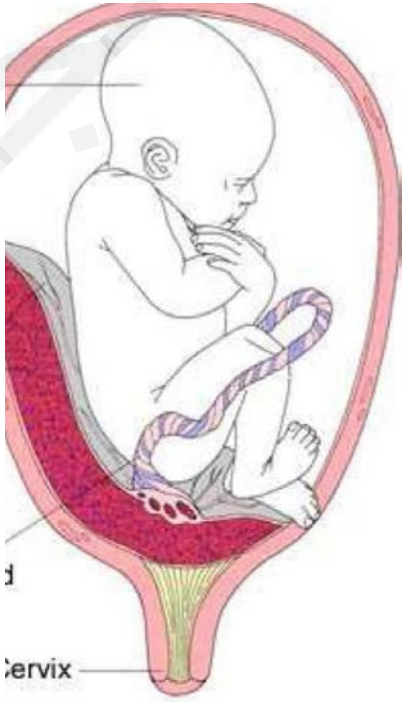


3. Treatment?

Management depends on amount of blood loss, status of the fetus and mother and GA but generally:

- Admission
- Conservative: steroids
- Deliver (we tend to go for vaginal)

Q43: 34 weeks pregnant lady complaining of vaginal bleeding:



1. Mention two initial Dx:

- Placenta Previa
- Abruptio Placenta
- Any other local causes

2. Three points to ask in Hx?

- Hx of similar attacks
- Abdominal pain, amount and color of blood
- Uterine scars: previous C/S, myomectomy, D&C..

3. What is your initial investigations?

- Abdominal US

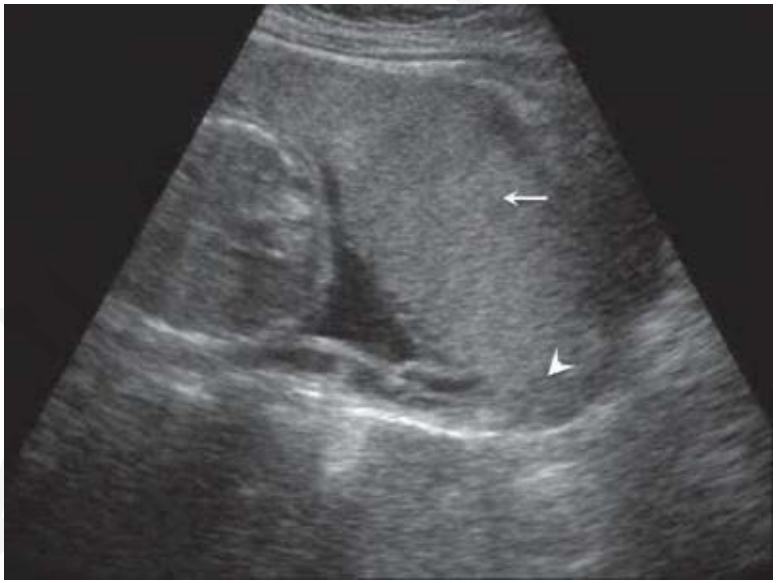
4. If she was stable how will you manage her (3 points)?

- Admission
- Blood type and cross matching
- Steroids (Dexamethasone – for lung maturity)
- Anti-D if indicated

5. What is the MOD?

- C/S

Q44: 37 y/o pt, with a Hx of two C/S presented with this US:



1. What is the Dx?

- Placenta Previa

2. Mention two risk factors?

- Scarred uterus (previous C/S)
- Age (>35)

3. Mention the grades of this condition?

- Grade 1: low lying – lower segment but does not reach os
- Grade 2: Marginal – reaches os but does not cover it
- Grade 3: Partial – cover part of the os
- Grade 4: Complete/Central – completely covers the os

4. Mention two complications on the mother and the fetus?

- Major hemorrhage, shock, DIC, C/S
- PTL, PTD, fetal distress, IUGR, IUFD

Q45: 30 y/o, presented with 15 min bleeding after normal vaginal delivery:

1. What is the Dx?

- Primary PPH (primary if within 24 hr, secondary if after)

2. Mention four causes?

- 4 T's (Tone, Tissue, Trauma, Thrombin)

Atony (most common), Retained tissue, Trauma, Thrombin (bleeding disorder)

3. Mention two complications?

- Sheehan Syndrome, Hypovolemic Shock, Asherman Syndrome, Transfusion Hepatitis, DIC, Anemia

Q46: PPH

1. Mention 8 risk factors?

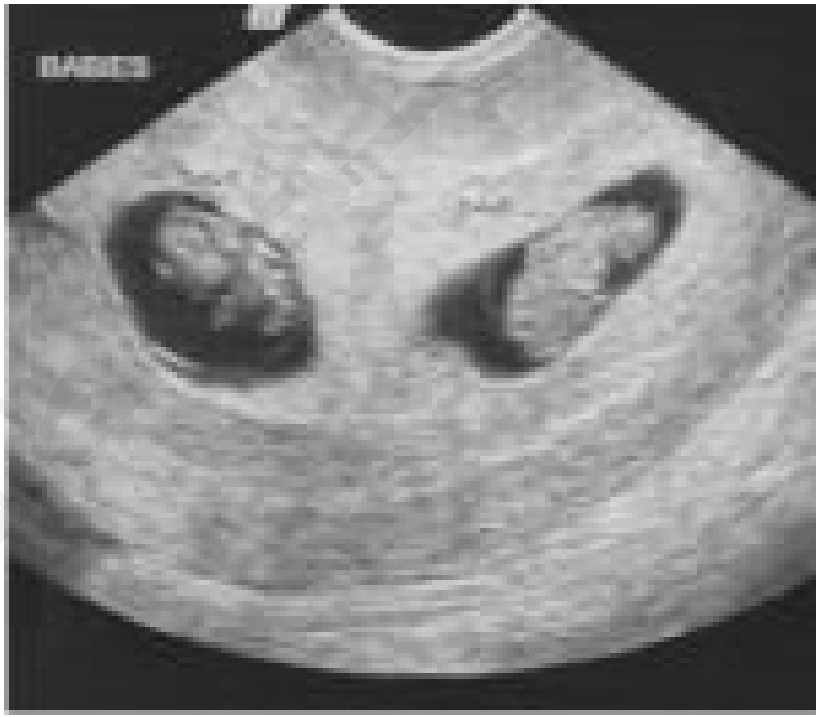
1) Over distended uterus (multiple pregnancies, polyhydramnios, macrosomia)
2) Instrumental deliveries
3) High parity
4) APH
5) Drugs: Oxytocin, $MgSO_4$, Halothane
6) Prolonged Labor
7) Precious PPH
8) Bacterial toxins (endometritis, chorioamnionitis, septicemia)

2. Mention 8 lines of Mx?

1) Call for help
2) ABC
3) 2 large IV lines
4) Foleys catheter
5) Anti-D (if Rh (-))
6) Uterine Massage
7) Uterine Packing
8) Uterotonic drugs - Oxytocin
9) Internal iliac artery ligation
10) B-Lynch Suture
11) Hysterectomy (last option)

Twins

Q47: A 35 years-old patient, G2 P1 with the following US:



1. What is the likelihood for them to be identical?

- Not likely

2. What is it in terms of chronicity and amnionicity?

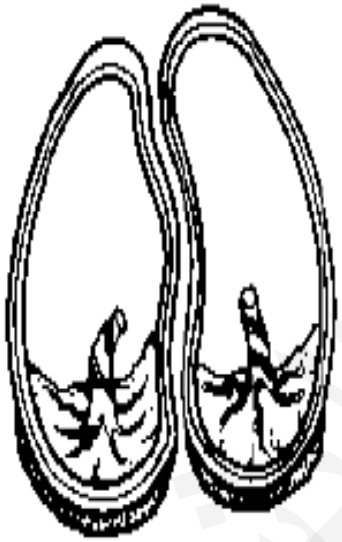
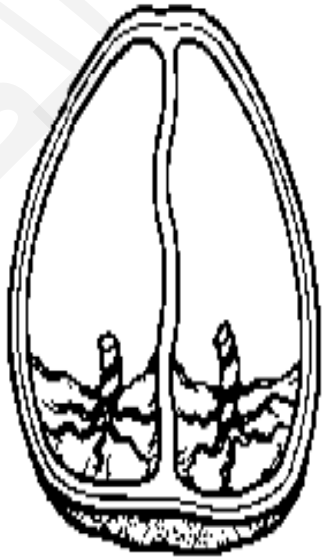
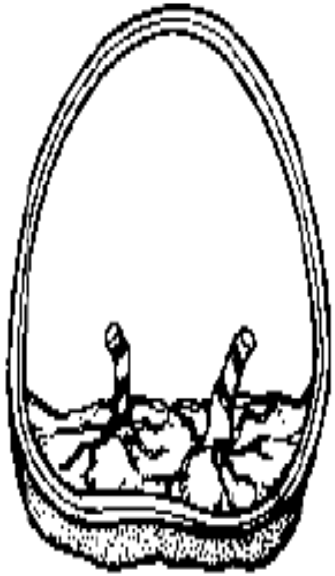
- Dichorionic and Diamniotic

3. What is the time of delivery?

37 Weeks

4. Mention two complications for the mother and two for the twins?

- **Mother:** Increased risk of: PTL, PPH, CS, HTN & PET, GDM, UTI… etc.
- **Twins:** Unequal weights (discordance), Prematurity, Congenital anomalies, Umbilical cord problems (single umbilical artery, velamentous cord insertion…)

Zygote	Dizygotic	Monozygotic		
Day of division		0–3	3–8	8–13
Placenta				
Central membrane	2 Amnion 2 Chorion	2 Amnion 2 Chorion	2 Amnion	None

Other Obstetric Complications

Q48: Hope 29 years old lady, 13 weeks gestation, complaining of recurrent vomiting that lets nothing stays in her stomach.

1: Define Hyperemesis Gravidarum:

- intractable vomiting
- greater than 5% weight loss
- dehydration
- ketosis
- electrolyte imbalance.

2: Mention two Maternal/ two Fetal complications?

Maternal	Fetal
• Hyponatraemia • Hypokalaemia • Vit B1 (thiamine) deficiency • Vit B12 & B6 deficiency • Metabolic hypochloraemic alkalosis • Mallory-Weiss tears	• small for gestational age • fetal growth restriction. • preterm delivery. • IUFD

3: write four investigations you will order?

- Urine analysis for ketones
- Liver function test
- Electrolytes
- Thyroid function test
- HCT concentration

4: four lines of management?

- admission + rehydration
- Corticosteroids
- antiemetic therapy and vitamins
- Thromboprophylaxis

Q49: Case of maternal collapse.

1. What is the definition of maternal collapse?

- Any acute event involving the cardiorespiratory systems and/or brain, resulting in a reduced or absent conscious level (and potentially death), at any stage in pregnancy and up to six weeks after delivery.

2. How to position the mother?

- Left Lateral Position

3.Mention two causes for difficult intubation in pregnancy?

- Weight gain in pregnancy, large breasts inhibiting the working space and laryngeal edema can all lead to make intubation more difficult

4.Mention two causes for increase risk of aspiration in pregnancy?

- The pregnant woman is at a significantly higher risk of regurgitation and aspiration secondary to the progesterone effect relaxing the lower oesophageal sphincter and delayed gastric emptying, along with the raised intra-abdominal pressure secondary to the gravid uterus.

5. Perimortem cesarean, when to perform and why? (Medscape ans.)

- after 24 weeks (<24 weeks GA is a contraindication!)
- to remove the fetus & continue resuscitation of both mother & fetus

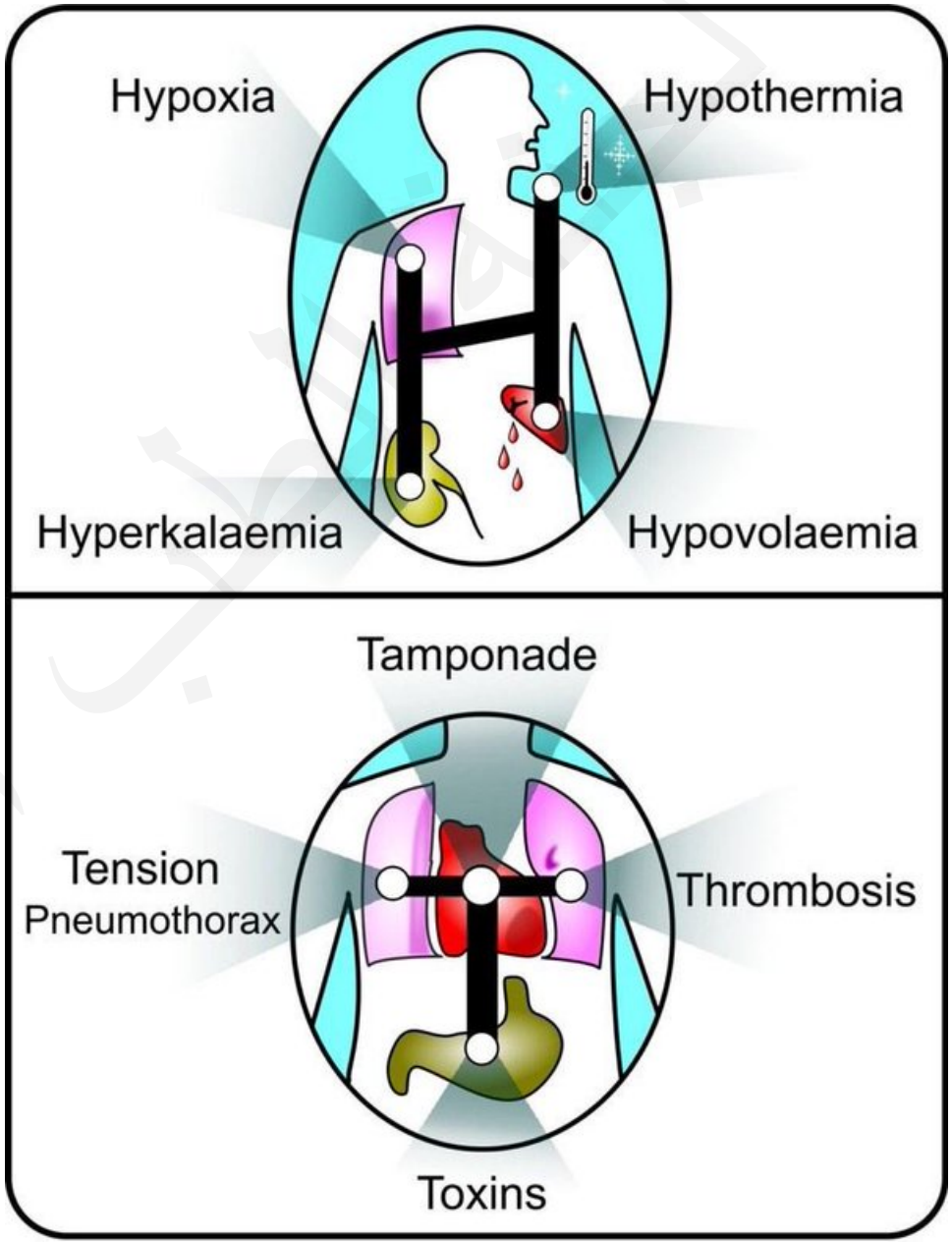
Q50: Case of maternal collapse.

1. G6, 36 GA, comes for induction of labor, because of polyhydromionous, what is the most likely cause of collapse?

- Uterine Rupture

2. Mention 2 reversible causes in pregnancy and puerperium?

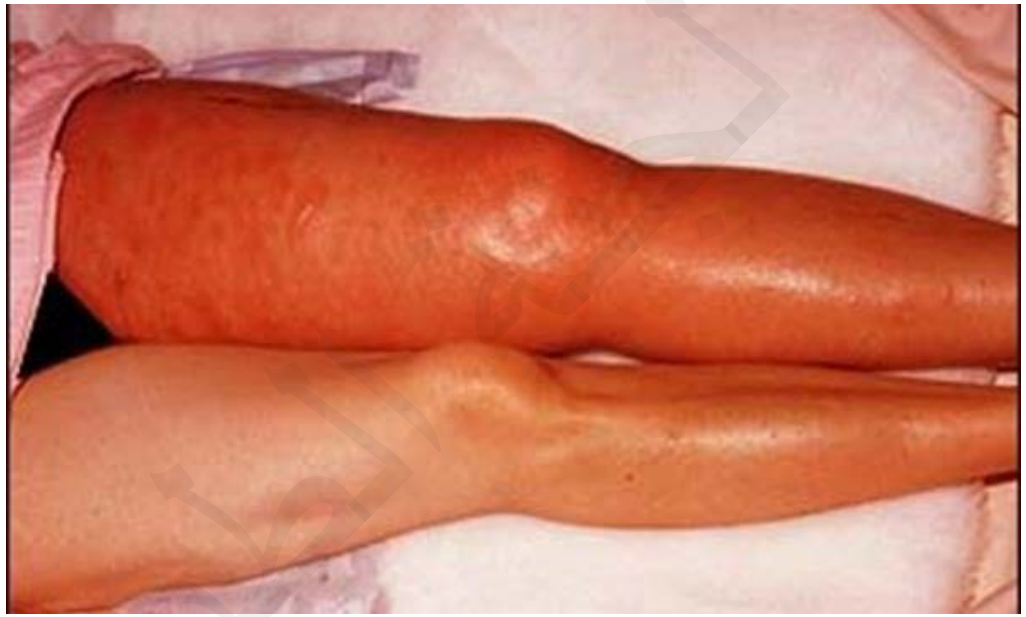
- 4 T's and 4 H's and PET



Reversible cause		Cause in pregnancy
4 H's	Hypovolaemia	Bleeding (may be concealed) (obstetric/other) or relative hypovolaemia of dense spinal block; septic or neurogenic shock
	Hypoxia	Pregnant patients can become hypoxic more quickly
		Cardiac events: peripartum cardiomyopathy, myocardial infarction, aortic dissection, large-vessel aneurysms
	Hypo/hyperkalaemia and other electrolyte disturbances	No more likely
	Hypothermia	No more likely
4 T's	Thromboembolism	Amniotic fluid embolus, pulmonary embolus, air embolus, myocardial infarction
	Toxicity	Local anaesthetic, magnesium, other
	Tension pneumothorax	Following trauma/suicide attempt
	Tamponade (cardiac)	Following trauma/suicide attempt
Eclampsia and pre-eclampsia		Includes intracranial haemorrhage

CAUSES OF MATERNAL COLLAPSE

Q51: 37 y/o obese woman, G3P3, is now in her 1st day post-C/S.



1. What is the Dx?

- DVT

2. Mention 4 RF?

1) Pregnancy
2) Obesity
3) Major Surgical Procedures
4) OCP's
5) Immobilization

3. What is your plan in Mx?

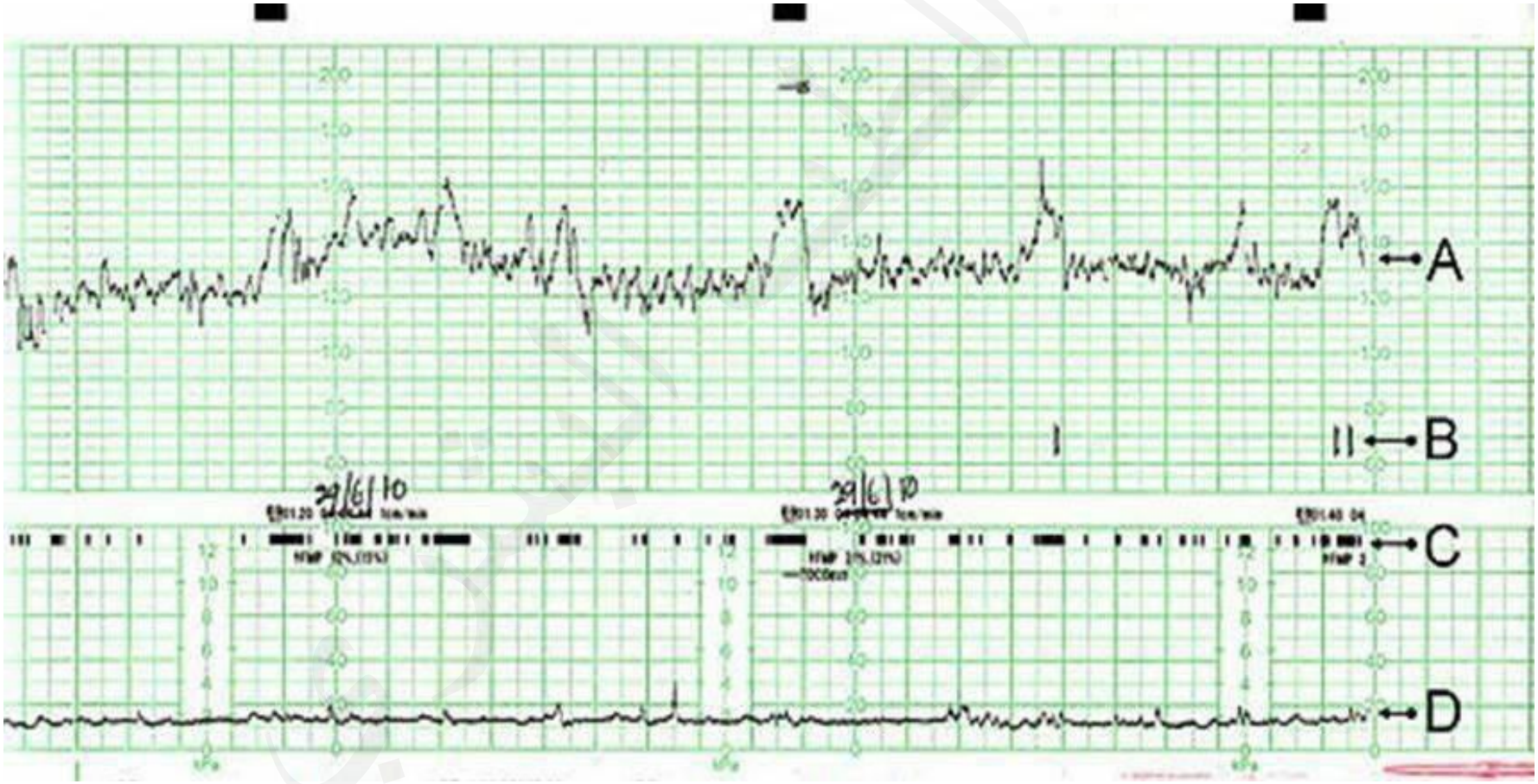
1) Elevate legs + Elastic compression
2) Anti-coagulation by LMWH or low dose heparin

4. Mention 2 SE of the drug you chose?

1) Heparin induced thrombocytopenia
2) Osteoporosis
3) Allergic reaction

CTG & Partogram

Q52: Sara 25 Y/O, primigravida, 41 weeks gestation, this test was done for her.



1. What is the name of this test?

- Cardiotocography (CTG)

2. What does line B stands for ?

Fetal movement noticed by mother

3. Mention two other tests to be done.

NST, Fetal scalp PH

4. Write three things you should comment on.

Fetal heart rate, variability, presence of accelerations, absence of decelerations,...etc.

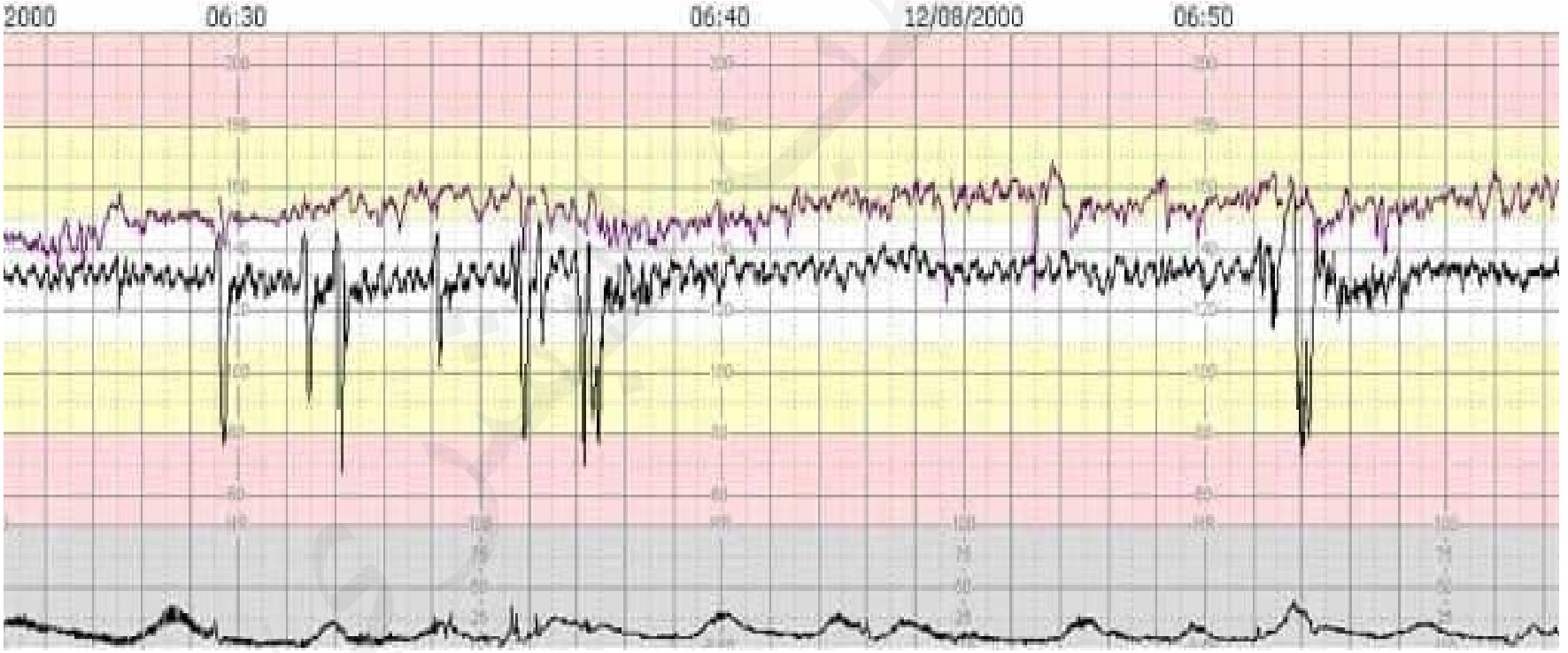
5. What is the next step of management

Admit to hospital and induce labor

admission /
IOL /
delivery.

Q53: A CTG of a 36 weeks pregnant lady presented to the ER with bleeding:

* كل مربع دقيقة



1.What is your comment in this CTG?

- CTG of twins
- the FHR of the first is 160 and of the second is 140,
- good variability for both,
- accelerations present in the first,
- there is variable decelerations in the second,
- efficient uterine contractions are present

2. Mention 3 causes of her bleeding?

- Abruption placenta, placenta previa, local causes

3. Mention 2 fetal complications of monochorionic twins?

- Twin to twin transfusion syndrome (TTTS)
- Discordance

(1)
(2) umbillical cord compression
(3) inter-placental vascular anastmosis.

4. Mention 2 criteria for vaginal delivery?

- The 1st twin is cephalic
- Diamniotic twins

Q54:

1. Mention 5 findings?

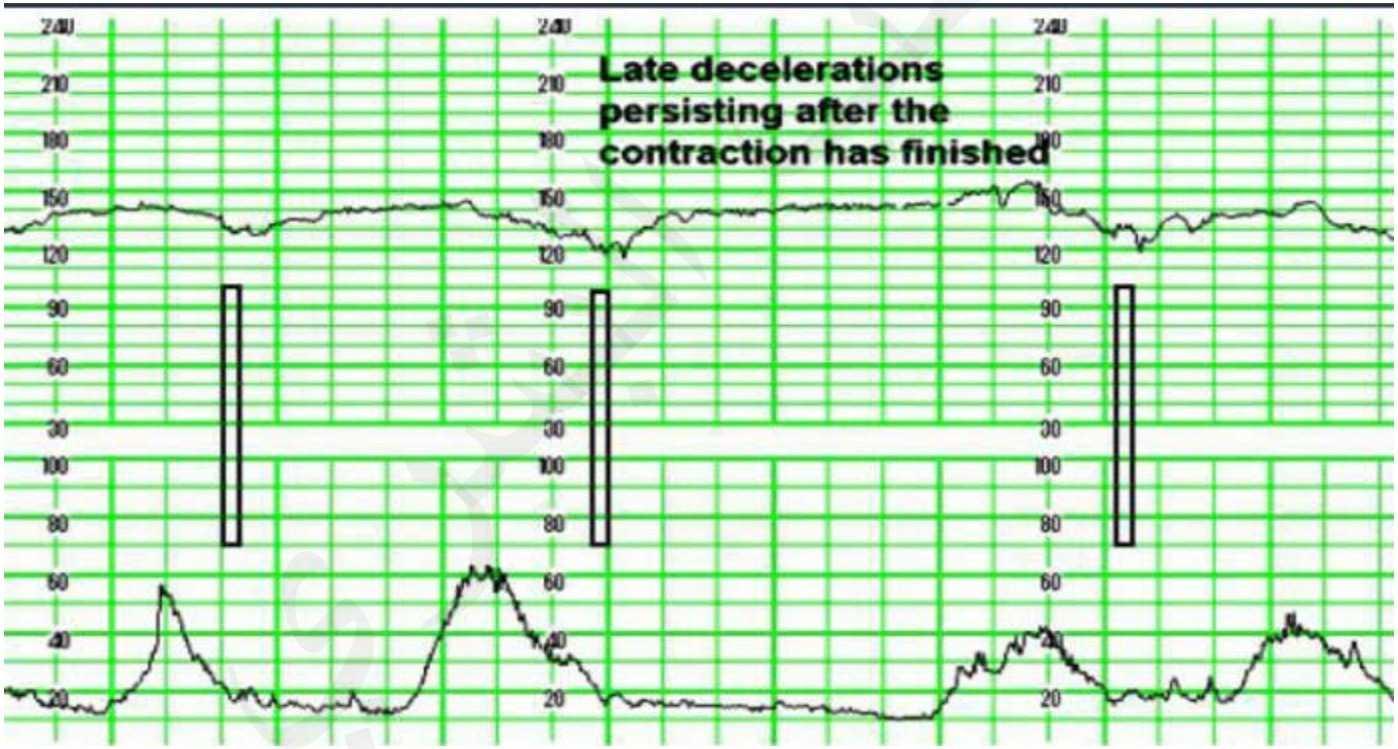
1) FHR 130 variability
2) Reduce beat to beat
3) No Acceleration
4) Late Deceleration
5) 3 Uterine contraction/10 min

2. Mention 3 causes?

1) Uteroplacental insufficiency
2) Fetal hypoxia, Fetal sleep, Distress
3) Infection

3. If cervix is fully dilated, cephalic presentation, station +2, your Mx?

- Induction of labor by PGE_2



Q55:

1. What is the most important abnormality, why?

- Reduce viability and no accelerations
-

2. What are the normal components for this?

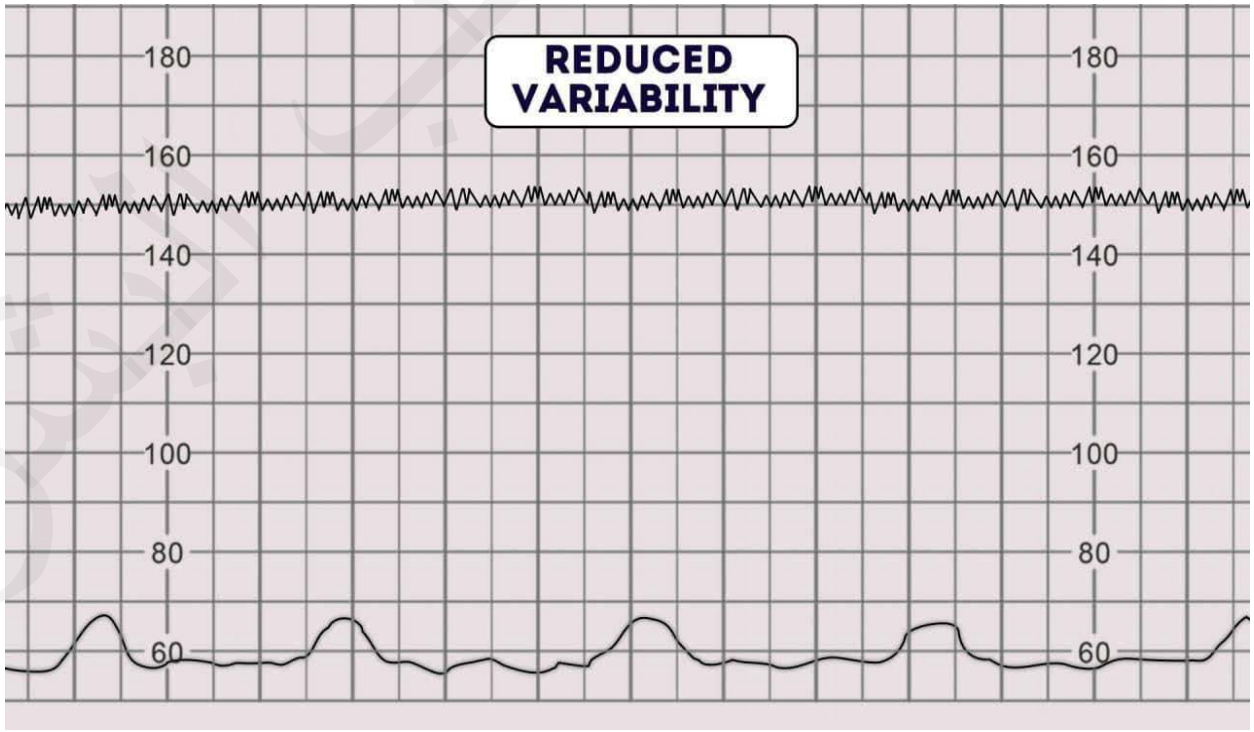
1) FHR
2) Variability
3) Accelerations
4) No decelerations
5) Uterine Contractions

3. What is the next step in Mx?

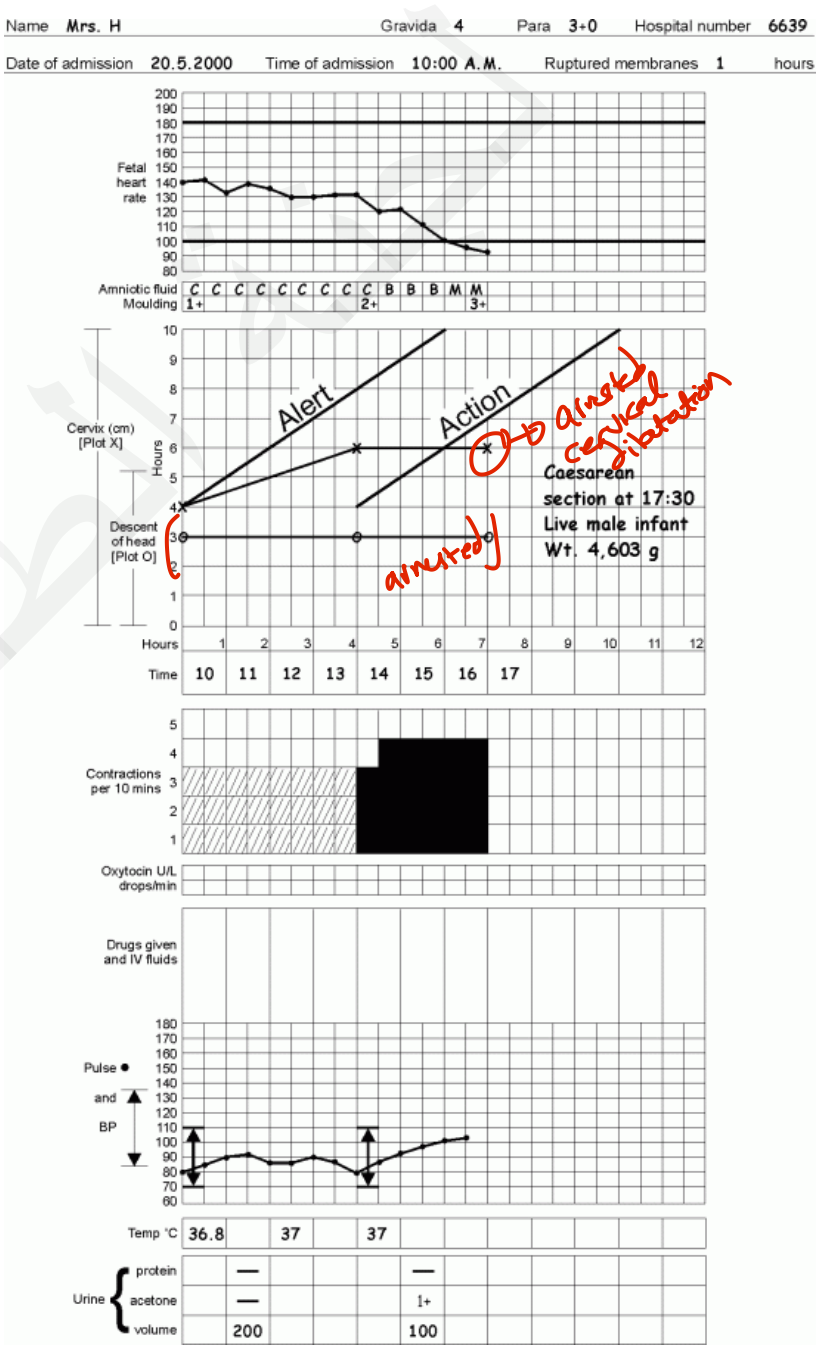
- Fetal scalp pH

4. If the cervix is 6 cm dilated, station +1, your Mx and why?

- Emergency C/S
- baby is in early stage of distress



Q56: Sawsan is 25 y/o, G2 P1, 39 GA came to the ER complaining of regular uterine contractions and was admitted to the labor ward, and you used the following obstetrical device:



1. Name of the device?

- Tocogram/Partogram

2. What is your Dx?

- Obstructed Labor

3. What findings did you see that support your Dx?

- Plateau of the head descend (mainly because of macrosomia)
- Fetal distress (FHR <100)

4. What do we measure with this device?

1) Patient identification
2) Time: It is recorded at an interval of 1 hour.
3) Fetal heart rate: It is recorded at an interval of thirty minutes.
4) State of membranes and color of liquor: "I" intact membranes, "C" clear and "M" meconium stained liquor.
5) Progression of labor: cervical dilatation and descent of the head.
6) Uterine contractions: Squares in vertical columns are shaded according to duration and intensity.
7) Drugs and Fluids.
8) Blood pressure: It is recorded in vertical lines at an interval of 2 hours.
9) Pulse rate: It is also recorded in vertical lines at an interval of 30 minutes.
10) Oxytocin: Concentration is noted down in upper box; while dose is noted in lower box.
11) Urine analysis
12) Temperature record

Instruments

Q57:

1.What is this tool?

- Cusco's speculum

2. Mention 3 Gynecological uses and 3 Obstetric uses.

Gynecological Uses	Obstetric Uses
Pap Smear	PROM
High Vaginal Swap	APH
IUCD Insertion & Removal	PPH

3. What is the other type of this tool and what is the indication for it?

- Sim's speculum, used in D&C

4. What is the main pre-requisite for this procedure?

- Patient's consent

Others

Q58: Patient Emma present to the emergency department complaining of constant severe lower abdominal pain radiating to her Right iliac fossa , her LMP was 28 days ago, she says that she has had an IUD inserted 10 days ago. (She had an appendectomy 2 years ago).

1. Mention four DDx?

- PID → this is asymptom not a diagnosis
- Ectopic pregnancy (1)
- IUD caused perforation (2)
- UTI (3)
- Ovarian cyst (complicated ovarian cyst) (4)
(rupture, hemorrhage, torsion)
- Pelvic abscess (5) endometriosis.

2. Write the investigations that you would order (five)?

- Urine analysis and culture
- Pregnancy test
- Triple swabs for PID
- CBC, ESR, Urea and electrolytes
- US

3. Mention S/Sx that you might see?

- Fever, discharge, abdominal tenderness/rigidity, cervical motion tenderness, peritoneal signs, guarding, referred pain to the inner thigh down to the knee (coetaneous distribution of the obturator nerve)

Q59: 28 y/o, G2 P1, at 12 weeks gestation she came for a routine visit, and her BG is (A-):

1. What lab test will you routinely order for this woman during her anti-natal care?

- CBC, Urine (analysis and culture), STD screen, Rh antibody screening +blood grouping / HbsAg / rupella antibodies

2. What are the indication for anti-D in this woman?

- Bleeding, abortion, amniocentesis, placental abruption

3. What would you give the mother after the 3rd trimester and after delivery?

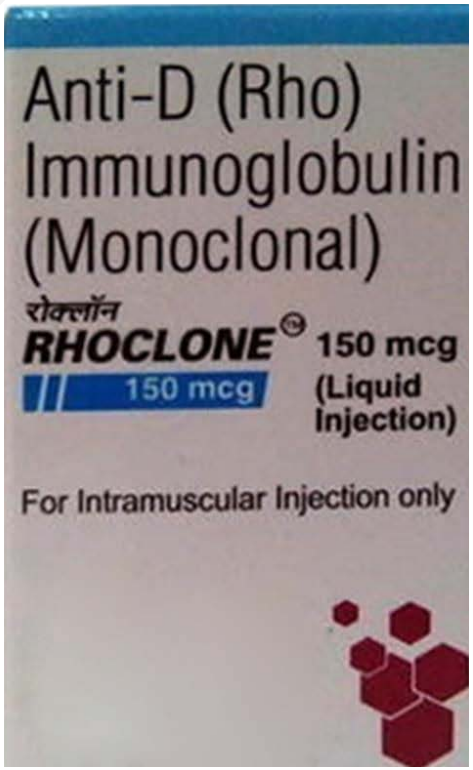
- **3rd Trimester:** we give it
- **After Delivery:** we check if the baby is Rh+ we give it within 72 hours

4. What complication might result if you don't administer anti-D?

- Hemolytic disease of newborn or hydrops fetalis

+immune

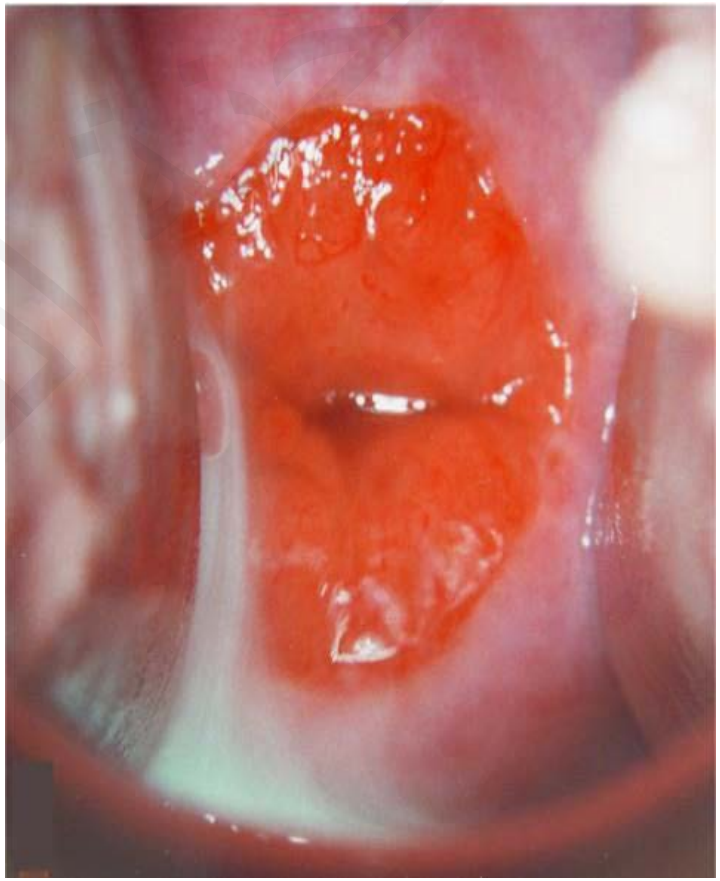
+hyperbillirubinemia +Jaundice



Q60:

1. Name the lesion?

- Cervical Ectropion



2. What does the strawberry lesion on the cervix consist of?

- Columnar Epithelium

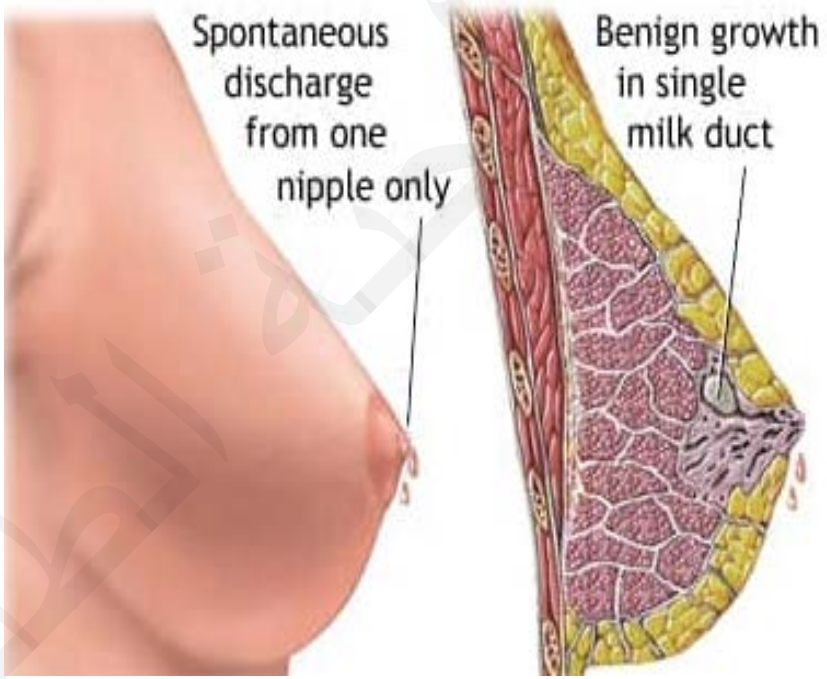
3. Mention the most common presentations of this lesion (3 points)?

1) Vaginal discharge
2) Dyspareunia and post coital bleeding
3) Intermenstrual bleeding

4. Name two investigations you would do?

1) Pap Smear
2) Con Biopsy → or colposcopy and biopsy.

Q61: (Question not collected)



1. What is the condition?

- Galactorrhea

2. Name a test to confirm it?

Microscopy to visualize fat droplets
(and also : Blood sample for HCG, prolactin and TSH)

↳ pregnancy test β-HCG.

3. Mention 3 drugs that can cause it?

- Antidepressants (TCAs)
- Anti psychotics
- OCPs
- Anti hypertensives
- Dopamine antagonists (metoclopromide)

Symptoms of galactoria :-

① amenorrhia
② acne
③ milk discharge
④ osteoprosis

4. Mention 2 drugs used to treat it?

-Bromocriptine (dopamine agonist)
-Cabergoline

5. When do you do surgical Mx?

When medical therapy (for 3 months) has failed to stop galactorrhea and the cause is a prolactinoma
or if the tumor is compressing other structures
→ surgery : transsphenoidal microsurgical resection

Q62: A female presents with abdominal pain and vaginal bleeding, take history from the patient:

(inaccurate answers)

1. Mention 4 investigations that you'll want to do for her

-BHCG, US, CBC and ESR, triple swab for PID

2. if it was ectopic, which surgery will you do for her, and why?

Salpingoctomy if contralateral tube is healthy, or salpingostomy if bot tubes are unhealthy.

3.If you found fluid in the POD and no adnexal masses, and you suspect ruptured ovarian cyst, how will you manage her?

Observation, repeat US after 6 weeks, give OCPs to prevent future cyst formation.

صيدلية الحل صح ؛)

Q63: CS has 2-3 folds more complications than normal vaginal delivery

1. Mention 2 indications

-transverse lie

-Major placenta previa

2. How do you prepare the patient before the surgery?

Base line lab tests, empty the bladder, anesthesia + ① give antibiotics ② give omeprazole

3.What to tell the patient for her post-natal care?

Encourage breastfeeding, family planning options, immediate consult for any complains, follow up for the incision, to mobilize and eat.

4.Mention 2 late complications

- hernia
- abnormal placentation
- uterine rupture
- infertility

-DVT

-Incisional hernia, scarred uterus due to adhesions, ectopic and previa

تنويه مهم

- هذا التجميع يحتوي على جميع سنوات امتحانات النسائية (الميني أوسكي) في الجامعة الهاشمية لكل من السنة الخامسة والسادسة, موزعين حسب المواضيع.

- نود التنبيه على أن هذه الأسئلة واجاباتها هي تجميع طلاب وقد تحتمل الصواب والخطأ, تم محاولة تدقيق جميع الأسئلة قدر الامكان لكن من الممكن وجود بعض الأخطاء المتبقية.
- في حال اكتشاف خطأ في إجابة أي سؤال يرجى التواصل مع أحد أعضاء الفريق الأكاديمي في دفعتك ليقوم بإيصال الملاحظة لنا وتعديلها.

- شكر جزيل لكل من ساهم في جمع هذه الأسئلة, لم يكن ليتم هذا العمل لولاكم, وشكر خاص للزميل **يزن علاونة** من دفعة إحسان على جهوده الكبيرة في جمع وتنسيق هذا الملف.

كل التوفيق نرجوه لكم

دمتم جميعاً بود

OBS-GYNE MINI OSCE
6th year - Group A

21.11.2019

Question 1

1. What is the name of the condition seen in the picture?
   Urgency

2. Define it.
   Sudden compelling desire to pass urine, which is difficult to defer.

3. Explain the mechanism for this condition. Detrusor over activity, over active bladder.

4. If the patient in the picture doesn't make it to the toilet and has incontinence when cough or sneeze, what does she has?
   Mix incontinence

5. Name a test to differentiate between the 2 types.
   Urodynamic study

5. If she experienced it for the first time, mention 4 lines of management.
   - Lifestyle modification
   - Pelvic Floor Muscle Training
   - conservative
   - medical (Anti-muscarinic drugs)
   - surgical

“don’t know if these are the exact correct answers”

a
.


SONOLINE B

b
.


136
160
30
COMEN

c
.

d
.


NDC 0641-6114-01
Oxytocin Injection
(synthetic)
10 USP Units/mL
For IV Infusion or IM Use
1 mL Single Dose Vial

Question 2

Scenario about lady in first stage of labor.

1. What is the name of the device in picture a & b ?
   A: Sonicaid, Doppler fetal monitor, Intermittent Fetal heart monitor B: Cardiotocogram

2. Why is device A used for, and when/how?
   Listen to fetal heart rate: every 15 minutes or after every other contraction (in 1st stage according to the slides)

3. What is in picture c? Why is it used for?
   Amnio-hook, artificial rupture of membrane (amniotomy), shortens the length of labour if the woman is contracting regularly, or as induction

4. Give 2 indications for oxytocin.
   Induction of labor, control postpartum bleeding

5. Give 2 side effects of oxytocin.
   Uterine hyperstimulation, fetal heart rate deceleration.

① ② water toxicity and hyponatremia.

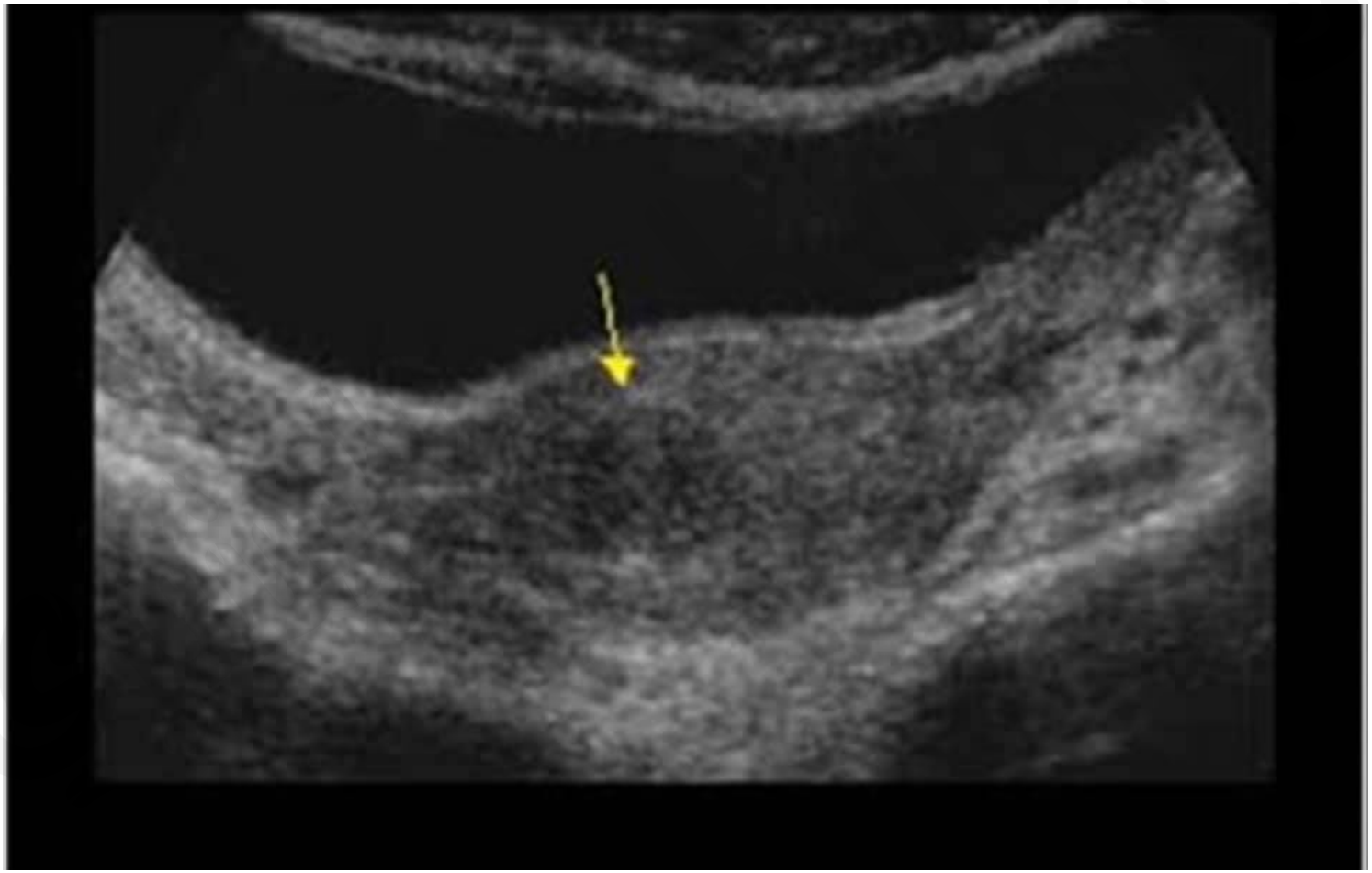
Question 3

1. Give 3 indications for elective cesarean section.
   Transverse lie, previous 2 CS, placenta previa

2. How would you care for woman next day following cesarean section, 4 points.
   This question had wide range of answers!

3. Mention 2 early complications for CS.
   Bleeding, surgical injury (bladder, ureter..)

4. Mention 2 late complications for CS.
   DVT, incisional hernia



Question 4

Lady came to your clinic complaining of dysmenorrhea, 35 years old, G3 p3.

1. What is in the picture? Fibriods

2. How does cause infertility? 4 points

   affect tubal motility, anatomical blockage, affect implantation (sick endometrium), mechanical obstruction of tubs

3. Mention 3 lines of management. Conservative, medical, surgical

4. What is the benefit of medical therapy before surgery?
   Shrink in size, less bleeding, alleviate symptoms, can change incision from midline

5. In fertility point of view, what are the indications for surgery?
   Question wasn't clear, Dr. Feras didn't answer it.
   Some said: >4cm, recurrent abortions, multiple fibroids

OSCE cases- OBS

Examiner tells you there's 6 marks on the first page, if you moved to the next page you cant go back.

In the first page of questions:

Mrs. Suzan, G3 P2, EDD 1/12/1019, presented with gush of fluid, ...etc. "PROM case"

- What you do to her as physical examination?

You need to mention only physical examination, start with vitals, general examination, abdominal; Leopold's maneuver **in details**, speculum, bishop score in details, tests to confirm PROM (these are the main points).

Things like U/S, fetal heart ...etc. are not counted.

OSCE cases- OBS

- In the second page:

Patient's vitals (all normal), bishop score findings (cervix anterior, soft, station +3, length 1cm, dilation 5cm)

Is it favorable cervix? "Some doctors asked to calculate the score"

What would you do for her? Induction

OSCE cases- OBS

- In the third page:

What's the progress of cervical dilation? "you need to remember that she's multi from the first page"

1.2cm/hour

How would you monitor fetal heart? ???

every 5 minutes or after every other contraction

OSCE cases- GYNE

- IUCD insertion consultation.

(patient profile, LMP, G/P , contraindications, risk assessment, fertility
plan...)

- When to follow up after insertion? 4-6 weeks

- After vaginal delivery, when to put it? 4-6 weeks

- Differential diagnosis of missing thread & management.
  Expulsion, Perforation, Pregnancy, Short thread,
  Mx: U/S, abdominal X-ray

- IUCD complications.
  Expulsion, PID, Perforation, Ectopic pregnancy,
  bleeding pattern & pain. Lost threads. Pregnancy

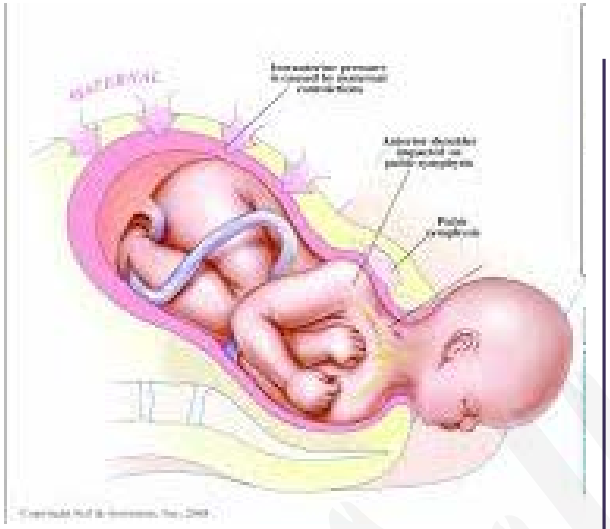
- Good luck!

Obs + Gyne MiniOSCE 09/26/2019 Ihsan Batch - Group B – 6th Year

Q1: Nadia, a 25 years old G1P1 came to the clinic came to the clinic complaining of galactorrhea and oligomenorrhea

1. What is your first investigation?
   Prolactin level
2. Write other 2 investigation you want to order?
   -Brain CT -FSH, LH , TSH
   -Microscopy to visualize fat droplets
3. Write 2 drugs can cause it?
   -Antidepressants (TCAs)
   -Anti psychotics
   -Dopamine antagonist (Domperidone)
   -OCPs
4. Write 2 drugs for the treatment ?
   -Bromocriptine (dopamine agonist)
   -Cabergoline
5. If this pt. doesn't want to be pregnant , does she still in need for treatment and why?
   Yes , because this condition could be caused by a prolactinoma which needs treatment (inaccurate answer)

Q2:



1. What is the name of the condition in this image?
   Shoulder dystocia
2. What is the incidence?
   0.2-3% (other books say 1%)
3. Mention 3 risk factors?
   Maternal DM, obesity, post date pregnancies, fetal macrosomia, prolonged 1st or 2nd stage of labor, Hx of shoulder dystocia
4. Mention 3 fetal complications that can occur?
   Brachial plexus nerve injuries, Erb'spalsy, fetal humeral/clavicular fractures, hypoxia/death, permanent neonatal neurological damage
5. Mention 4 maneuvers to deliver the baby?
   -McRoberts Maneuver
   -Woods screw maneuver
   -Suprapubic pressure
   -Rubin maneuver
   -Zavanellimaneuver
   -Manual delivery of the posterior arm

Q3: 30 years old lady, Para 6, previous CS, NVD 30 minutes ago and now suddenly patient collapsed

1. What's the definition of maternal collapsed?
an acute event involving the cardiorespiratory systems and/or brain, resulting in a reduced or absent conscious level (and potentially death), at any stage in pregnancy and up to six weeks after delivery.
2. What is the incidence?
0.14 – 6 per 1000 births (as per the RCOG guidelines)
3. Write 4 obstetric causes of maternal collapsed?
-Uterine rupture –Uterine Inversion
-Amniotic fluid embolism –Post partum H.
4. What is the most likely cause in this pt. And why?
Uterine rupture , because:
1-multiparous 2-Previous CS
5. Write 2 non obstetric causes of maternal collapsed?
-MI
-Cardiac Tamponade

The 4H's and 4T's

Q4:

Pt. 33weeks GA . Presented with PROM

1. After Hx. What's your investigation for this pt.?
   -Speculum and abdominal exam
   -Nitrazine test, Ferning pattern
   -Maternal wellbeing (Vital signs, WBC, CRP)
   -Fetal wellbeing (NST) -US
   -Amnisure
2. What are you looking for in abd. Examination (4)?
   -Fundal height –Lie –Presentation –Oligohydramnios – Uterine tenderness
3. If the fetus was breech and the pt. is term what is the most common cause? And is there any maneuver can be done to prevent C/S?
   -Placenta Previa
   -External Cephalic version
4. Mention 2 drugs for treatment and why?
   -Steroids → fetus lung maturity
   -Erythromycin for 10 days → to prevent chorioamnionitis

Consultation station:

A pregnant lady with twins (dichrionic,diamniotic) came to the clinic:

1-What are the risk factors for twin pregnancy

2-What are the complications on the mother

3-What are the possible complications on the fetuses

Hx Station: A pt. is scheduled for a laparoscopic hysterectomy, how to take consent from her (what would be written on the consent paper?:P)

Here are some things you need to mention:
-Pt name + الرقم الوطني
-Name of the doctor
-Name of the hospital
-Date of consent + date f the surgery
-Diagnosis
-Indication for the surgery
-Explain the procedure to the pt
-Pt signature
-Complication:
intra op→ Injury to other organs(4): ureter, bladder, rectum, bowel and blood vessels and other intra op complications
Post op→ Thrombosis, adhesions, post op blood transfusion, re-opening, wound infection, etc

Obstetrics and Gynecology miniOSCE

Group D- Ihsan batch

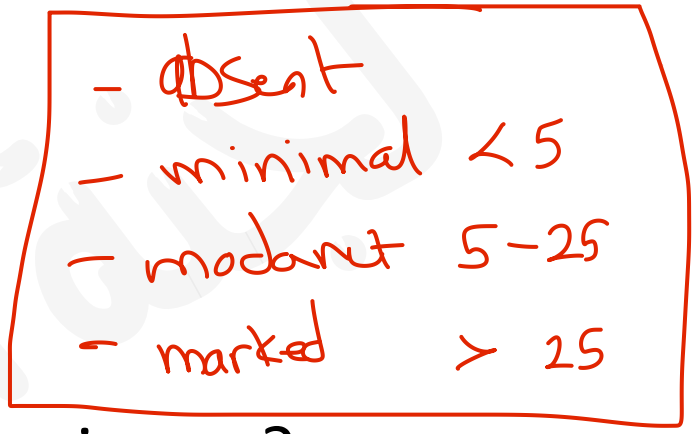
30-1-2020

- Q1:

CTG image

1-What is the above tracing called?

CTG



2-what are the components of this tracing in the image?

FHR:130-140

Baseline: moderate variability

No accelerations

Late decelerations are present

2 contractions per minute

3-what are the causes of the above abnormality?

Acidosis,inflammation

Uteroplacental insufficiency

4-what is the next thing to do if the station is +2, cervix is fully dilated,, presentation cephalic?

- Q2:

A pregnant lady, 32w GA, presented with abdominal pain, headache, no known medical illnesses, then developed a self limited seizure

1-what is the likely diagnosis?(mention 2)

-eclampsia

2-what is the most important sign on examination?

Blood pressure

3- mention 3 lines of treatment with their indications

-hydralazine to lower blood pressure

-MgSO4 for seizure prophylaxis

-Corticosteroid for fetal lung maturity

- Q3:

1

canula

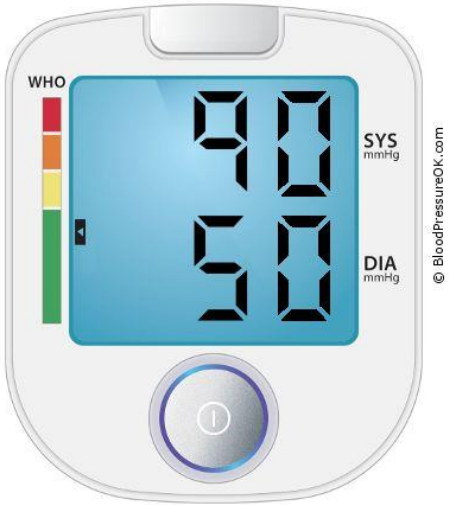
2

drain

3

urine bag

4



Hypotension (Too Low)

1- what do you comment on in the first image?

-color, time and date of insertion, site, presence of inflammation

2- what is the object in image 2 called?

redivac drain

-What is its type?

Closed negative pressure active drain

- when do you remove it?

When the output is less than 50ml in 24h, serous fluid

3-what do you comment on the image 3?

The color, the output

-when do you remove it?

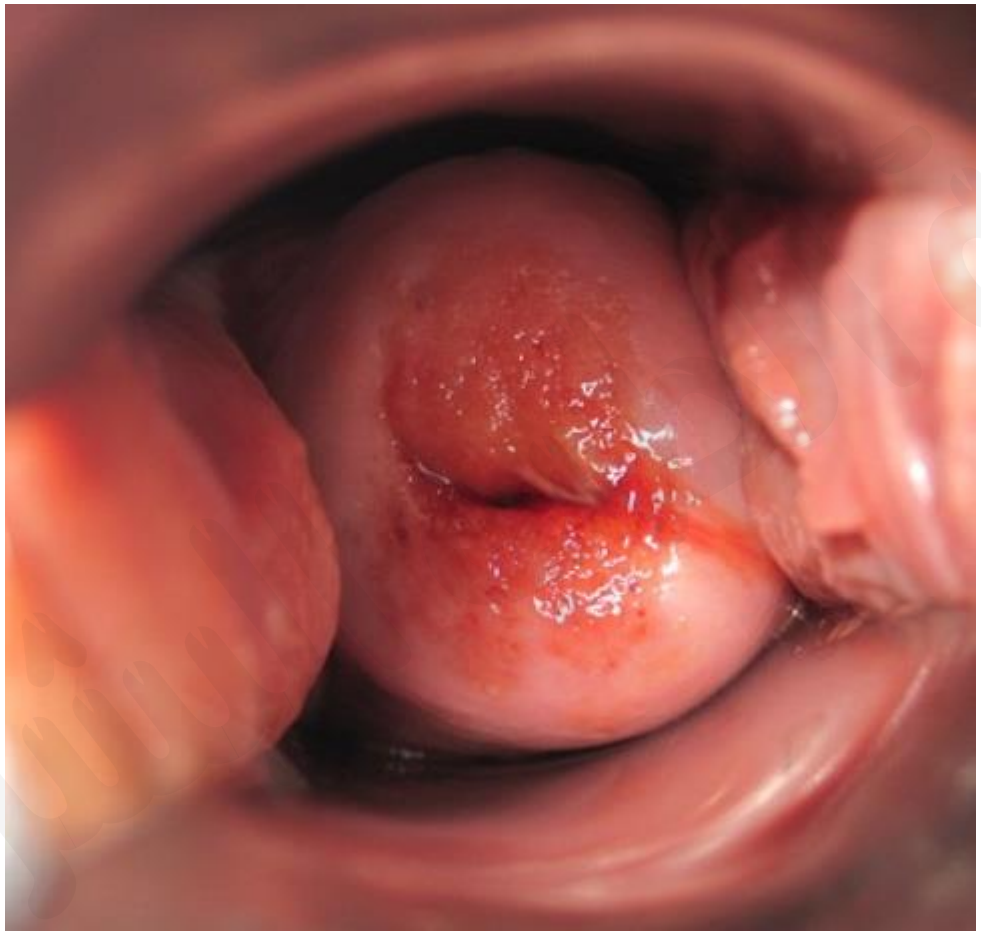
When the patient starts mobilizing

4- the patient had hysterectomy, her blood pressure is as shown,pulse is 110 bpm, what is the first differential diagnosis?

Surgical hematoma

↳ internal bleeding.

- Q4:



A patient presented with vaginal discharge of 7 months duration and postcoital bleeding

1-What is the most likely dx?

Cervical ectropion

2- mention 2 things you should ask the patient about

Pap smear, smoking, history of STDs

3-Mention 5 relevant investigations

- Pap smear
- High vaginal swabs for gonorrhea
- High vaginal swab for chlamydia
- Cone biopsy

4- if all results are negative, what is the next step?

Follow up on pap smear

OSCE stations

1- A couple married for 2 years, the lady is 35 year old but still did not conceive

- Take relevant history
- What investigations do you order?

TSH, prolactin, FSH, LH , ovarian reserve tests: day 2-3 FSH, AMH, AFC,

Day 21 progesterone to check for ovulation

Hysterosalpingogram, hysteroscopy

-on hysteroscopy an endometrioma was found, how do you treat this patient?

if more than 3cm → Laproscopic resection

-how do you explain the cause of this condition to the patient?(mention the theories: retrograde flow, coelomic metaplasia, lymphatic)

2- A pregnant lady, 34w GA , presented with abdominal pain

- abruption
- uterine rupture

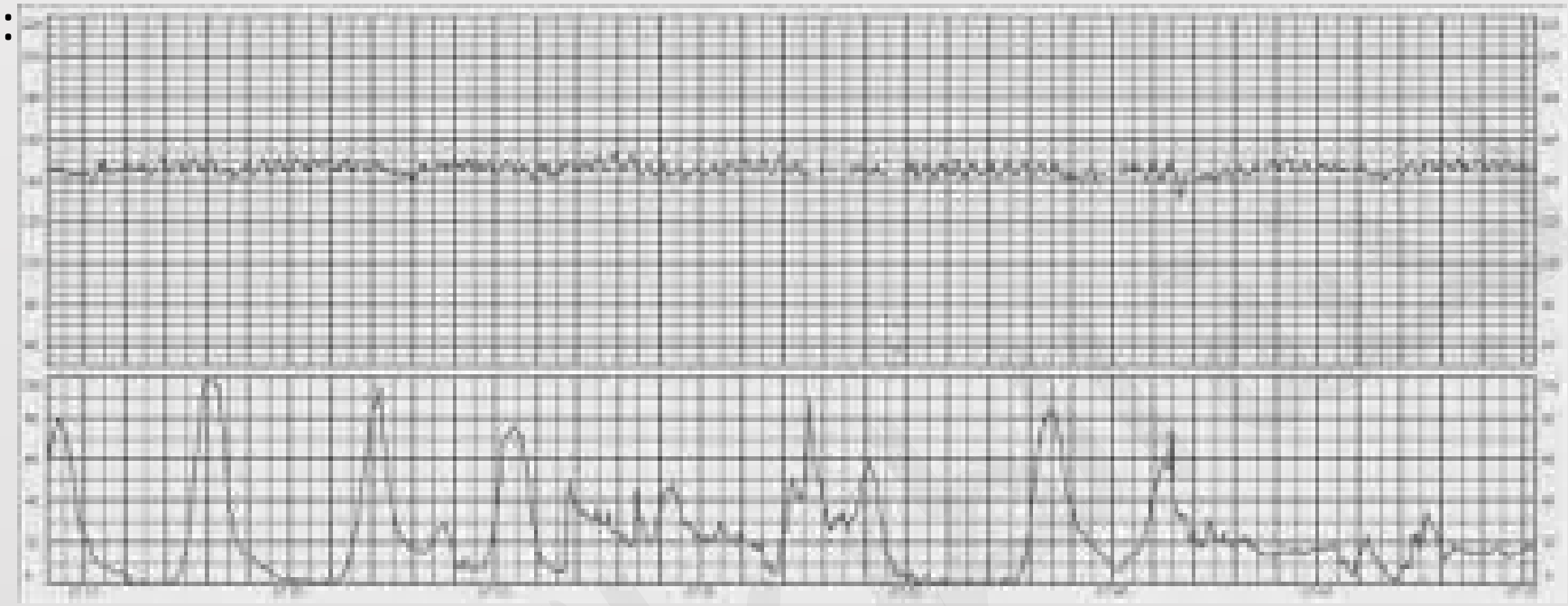
- Take relevant history

Take patient profile, pain analysis, ask about contractions, vaginal bleeding, show, fetal movement, history of trauma, uti sx…

SOUL BATCH- Group A

20-2-2020

Q1:



1- Is it a screening or diagnostic test? And what is the false positive rate?

2-What is the most important thing to look for first? Why?

3-What are the criteria of the reactive test (the normal one)?

4-What to do for this case if the cervical dilatation is 6 cm?

5-mention 4 components of bishop score?

1-Screening test, 50% from Google *in Kaplan it is higher about 98% we don't know the correct answer.

2-Presence of accelerations, because accelerations occurring alongside uterine contractions is a sign of a healthy fetus.

normal with accelerat

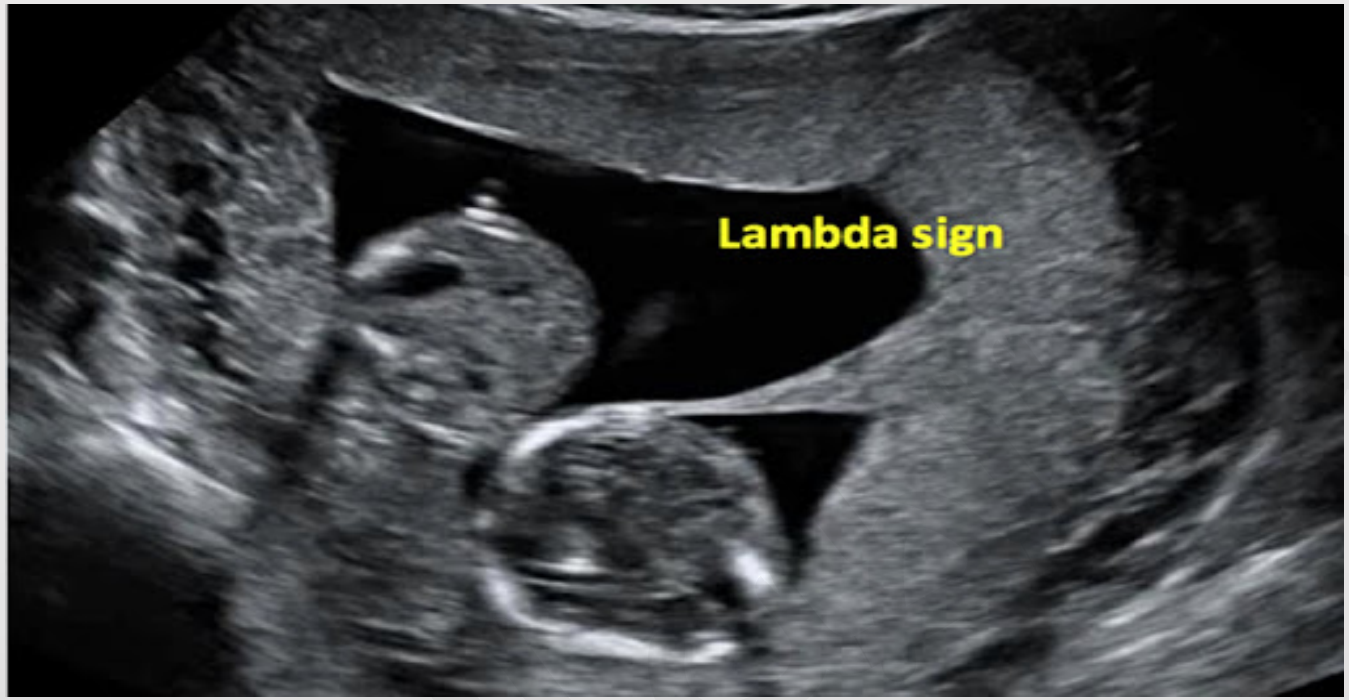
3-Presence of accelerations, absence of decelerations, basal FHR between 110-160 bpm,moderate variability.

2 accelerations / 20 mins.

4- CS delivery (not sure)

5-Cervical position, cervical effacement, fetal station, cervical consistency ,cervical dilatation.

Q2



1-what is the name of this sign?
2-classify this pregnancy in term of chorionicity and amnionicity?
3-when was the time of cleavage in this case?
4-what are the risk factors for this condition?
5-mention tow fetal complications?

1- lambda sign.

2- monochorionic diamniotic.

3- 4-8 days.

4-Family history, assisted reproductive technology, increasing maternal age.

5- TTT syndrome ,fetal anomalies, weight discordance.

Q3:

PET case with headache, her blood pressure was 170\90, LMP 5th\December\2019:

1- calculate the gestational age and the EDD for this lady?

12/9/2020

10+5 GA

2-what is your diagnosis? chronic HTN

3-mention tow symptoms? head ache / ↑ BP

4- mention tow physical signs?

5-mention tow long-term complications?

- placenta abruption
- super-imposed pre-eclampsia.

6-what are the clinical parameters of your diagnosis?

1- ~11 weeks gestation, 12/9/2020.

2-Preeclampsia.

3- vomiting, photophobia, right upper quadrant pain..

4-Edema, elevated liver enzymes, low platelet count..

5-neurological dysfunction, developing hypertension later on.

6- Lifestyle -Fetal Assessment -Fluid management –Medications.

Q4:

Apical uterine prolapse case with this picture:

1-what are these devices?

2-mention tow complications of their use?

3-what are the symptoms that the patient may complain other than those mentioned above?

4-mention three structures that support the uterus?

4- if this method failed, what is your treatment if she is sexually active/inactive?

1-Vaginal pessaries.

2-Infection,expulsion,discomfort.

3- back pain, impaired sexual activity, heaviness, dragging sensation..

4- Uterosacral, Cardinal ligaments, Arcus Tendineus,Perineal body and membranes.

5-If sexually active: Primary Paravaginal repair Hysteropexy.
If sexually not active: Primary Vaginal hysterectomy with Anterior/Posterior repair.

Q5:

The case was about lady that was complaining of lower abdominal pain and vaginal bleeding for the last 2 weeks, the bleeding got worse in the last few days ,her last menstrual period was before 7 weeks, ultrasound was performed and revealed an empty sac with no fetal heart.

1-give three differential diagnosis?

2-mention one clinical sign that support your diagnosis?

3-what are the lines of your management?

4- if her blood group was negative and her husband's blood group was positive, what do you recommend ? (pardon me for being unable to remember the question exactly but the aim of it was whether to consider anti-D in your management or not)

1-Missed miscarriage, gestational trophoblastic disease, local cause(cervical polyp),bacterial vaginitis.

2- BhcG level drop. or βHCG increasing by < 66% in 48 hrs

3- expectant, medical with uterotonics(misoprostol), surgical with D&C, E&C.

4- yes I recommend anti-D.

OSCE cases ☺

There was an ovarian cancer case ,the lady was complaining of lower abdominal pain, physical examination was done and revealed bilateral masses with an ultrasound finding of fluid in the pouch of douglas , CA125= 800 IU\l.

-What is the most likely diagnosis?

-What would you ask in the history?

-what are the clinical signs that you might find?

-what is your management?

to ① calculate RMI
then ② do tumor markers
③ cyto reductive surgery

③ CT TAP and staging.

A(para4) lady with a history of previous CS that was done because of a transverse presentation of the baby, she had delivered vaginally and now she is hypotensive with no evidence of haemorrhage.

1-What are the causes of this condition and what is the most likely cause?

2-mention the risk factors?

3- Physical examination findings?

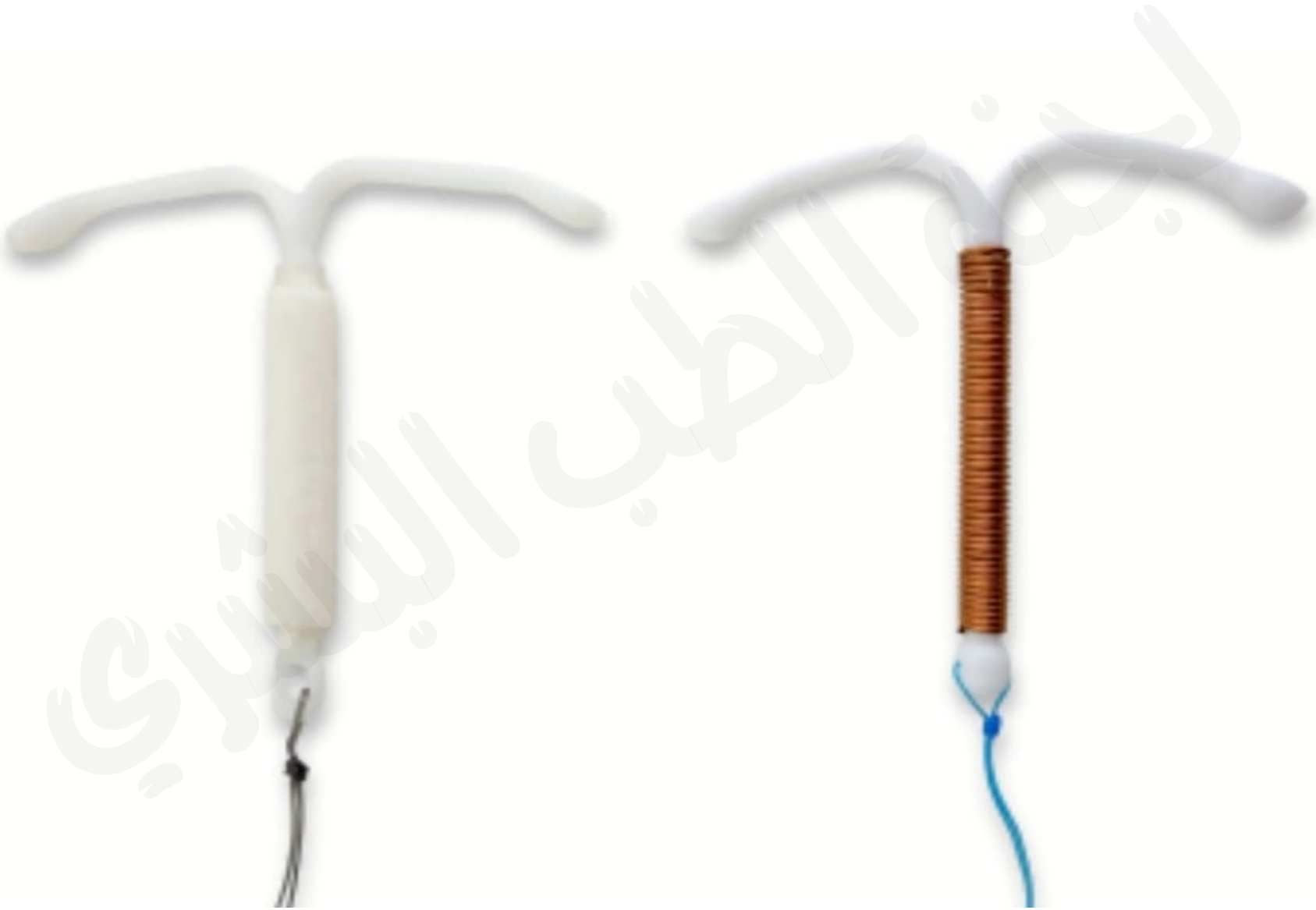
4-what is your management?

Mini OSCE + OSCE (C-Groups)

16/10/2019

Mini OSCE

Q1



- 1-Name of these:
  - IUCD "intra-uterin cupper device"
  - IUS "intra-uterin system"

  2-How longe action:
  - IUCD>> 10 years.
  - IUS>> 5 years.

  3- When to insert it in menustral cycle ? , and why?
  Immediately after period, Because there's no uterine contraction , to rule out pregnancy, and For easier insertion(cervix still open)

  4-Non contraceptive benefits (the medicated one):
  - reduces the vaginal bleeding and pain.
  - endometrial protection.
  - Management of endometriosis.

  5-Mention two complicantions at time of insertion of device or one week after:

  - perforation
  - vasovagal syncope
  - loss of threads
  - ectopic pregnancy
  - PID

Q2 Primary amnorrhea

1) Define primary amnorrhea

Absence of menstruation

Investigated at age of 14 years if there are no 2ry sexual characteristic or age of 16 with 2ry sexual char.

2)four things you ask about in history

- chronic systemic illness such as D.M, cystic fibrosis, R.F
- History of delayed puberty in mother or sibling
- Anosmia(suggestive of Kallman's)
- Excessive exercise or competitive sportss
- Anorexia nervosa
- Childhood cancer requiring chemotherapy or rdiotherapy
- Cyclical pelvic pain.

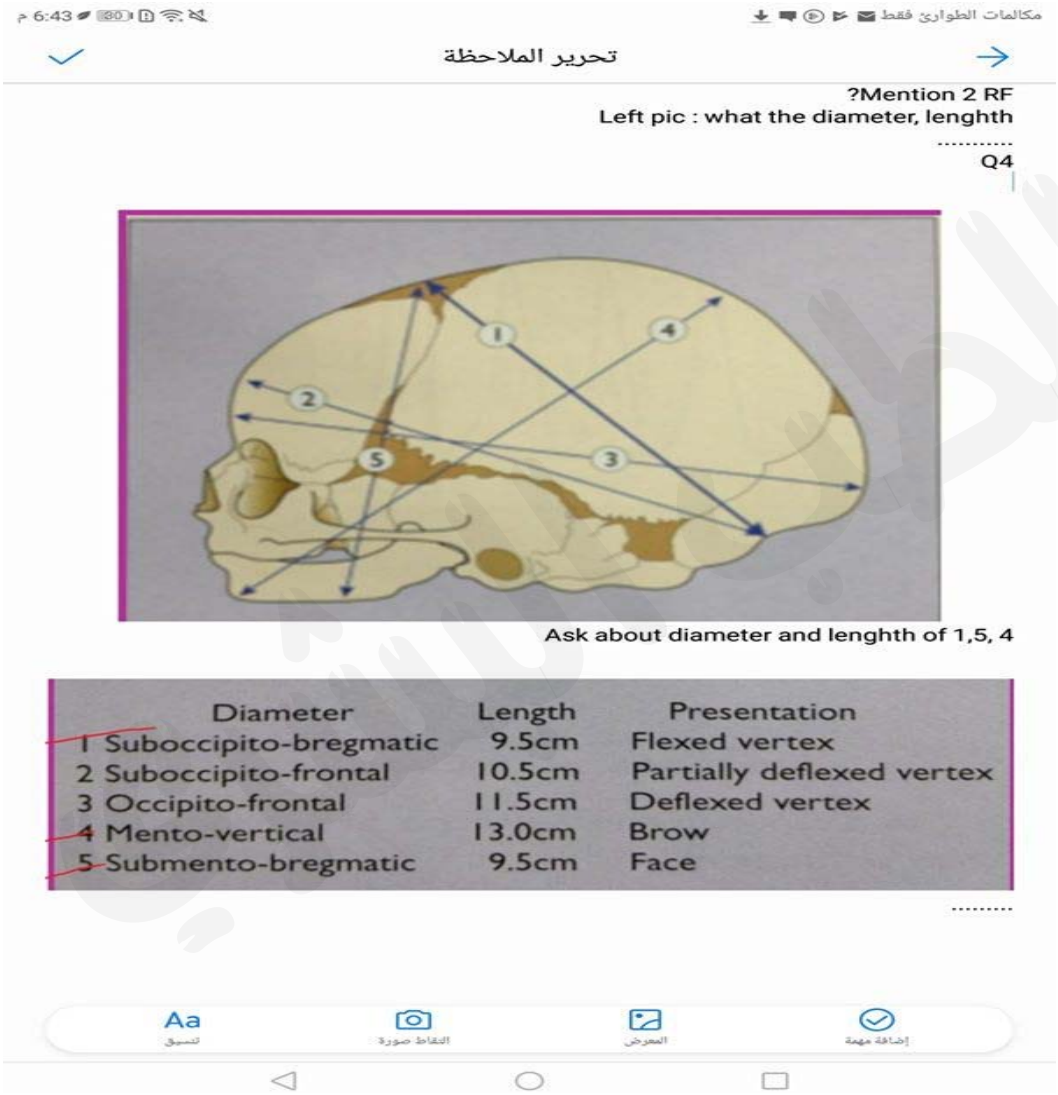
3)What will you look at in physical examination ?
- Stature - BMI - Breast development
-Presence of pubic and axillary hair - Inguinal masses - Hirsutism and evidence of virilism

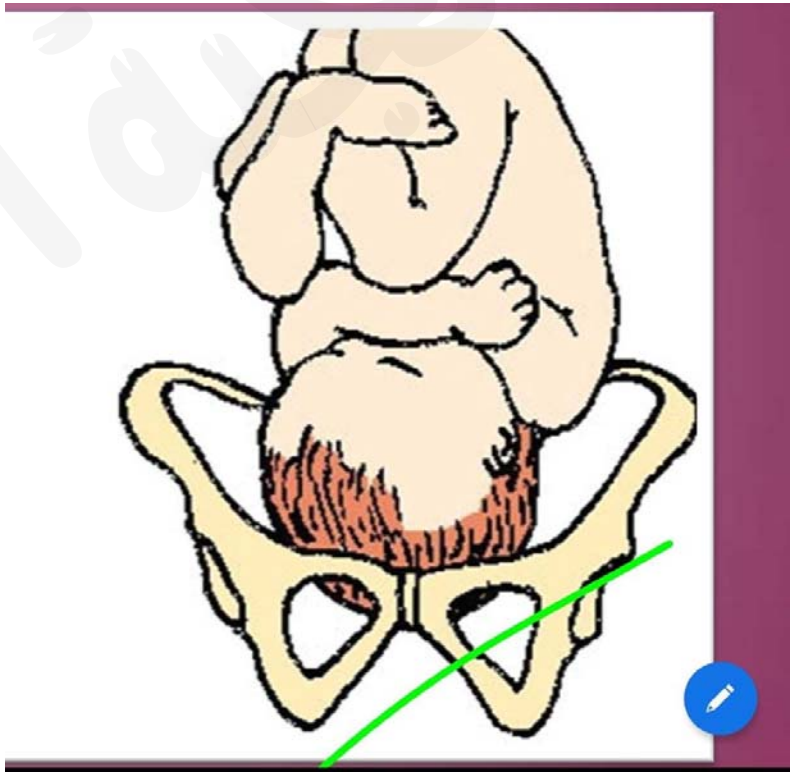
4)Investigations
- FSH and LH
- Oestradiol level
- Peripheral blood karyotype
- Pelvic U/S and MRI

5)if there's absent uterus in pelvic MRI, what are your DDx?
-CAIS - uterine agenesis *(Mayer- Rokitansky syndrome)*

6)what is the investigation you do based on your DDx?
karyotype

Q3 :


تحرير الملاحظة
?Mention 2 RF
Left pic : what the diameter, lenghth
.....
Q4
1
2
3
4
5
Ask about diameter and lenghth of 1,5, 4
Diameter | Length | Presentation
1 Suboccipito-bregmatic | 9.5cm | Flexed vertex
2 Suboccipito-frontal | 10.5cm | Partially deflexed vertex
3 Occipito-frontal | 11.5cm | Deflexed vertex
4 Mento-vertical | 13.0cm | Brow
5 Submento-bregmatic | 9.5cm | Face
.....
Aa



* left picture :

- The names and lengths of these diameters (1/4/5)

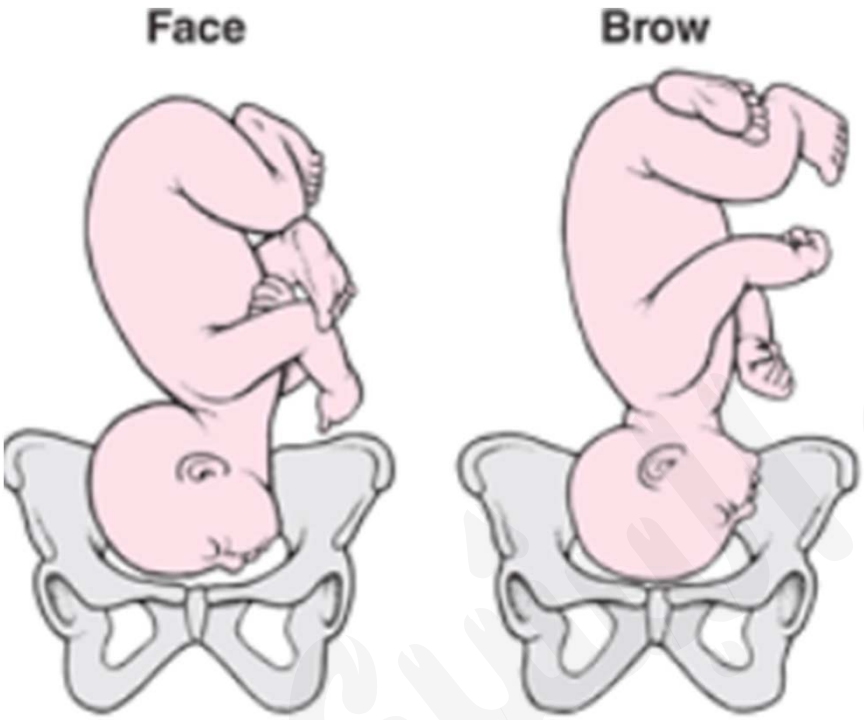
* Right picture :

- What' the station in the picture? Ans -3
- What is the station when the head is engaged? Ans: 0

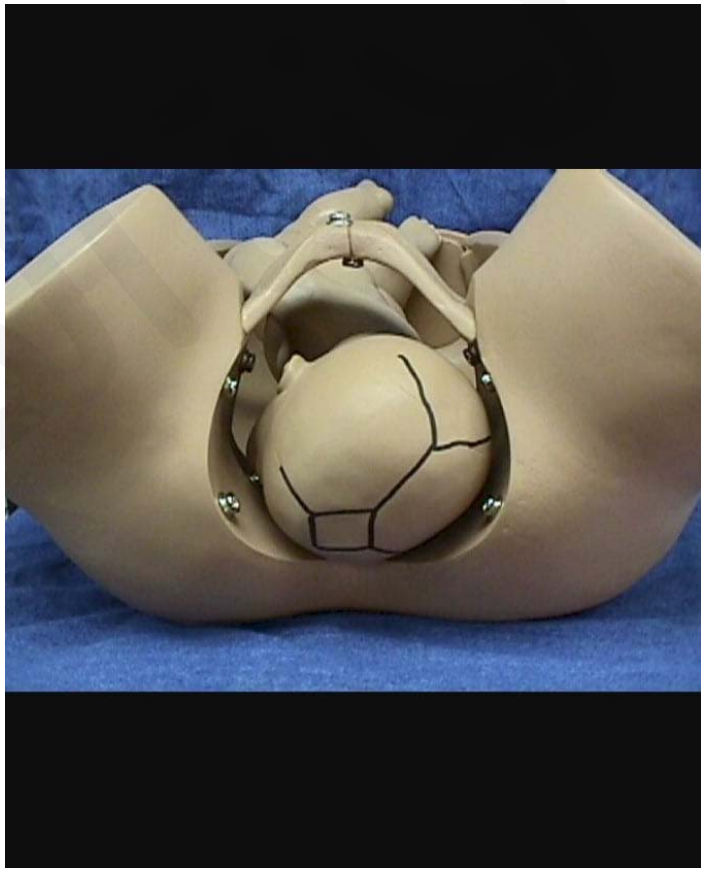
Q4 : Case Of APH

- What are you most concern about? 1- 2-
- investigations?
- what you look at in ultrasound?? 1- 2- 3- 4-
- what do you do to decrase maternal and neonatal mortality?

Q5 :



Pic A



Pic B

- Q5 :
  Pic A :
  1- Name the presentation in the right and left pictures ?

  2- can we do a normal vaginal delivery in the right picture? And when?

  3- Mention 2 risk factors for the left picture

  4- what is the diameter and its length in the left picture?

  Pic B :
  5- Name the position in this picture ?

OSCE

- Case of bleeding at 7 week of gestation
  Q1 relative history?
  Q2 physical examination?

- case of gestational DM
  Q1 : Diagnostic cretria (with numbers)?
  Q2 : 2 maternal and 2 fetal complicantions
  Q3 : 2 risk factors
  Q4 : Physical examination findings 2 ?

Online MiniOSCE exam

1.A 28-year-old G3P2 (both vaginal deliveries) presents on the labour ward with PPROM at 36 weeks of gestation. She had a cervical suture placed at 17 weeks of gestation following premature labour in her previous pregnancy, which resulted in a vaginal delivery at 29 weeks of gestation. She shows no signs of clinical infection, the CTG is normal and the fetus is normally grown and cephalic presentation on ultrasound. What is the most appropriate management step?

A. Remove the suture and consider induction if spontaneous labour does not occur
B. Give betamethasone and erythromycin and remove cerclage after 48 hours
C. Give betamethasone and erythromycin and remove cerclage when there are signs of labour
D. Perform a caesarean section
E. Give betamethasone and atosiban and remove cerclage after 48 hours

Answer A (not sure)

2.A 40-year-old woman presents with heavy menstrual bleeding and she has completed her family. Endometrial biopsy shows endometrial hyperplasia without atypia. What is the best treatment option?

A. Tranexamic acid in addition to Mirena coil
B. Total abdominal hysterectomy and bilateral salpingo-oophrectomy
C. Oral contraceptive pills
D. Insert a Mirena coil
E. Total abdominal hysterectomy

Answer is

3.One of the following matches is false:

A. Hypertonus: A contraction lasting for > 1 minute in association with changes in the fetal heart trace.
B. Tachysystole: > five contractions in 10 minutes over a period of at least 20 minutes
C. Acceleration of uterine contractions when labour has already started: Augmentation of labour
D. Thinning and shortening of cervix: Effacement
E. The artificial starting of labour before its spontaneous onset: Induction of labour

Answer is A

4.A 17-year-old girl without a significant past medical history has been diagnosed and treated for a yolk-sac tumour. Which tumour marker would be most appropriate to use for follow-up?

A. α-fetoprotein
B. Lactate dehydrogenase
C. CA125
D. hCG
E. Placental alkaline phosphatase

Answer is A

5.Complications of instrumental delivery, one statement is false

A. Ventouse compared with forceps is more likely to fail
B. Ventouse is less likely to be associated with significant maternal perineal and vaginal trauma
C. Operative vaginal delivery with the ventouse should be completed within 5 minutes of cup application
D. 10% of ventouse deliveries are associated with cephalhematoma
E. Anal sphincter defects are more common with forceps than with ventouse deliveries.

Answer is C

6.A white 40-year-old woman presents with moderate uterine prolapse, severe anterior and posterior vaginal wall prolapse. She has 3 children, all born vaginally. She suffers from asthma, which is well controlled on inhalers (seretide 2 puffs 3 times a day and ventolin as required). Her mother had vaginal hysterectomy for pelvic organ prolapse. Her BMI is 37. Which risk factor could be modified to improve the safety and effectiveness of any surgical procedure carried out for her pelvic organ prolapse?

A. Being white
B. Parity
C. Asthma
D. Family history of pelvic organ prolapse
E. Body mass index

Answer is E

7.A normal cardiotocograph (CTG) pattern does not include:

A. A baseline variability of 5–25 bpm
B. The baseline FHR is 110–160 beats per minute (bpm)
C. A trace with two accelerations in a 20-minute window is termed reactive
D. Baseline variability is a reflection of the integrity of the central nervous system
E. Baseline FHR depends on the gestation age

Answer is d

8.A 32-year-old woman has had three admissions in the last year with functional cyst rupture. What is the most appropriate treatment to reduce her risk of this recurring?

A. Progesterone-only pill
B. Combined oral contraceptive pill
C. Clomiphene citrate
D. Norethisterone to be taken mid-cycle
E. Gonadotrophin-releasing hormone analogues

Answer Is B

9.All the following pairs are correct except

A. Lie: oblique
B. Engagement: two fifths are palpable abdominally
C. Presenting part: shoulder
D. Station: at level of ischial spine
E. Position: flexed

Answer is E

10.Intrapartum management of twin pregnancy, one is correct

A. Amongst vaginally delivered twins, the perinatal mortality rate for the first twin is higher than for the second twin
B. During vaginal delivery, the presentation of the second twin may change
C. Randomised controlled trials have demonstrated that planned caesarean section is the optimal mode of delivery
D. The perinatal mortality rate for twins is similar to that for singletons
E. Following vaginal delivery of the first twin, caesarean section is always indicated if the second twin is breech
   Answer is E (not sure)

11.Ovarian torsion; one of the following is true(1 Point)

A. Associated with dermoid cyst
B. Managed conservatively with antibiotics, fluids, and analgesia
C. Untwisting and fixation of the ovary to the pelvic side wall
D. Abdominal tenderness is always related to the severity of abdominal pain
E. Pyrexia is an early symptom

   Answer is c

12.Mrs. Adams' LMP was 07/03/2020. She has regular 28-day cycles. Her EDD will be

A. 14/12/2020
B. 16/10/2020
C. 10/12/2020
D. 14/11/2020
E. 16/12/2020

Answer is A

13.When performing vaginal breech delivery,

A. May use suprapubic pressure to deliver the fetal head
B. Pull the umbilical cord to ensure it remains loose
C. Attempt to deliver flexed legs by pulling the heels
D. Attempt to keep the sacrum posterior
E. Wrigleys forceps should always be used to deliver the fetal head

Answer is a (not sure)

14.A 70-year-old woman presents with constipation and a sensation of a vaginal lump. Examination reveals a rectocele. Which point on the POP-Q scoring system corresponds to the posterior vaginal wall?

A. D
B. Aa
C. Ap
D. C
E. Ba

Answer is C

15.Breech presentation,

A. Perinatal mortality and morbidity are increased with breech presentation compared with cephalic presentation
B. Pelvimetry is essential before vaginal breech delivery can be considered
C. Footling breech is the most common type of breech presentation
D. The intrapartum diagnosis of breech presentation is a contraindication to vaginal breech delivery
E. The incidence of breech presentation is 3–4% at 28 weeks of gestation
Answer is

16.A 24-year-old woman presents to the emergency department at 4 days postnatal feeling unwell with generalised malaise, nausea and headache. She had a normal vaginal delivery of a 3.4 kg baby boy. On arrival her observations were as follows: pulse = 100 bpm blood pressure = 165/115 mmHg temperature = 36.3°C oxygen saturation = 97% on room air. she has a tonic–clonic seizure that lasts 1 minute whilst receiving hand-over from the admitting doctor. The emergency department team has already secured intravenous access and sent relevant blood for investigations (results not yet available) and is administering oxygen. What is the most appropriate immediate management option?

A. Give 4 g magnesium sulfate over 5 minutes
B. Give 1 g magnesium sulfate over 1 hour
C. Give labetalol 200 mg orally
D. Give 10 mg IV diazepam
E. Give 4 g magnesium sulfate over 1 hour

Answer is D (not sure)

17.A 24-year-old with PCOS and primary subfertility of 1 year attends the fertility clinic with her husband. Her cycles are irregular. Her BMI is 35. Hysterosalpingogram confirmed bilaterally patent tubes. SFA (Seminal fluid analysis) shows sperm concentration of 5 million spermatozoa per ml. What is the most appropriate management option of her subfertility?

A. Ovulation induction with clomiphene 50 mg for 6 months
B. Repeat SFA
C. Intrauterine insemination for six cycles
D. Recommend one cycle of IVF treatment
E. Laparoscopic diathermy to ovaries

Answer is B

18.A 52-year-old woman presented to the postmenopausal bleeding clinic. A transvaginal scan showed an endometrial thickness of 5 mm. She has previously used tamoxifen for 5 years for breast cancer. The next step in her management would be:

A. Do nothing as she her bleeding was minimal
B. MRI abdomen and pelvis
C. Mirena IUS insertion
D. Hysteroscopy and endometrial biopsy
E. High dose oral progestogens

Answer is D

19.Regarding intermittent auscultation of the fetal heart, one is false

A. Listen to heart rate for 1 minute every 15 minutes after a contraction in the first stage of labour
B. Listen to heart rate for 1 minute every 5 minutes in the second stage of labour
C. Baseline variability is not detectable on auscultation
D. Listen to heart rate for 1 minute after each contraction in the first stage of labour
E. can be achieved with a Pinard stethoscope, or a Doppler device
Answer is D

20.The minimum physical observations in labour, one is false:

A. Temperature – every 1 hour
B. frequency of bladder emptying and the results of urinalysis if performed
C. Frequency and duration of contractions at 30 min intervals
D. Pulse – at least every hour in the first stage of labour and every 15 minutes in the second stage of labour
E. Blood pressure and respiratory rate – every 4 hours in the first stage of labour and every 1 hour in the second stage of labour

Answer is A

21.Which of the following conditions can permit the use of either forceps or ventouse, and not forceps exclusively?

A. Prematurity (gestation less than 34 weeks)
B. Face presentation
C. Suspected coagulopathy in the fetus
D. After-coming head of a breech
E. Occipito–posterior position
Answer is E

22.Changes during normal puberty, one statement is false

A. The physical changes are progressive and are described as 'Tanner' stages
B. Menstruation is a late feature of puberty and correlates with slowing down of the growth spurt
C. Initially, there is an increase in the pulsatile secretion of FSH from the pituitary gland in response to an increase of pulsatile GnRH from the hypothalamus at night
D. Pubic hair begins approximately six months after breast bud.
E. The endocrine onset of puberty begins several years before physical changes are visible

Answer is D not sure

23.A 25-year lady presented earlier this morning to the labour ward. Her LMP was 03/09/2019. The gestational age will be

A. Term + 5 days
B. 41 weeks + 0 days
C. Term + 6 days
D. 40 weeks + 2 days
E. 40 weeks + 0 days

Answer is C

24.A 39-year-old woman with intermenstrual bleeding had an endometrial biopsy that has been reported as simple hyperplasia. What is characteristically associated with this diagnosis?

A. Hyperprolactinemia
B. Anovulatory cycles
C. Hypothyroidism
D. Vagina adenosis
E. Hyperthyroidism

Answer is B

25.Blood components can cross the placenta in pregnancy, but some are not able to do so. Which of the following can cross the placenta?

A. IgA
B. IgG
C. Insulin
D. IgM
E. Heparin

Answer is B

26.Which of the following is either a risk factor or a suggestive symptom of endometriosis?

A. Multiparous
B. Low socioeconomic class
C. Afro-Caribbean race
D. Mid-cyclic pain
E. Chronic pelvic pain

Answer is E

27.Which of the following is less likely to cause abdominal pain in a 34-week pregnant lady?

A. Acute fatty liver of pregnancy
B. ovarian torsion
C. Urinary tract infection
D. Preterm labour
E. Acute cholecystitis

Answer is A

28.A 42-year-old para 4 who has completed her family presents with a history of painful heavy menstrual cycles for 1 year. Her BMI is 36. She is currently on iron supplements for anaemia. Abdominopelvic examination is unremarkable. Pelvic ultrasound shows a bulky uterus and normal ovaries with no pelvic pathology. Endometrial biopsy suggests a proliferative endometrium. What treatment is best suited for her?

A. Mirena IUS
B. Tranexamic acid
C. Combined oral contraceptive pill
D. GnRH Analogues
E. Mefenamic acid

Answer is A

29.A 30-year-old woman presents with vaginal blood spotting for the last few days. There is no pain, and a pregnancy test is positive. A 4-mm fetal pole is identified on transvaginal ultrasound scan. No heartbeat is detected. Choose the single most appropriate management option.

A. Repeat scan in 7 days
B. Offer surgical management of miscarriage
C. Offer medical management of miscarriage
D. Admit for surgical management
E. Repeat scan in 3 weeks

Answer is A

30.Mrs. Adam is a 36-year lady with 3 boys, 2 girls and she had a miscarriage. She had a boy who died in utero 2 weeks before the expected date. She is now 10 weeks pregnant. What is the correct description of Mrs. Adam's Parity?

A. G7 P5+2
B. G7 P6+1
C. G7 P5+1+1
D. G8 P5+2
E. G8 P6+1

Answer is E

31.A 35-year-old pregnant woman with a history of previous recurrent venous thromboembolism (VTE) associated with antiphospholipid syndrome presents at 8 weeks of gestation with hyperemesis gravidarum. The woman is admitted to hospital for rehydration and antiemetics. You prescribe prophylactic low-molecular-weight heparin as prophylaxis against VTE. Which of the following is the single best answer?

A. This should be continued until the woman is discharged from hospital
B. This should be continued antenatally and for 6 weeks postpartum
C. This should be continued whilst the woman has hyperemesis
D. This should be continued throughout pregnancy until delivery
E. This should be continued throughout pregnancy and for 7 days following delivery

Answer is B

32.Mrs. Adam, a 43-year-old lady presents to your clinic complaining of heavy vaginal bleeding for 1 week. The first investigation you would request is

A. BG, Rh
B. TSH, T4
C. CBC
D. PT, PTT
E. B-HCG

Answer is E

33.One of the following is not a mandatory prerequisite for an instrumental vaginal delivery

A. Episiotomy
B. Adequate contractions
C. Ruptured membranes
D. Fully dilated cervix

E. Empty bladder

Answer is A

34.You review a primigravid woman in spontaneous labour at 39 weeks of gestation due to failure of progress during the second stage of labour. On vaginal examination you diagnose a face presentation. The cervix is fully dilated and the CTG is reassuring. Which of the following suggests that a forceps delivery could be attempted?

A. Mento–posterior position
B. four-fifths of head palpable per abdomen
C. Brow presentation
D. A hollow sacrum
E. Mento–anterior position

Answer is E

35.The following questions are on decelerations in a CTG trace are true, except

A. A baseline of 110 bpm, with other features in the normal range, is considered reassuring
B. Early decelerations may be a normal feature
C. Variable decelerations are due to head compression
D. A deceleration is a transient decrease in FHR of at least 15 bpm below the baseline that lasts for at least 15 seconds
E. Variable decelerations are due to cord compression

Answer is C

Gyne Mini-Osce group C (6th year)

Q1

-Name the lesion :

condyloma acuminatum / genital warts

-What's the most common cause

HPV 6&11

-2 risk factors

Multiple sexual partners , Low immunity

-2 lines to manage

1

Cryotherapy , Laser therapy

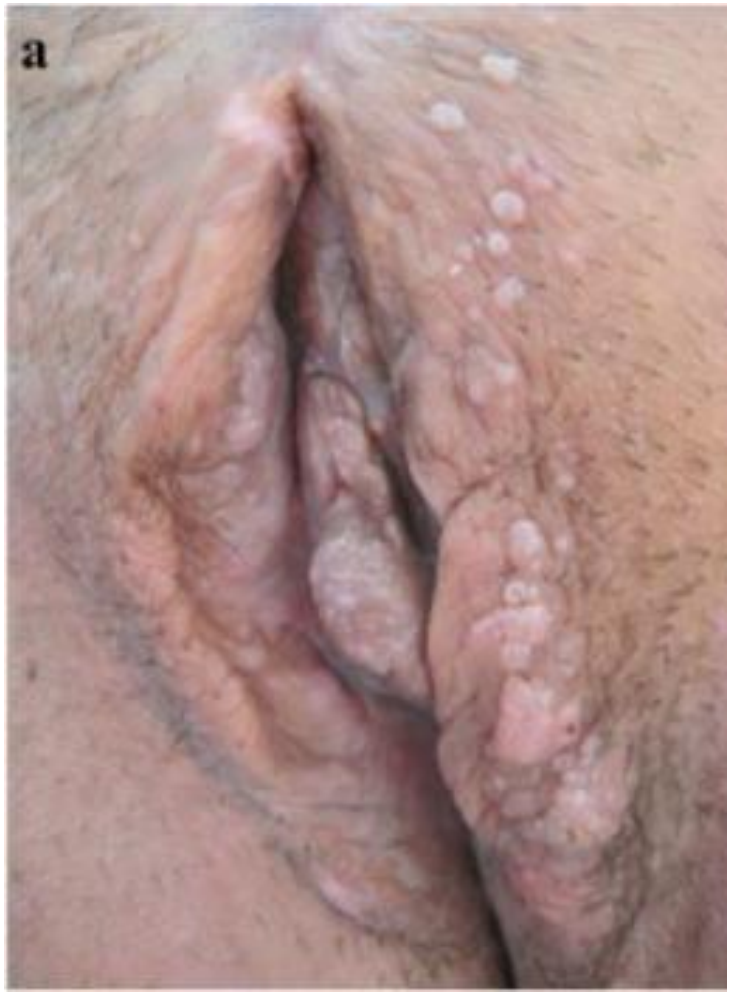
2

Surgical excision

-How to protect?

Barrier contraceptives /condoms

Vaccines for HPV 6&11 strain



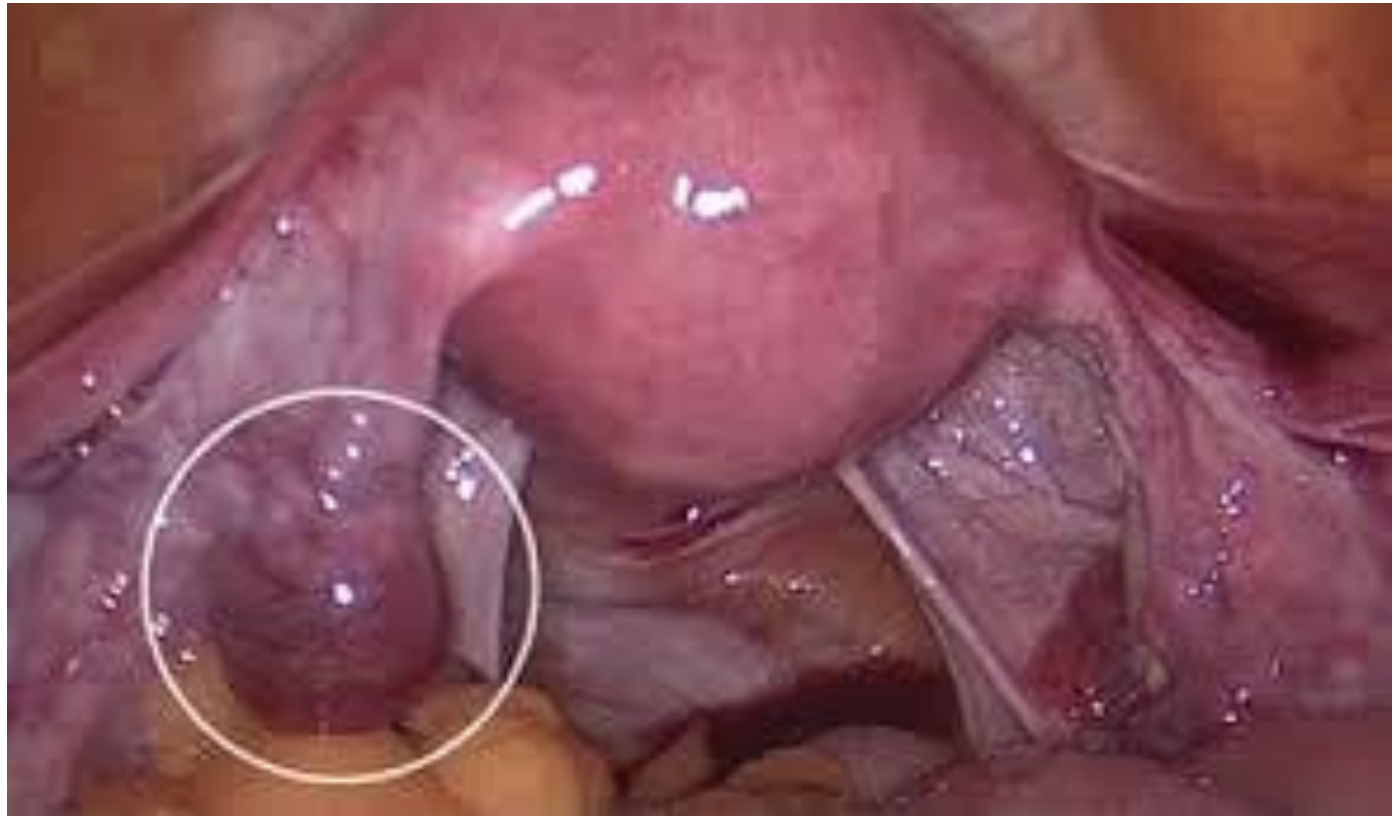
Q2

- **Dx**?

Ectopic pregnancy

- **Risk factors?**

Prior ectopic , prior surgery or procedure in the tubes / adhesions



- **4 pre requisites before medical Mx :**

in the slides (bHCG ≥5000, sac ≥3cm , no CI for methotrexate …) No, fetal heart activity.

- **Mention 2 diagnostic methods**

Serial bHCG 1

Laproscopy 2

Ultrasound 3

- Q3: 39 years old newly married want to get pregnant, has DM, HTN
- **What to advice her before pregnancy?**
  switch to non teratogenic anti-hypertensives
  Switch to insulin & give folic acid 4mg since she is high risk (DM)

- **Beside controlling her HTN & DM, What to do in 1st trimester and at what age and mention the aim?**

At 10 -14 wks: Nuchal translucency , Bhcg and PAPP-A to scan for fetal anomalies

At 16-20 wks: quadruple test

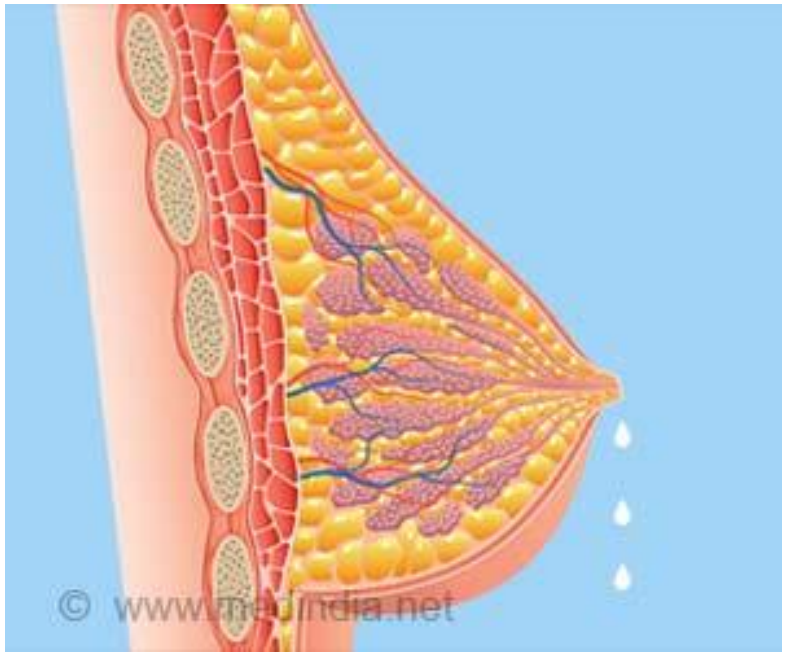
- **She came to u at 39week(not sure of the weeks) complaining of contractions and rupture of membrane with fetal bradycardia**

Dx? Cord prolapse

Mx? Prepare for C/S

- Q4:
- **dx and definition :**

galactorrhea : a milky nipple discharge unrelated to the normal milk production of breast-feeding



- **4 causes :**

Medications, prolactinoma, pregnancy , thyroid disease

- **2 medications that causes it :**

OCPs , anti hypertensives, antipsychotics, spironolactone ..ect

- **2 imaging modalities:**

Brain CT/MRI, pelvic MRI W/S

- **if you found it to be idiopathic, mention two lines of management?**

Bromocriptine, cabrigoline

Q5 : patient came to you after she did her pap smear :

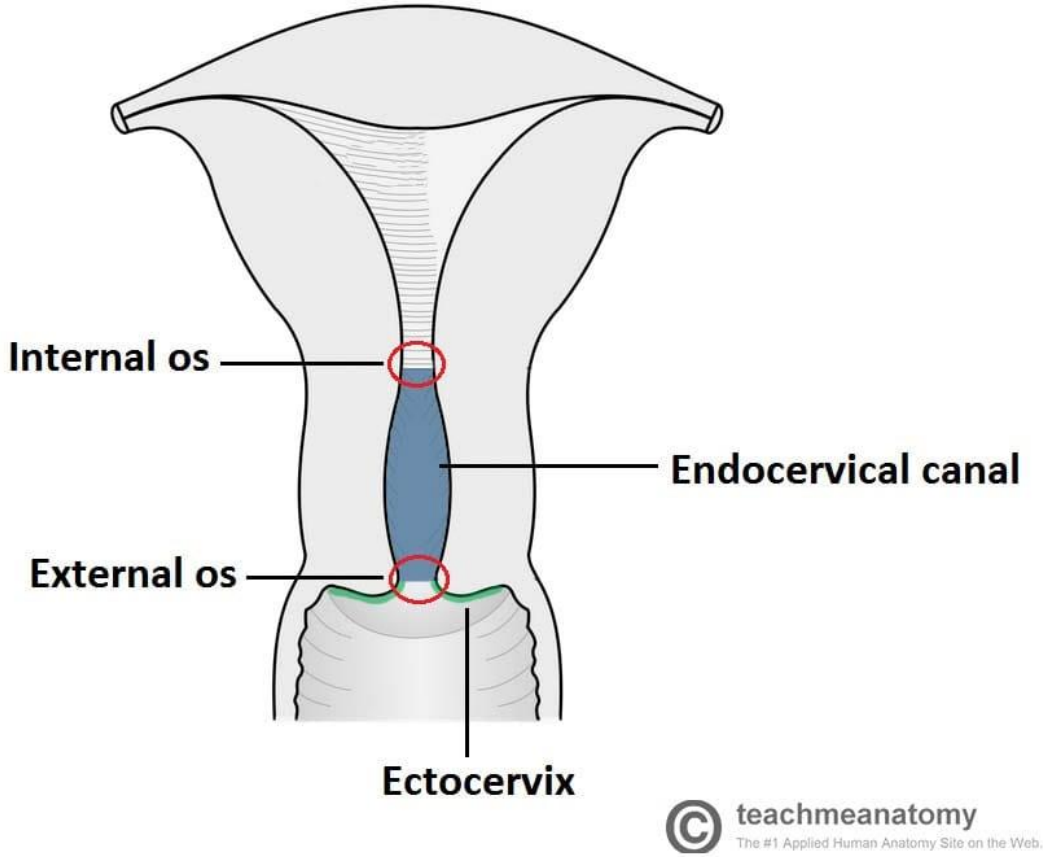
- **Name the parts with an arrow pointed at them ?**

- **Most common HPV low risk and high risk**

Low risk: 6&11
High risk : 16 & 18

- **What does the terms stand for ?**

HSIL, LSIL, ASC-US, CIN



- Q6 : GDM case, She did 75g OGTT results were

Fasting 100 , 1hour 190 , 2 hour 140

- **What's the dx and what the criteria you depend on for the Dx?**

Gestational DM , criteria : fasting >95, 1hr >180 , 2hr >155, 3hr >140 , any 2 abnormal results are diagnostic

- **Mention 2 Fetal and 2 maternal complications?**

Fetal: macrosomia, dystocia , …

Maternal : long term DM , instrumental delivery PTL , …

- **Name 3 risk factors ?**

Obesity, FHX, age , …

instrumental delivery

A. What are the instruments in the picture

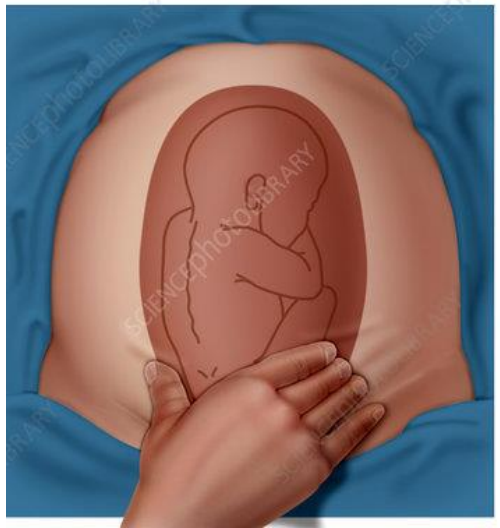
B.what are the prerequisites for using them

C. What are the contradictions of using vaccum

D.which of them is associated with, Maternal worry about fetus, Retinal hemorrhage, vaginal and perineal lacerations

leopold's maneuvers :

A. Name them in order of the picture and what each one is used for :



Name these parts :

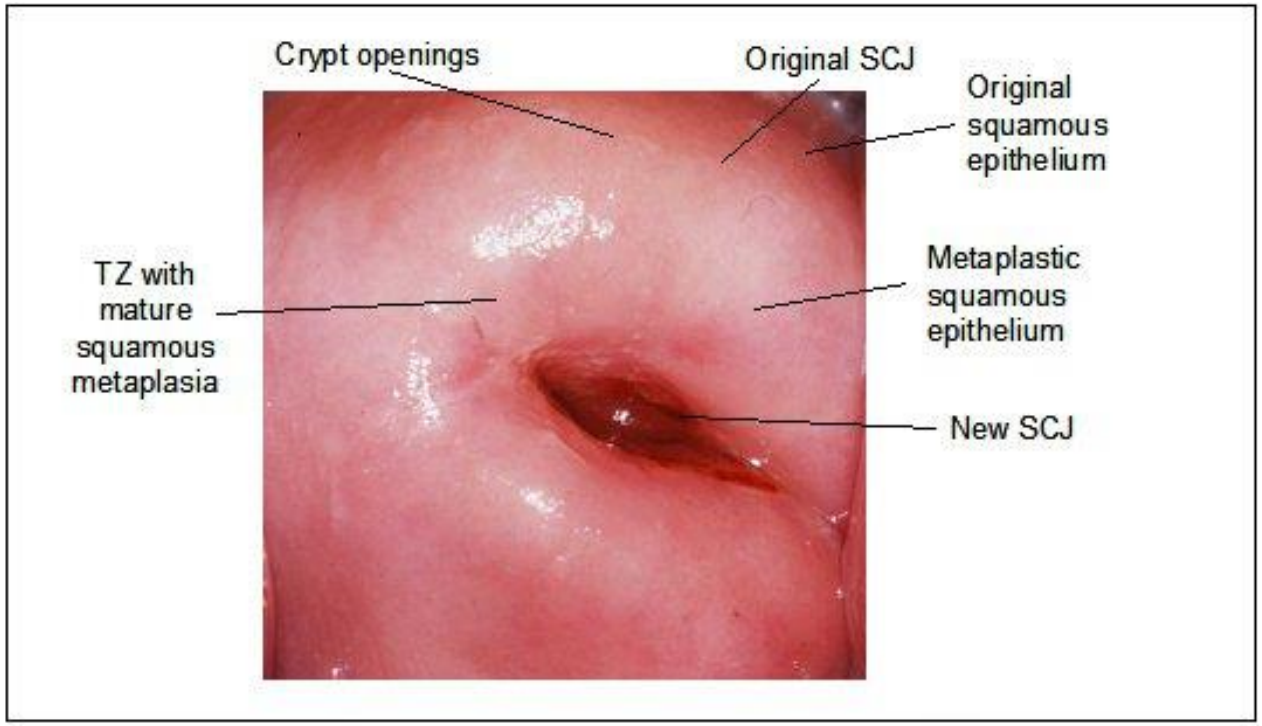
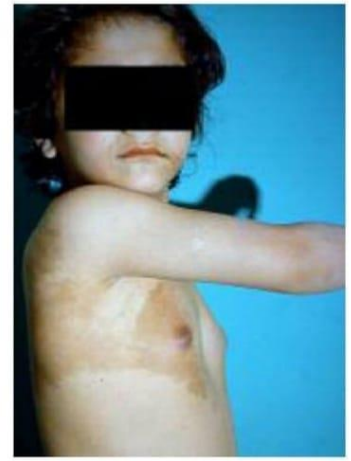


FIGURE 6.1: The entire new squamocolumnar junction (SCJ)is visible, and hence the colposcopic examination is satisfactory; the transformation zone (TZ) is fully visualized. The metaplastic squamous epithelium is pinkish-white compared to the pink original squamous epithelium

Q: 8 y/o, her mother is complaining that her baby girl is showing early signs of puberty:

1. Define Precocious Puberty?

- Onset of pubertal development before the age 8 in girls & 9 in boys



2. Classification/Types with examples?

A. *Central, gonadotrophin dependent, or true PP*:
e.g. brain tumors, or CNS malformation, 75% idiopathic

B. *Peripheral precocious puberty, Pseudopuberty*:
e.g. hormone producing ovarian tumors, exogenous estrogen administration, McCune Albright
Note: Central is the majority (80%!), & peripheral is always pathological

3. Investigations to do?

- FSH/LH (high in central, low in peripheral)
- Brain imaging
- Pelvic and abdominal imaging

4. How will you manage and why?

- Surgical resection if it's a lesion
- GnRH analogues to suppress pubertal development.
- Cause: to slow down the growth velocity and avoid early skeletal maturation. Furthermore, early development of sexual characteristic is distressing to a young girl.

5. If the patient has brown lesions on her skin and bone abnormalities, what syndrome you may consider?

McCune Albright Syndrome (Polyostotic fibrous dysplasia, Café au lait, & precocious puberty)

- Case about PPH :

A. What is your diagnosis

B. Risk factors from case

C. Steps of management

D. Possible complications

E. What are the main causes of your diagnosis

- IUCD counseling:

-What do you ask her in the history

-What are the possible complications

- If she presents 3 weeks after delivery when do you insert the IUCD

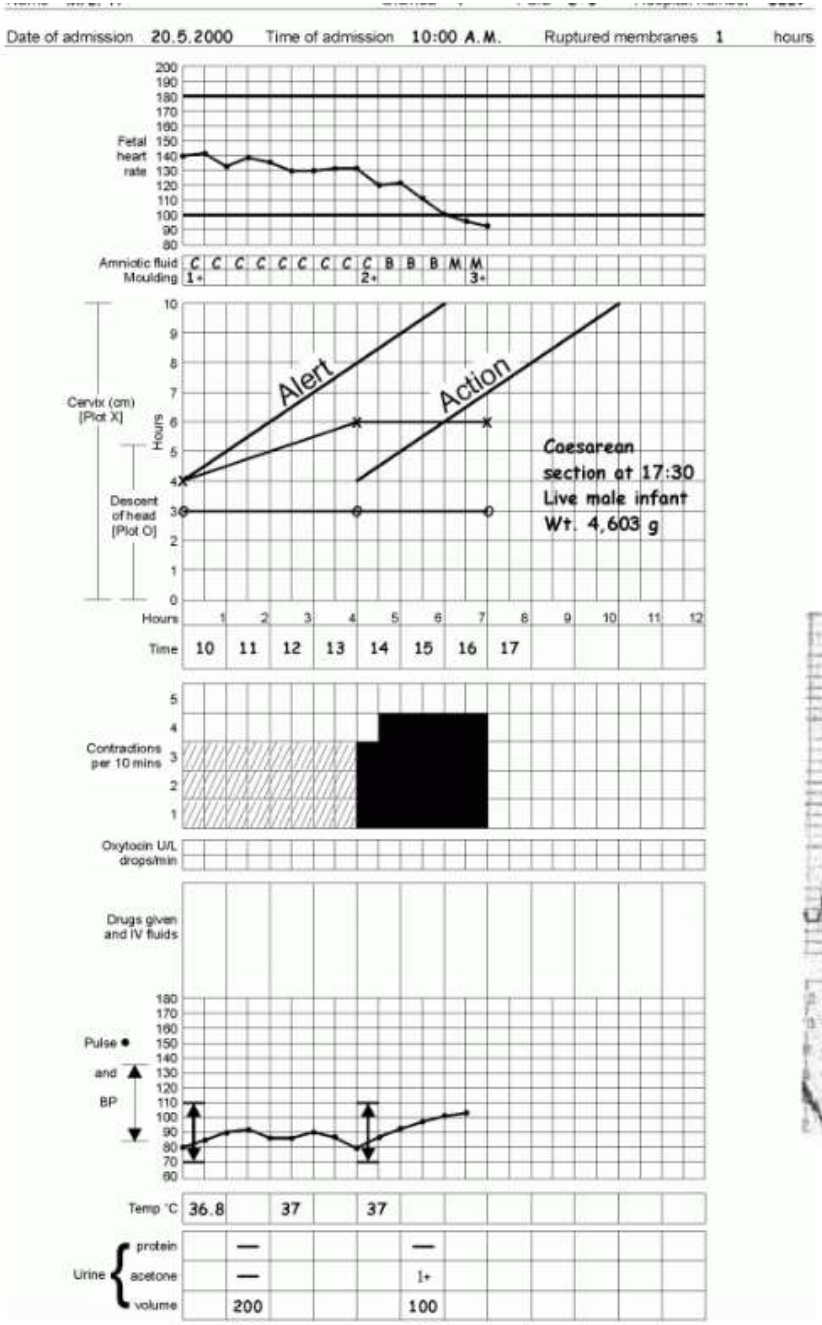
-When do you ask her to return for follow up and what is your follow up plan if you notice a missed thread on speculum examination

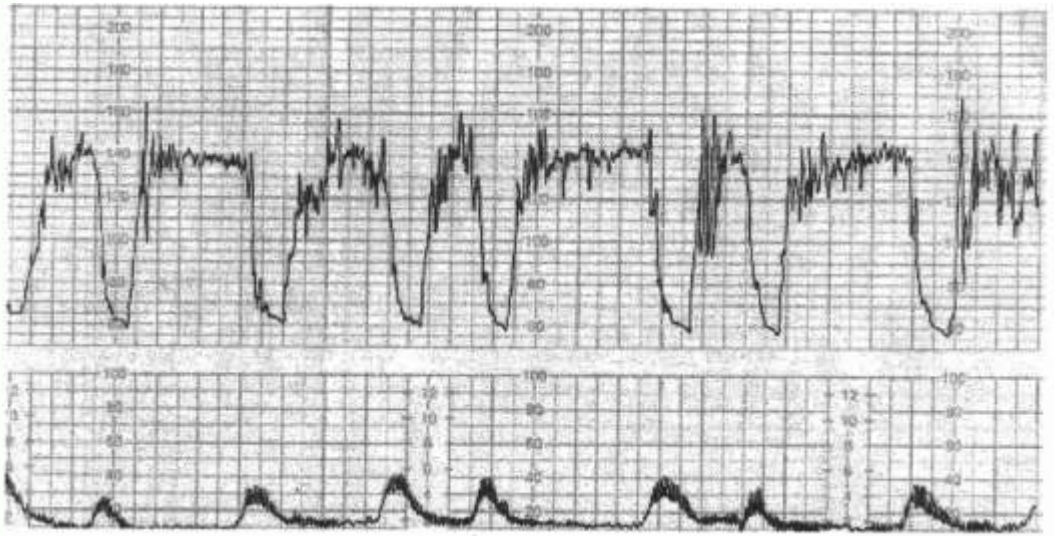
Group D
7/1/2021
5th year

The most problem in this exam was the time ☹ Be smart.

Good luck.

Q1)DR.DEMA


Date of admission 20.5.2000
Time of admission 10:00 A.M.
Ruptured membranes 1 hours
Fetal heart rate
Amniotic fluid
Moulding
Cervix (cm) [Plot X]
Descent of head [Plot O]
Hours
Alert
Action
Caesarean section at 17:30
Live male infant
Wt. 4,603 g
Time 10 11 12 13 14 15 16 17
Contractions per 10 mins
Oxytocin U/L drops/min
Drugs given and IV fluids
Pulse
and
BP
Temp °C 36.8 37 37
Urine protein — —
acetone — I+
volume 200 100



- Q1) According to the previous partogram

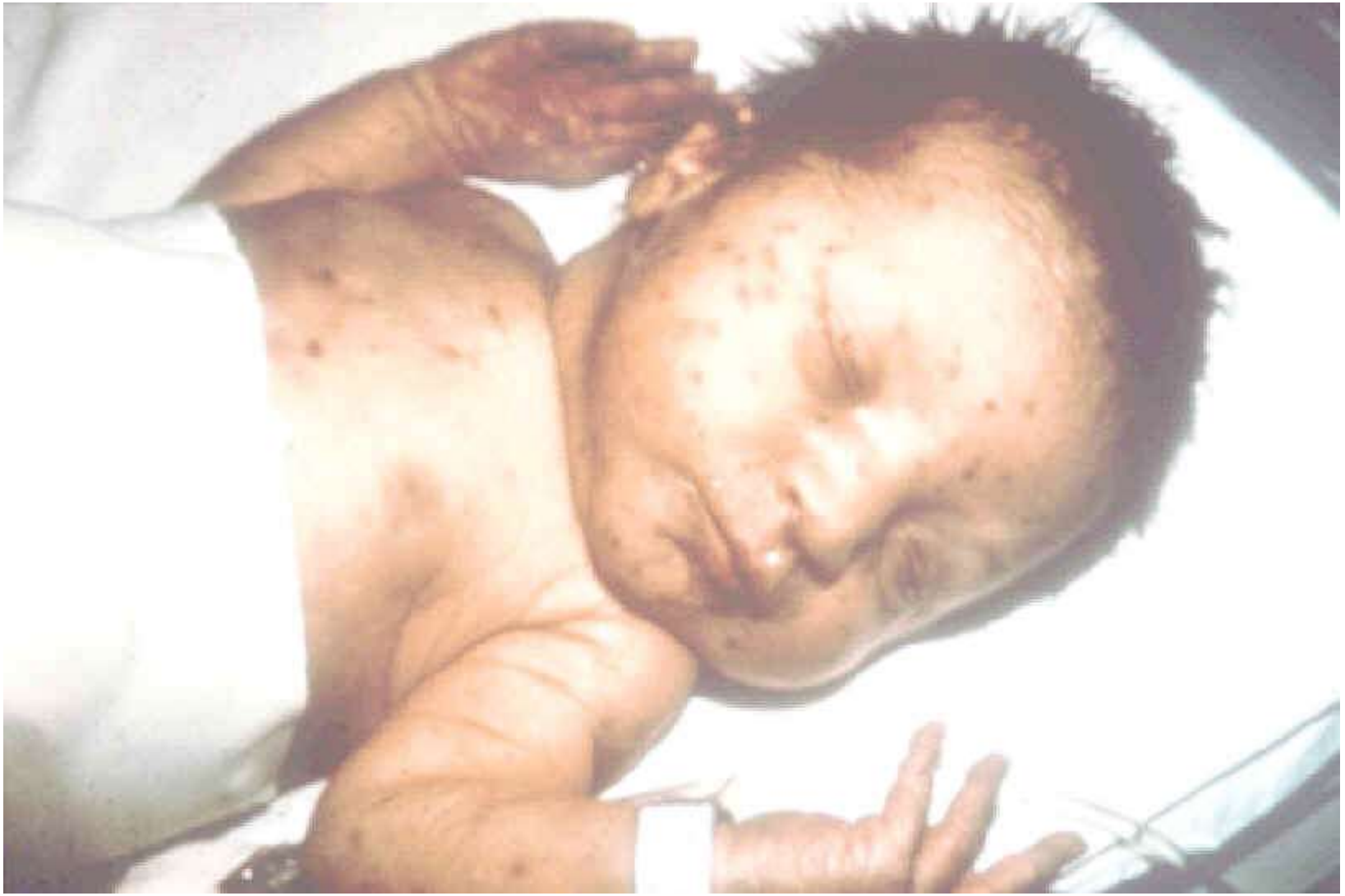
A) Describe:

- 1)Cervical dilatation
- 2) Moulding
- 3) Uterine contraction
- 4) Fetal descend
- 5) Amniotic fluid

B) give 2 causes for this case ?

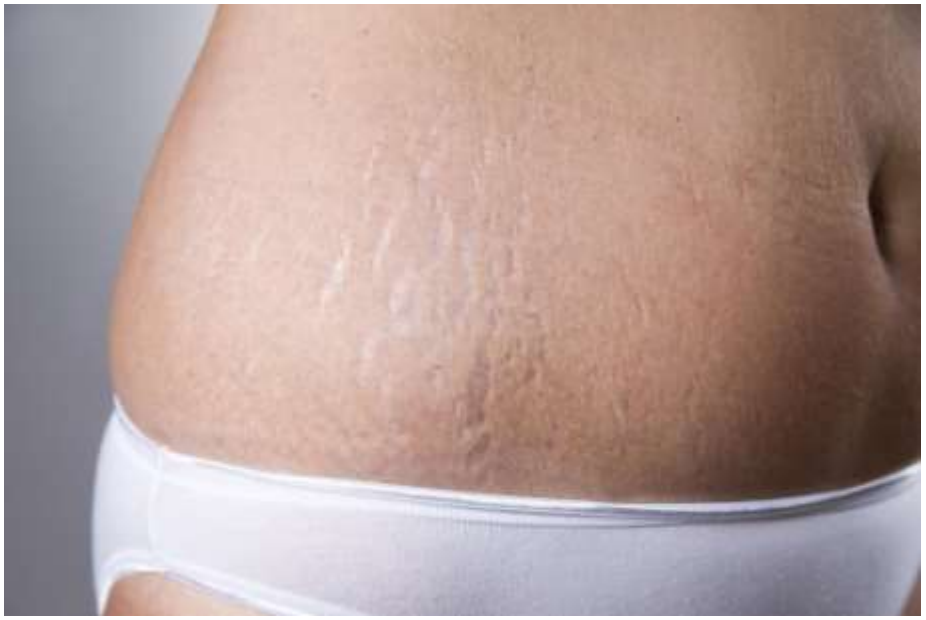
- Q2) Describe 3 things in previous CTG?

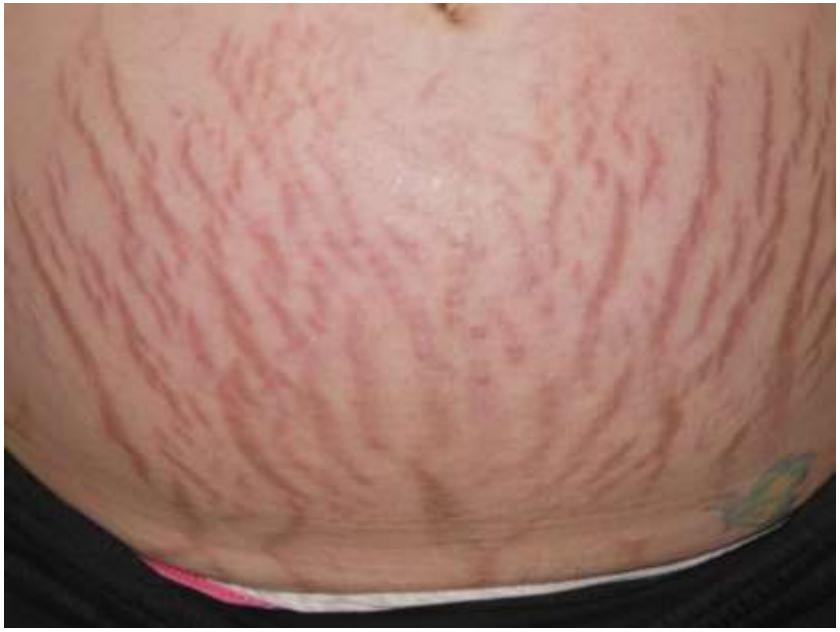
Q2) DR.TAMARA



- 1) What is the diagnosis ?
- 2)what is the presentation ?
- 3) give the triad ? 3 points
- 4)what is the most common way to infect the baby ? , what is the common time of infect the baby ? (Haematogenous via placenta, first trimester)
- 5)How to prevent ? Give 3
- 6)How can you diagnosis ? Give 2
- 7) What is the sign of retinopathy ?
- 8)what is the most common symptoms ? Neurosensory deafness 80%.

Q3 : DR.FEDAA





- 1) What is the diagnosis ?
- 2) How you can differentiation between them ?
- 3)give 2 risk factors ?
- 4) case of 36 weeks of gestation , if you measure the SFH & you find it 32 cm ,Give 2 causes ?
- *CASE of secondary postpartum hemorrhage (a lot of information in the question but the most important key was the time of the case is after 10 days of delivery)
- Give 2 most common causes ?
- Give 2 most immediately treatment ?

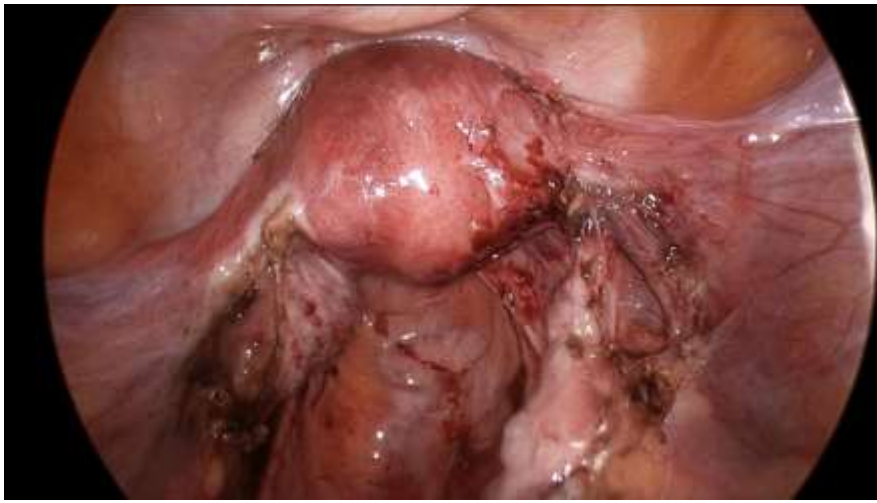
Dr Murad

- Mrs Green diagnosed with gestational diabetes
- 1)what is the modified Bishop score ? (5 POINTS)
- 2) The score was 9 : what is the best way to induction the labor ? oxytocin

- *case about brow presentation (key was when you do bimanual exam you find the space between two eyes)
- What is the diagnosis ? Brow Presentation
- What is the treatment? Cesarean section

- * what is the level for each in the baby with gestational diabetes (increase,decrease,normal)?
- Bilirubin : Increased
- Calcium : Decrease

Dr Rami



- Case about

Chronic pelvic pain .

- What is the diagnosis? Endometriosis
- Give other differential ?
- Give 3 symptoms ?
- Give 3 Medical treatment ?
- Give 2 Surgical treatment ?

Dr. Feras

- Case about lady 27 years old. BMI Is 35 , and she married since 2 years ago .She is sad because she doesn’t pregnant until now .
- ASK 5 RELATED HISTORY ?
- Give 4 workup to do , and why ?
- If her partner have azospermia .what is the investigation for him ? 2 points
- If the lady according to WHO have a ovarian disorder type 2 , what is the treatment ? (3 points)

DR HAMZEH

- POP-Q
- I forget the numbers but the questions was:
- 1)give 5 pathogenesis according to POP-Q?
- 2) What is the number meaning ?

The numbers in the question was related to (Genital hiatus , perianal body , cervix)

- 3) can you do a **sacrospinous fixation** for this women ? Why ? The answer was no because the total vaginal length is short. (2 marks)

Harmony MiniOSCE

Group A – 10/5/2021

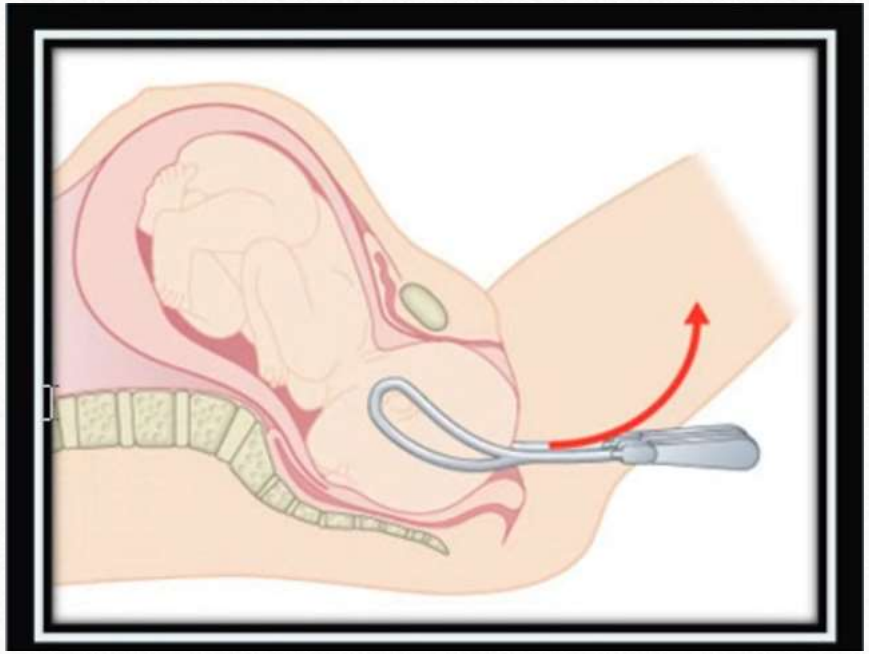
Station 1 (Q 1-6)

Mrs Anwar is a 34- year lady. She is G3P2 who presented in labour at 40 weeks of her pregnancy. She progressed smoothly till full dilation. You decided to deliver her using the pictured method (in question 2) in view of CTG changes.

Q1: Define second stage of labour.

Q2: What are the types of the pictured method?

Forceps



Q3: Name 2 prerequisites for this method.

① fully dilated cervix

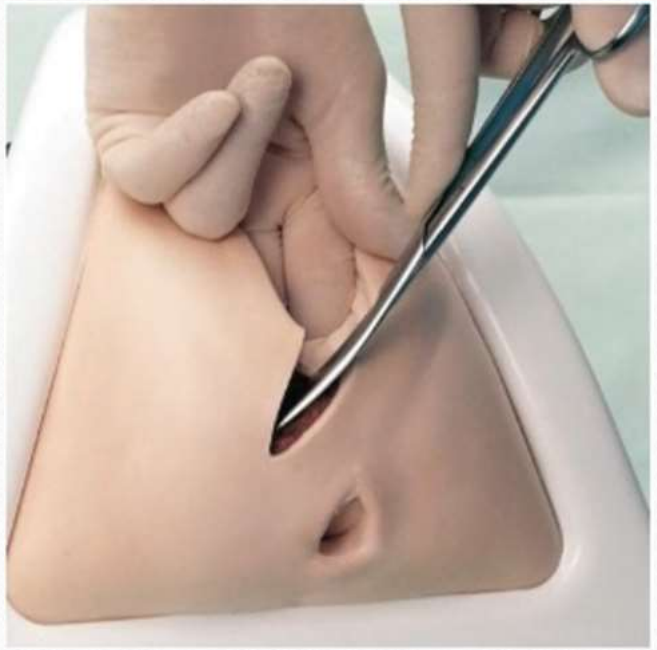
② ruptured of membrane

Q4: When you deliver the baby, you note 'turtle-sign' - the delivered head becomes tightly pulled back against the perineum and there is difficulty delivering the chin. What is your diagnosis?

Shoulder dystocia.

Q5: You do an incision in the perineum (as shown in the picture) to facilitate delivery. What are the types of this incision?

- mediolateral
- midline.

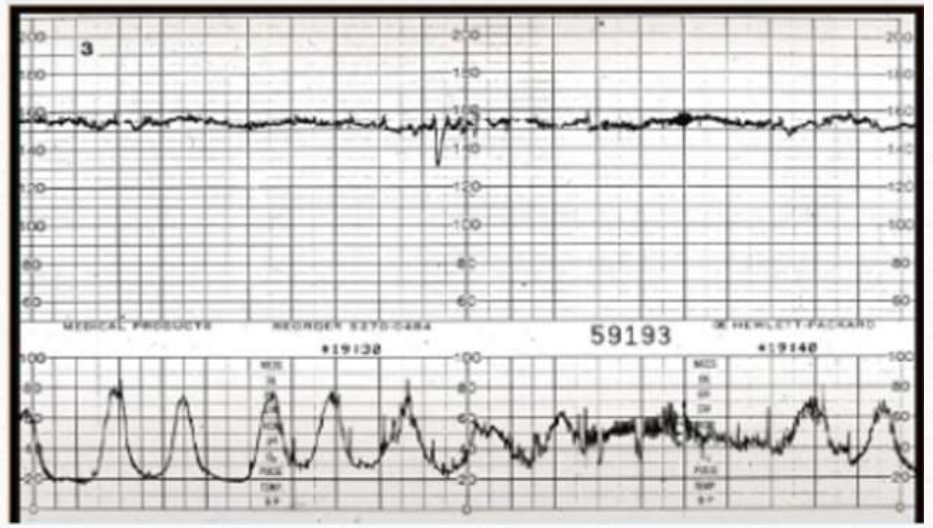


Q6: Anwar starts bleeding immediately after delivery. Name the 2 most likely causes of her bleeding.

① uterin atony
② trauma or laceration to genital tract.

Station 2 (Q 7-11)

Mrs. Roo'a (G4P2+ 1) was admitted to the labour ward at 42 weeks gestation for induction of labour. 1 hour after the onset of regular uterine contraction,



Q7: Name the test in image, Is it a screening or a diagnostic test?

Q8: What is the most important abnormal component in the shown test and why?

Q9: Vaginal exam is done (Vertex at zero station, 4 cm dilatation, fully effaced cervix, Membranes not felt). What will you do next to confirm the findings in the shown test?

Q10: If she is 6 cm dilated, vertex at + 1 station and the findings as shown in the picture are confirmed, what you will do and why?

Q11: Define the followings:

a- Active phase of labour: increased rate of cervical dilation and descent of the presenting fetal part (4-10

b- Miscarriage:

c- Augmentation of labour

Station 3 (Q 12-17)

Mrs. Maria is a 42 year old lady, this is her first pregnancy. GA= 32 weeks. This pregnancy is an IVF pregnancy due to male factor infertility. She is known to have SLE. Her pregnancy was going smoothly until today when she presented to the emergency department complaining of severe epigastric pain

Q12: What is your diagnosis?

Q13: name 4 principles of management for this condition.

Q14: From her history, Mention 2 possible risk factors for her presentation.

Q15: Why do women with this entity present with epigastric pain?

maternal vasoconstriction causes ischemic injury to liver, and the cause capsular distention and pain

Q16: After admission, blood film was done and revealed the presence of haemolysis. What is your diagnosis?

HELLP ?
Syndrome

Q17: What medication does she need to take in her next pregnancy to prevent this same presentation? LMWH + aspirin.

Station 4 (Q 18-21)

Mrs. Green is 32-year-old pregnant lady (G3P2: previous 2 caesarean sections) attended OBGYN clinic at 33 weeks gestation complaining of gush of clear watery vaginal leak of 2 hours duration with no uterine activity.

Q18: If speculum exam confirms PPROM by positive cough sign, mention 2 other things you need to comment on during speculum exam for this lady.

① any cervical dilation
② cord prolapse

Q19: After admission, CTG was done and baseline investigations were sent. Mention 2 mandatory steps of management.

Q20: Mention 4 possible complications.

Q21: When will you deliver this lady if maternal and foetal wellbeing are normal? what is the mode of delivery.

Station 5 (Q 22-26)

Khuloud is a 22-year-old G5P 0 + 4 (Previous 3 miscarriages + 1 ectopic pregnancy) @ 6 weeks of amenorrhea with a positive pregnancy test. Ultrasound shows an empty uterus, no adnexal masses and no free fluids. Quantitative BHCG was 700 IU.

Q22 : What is the next step in her management? Why?

Q23: What is the definition of discriminatory zone?

Q24: List 4 requirements for medical treatment with methotrexate for ectopic pregnancy.

Q25: What is the proper next step if BHCG level drops less than 15% between day 4 and day 7 after administration of methotrexate?

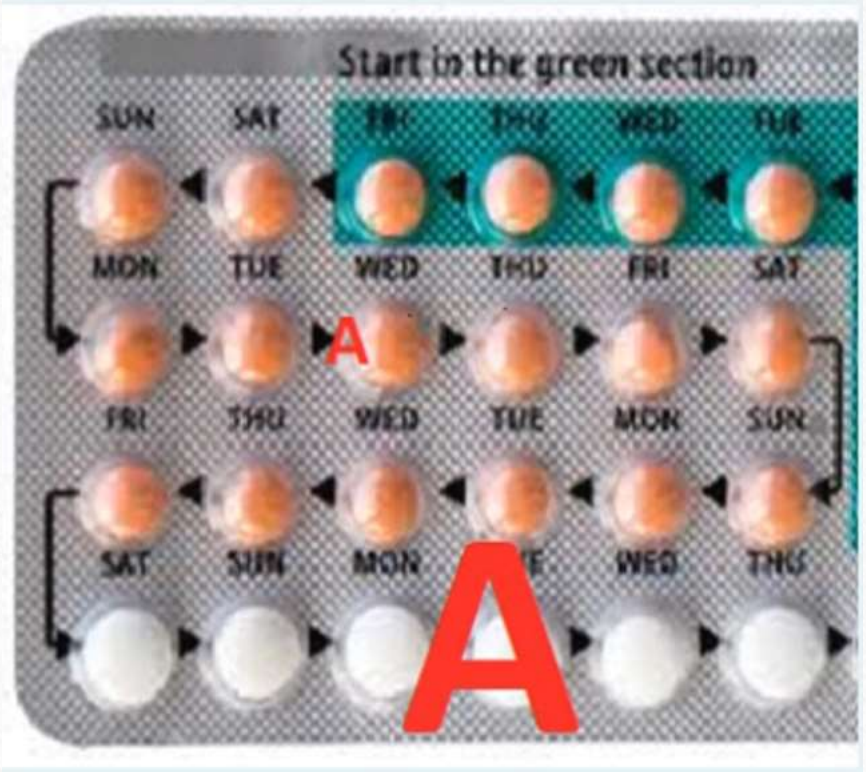
Q26: List 2 specific side effects of methotrexate therapy for ectopic pregnancy. megaloblastic anemia

liver injury

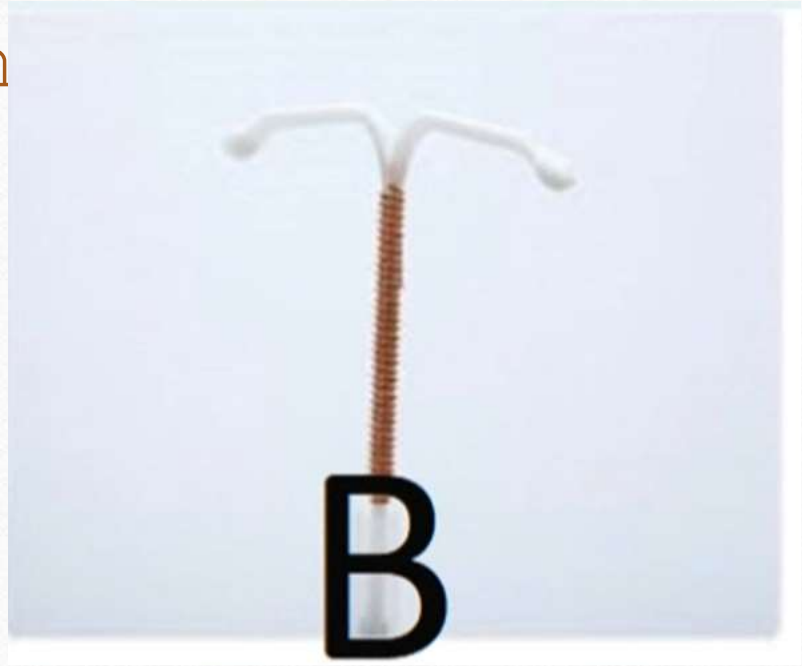
Station 6 (Q 27-33)

Q27: Name the different contraceptive methods you see in A

COC



Q28: Name the differen
contraceptive methods
you see in B



Q29: Mention 2 therapeutic uses of the system shown in (c):

In the following scenarios (Q 30, 31, 32) What is the best method of contraception would you advice those ladies to initiate? (NOT only from the pictures given)

Q30: 36 year old lady, at 6 weeks post partum after giving birth of her 4th child by caesarean section. Previously healthy. Smokes 20 cigarettes per day. Her menstrual

Q31: 29 year old woman experienced a first trimester uncomplicated miscarriage two weeks ago. She would like to get pregnant again but wants to delay it for few months. She is concerned about taking hormones and wants a method that provides some protection against STIs.

Q32: 40 year old woman was diagnosed to have breast cancer in the last year. She had 4 children and feels strongly about not having more children.

Q33: A 26 year old lady , 4 weeks post vaginal delivery of her second child. Asking you about breastfeeding as method of contraception. Advice her about this method mentioning the failure rate.

Station 7 (Q 34-40)

Q34: What do we call the condition that this lady is suffering from?

Q35: How do you define this condition?

Q36: What is the mechanism responsible for this condition?

Q37: If the lady leaks before she gets to the toilet and when she coughs as well, what is the name of this condition?

Q38: What investigation do you need to do to distinguish between the two conditions?

Q39: Name three common conservative management measures you will offer this lady if she only suffers from the first condition (in the picture)?

Q40: Name two medical management options you can offer this lady.

Year 5 End of Rotation Exam, Group B (Year 5- Group B)

7 stations, each station has its questions Station 1 Q 1-5 Station 2 Q 6 -10 Station 3 Q 11-14 Station 4 Q 15-20 Station 5 Q 21- 23 Station 6 Q 24- 29 Station 7 Q 30- 35 Total exam mark 70

Points:

-/70

11,

Station 1 A 26-year-old woman para 4 at 24 weeks of gestation presents feeling tired and dizzy. A full blood count is taken, and the results are: Hb = 10.0 g/dl, MCV - 74 fl, Platelets = 205 (10 9)Required to answer. Multi Line Text.

(-/2 Points)

What 2 investigations would you wish to perform?

ferritin.

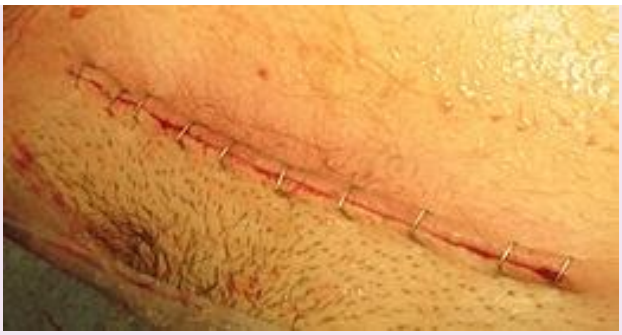
22,

Iron deficiency anaemia was diagnosed, Ferrous sulfate treatment, 200 mg bd (twice daily) was started. She re-attended the clinic 6 weeks later and her Hb was 8.0 g/dl.Required to answer. Multi Line Text.

(-/3 Points)

What are the diagnostic possibilities and the possible solutions? 3 points

33,



You see this patient 2 days after her caesarean section. The surgical incision is shown in the picture.Required to answer. Multi Line Text.

(-/1 Point)

What is this incision called?

44,

Name 2 long term obstetric complications for caesarean section.Required to answer. Multi Line Text.

(-/2 Points)

55,

Name 2 disadvantages for this incision.Required to answer. Multi Line Text.

(-/2 Points)

66,

Station 2 Mrs. Sophie is a 26-year-old lady. PG. GA= 33 weeks. Presented in labour. She progressed smoothly in labour and was given epidural anaesthesia for pain control. At 4:00 pm she had a fully dilated cervix, vertex at +1 station. 3 hours later, she still had the same vaginal exam, and was severely exhausted and had no power to push anymore.Required to answer. Multi Line Text.

(-/1 Point)

How should you deliver this patient?

77,

Mention three pre-requisites needed before proceeding with your choice of the method of delivery.Required to answer. Multi Line Text.

(-/3 Points)

88,

Mention three complications of instrumental deliveryRequired to answer. Multi Line Text.

(-/3 Points)

99,

When should you abandon the method you chose for delivery?Required to answer. Multi Line Text.

(-/2 Points)

1010,

If your method of delivery failed, what would be your next choice?Required to answer. Multi Line Text.

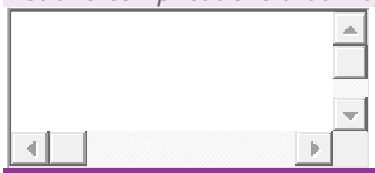
(-/1 Point)

1111,

Station 3 A 37-year-old lady who is unbooked and G7P4+2 presented at a gestational age of 41 weeks and 4 days for induction of labour.Required to answer. Multi Line Text.

(-/2 Points)

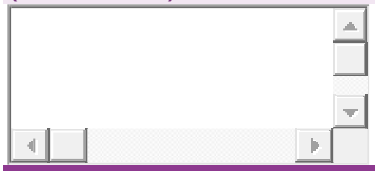
List two complications that may occur to the mother from induction of labour.



1212,

Mention 2 benefits from ultrasound for this patient before starting the induction of labour?Required to answer. Multi Line Text.

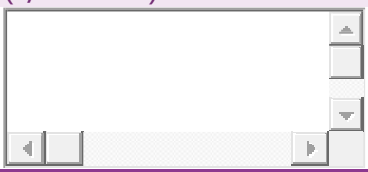
(-/4 Points)



1313,

If she is 4 cm dilated and the cervix is anterior in position, 50% effaced and she has no uterine contraction which method of induction you will use?Required to answer. Multi Line Text.

(-/1 Point)

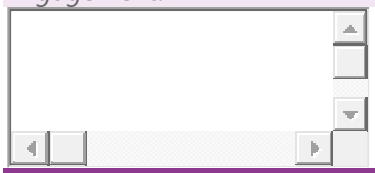


1414,

Define the following obstetric termsRequired to answer. Multi Line Text.

(-/3 Points)

a- Asynclitism of the presenting part: b- Failure to progress in the second stage of labour: c- Engagement:



1515,

Station 4 Zain is 8 weeks pregnant, this is her first pregnancy, presented to the A&E (Accidents & Emergencies) with few hours' history of vaginal bleeding. Examinations showed: stable vital signs, mild vaginal bleeding, cervical os closed.Required to answer. Multi Line Text.

(-/2 Points)

Mention two diagnoses you should think of at this stage.

1616,

Ultrasound scan showed intrauterine sac with fetal echoes, fetal heart was seen. What is the diagnosis?Required to answer. Multi Line Text.

(-/0.5 Points)

1717,

How you will manage Zain? Mention 4 pointsRequired to answer. Multi Line Text.

(-/4 Points)

1818,

You see Zain one week later, she is still having mild bleeding, examination is the same as the previous time. Ultrasound showed no fetal heart, what is the diagnosis now?Required to answer. Multi Line Text.

(-/1 Point)

1919,

What management options you will offer Zain? Mention 3Required to answer. Multi Line Text.

(-/1.5 Points)

2020,

If you want to operate on Zain, how you will reduce the risk of cervical injury?Required to answer. Multi Line Text.

(-/1 Point)

2121,

Station 5 A healthy couple attended the assisted reproduction clinic complaining of primary infertility: Define the following terms regarding male seminal fluid analysis:Required to answer. Multi Line Text.

(-/3 Points)

a- Oligospermia: b- Asthenospermia: c- Teratospermia:

2222,

Mention 3 primary lines of investigations for the female:Required to answer. Multi Line Text.

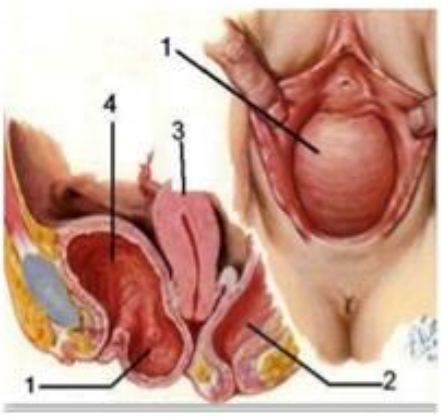
(-/3 Points)

2323,

Mention 4 potential uterine causes of infertility:Required to answer. Multi Line Text.

(-/4 Points)

2424,



Station 6Required to answer. Multi Line Text.

(-/2 Points)

Identify the defect showed in (1):

2525,

Identify the anatomic structures in:Required to answer. Multi Line Text.

(-/2 Points)

2 4

2626,

Name 2 clinical presentations for this lesion.Required to answer. Multi Line Text.

(-/2 Points)

2727,

Mention 2 predisposing factors.Required to answer. Multi Line Text.

(-/2 Points)

2828,

What is the name of the operation for this lesion.Required to answer. Single line text.

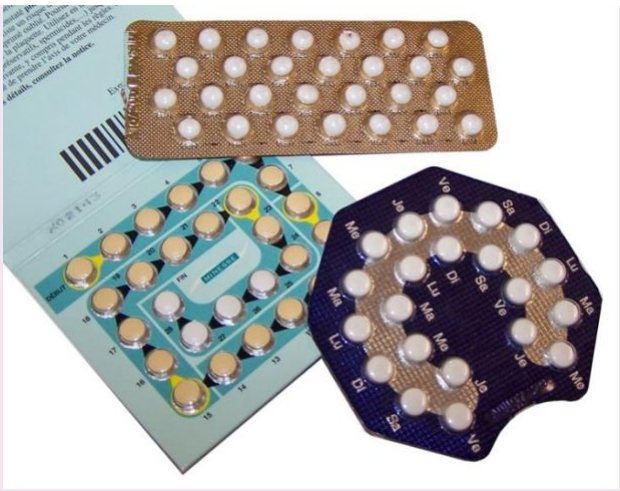
(-/1 Point)

2929,

When surgery is planned, what is the most important point to counsel the patient about?Required to answer. Multi Line Text.

(-/1 Point)

3030,



Station 7 Alaa is a 23-year-old P1 lady. She is interested in the contraception method shown in the picture.Required to answer. Multi Line Text.

(-/2 Points)

1. What is the main mechanism of action?

3131,

List two non-contraceptive benefits of this method.Required to answer. Multi Line Text.

(-/2 Points)

3232,

Alaa has epilepsy, which is well controlled with carbamazepine, can she use the above shown method?Required to answer. Multi Line Text.

(-/1 Point)

3333,

List 2 absolute contraindications for using this methodRequired to answer. Multi Line Text.

(-/2 Points)

3434,

Alaa asks what to do if she forgets One pill on the fourth day?Required to answer. Single line text.

(-/1 Point)

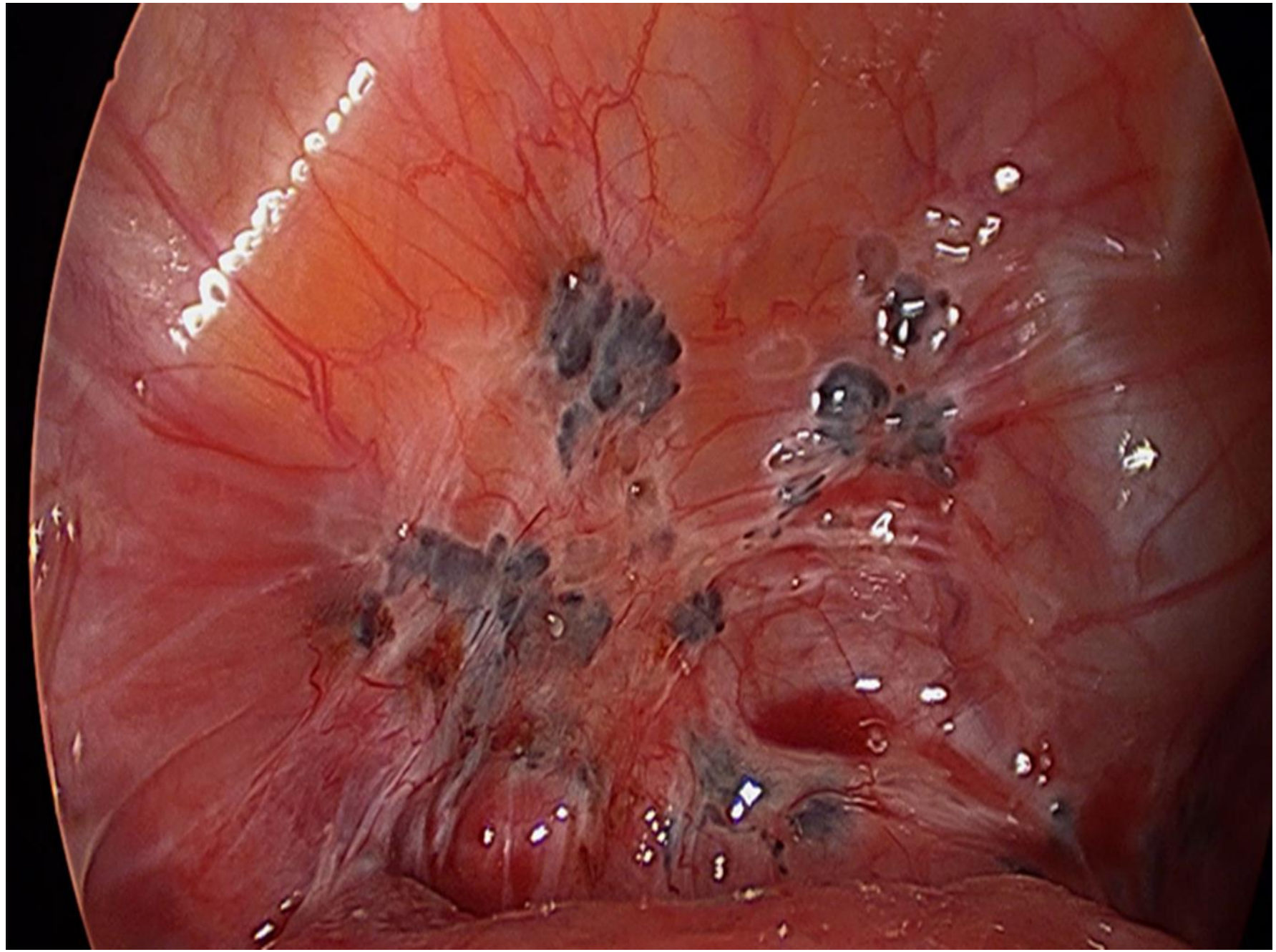
3535,

What to do if she misses Two pills on the 12th and 13th day?Required to answer. Multi Line Text.

(-/2 Points)

Go back to thank you page

Year 5 group C Obgyn miniOsce exam



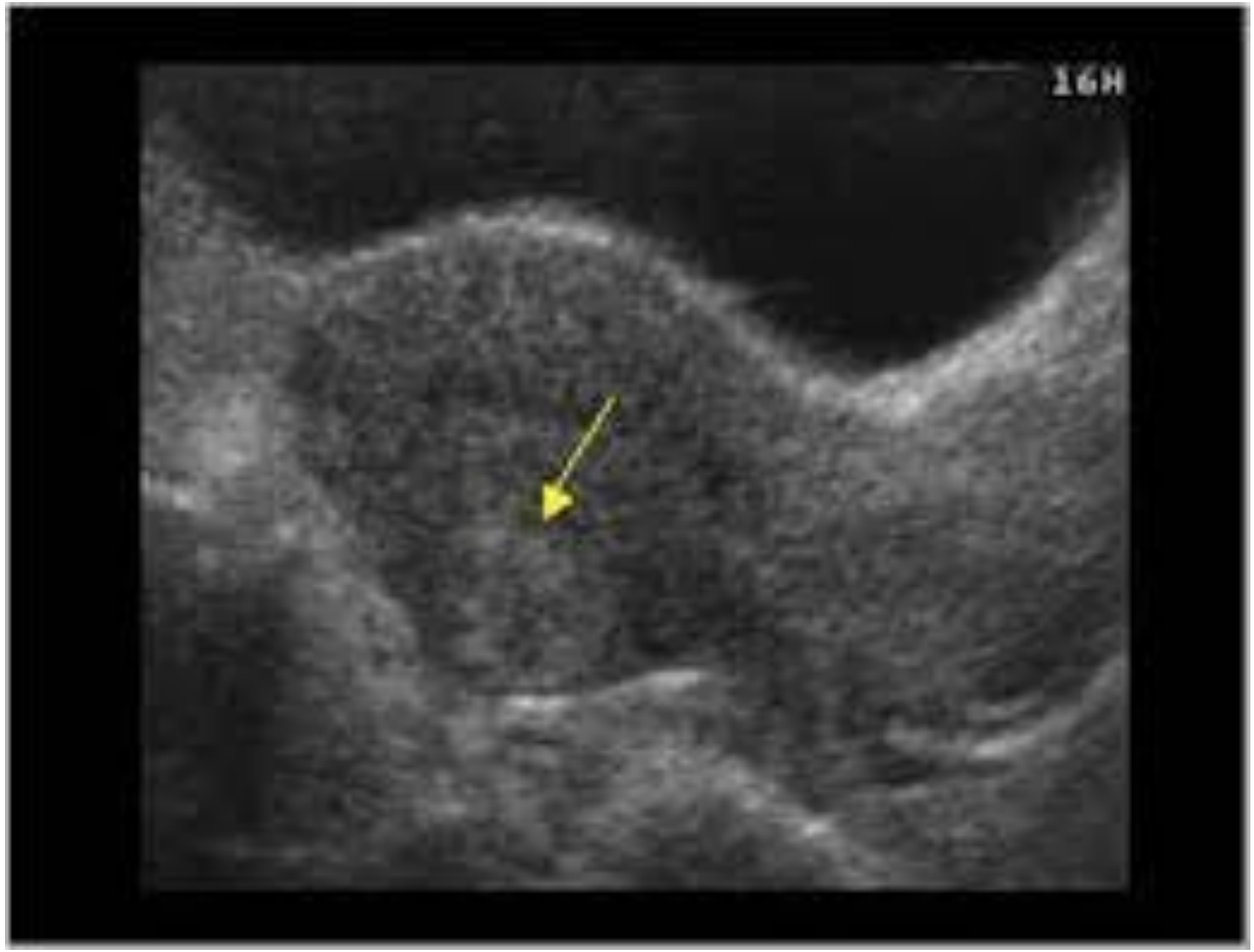
- What is the diagnosis?
- What is the presentations (symptoms)of the disease?
- What is the definition of the disease?
- How it can cause infertility?
- what is the theories which explain the pathophysiology?

dysmenorrhia
dyspareunia
pelvic pain
infertility.

endometrial tissue outside uterine cavity

- celeomic metablasia
- retrograde menstrual
- embryonyl origin
- Lymphatic or blood dissaminate

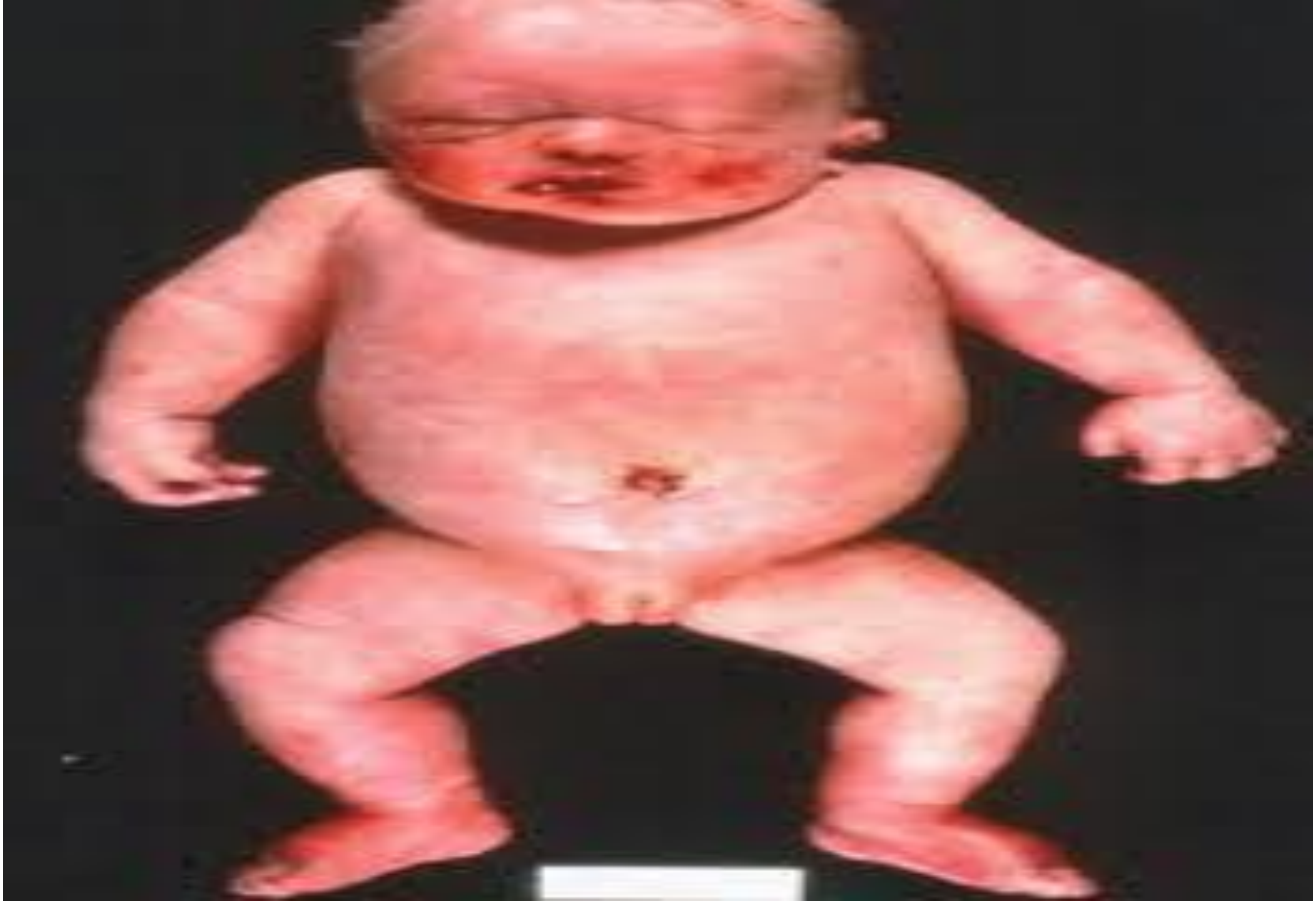
Dx is endometriosis ….


16H

- What is the diagnosis? fibroid
- What is the two commonest sites where it found? ① intramural ② submucosal
- How it can cause infertility ? ① impair implantation ② atomic pelvic distortion and obstruction of fallopian tube ③ alter blood supply of endometrium
- What is the symptoms of the disease?
- What is the management for a women still want to get pregnant?

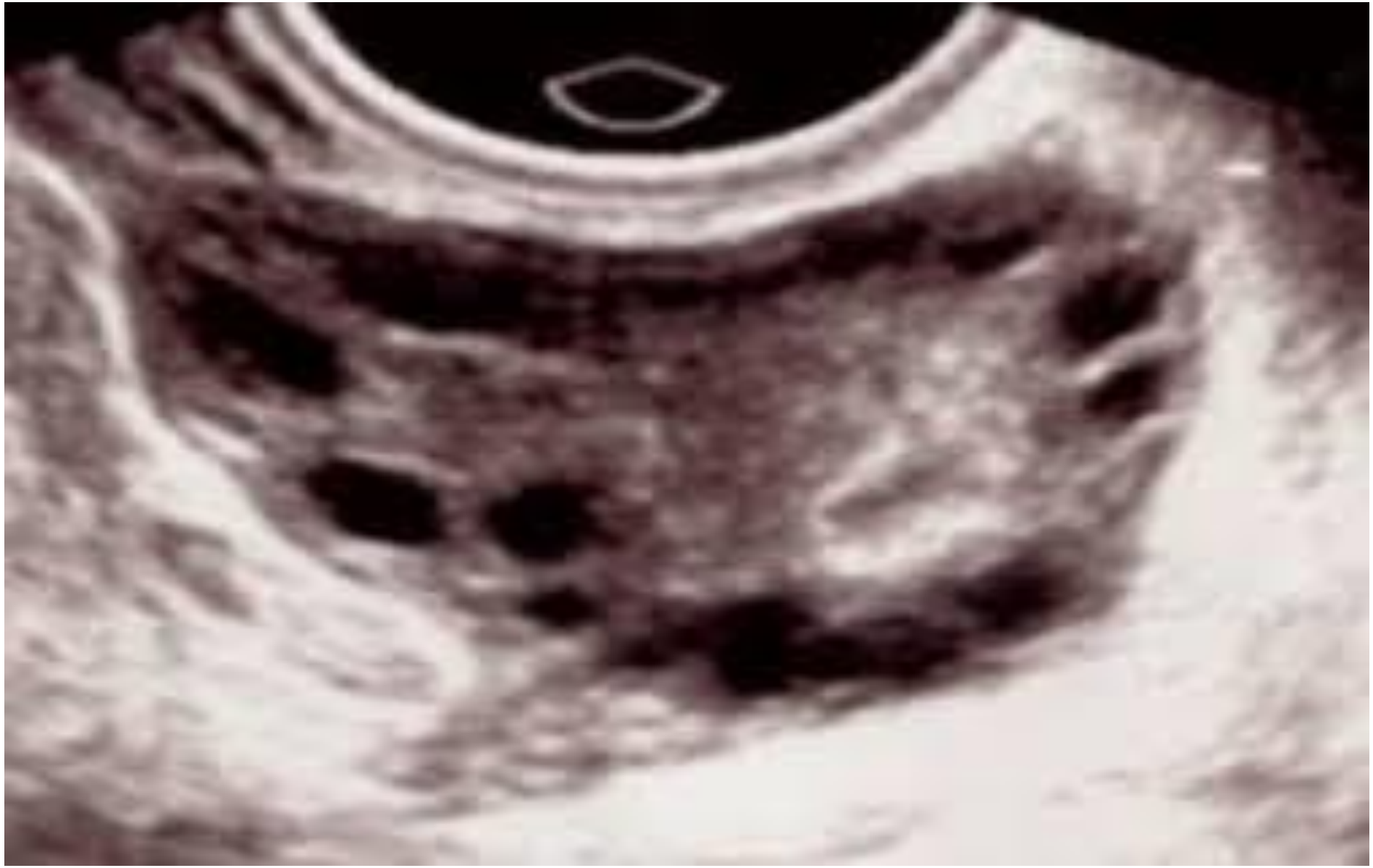
① myomectomy

Dx is fibroid…..



- What is the diagnosis? hydrops fetalis
- What is the types non-immune / immune
- Mention the findings on US ? ① fluid collection in two or more compartment ② AFI > 25 or SDP > 8
- There was a question about anti D ….

- Dx is hydrops fetalis……



- This is an US image done for a left ovary …
- What is the diagnosis?
- What is the US findings to diagnose the disease? ≥ 12 cyst, in each ovary / with 2–9 mm. and ovary volume >10
- What is the long term complications & symptoms ?
  - DM,
  - obesity
  - cardiovascular diseased
  - infertility
  - ca endometrium.
- Dx is PCOS….

- A pregnant women with GA 30 weeks ….
- What is the test on picture? ferning pattern
- Mention 2 other investigations to confirm diagnosis? - nitrazine test - amniocsur
- What is the complications which make you start delivery ? chorioaminit
- What is the management for this lady ?

-

- Dx is P PROM…..

- G4PO+3 pregnant women at 34 GA develop HTN …….

- What will you ask about in history (3 points)
- What will you do in physical examination (3 points)
- If a patient develop a lower abdominal pain with fetal compromise , what is the diagnosis ? Placental abruption
- If a patient develop a severe head pain which lead to eclampsia , what is the management? admission + resuscitation + IV lines and foly's. + give MgSO4 / if refractory, give Lorazipam. / if status → Lorazipam + intubation
- What is the first investigation you will order for this lady after delivery? Antiphospholipid syndrome screening

- A women came with sever lower left quadrant abdominal pain ….

- Take a prober history (12 points)
- If you find on US the uterus empty with no adnexal mass , mention 4 investigations you should do ?

Obstetrics and Gynecology

Wateen batch

6th year

MINI OSCE

Q1) liquid based pap smear (Thin Prep) :

1) advantages
2) auscs managment
3) ablation options

Q2) endometrioma :

1) pathology
2) diagnosis
3) pain mx
4) physical findings
5) infertility mx
6) other symptoms

Q3) twins :

1) chorionicity and amniocity
2) sign in us and 3 other findings
3) mono specific complications
4) most common complication
5) risk factors

Q4) breech + ecv :

1) abnormality in picture
2)risk factors of this abnormality:
2) menauver in picture
3) risk of menauver
4) prerequesities

OSCE

Station one:

US image of simple ovarain cyst & history of female P7+1, LMP before 6 weeks, came complain from severe abdominal pain

-Most likely diagnosis, and what is the most common types?
Simple ovarain cyst, functional ovarian cyst (follicular, theca luteal cyst, corpus luteum cyst)
-the Most imp management to do first and why? BHCG to role out ectopic pregnancy
-if the BHCG was negative but patient collapsed and you find free fluid in pelvis, what happened?
-how will you manage the pt: Admission NPO IV fluids Serial CBC
Stable for 24 hrs-- discharge (expectant Mgx) If collapsed--- internal bleeding risk-- go to theater

Station 2

Shoulder dystocia:

Definition 2 Risk Factors
How to manage
maneuvers
2 maternal and fetal complications

Obstetrics and Gynecology

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OSCE

Pop q (high parity, NVD. BMI >35
Cystocel +ureterocele+ Rectocel + enterocel
Narrow vagina
Difinciient perineum
3 Investigation to do
What is most significant risk Factors

CASE OF Sever PET 2 Clinical symptoms 2 biochemical How to prevent it in antenatal care and when Mangement of sever pet

MINI OSCE

***Case shoulder dystocia (turtle sign, maneuvers, risk factors, complications)

***Case of primary amenorrhoea (Hx, PE. Investigates, if uterus absent what diagnosis and what next

***Cesarean incision (low transverse and veritacal) (name, advantages of of transverse

***complication of cs, 2 most common indication for elective and emergency cs

***Case about endometrial hyperplasia (how to take biopsy, Mangement, surgical management and risk factors