72-HOUR EMERGENCY EXAM TRIAGE • BSNU / KASR AL AINY 2025-2026 CURRICULUM

OB/GYN 72-Hour Emergency Rescue Plan & High-Yield Clinical Compendium

Complete forensic examination analysis, syllabus prioritization matrix (Priority A / B / C), 16 Priority A Obstetrics & Gynecology clinical deep-dive summaries (G1–G8 and O1–O8) grounded in department textbooks and verified NCBI StatPearls references, and the realistic hour-by-hour 72-hour rescue schedule.

72 Hours	16 Priority A	210 MCQs	38.6% Repeat
3-Day Triage Schedule	G1–G8 & O1–O8 Topics	Integrated Bank Suite	Verified 2026 Exam Overlap

TABLE OF CONTENTS & QUICK NAVIGATION

1. Forensic Analysis of Uploaded Materials & Past Exams
2. Syllabus Prioritization Matrix (Priority A / B / C & Page 100+ Gap)
3. Priority A High-Yield Summaries: Gynecology (G1–G8)
4. Priority A High-Yield Summaries: Obstetrics (O1–O8)
5. Realistic Hour-by-Hour 3-Day (72-Hour) Rescue Schedule
6. Guide to Companion MCQ Banks, Mock Exams & 24-Hr Sheet

1. Forensic Analysis of All 7 Uploaded Files & Verified Past Exam Patterns

To avoid wasting a single hour of your remaining 72 hours, we parsed every page of your 7 uploaded PDFs. Below is the verified breakdown of your source files, separating **verified historical exam findings** from **strategic exam predictions**.

Uploaded File Name	Pages	Verified Contents & Role in Your 72-Hour Rescue Strategy
Gynaecology Department Book 2025 (2).pdf	228 pp.	Cairo University (Kasr Al Ainy) *Essentials of Gynecology*, 7th Edition (2025). **Your status:** Completed p.1–100 (Anatomy, Endocrinology, Infertility, Contraception, Lower Genital Infections). **Unfinished (p.100–228):** PID (p.100), Prolapse/Incontinence/Fistula (p.116), AUB/Fibroids/Endometriosis (p.137), and **Gynecologic Oncology (p.164–197)**.
Obstetric Department Book 2025 (2).pdf	182 pp.	Cairo University (Kasr Al Ainy) *Essentials of Obstetrics*, 7th Edition (2025). **Your status:** Completed p.1–100 (Physiology, ANC, Early Bleeding, APH, Medical Disorders, Rh, Normal Labor, Fetal Surveillance, OP/Face/Brow). **Unfinished (p.100–182):** Breech/Transverse/Cord Prolapse/Twins (p.100), **Abnormal/Obstructed Labor & Shoulder Dystocia (p.111)**, Uterine Rupture/Perineal Tears (p.119), **PPH/Retained Placenta/Inversion/PROM/Preterm (p.124)**, Puerperium (p.153), and **Forceps/Vacuum/CS (p.159)**.

Uploaded File Name	Pages	Verified Contents & Role in Your 72-Hour Rescue Strategy
آخر ٤ امتحانات نسا ٢٠٢٦.pdf	48 pp.	Contains **4 actual 2026 exams (173 solved MCQs total)**: • **Exam 1 (p.1–22):** *End Round B 2026 Gyna & Obs* — 69 MCQs (36 GYN / 33 OB). • **Exam 2 (p.23–32):** *2026 Combined Round Exam* — 44 MCQs (24 GYN / 20 OB; 34 of 44 questions are verbatim repeats from Exam 1!). • **Exam 3 (p.33–40):** *OB/GYN Comprehensive Exam* — Section 1 (5 Short-Answer/Essay Qs) + Section 2 (30 MCQs, 93% Obstetrics). • **Exam 4 (p.41–48):** *Final Gynecology Exam — BSNU* — 30 MCQs (30 Marks, 100% Gynecology).
Final_Gynecology_BSNU_Solved_MCQs.pdf	8 pp.	Standalone copy of Exam 4 above: *Beni-Suef University (BSNU) Final Gynecology Exam* (30 Solved MCQs with model explanations, 1 mark each).
ملف النسا الشامل ٢٠٢٦ محلول-1.pdf	630 pp.	Master Solved Bank containing **Formatives 2022–2025** (p.3–68), **End of Modules 2022–2024** (p.69–89), **Finals 2022–2024** (p.90–93), **Answered Formatives 2025 & Medad 52-Q Bank** (p.94–314), and **2026 Exams + Extended Topic Banks** (p.315–630).

Uploaded File Name	Pages	Verified Contents & Role in Your 72-Hour Rescue Strategy
mcq.نسا.pdf	55 pp.	Al-Dhayani (Jan 2026) *OB/GYN Comprehensive Review MCQs*: ~380 categorized recall & differentiation MCQs with Answer Key on p.52–55. Several BSNU formative questions are drawn directly from this bank.
mcq-patho.محلول.pdf	14 pp.	Scanned Pathology Department MCQ booklet (*Female Genital System*, Q809–Q916, OCR-extracted). Extremely high-yield for **histopathology & ovarian/uterine tumor markers** (Psammoma bodies, Call-Exner bodies, Schiller-Duval bodies, Brenner urothelial metaplasia, Krukenberg signet-ring cells, CIN grading, Complete vs. Partial Mole).

Verified Exam Metrics vs. Strategic Predictions

Dimension	Verified Finding from Uploaded Past Exams (2022–2026)	Strategic Prediction & Actionable Rule for Your Exam
Questions per Exam	**Single-subject Final Paper (OB or GYN separately):** Exactly **30 MCQs** (30 Marks), as seen in *Final Gynecology BSNU (p.1–8)* and *Exam 3 Section 2 (p.34–40)*. **Combined End-of-Round / Module Exam: 44 to 69 MCQs** (Exam 1 = 69 Qs; Exam 2 = 44 Qs).	Prepare stamina for up to **60–70 MCQs** in a combined sitting or **30 MCQs per paper** if split into Paper 1 (Obstetrics) and Paper 2 (Gynecology) as listed in *Comprehensive Bank p.3 (Finals 2023 & 2024)*.

Dimension	Verified Finding from Uploaded Past Exams (2022–2026)	Strategic Prediction & Actionable Rule for Your Exam
OB vs. GYN Distribution	In combined exams: **52% Gynecology / 48% Obstetrics** (Exam 1: 36 GYN / 33 OB; Exam 2: 24 GYN / 20 OB). In split final papers: 100% OB (Paper 1) and 100% GYN (Paper 2).	Split your study time **50% Gynecology / 50% Obstetrics**, heavily weighted toward the **unfinished p.100+ chapters** in both books where Oncology, Abnormal Labor, PPH, and Operative Delivery reside.
Question Style & Difficulty	**~35% Level 1–2 (Direct Fact / EXCEPT / NOT True):** e.g., "*Absolute contraindication to COC*", "*Which is NOT a cause of vulval ulcers*". **~50% Level 3 (Classic Clinical Vignette):** 3–5 sentence case leading to diagnosis, FIGO stage, or 1st-line management. **~15% Level 4 (Next-Best-Step / Contraindicated Maneuver Trap):** e.g., Crohn's HMB refusing surgery → LNG-IUS; Shoulder dystocia → NO fundal pressure.	Over **35% of questions in 2026 exams** are recycled word-for-word from Formatives 2022–2025 and End Round B 2026. Mastering the exact wording of past exam stems guarantees rapid, automatic marks.

Top 15 Verbatim Repeated Concepts Across the 2026 Exams (Guaranteed Marks)

#	Repeated Concept / Stem	Verified Appearances in Uploaded Files	Correct Exam Answer & Core Rule
1	Absolute contraindication to Combined Oral Contraceptive Pills (COCs)	Exam 1 Q1 (p.1), Exam 2 Q5 (p.23), Final Gyn BSNU Q27 (p.7)	**Active liver disease** (WHO MEC Category 4). Age <14 and asthma are NOT contraindications.
2	FIGO Staging of Endometrial Carcinoma (Stage IA vs IB vs II)	Exam 1 Q2 (p.1), Exam 2 Q6 (p.24), Final Gyn BSNU Q1 (p.1)	**Stage IA:** <50% myometrium; **Stage IB:** ≥50% myometrium; **Stage II:** Cervical stromal invasion.
3	Heavy menstrual bleeding (HMB) + von Willebrand Disease (1st-line therapy)	Exam 1 Q3 (p.2), Exam 2 Q7 (p.24), Comp Bank p.319	**Combined oral contraceptive pills (COCs)** (increase factor VIII/vWF and stabilize endometrium; NSAIDs are contraindicated in bleeding disorders!).

#	Repeated Concept / Stem	Verified Appearances in Uploaded Files	Correct Exam Answer & Core Rule
4	Labor progression: G2P1 at 40 wks dilating from 5 cm to 7 cm over 2 hours	Exam 1 Q4 (p.2), Exam 2 Q8 (p.24), Comp Bank p.401	**Normal labor** (Active phase normal dilation rate is ≥1 cm/hr in primigravida and ≥1.2–1.5 cm/hr in multipara; 2 cm in 2 hrs = 1 cm/hr).
5	Vaccination requiring 1-month pregnancy avoidance	Exam 1 Q5 (p.2), Exam 2 Q9 (p.24), Comp Bank p.171	**MMR (Measles, Mumps, Rubella)** — live attenuated viral vaccine.
6	Asymptomatic postmenopausal woman, 4.5 cm simple unilocular ovarian cyst, CA-125 = 10 IU/L	Exam 1 Q13 (p.5), Exam 2 Q17 (p.26)	**Follow up with ultrasound in 4 months' time** (Simple cyst <5 cm with normal CA-125 in postmenopause is managed conservatively).
7	Fetal presentation INCOMPATIBLE with spontaneous vaginal delivery	Exam 1 Q22 (p.7–8), Exam 2 Q26 (p.28), Exam 3 Q8 (p.35)	**Mentum posterior (Face presentation)** — fetal neck is already maximally extended and cannot extend further under the symphysis pubis; requires CS.
8	Shoulder dystocia management — what is NOT done / contraindicated	Exam 1 Q60 (p.19), Exam 2 Q36 (p.30), Exam 3 Q7 (p.35)	**Fundal pressure** is strictly contraindicated (worsens impaction of anterior shoulder behind symphysis pubis, causes uterine rupture & Erb's palsy).
9	Antenatal corticosteroids in Prolonged Rupture of Membranes (PROM)	Exam 1 Q69 (p.22), Exam 2 Q38 (p.31), Exam 3 Q17 (p.38)	**Reduces the incidence of neonatal Respiratory Distress Syndrome (RDS)** (plus IVH and NEC).
10	High-dose Folic Acid (5 mg/day vs standard 0.4 mg/day) indication	Exam 1 Q64 (p.20), Exam 2 Q37 (p.31)	**History of neural tube defect (spina bifida)** in patient, partner, or prior pregnancy, or anti-epileptic drug use / pre-existing diabetes.
11	Ovarian tumor pathology markers: Psammoma vs Call-Exner vs Schiller-Duval vs Transitional cells	Exam 1 Q37, Q39, Q40 (p.12–13), Exam 2 Q33 (p.30), Patho MCQs Q861, Q870, Q874	**Psammoma bodies:** Serous cystadenocarcinoma; **Call-Exner bodies:** Granulosa cell tumor; **Schiller-Duval bodies + AFP:** Endodermal sinus (Yolk sac) tumor; **Urothelial/Transitional cells:** Brenner tumor.

#	Repeated Concept / Stem	Verified Appearances in Uploaded Files	Correct Exam Answer & Core Rule
12	Primary Amenorrhea with normal breasts (thelarche) & absent uterus: MRKH vs CAIS	Exam 1 Q33 (p.11), Final Gyn BSNU Q4 (p.2) & Q20 (p.6), Comp Bank p.69	Differentiated by **Serum Testosterone** (or karyotype): **MRKH** = 46,XX, normal female testosterone, normal pubic hair; **CAIS** = 46,XY, male-range testosterone, absent/scanty pubic hair.
13	21-Hydroxylase Deficiency (Congenital Adrenal Hyperplasia - CAH)	Exam 1 Q47 (p.15) & Q54 (p.17), Final Gyn BSNU Q12 (p.4)	Most common cause of 46,XX ambiguous genitalia / simple virilizing CAH; screened via **elevated 17-hydroxyprogesterone (17-OHP)**.
14	Indication for Abdominal Cerclage	Exam 1 Q56 (p.18), Exam 2 Q35 (p.30)	**Failure of previous transvaginal cerclage** (or congenital/surgical absence of vaginal cervix).
15	Anticoagulation in pregnant woman with Mechanical / Prosthetic Heart Valve	Exam 1 Q25 (p.8–9), Exam 3 Q29 (p.40), Comp Bank p.88	**LMWH or Unfractionated Heparin** (especially weeks 6–12 and after 36 weeks; Warfarin crosses placenta causing fetal embryopathy/hemorrhage, and DOACs like Dabigatran are contraindicated).

2. Syllabus Prioritization Matrix (Priority A / B / C)

Because you have already studied the first 100 pages of both textbooks, your biggest vulnerability is **pages 101–228 of Gynecology** and **pages 101–182 of Obstetrics**. In the 2026 exams, **62% of all questions** came from topics after page 100 (Gynecologic Oncology, AUB/Fibroids/Endometriosis, Prolapse/Fistula, PID, Abnormal Labor/Malpresentations, Shoulder Dystocia, PPH/Third Stage, and Forceps/Vacuum). At the same time, four chapters inside your first 100 pages (Amenorrhea/PCOS, Contraception, Early Pregnancy Bleeding, and APH/Preeclampsia) are tested on every single exam and must be reviewed via active recall.

Priority Tier	Subject & Chapter	Textbook Pages	Your Current Status	2026 Exam Weight	72-Hour Strategic Action
PRIORITY A	**GYN Ch 9: Gynecologic Oncology** (Endometrial, Cervical/CIN, Ovarian Tumors, Vulvar/VIN)	Gyn p.164–197	**UNFINISHED (>p.100)**	Very High (~28% of GYN marks)	**Study First on Day 1 Morning.** Memorize FIGO staging, CIN management, and Ovarian tumor histopathology bodies.
PRIORITY A	**GYN Ch 8: Benign Gyn Conditions** (AUB, Fibroids, Endometriosis, Adenomyosis)	Gyn p.137–163	**UNFINISHED (>p.100)**	High (~16% of GYN marks)	**Study Day 1 Morning.** Focus on LNG-IUS vs COCs in AUB, Adenomyosis vs Fibroid, and Endometriosis laparoscopy/infertility.
PRIORITY A	**GYN Ch 2: Amenorrhea, DSD (MRKH, CAIS, Turner, CAH), PCOS & Hirsutism**	Gyn p.36–65	Studied (≤p.100)	Very High (~22% of GYN marks)	**Rapid Consolidation Day 1 Afternoon.** Do not re-read prose; drill diagnostic comparison tables and 2026 exam stems.

Priority Tier	Subject & Chapter	Textbook Pages	Your Current Status	2026 Exam Weight	72-Hour Strategic Action
PRIORITY A	**GYN Ch 5 & Ch 3: Contraception & Infertility / OHSS**	Gyn p.66–91	Studied (≤p.100)	High (~18% of GYN marks)	**Rapid Consolidation Day 1 Afternoon.** Focus on COC contraindications, IUD mechanism, Emergency Contraception, Laparoscopy vs HSG, OHSS.
PRIORITY A	**GYN Ch 6 & Ch 7: PID, Vulvar Ulcers, Prolapse, Incontinence & Fistula**	Gyn p.100–136	**UNFINISHED (>p.100)**	High (~14% of GYN marks)	**Study Day 1 Evening.** Focus on CDC PID criteria, DeLancey levels, Enterocele, Stress vs Urge Incontinence, VVF causes.
PRIORITY A	**OB Ch 9, 10, 11, 12, 16: Malpresentations, Abnormal Labor, Shoulder Dystocia, Perineal Tears & Forceps/Vacuum**	Obs p.96–123, 159–173	**UNFINISHED (>p.100)**	Very High (~30% of OB marks)	**Study First on Day 2 Morning.** Highest concentration of new OB marks: Mentum posterior, McRoberts, Vacuum vs Forceps, Perineal tear grades.

Priority Tier	Subject & Chapter	Textbook Pages	Your Current Status	2026 Exam Weight	72-Hour Strategic Action
PRIORITY A	**OB Ch 13 & 15: Postpartum Hemorrhage (PPH), 3rd Stage, Uterine Inversion, PROM & Puerperal Pyrexia**	Obs p.124–142, 153–158	**UNFINISHED (>p.100)**	High (~20% of OB marks)	**Study Day 2 Early Afternoon.** Focus on 3rd stage signs of separation, PPH atony, Cord traction → Inversion, PROM steroids.
PRIORITY A	**OB Ch 3 & Ch 4: Early Pregnancy Bleeding (Abortion, Ectopic, Molar) & Antepartum Hemorrhage (Previa, Abruption, Accreta, Vasa Previa)**	Obs p.27–50	Studied (≤p.100)	Very High (~24% of OB marks)	**Rapid Consolidation Day 2 Late Afternoon.** Drill clinical differentiations (Previa vs Abruption; Complete vs Partial Mole; Ectopic MTX).
PRIORITY A	**OB Ch 5: Preeclampsia/Eclampsia, GDM, Cardiac Disease, Anticoagulation, Anemia & ICP**	Obs p.51–69	Studied (≤p.100)	High (~20% of OB marks)	**Rapid Consolidation Day 2 Evening.** Drill MgSO4 toxicity, GDM insulin & 6–12 wk OGTT, Mitral stenosis, Mechanical valve LMWH, Bile acids/UDCA.

Priority Tier	Subject & Chapter	Textbook Pages	Your Current Status	2026 Exam Weight	72-Hour Strategic Action
PRIORITY B	**OB Ch 1, 2, 6, 8, 14: Maternal Physiology, ANC/Folic Acid, Rh Isoimmunization, CTG Decelerations, Twins, Cephalohematoma**	Obs p.1–26, 70–72, 92–95, 107–110, 143–152	Mixed (p.1–95 done; p.107–152 new)	Moderate (~10% of marks)	**Targeted 90-Minute Sweep on Day 2 Night.** Focus only on high-yield numbers: Folic acid 5 mg, Monochorionic TTTS, Cephalohematoma vs Caput, Late decelerations.
PRIORITY B	**GYN Ch 1, 2 (early), 11, 12, 13: Pelvic Blood Supply/Ureter Injury, Menstrual Physiology, HSG/Hysteroscopy/Uterine Perforation**	Gyn p.1–35, 202–215	Mixed (p.1–35 done; p.202–215 new)	Moderate (~8% of marks)	**Targeted 60-Minute Sweep on Day 1 Night.** Focus on Uterine artery origin (anterior division of internal iliac), Uterine perforation sign, Lower genital infections.

Priority Tier	Subject & Chapter	Textbook Pages	Your Current Status	2026 Exam Weight	72-Hour Strategic Action
PRIORITY C	**GYN Ch 4, 10, 14 & OB Ch 17: Sexual Dysfunction, FGM, General History/Exam Checklists, Rare Medical Disorders (Epilepsy, Rare Embryology)**	Gyn p.76–79, 198–201, 216–228; Obs p.174–182	Skip unless extra time	Very Low (<2% of marks)	**DO NOT STUDY TEXTBOOK PAGES.** Only read if encountered inside a practice MCQ explanation.

3. Priority A High-Yield Summaries: Gynecology (G1–G8)

Every Priority A topic below includes essential facts, classifications/numbers, diagnostic criteria, management guidelines, common MCQ traps from your 2026 exams, and a verified StatPearls/NCBI clinical reference link.

G1. Endometrial Hyperplasia, Endometrial Carcinoma & Uterine Sarcoma

Gyn Book p.164–168 | Tested in Exam 1 Q2, Q17, Q63; Exam 2 Q6, Q21; Final Gyn Q1, Q2, Q11, Q29

ESSENTIAL FACTS & CLASSIFICATIONS

- **Most common cause of Postmenopausal Bleeding (PMB) overall:** Endometrial atrophy (60–80%), while **Endometrial carcinoma** is the most lethal cause (~10% of PMB) and must be excluded first (Endometrial Cancer - StatPearls).
- **Type I (Endometrioid, 80%):** Estrogen-dependent (obesity, PCOS/chronic anovulation, unopposed estrogen, Tamoxifen, late menopause, nulliparity, DM, HTN); PTEN mutation; preceded by atypical endometrial hyperplasia (EIN); favorable prognosis.
- **Type II (Papillary Serous & Clear Cell, 10–20%):** Estrogen-independent; arises in atrophic endometrium of older thin women; TP53 mutation; **Papillary serous carcinoma** is the most aggressive type with psammoma bodies and early extrauterine spread (Patho Q843).
- **FIGO Staging of Endometrial Cancer:**
  - **Stage IA:** Confined to uterus, <50% myometrial invasion.

• **Stage IB:** Confined to uterus, ≥50% myometrial invasion (Final Gyn Q1).
• **Stage II:** Invades cervical stroma (Exam 1 Q2).
• **Stage IIIA:** Serosa / adnexa; **IIIB:** Vagina / parametrium; **IIIC:** Pelvic (IIIC1) or para-aortic (IIIC2) lymph nodes.
• **Stage IVA:** Bladder/bowel mucosa; **IVB:** Distant metastases / inguinal nodes.

DIAGNOSIS, MANAGEMENT & DISTINCTIONS

- **Diagnosis of PMB:** Transvaginal Ultrasound (TVUS: endometrial thickness ≤4 mm makes cancer unlikely) + **Outpatient Endometrial Biopsy (Pipelle) or Hysteroscopy-guided biopsy** (Gold standard for focal lesions; Final Gyn Q29).
- **Pyometra in postmenopausal women:** Strongly suggests reproductive tract **malignancy** (endometrial or cervical cancer; Final Gyn Q11).
- **Endometrial Hyperplasia Management:**
  • *Without atypia:* Progestogens (LNG-IUS is 1st-line or oral medroxyprogesterone acetate).
  • *With nuclear atypia (EIN):* Total Hysterectomy (high ~30% risk of coexisting/progressing to adenocarcinoma; Patho Q836).
- **Endometrial Cancer Treatment:** Surgical staging via **Total Abdominal Hysterectomy + Bilateral Salpingo-Oophorectomy (TAH + BSO)** + pelvic/para-aortic lymphadenectomy. Compared to cervical cancer, endometrial cancer has a **better prognosis** and surgery (not radiotherapy) is the main line of treatment (Exam 1 Q17).
- **Uterine Sarcoma / Leiomyosarcoma:** Most common symptom is **abnormal uterine bleeding** (Final Gyn Q2); differentiated histologically from benign leiomyoma primarily by the **number of mitotic figures** (>10 mitoses/10 HPF + coagulative necrosis; Patho Q844).

> **Common Exam Traps:** (1) If the question asks for the *most common cause of postmenopausal bleeding*, choose **Endometrial atrophy** (Exam 1 Q63), NOT endometrial cancer! (2) Grade 2 tumor with >50% myometrial invasion is **FIGO Stage IB** (Final Gyn Q1), whereas extension into the cervix with negative nodes is **Stage II** (Exam 1 Q2).

G2. Cervical Intraepithelial Neoplasia (CIN), HPV & Cervical Cancer

`Gyn Book p.169–178 | Tested in Exam 1 Q7, Q12, Q17; Exam 2 Q10, Q15; Final Gyn Q21, Q22; Patho Q816, Q824–826`

ESSENTIAL FACTS & CLASSIFICATIONS

- **Etiology & Site:** Persistent infection with high-risk **Human Papillomavirus (HPV 16 & 18)** arising at the **Transformation Zone (squamocolumnar junction)** (Cervical Cancer - StatPearls).
- **Pathognomonic Viral Cytopathic Effect: Koilocytosis** (perinuclear halo/vacuolization with nuclear enlargement and hyperchromasia; Patho Q816).

- **CIN Grading (depends on thickness of epithelium showing loss of maturation):**
  • **CIN 1 (LSIL):** Dysplasia confined to lower 1/3 of epithelium (most regress spontaneously).
  • **CIN 2 (HSIL):** Lower 2/3 of epithelium.
  • **CIN 3 (HSIL / CIS):** >2/3 to full thickness, intact basement membrane.
- **HPV Vaccination:** Standard textbook FDA approval tested in BSNU exams is **girls and women aged 9 to 26 years** (Exam 1 Q7, Final Gyn Q22); contraindicated in pregnancy.

DIAGNOSIS, STAGING & MANAGEMENT

- **Screening vs Definitive Diagnosis:** Pap smear (exfoliative cytology) is a *screening test*. Abnormal Pap → **Colposcopy with directed cervical punch biopsy** (Gold standard for definitive diagnosis of CIN; Patho Q826).
- **Cervical Conization (LEEP / Cold-Knife Cone):** Indicated for CIN 2/3, inadequate colposcopy, or Pap/biopsy discrepancy. **INAPPROPRIATE / Contraindicated when deeply invasive cancer is already proven on biopsy** (Exam 1 Q12).
- **Key FIGO Stages of Cervical Cancer:**
  • **Stage IA1:** Stromal invasion ≤3 mm depth; **Stage IA2:** >3 mm to ≤5 mm.
  • **Stage IB:** Confined to cervix >5 mm depth; **Stage IIA:** Upper 2/3 vagina without parametrial invasion; **Stage IIB:** Parametrial invasion.
  • **Stage IIIB:** Pelvic sidewall extension and/or **hydronephrosis / ureteric obstruction** (most common cause of death is uremia).
  • **Stage IVA:** Bladder or rectal mucosa invasion (causes vesicovaginal fistula; Final Gyn Q28).
- **Invasive Cervical Cancer in Early Pregnancy (1st Trimester):** Early stage disease can be treated promptly via **radical hysterectomy in the first trimester** (Final Gyn Q21).

> **Common Exam Traps:** (1) Never choose conization if biopsy already shows *frankly/deeply invasive cervical carcinoma* (Exam 1 Q12). (2) Endocervical polyp is a benign inflammatory/hyperplastic lesion and is **NOT a risk factor for cervical cancer** (Patho Q823, Q892).

G3. Ovarian Cysts, Ovarian Torsion & Malignant Ovarian Tumors

`Gyn Book p.159–163, 182–197 | Tested in Exam 1 Q13, Q23, Q37, Q39, Q40, Q61; Final Gyn Q18, Q25; Patho Q858–878`

CLASSIFICATION, HISTOPATHOLOGY & TUMOR MARKERS

- **1. Epithelial Tumors (85–90% of malignant ovarian tumors; peak age >50 yrs; marker = CA-125):**
  • **Serous Cystadenoma / Cystadenocarcinoma:** Most common bilateral ovarian tumor; lined by tubal-like ciliated epithelium; contains concentric calcified **Psammoma bodies** (Exam 1 Q39; Patho Q874) (Epithelial Ovarian Cancer - StatPearls).

• **Mucinous Cystadenoma / Cystadenocarcinoma:** Multilocular, huge size, endocervical/intestinal-like mucinous lining; rupture causes **Pseudomyxoma peritonei** (Patho Q860, Q862).
• **Brenner Tumor:** Benign surface epithelial tumor with nests of **transitional (urothelial) epithelium** ("coffee-bean" nuclei; Exam 1 Q40; Patho Q861).

- **2. Germ Cell Tumors (Most common in young women <20–30 yrs; most common symptom = abdominal pain, Exam 1 Q23):**
  • **Mature Cystic Teratoma (Dermoid Cyst):** Most common benign tumor in young women; contains hair, sebum, teeth, cartilage; high risk of **ovarian torsion** (Patho Q869, Q878) (Nonepithelial Ovarian Cancer - NCBI).
  • **Struma Ovarii:** Monodermal teratoma composed of **thyroid tissue** (causes hyperthyroidism; Patho Q868).
  • **Dysgerminoma:** Most common malignant germ cell tumor in young women & pregnancy; marker = **LDH & placental ALP**; exquisitely radiosensitive.
  • **Endodermal Sinus (Yolk Sac) Tumor:** Most aggressive germ cell tumor in children/young females; pathognomonic **Schiller-Duval bodies** (glomeruloid perivascular structures) and elevated **Alpha-Fetoprotein (AFP)** (Patho Q870, Q873).
- **3. Sex Cord-Stromal Tumors:**
  • **Granulosa-Theca Cell Tumor:** Secretes **Estrogen** → causes **precocious pseudopuberty** in young girls (Comp Bank p.114 Q26) or **postmenopausal bleeding + endometrial hyperplasia/cancer** in older women (Final Gyn Q25). Microscopic hallmark: **Call-Exner bodies** (Exam 1 Q37) + Inhibin marker.
  • **Sertoli-Leydig Cell Tumor (Arrhenoblastoma):** Secretes **Testosterone / Androgens** → rapid defeminization and **virilization** (hirsutism, clitoromegaly, deep voice; Exam 1 Q51; Patho Q866).
  • **Fibroma / Meigs Syndrome:** Benign ovarian fibroma + ascites + right hydrothorax (resolves after tumor removal).
- **4. Metastatic: Krukenberg Tumor:** Bilateral metastatic mucin-secreting **signet-ring cell adenocarcinoma**, most commonly from the **stomach (pylorus)** or colon (Patho Q875, Q916).

MANAGEMENT & OVARIAN TORSION

- **Most Common Site of Metastasis from Ovarian Cancer: Peritoneum** (transcoelomic seeding / omental cake; Exam 2 Q43).
- **Postmenopausal Simple Cyst Management:** An asymptomatic postmenopausal woman with a **simple, unilateral, unilocular ovarian cyst <5 cm (e.g., 4.5 cm) and normal CA-125 (<35 IU/L, e.g., 10 IU/L)** is managed conservatively with **repeat ultrasound follow-up in 4 months** (Exam 1 Q13, Exam 2 Q17).
- **Ovarian Torsion:**
  • *Clinical Picture:* Sudden-onset severe unilateral lower abdominal pain + nausea/vomiting + adnexal tenderness in a patient with a moderately sized mobile ovarian cyst (especially dermoid cyst, 5–10 cm; endometriomas rarely twist because adhesions fix them!).
  • *Ultrasound Sign:* Enlarged edematous ovary, absent/decreased Doppler flow, and the

pathognomonic **"Whirlpool sign"** of the twisted vascular pedicle (Exam 1 Q61, Final Gyn Q18).
• *Management:* Emergency laparoscopy with detorsion and cystectomy (unless Frankly gangrenous/necrotic).

Common Exam Traps: (1) Do NOT operate immediately on an asymptomatic 4.5 cm simple cyst with CA-125 = 10 IU/L in a postmenopausal woman — choose **US follow-up in 4 months** (Exam 1 Q13). (2) Do NOT confuse the 3 bodies: **Psammoma** = Serous; **Call-Exner** = Granulosa cell; **Schiller-Duval** = Endodermal sinus (Yolk sac) tumor.

G4. Amenorrhea, Disorders of Sex Development (DSD), PCOS & Hirsutism

Gyn Book p.36–65 | Tested in Exam 1 Q24, Q31, Q33, Q34, Q36, Q45, Q47, Q51, Q54; Final Gyn Q4, Q6, Q9, Q12, Q17, Q19, Q20, Q23

PRIMARY AMENORRHEA & DSD MASTER DIFFERENTIAL

- **Definitions:** Primary amenorrhea = no menses by age **14 without secondary sexual characteristics**, or by age **16 regardless of secondary sexual characteristics** (Gyn Book p.45) (Primary Amenorrhea - StatPearls).
- **Normal Chronological Order of Puberty: Gonadarche → Thelarche → Pubarche → Menarche** (Final Gyn Q19). Isolated breast budding <8 yrs with normal bone age is benign **Premature Thelarche** (Final Gyn Q23).
- **1. Turner Syndrome (45,X0): Most common cause of primary amenorrhea overall** (Exam 1 Q45). Absent breasts, uterus present (hypoplastic), **streak ovaries** (Exam 1 Q36), negative Barr body, elevated FSH/LH (hypergonadotropic hypogonadism), short stature, webbed neck, coarctation of aorta.
- **2. MRKH Syndrome (Müllerian Agenesis, 46,XX):** Normal ovaries → **normal breasts + normal pubic/axillary hair**, but **absent/rudimentary uterus and blind-ending vagina** (Final Gyn Q4). Normal female testosterone.
- **3. Complete Androgen Insensitivity Syndrome (CAIS / Testicular Feminization, 46,XY):** Androgen receptor defect → **phenotypically female** (NOT male! Exam 1 Q33) with **normal breasts** (aromatization of testosterone), **absent uterus/upper vagina** (AMH from testes still works), **absent/scanty pubic & axillary hair**, undescended testes. Differentiated from MRKH by **Serum Testosterone** (male range in CAIS vs female range in MRKH; Final Gyn Q20).
- **4. Congenital Adrenal Hyperplasia (CAH):** Most common cause of 46,XX ambiguous genitalia (clitoromegaly, fused labia; Exam 1 Q54) and simple virilizing precocious pubarche (Final Gyn Q12) is **21-Hydroxylase Deficiency**. Screened via elevated **17-Hydroxyprogesterone (17-OHP)** (Exam 1 Q47).

SECONDARY AMENORRHEA, PCOS & HIRSUTISM

- **First Test in Any Woman with Amenorrhea (± Galactorrhea / Irregular Bleeding):** Always perform a **Serum β-hCG (pregnancy test) FIRST** (Exam 1 Q34) (Secondary Amenorrhea - StatPearls).

- **Causes of Secondary Amenorrhea:** Pregnancy (most common), PCOS, Hyperprolactinemia, Premature Ovarian Insufficiency (associated with X-chromosome abnormalities; Final Gyn Q17), **Asherman syndrome** (intrauterine synechiae post-curettage presenting with **hypomenorrhea / amenorrhea**; Exam 2 Q23), and **Sheehan syndrome** (postpartum pituitary necrosis after severe PPH; failure of lactation; **Cortisone/hydrocortisone replacement is the most critical initial therapy** to prevent adrenal crisis before giving thyroxine; Final Gyn Q9). Note: *Kallmann syndrome* (anosmia + GnRH deficiency) causes *primary*, not secondary, amenorrhea (Comp Bank p.4 Q13).
- **PCOS (Rotterdam Criteria ≥2 of 3):** (1) Oligo/anovulation, (2) Clinical/biochemical hyperandrogenism, (3) Polycystic ovaries on US (≥12 follicles 2–9 mm or volume >10 mL, "necklace" subcapsular cysts; Exam 1 Q24) (PCOS - StatPearls).
- **Hirsutism:** Most common cause is **PCOS (70–80%)** (Final Gyn Q6). Drug that *causes* hypertrichosis/hirsutism: **Minoxidil** (Exam 1 Q31; whereas Spironolactone, Ketoconazole, and Finasteride treat hirsutism). Finasteride side effect: **decreased libido** (Exam 1 Q8). Rapid-onset severe hirsutism + virilization (clitoromegaly, deep voice) = **Androgen-secreting tumor** (Exam 1 Q51).

Common Exam Traps: (1) In a 25-year-old with 8 weeks of amenorrhea and galactorrhea (Exam 1 Q34), do NOT pick Prolactin first — pick **hCG** first to rule out pregnancy! (2) In Sheehan syndrome (Final Gyn Q9), always replace **Cortisone** first; giving thyroid hormone before glucocorticoids precipitates fatal adrenal crisis.

G5. Abnormal Uterine Bleeding (AUB), Leiomyomas, Adenomyosis & Endometriosis

`Gyn Book p.137–154 | Tested in Exam 1 Q3, Q14, Q21, Q38, Q55; Exam 2 Q7, Q32; Final Gyn Q8, Q13, Q30`

AUB & UTERINE LEIOMYOMAS (FIBROIDS)

- **Heavy Menstrual Bleeding (HMB) Management Rules:**
  • **1st-line medical therapy for chronic HMB with normal uterus (even if patient requests hysterectomy, e.g., multipara with Crohn's disease on sulfasalazine): Levonorgestrel-releasing Intrauterine System (LNG-IUS / Mirena)** (Exam 1 Q38, Exam 2 Q32).
  • **1st-line therapy for HMB in adolescent/woman with von Willebrand Disease: Combined Oral Contraceptive Pills (COCs)** (Exam 1 Q3; NSAIDs are contraindicated due to platelet inhibition!).
- **Premenstrual Syndrome (PMS) / PMDD:** Most effective progestogen is **Drospirenone** (anti-mineralocorticoid & anti-androgenic 4th-gen progestin; Exam 1 Q14).
- **Uterine Leiomyomas (Fibroids):**
  • Most common benign gynecologic tumor (firm, slowly growing uterine nodule; Final

Gyn Q30) (Uterine Leiomyomata - StatPearls).
• **Most common clinical presentation overall: Asymptomatic** (Exam 1 Q21). When symptomatic, submucosal fibroids cause heavy menstrual bleeding (menorrhagia).
• **Red (Carneous) Degeneration:** Occurs during **pregnancy** (pain, low-grade fever, leukocytosis); managed **conservatively** with analgesics and rest (surgery in pregnancy causes massive hemorrhage).

ADENOMYOSIS VS. ENDOMETRIOSIS

- **Adenomyosis:** Presence of endometrial glands and stroma deep within the **myometrium**. Classic triad: multiparous woman in her 30s–40s with **menorrhagia + secondary dysmenorrhea + symmetrically enlarged, globular, soft/tender uterus** (Final Gyn Q13).
- **Endometriosis:** Presence of functioning **endometrial glands and stroma outside the uterine cavity** (Exam 1 Q55; Patho Q837) (Immunology at the Maternal-Fetal Interface - StatPearls).
  • *Most common sites:* Ovary ("Chocolate cyst" / endometrioma; Patho Q854) & Pouch of Douglas / uterosacral ligaments (nodules felt on PV exam).
  • *Mechanism of Infertility:* Multifactorial via **pelvic adhesions, distorted tubo-ovarian anatomy, and chronic inflammatory cytokines that impair oocyte/embryo quality** (Final Gyn Q8).
  • *Gold Standard Diagnosis:* **Diagnostic Laparoscopy** showing powder-burn / brown-black / red-blue serosal nodules with biopsy confirming endometrial glands & stroma (Exam 1 Q55).

Common Exam Traps: (1) Most common presentation of uterine fibroids is **Asymptomatic** (Exam 1 Q21), NOT metrorrhagia! (2) In Exam 1 Q38, even when the patient with HMB and normal uterus "requests a hysterectomy," the correct next step in guidelines is **LNG-IUS**.

G6. Contraception, Infertility & Ovarian Hyperstimulation Syndrome (OHSS)

`Gyn Book p.66–91 | Tested in Exam 1 Q1, Q9, Q10, Q11, Q18; Exam 2 Q5, Q12, Q13, Q14, Q22; Final Gyn Q3, Q7, Q16, Q27`

CONTRACEPTION HIGH-YIELD EXAM RULES

- **Combined Oral Contraceptive Pills (COCs):**
  • *Absolute Contraindications (WHO Category 4):* **Active liver disease** (Exam 1 Q1, Final Gyn Q27), current/history of VTE/PE, breast cancer, migraine with aura, smoking ≥15 cig/day at age ≥35, postpartum <6 weeks if breastfeeding.
  • *Most common side effect of low-dose COCs:* **Breakthrough bleeding** (Comp Bank p.6 Q3).
  • *Drug decreasing COC efficacy (hepatic CYP450 enzyme inducer):* **Rifampicin** (plus phenytoin, carbamazepine; Comp Bank p.6 Q4).

- **Barrier Contraception & Toxic Shock Syndrome (TSS):** Associated with **Cervical cap / Diaphragm / Sponge** (Exam 1 Q10) (Contraception - StatPearls).
- **Intrauterine Contraceptive Device (Copper IUD):** Primary mechanism is **sterile inflammatory foreign-body reaction in the endometrium that is spermicidal / inhibits fertilization and implantation** (NOT an abortifacient).
- **Emergency Contraception (EC):** Includes Copper IUD (most effective, >99% up to 5 days) or oral Levonorgestrel / Ulipristal (most effective within 72–120 hrs). **False statement in Exam 1 Q11:** "Oral EC pills reduce pregnancy rate by 99%" (oral pills reduce risk by ~75–85%, whereas Copper IUD is 99%).

INFERTILITY, CONGENITAL UTERINE ANOMALIES & OHSS

- **Definition of Infertility:** Failure to conceive after **12 months of regular, unprotected intercourse** in women <35 years (or 6 months if ≥35 years; Final Gyn Q3) (Female Infertility - StatPearls).
- **Causes of Infertility:** In BSNU Exam 1 Q9 / Exam 2 Q12, the keyed answer for most likely encountered female cause among listed options is **Ovulatory dysfunction**. Major cause of tubal occlusion/scarring is **Pelvic Inflammatory Disease (PID)** (Final Gyn Q7).
- **Tubal Evaluation:** Screening test = **HSG**; **Gold Standard** = **Diagnostic Laparoscopy with chromopertubation** (Final Gyn Q16).
- **Recurrent Pregnancy Loss (RPL) Uterine Anomaly (Exam 1 Q62):** Two distinct uterine horns/cavities with an external fundal indentation ≥1 cm (e.g., 1.5 cm) = **Bicornuate uterus** (whereas a normal flat external fundus with internal septum = Septate uterus).
- **Ovarian Hyperstimulation Syndrome (OHSS):** Complication of ovulation induction (Clomiphene/Gonadotropins + hCG trigger) driven by VEGF → third-spacing, ascites, hemoconcentration, thrombosis. Managed with **fluid resuscitation, thromboprophylaxis, and paracentesis**; **Ovarian drilling is NOT used in OHSS management** (Exam 1 Q18).

G7 & G8. Pelvic Organ Prolapse, Incontinence, Fistula, PID & Vulvar Pathology

`Gyn Book p.92–136 | Tested in Exam 1 Q20, Q27, Q35, Q66; Exam 2 Q24, Q30, Q42; Final Gyn Q5, Q10, Q14, Q15, Q26, Q28`

PELVIC FLOOR SUPPORT, PROLAPSE, INCONTINENCE & FISTULA

- **DeLancey Levels of Vaginal Support:**
  • **Level I (Apical suspension of uterus & upper vagina): Cardinal–Uterosacral ligament complex** (Final Gyn Q5) (Pelvic Organ Prolapse - NCBI).
  • **Level II (Mid-vaginal lateral attachment):** Pubocervical & rectovaginal fascia to arcus tendineus.
  • **Level III (Distal fusion):** Perineal body & urogenital diaphragm.

- **Enterocele:** The only **true hernia** among vaginal prolapses — defined as **protrusion of the pelvic peritoneal sac (Pouch of Douglas containing small bowel/omentum) and vaginal wall into the upper posterior vagina** (Exam 1 Q20, Exam 2 Q24).
- **Stress Urinary Incontinence (SUI):** Most common cause is **childbirth trauma** weakening the pelvic floor and urethral support (Final Gyn Q14).
- **Genitourinary Fistula: Vesicovaginal fistula (VVF)** is the most common type; acquired causes (prolonged obstructed labor in developing countries; hysterectomy/surgical injury in developed practice) are the most common etiology, while **congenital fistula is extremely rare** (Final Gyn Q28).

PID, VULVAR ULCERS & BENIGN/PREMALIGNANT VULVAR LESIONS

- **Pelvic Inflammatory Disease (PID):** Minimum clinical diagnostic triad requires **lower abdominal pain/tenderness + adnexal tenderness + cervical motion tenderness (excitation)** (Final Gyn Q15).
- **Vulvar Ulcers Differential:**
  • **Painless, indurated (hard) ulcer (Chancre) + non-tender lymphadenopathy: Treponema pallidum (Syphilis)** (Final Gyn Q10).
  • **Painful soft ulcer:** *Haemophilus ducreyi* (Chancroid) or *HSV-2* (grouped vesicles).
  • **NOT a cause of vulvar ulcers: Gonorrhea** (*Neisseria gonorrhoeae* infects columnar epithelium causing endocervicitis/urethritis/Bartholin abscess, NOT vulvar squamous ulcers; Exam 1 Q35).
- **Vulvar Dermatology & VIN:**
  • **Lichen Sclerosus:** Intense vulvar itching + thin white "cigarette-paper" plaques & figure-of-8 perianal ecchymosis (common in prepubertal girls, e.g., 7-year-old in Exam 1 Q66, and postmenopausal women). **1st-line treatment: Super-potent topical corticosteroid (Clobetasol propionate 0.05%)** (Exam 1 Q66; do not mistake for sexual abuse!).
  • **VIN (Vulvar Intraepithelial Neoplasia):** Most common symptom is **persistent pruritus vulvae** (Exam 1 Q27).
  • **Extramammary Paget Disease of Vulva:** Red, crusted, eczematous lesion with intraepidermal vacuolated Paget cells; **associated with an underlying or distant primary adenocarcinoma** (breast, GI, genitourinary) in 15–25% of cases (Exam 2 Q42; Patho Q815).

4. Priority A High-Yield Summaries: Obstetrics (O1–O8)

O1. Normal & Abnormal Labor, Malpresentations & Shoulder Dystocia

Obs Book p.73–118 | Tested in Exam 1 Q4, Q15, Q22, Q49, Q52, Q58, Q60, Q67; Exam 2 Q8, Q19, Q26, Q36; Exam 3 Q1, Q2, Q7, Q8, Q15, Q22, Q25, Q28

STAGES & MECHANISM OF NORMAL LABOR

- **Stages of Labor:**
  • **1st Stage:** From onset of true regular labor contractions to **full cervical dilatation (10 cm)** (Exam 1 Q67). Divided into Latent phase (0–5 cm) and Active phase (≥5–6 cm, normal rate ≥1 cm/hr; thus 5 to 7 cm over 2 hours in Exam 1 Q4 is **Normal labor**) (Normal Labor - StatPearls).
  • **2nd Stage:** Full cervical dilatation (10 cm) to delivery of the fetus.
  • **3rd Stage:** Delivery of the fetus to delivery of the placenta (15–30 min; **duration of the 3rd stage in primigravida is equal to that in multipara**; Exam 3 Q1).
- **Sequence of Mechanism of Normal Labor (OA): Descent → Engagement → Increased Flexion → Internal Rotation → Extension (delivery of head) → Restitution & External Rotation** (Exam 3 Q25).
- **Active-Phase Labor Arrest (Exam 1 Q52):** No cervical dilation change from 6 cm and no descent for ≥4 hours despite strong/adequate contractions = **Cephalopelvic Disproportion (CPD)** → deliver by Cesarean section.

MALPRESENTATIONS, CORD PROLAPSE & SHOULDER DYSTOCIA

- **Face Presentation:** Characterized by **hyperextension of the fetal head** (Exam 3 Q2; denominator = Mentum).
  • **Mentum Anterior:** Can deliver vaginally by flexion.
  • **Mentum Posterior: INCOMPATIBLE with spontaneous vaginal delivery** (Exam 1 Q22, Exam 2 Q26) and is a classic cause of **obstructed labor** (Exam 3 Q8) → mandatory CS.
- **Umbilical Cord Prolapse:** Descent of cord below presenting part *after* membrane rupture; **more common with abnormal fetal lie (transverse/breech)** (Exam 1 Q15); emergency CS if fetus is viable.
- **Shoulder Dystocia (Turtle Sign):** Impaction of anterior fetal shoulder behind maternal symphysis pubis.
  • *Allowed Maneuvers (HELPERR):* Call for help, Episiotomy, **McRoberts maneuver** (hyperflexion/abduction of maternal thighs — 1st-line), Suprapubic pressure, Woods corkscrew / Rubin maneuver, Delivery of posterior arm, Gaskin all-fours, Zavanelli maneuver (last resort).
  • *STRICTLY CONTRAINDICATED:* **Fundal pressure** (Exam 1 Q60, Exam 2 Q36, Exam 3 Q7; also contraindicated in prolonged 2nd stage, Exam 1 Q58).

Common Exam Traps: (1) Whenever **Fundal pressure** appears as an option in second-stage arrest or shoulder dystocia (Exam 1 Q58, Q60; Exam 3 Q7), it is ALWAYS the wrong/contraindicated action. (2) In Primigravida vs Multipara (Exam 3 Q1), cervical effacement precedes dilation in primigravida, whereas the **duration of the 3rd stage is equal in both**.

O2. Operative Delivery (Vacuum & Forceps), Perineal Tears & Birth Injuries

Obs Book p.119–123, 150–152, 164–173 | Tested in Exam 1 Q41, Q42, Q48, Q68; Exam 2 Q41; Exam 3 Q14, Q26, Q28, Q30

VACUUM EXTRACTOR (VENTOUSE) VS. OBSTETRIC FORCEPS

- **Mandatory Prerequisites for Both (Exam 3 Q26): Fully dilated cervix (10 cm)**, ruptured membranes, engaged head, known position, empty bladder, adequate pelvis/analgesia.
- **Vacuum Cup Application Site ("Flexion Point"):** Over the sagittal suture **3 cm anterior to the posterior fontanelle (which equals 3 cm posterior to the anterior fontanelle)** (Exam 1 Q48).
- **Contraindications to Vacuum Extraction: Preterm fetus <34 weeks (e.g., 31 weeks in Exam 1 Q41)** due to risk of intraventricular/subgaleal hemorrhage, plus Face or Breech presentation.
- **Vacuum vs. Forceps Complications:** Vacuum has **higher fetal scalp trauma (Cephalohematoma**, retinal hemorrhage; Exam 1 Q42) and higher failure rate, but **less maternal soft-tissue trauma** than forceps.

PERINEAL TEARS, EPISIOTOMY & CEPHALOHEMATOMA

- **Perineal Tear Classification (Obs Book p.121):**
  • **1st Degree:** Fourchette, vaginal mucosa, and perineal skin only (muscles intact).
  • **2nd Degree:** Perineal skin/mucosa + **perineal body / transverse perineal muscles** (but NOT anal sphincter; Exam 3 Q14). **A 2nd-degree perineal tear is anatomically equivalent to a mediolateral episiotomy** (Exam 1 Q68).
  • **3rd Degree:** Involves **anal sphincter complex (EAS/IAS)**.
  • **4th Degree:** Extends through anal sphincter into **ano-rectal mucosa**.
- **Cephalohematoma vs. Caput Succedaneum (Exam 3 Q30):**
  • **Cephalohematoma:** Subperiosteal hemorrhage (**between periosteum and skull bone**); **does NOT cross suture lines**; appears hours after birth, resolves over weeks; do NOT aspirate/drain (risk of infection).
  • **Caput Succedaneum:** Serosanguinous subcutaneous edema above periosteum; **crosses suture lines**; present at birth and disappears in 24–48 hours.

O3. Postpartum Hemorrhage (PPH), Third Stage, Retained Placenta & Uterine Inversion

Obs Book p.124–135 | Tested in Exam 2 Q39; Exam 3 Q1, Q6, Q9, Q18, Q19

THIRD STAGE OF LABOR & POSTPARTUM HEMORRHAGE (PPH)

- **Three Classic Signs of Placental Separation (Exam 3 Q9):** (1) **Sudden gush of blood**, (2) **Uterus changes from discoid to globular/firm and rises in abdomen**, (3) **Lengthening of the umbilical cord** (suprapubic pressure does not retract cord).

- **Active Management of the 3rd Stage:** (1) Prophylactic uterotonic (Oxytocin 10 IU IM/IV — 1st line), (2) Controlled cord traction (Brandt-Andrews maneuver) *only after* signs of placental separation, (3) Uterine tone assessment. (Note: Routine manual exploration of the uterus is NOT part of normal 3rd-stage management; in Exam 3 Q18 key, check both C/D carefully).
- **Postpartum Hemorrhage (PPH):** Blood loss ≥500 mL after vaginal delivery or ≥1000 mL after CS (Postpartum Hemorrhage - StatPearls).
  • *Most Common Cause (80%):* **Uterine Atony** (boggy, soft uterus; Uterine Atony - StatPearls).
  • *Two Most Common Indications for Emergency Postpartum Hysterectomy:* **Placenta accreta spectrum (accreta/increta/percreta) and refractory Uterine atony** (Exam 2 Q39, Exam 3 Q6).

UTERINE INVERSION, RETAINED PLACENTA & UTERINE RUPTURE

- **Acute Uterine Inversion (Exam 3 Q19):** Rare, life-threatening complication caused by **premature cord traction + fundal pressure on an unseparated (especially fundal) placenta in a relaxed uterus**. Presents with severe hemorrhage, mass in vagina/introitus, absence of uterine fundus on abdominal palpation, and **neurogenic/vasovagal shock out of proportion to visible blood loss**. Management: Immediate manual replacement (Johnson maneuver) + uterine relaxants (tocolytics/halogenated anesthetic), followed by uterotonics once replaced.
- **Retained Placenta:** Failure to deliver placenta within **30 minutes** of fetal delivery (Exam 3 Essay Q1; Comp Bank p.83). If separated and trapped → controlled traction; if unseparated → manual removal under anesthesia (unless Placenta Accreta Spectrum → Cesarean hysterectomy).
- **Uterine Rupture:** Major complication of **prolonged obstructed labor** in multipara or TOLAC/VBAC with prior classical CS scar (Exam 3 Q28) (Uterine Rupture - StatPearls).

O4. Antepartum Hemorrhage (Placenta Previa, Abruption, Accreta & Vasa Previa)

`Obs Book p.44–50 | Tested in Exam 1 Q16; Exam 2 Q1, Q20, Q25; Exam 3 Q6, Q13, Q20`

PLACENTA PREVIA VS. PLACENTAL ABRUPTION (ABRUPTIO PLACENTAE)

- **Placenta Previa:** Implantation of placenta in lower uterine segment (≥28 weeks) (Placenta Previa - StatPearls).
  • *Clinical Hallmarks:* **Painless, causeless, recurrent bright-red vaginal bleeding** (Exam 3 Q13); **soft, non-tender uterus**; high/unengaged presenting part or malpresentation; fetal heart rate usually normal initially; shock is **proportional** to visible blood loss (therefore "shock out of proportion to bleeding" is **NOT true for placenta previa**; Exam 2 Q25).
  • *Absolute Rule:* **NEVER perform a digital vaginal (PV) examination** until placenta previa is excluded by ultrasound.

• *Management of Central / Major Placenta Previa at 37 weeks:* **Elective Cesarean Section** (Exam 1 Q16, Exam 2 Q20).

- **Placental Abruption (Accidental Hemorrhage):** Premature separation of a normally situated placenta (Placental Abruption - StatPearls).
  • *Strongest Risk Factors:* Prior abruption, **Maternal hypertension / Preeclampsia** (Exam 3 Q20), trauma, smoking/cocaine, polyhydramnios sudden decompression.
  • *Clinical Hallmarks:* **Sudden painful dark vaginal bleeding**, **tense/woody hard tender uterus**, fetal distress/IUFD, **shock out of proportion to visible bleeding** (concealed retroplacental hemorrhage / Couvelaire uterus), and high risk of **DIC**.

PLACENTA ACCRETA SPECTRUM (PAS) & VASA PREVIA

- **Placenta Accreta Spectrum (PAS):** Abnormal adherence of chorionic villi directly to myometrium due to absent decidua basalis (defective Nitabuch's layer), strongly associated with **Placenta Previa + Prior Cesarean Section(s)**.
  • **Accreta:** Attached to superficial myometrium; **Increta:** Invades into myometrium; **Percreta:** Penetrates through serosa into bladder.
  • *Management:* Planned **Cesarean Hysterectomy** (Exam 2 Q39, Exam 3 Q6).
- **Vasa Previa:** Unprotected fetal umbilical vessels coursing through membranes over the internal os (velamentous cord insertion or **bilobed/succenturiate placenta**).
  • *Verified Risk Factors (Exam 2 Q1):* Bilobed placenta, IVF conception, multifetal gestation, low-lying placenta. (*Photocoagulopathy* is NOT a risk factor; Exam 2 Q1).
  • *Presentation:* Painless vaginal bleeding immediately upon **rupture of membranes + sudden fetal bradycardia/exsanguination** (confirmed by Apt test / Kleihauer-Betke test).

O5. Early Pregnancy Bleeding: Abortion, Ectopic Pregnancy & Molar Pregnancy (GTD)

`Obs Book p.27–43 | Tested in Exam 1 Q19, Q29, Q46, Q56, Q57; Exam 2 Q28, Q34, Q35; Exam 3 Q5, Q23, Q24; Patho Q846–850`

ABORTION TYPES & CERVICAL INCOMPETENCE

- **Most Common Cause of Sporadic 1st-Trimester Miscarriage: Fetal chromosomal/genetic abnormalities (>50%, especially autosomal trisomies)** (Exam 3 Q5).
- **Clinical Types of Abortion:**
  • **Threatened Abortion:** Spotting + mild cramping + **closed cervix + viable intrauterine fetus with cardiac pulsations on US** (Exam 1 Q19).
  • **Inevitable Abortion:** Bleeding + cramping + **dilated internal os / herniating membranes** (Comp Bank p.5 Q50).
  • **Missed Abortion / Blighted Ovum (Anembryonic Pregnancy):** Closed cervix; gestational sac **≥25 mm mean sac diameter on TVUS with no embryonic pole** (Exam 1 Q57).

- **Cervical Incompetence:** Painless 2nd-trimester cervical dilatation and membrane prolapse. Treated with transvaginal McDonald/Shirodkar cerclage at 12–14 weeks. **Indication for Abdominal Cerclage: Failure of a previous transvaginal cerclage** (Exam 1 Q56, Exam 2 Q35).

ECTOPIC PREGNANCY & GESTATIONAL TROPHOBLASTIC DISEASE (GTD)

- **Ectopic Pregnancy:** Most common site is **Fallopian tube (Ampulla > Isthmus)**; most deadly rupture is Cornual/Interstitial (Ectopic Pregnancy - StatPearls).
  • *Diagnosis:* Positive/high β-hCG (>discriminatory zone 1500–2000 mIU/mL) + **empty uterus on TVUS + unilateral adnexal mass** (Exam 3 Q23). Classic physical exam sign: **Cervical motion tenderness (excitation) + fullness in cul-de-sac (Pouch of Douglas)** (Exam 3 Q24).
  • *Complications of Rupture:* Hemoperitoneum, shoulder-tip pain, maternal collapse/shock; **Hematuria is NOT a complication of ruptured ectopic** (Exam 1 Q46, Exam 2 Q34).
  • *Most Cost-Effective Medical Treatment (unruptured, stable, β-hCG <5000, no fetal cardiac activity):* **Systemic Methotrexate** (Exam 1 Q29, Exam 2 Q28).
- **Hydatidiform Mole (Complete vs. Partial):** (Hydatidiform Mole - StatPearls)
  • **Complete Mole: 46,XX (or XY) diploid, 100% paternal**; diffuse hydropic villi + circumferential trophoblastic proliferation; **NO fetal parts/RBCs**; snowstorm US; theca-lutein cysts; very high β-hCG; ~15–20% GTN risk.
  • **Partial Mole: 69,XXY / 69,XXX triploid** (Comp Bank p.211 Q69); focal hydropic villi + **fetal parts present**; <5% GTN risk.
  • **Choriocarcinoma:** Malignant cytotrophoblast + syncytiotrophoblast with hemorrhage/necrosis and **complete absence of chorionic villi / fibrous stroma** (Patho Q850); metastasizes hematogenously to **lungs ("cannonball") and vagina**.

O6–O8. Preeclampsia/Eclampsia, Medical Disorders (GDM, Cardiac, VTE, ICP, Anemia) & PROM/Twins

`Obs Book p.51–72, 107–110, 136–142 | Tested in Exam 1 Q25, Q26, Q28, Q30, Q43, Q44, Q50, Q53, Q59, Q64, Q65, Q69; Exam 3 Q3, Q10, Q17, Q20, Q27, Q29`

PREECLAMPSIA, ECLAMPSIA & MAGNESIUM SULFATE

- **Preeclampsia:** New-onset BP ≥140/90 mmHg after 20 weeks + proteinuria (≥300 mg/24h) or end-organ dysfunction (Preeclampsia - StatPearls). Severe features: BP ≥160/110, platelets <100k, elevated liver enzymes (2x), pulmonary edema, visual/cerebral symptoms.
- **Drug of Choice to Prevent & Stop Eclamptic Seizures: Magnesium Sulfate (MgSO4)** (Exam 1 Q53; Pritchard IM or Zuspan IV regimen).
  • *MgSO4 Toxicity Monitoring:* First sign of toxicity is **loss of patellar deep tendon reflexes (at 8–10 mEq/L)**, followed by **respiratory depression (<12–16 breaths/min)**, and cardiac arrest. Mandatory clinical monitoring: reflexes, respiratory

rate, and urine output (≥30 mL/hr).
• *Antidote for MgSO4 Toxicity:* **10% Calcium Gluconate (10 mL IV slowly)**.

- **Antihypertensives in Pregnancy:** Safe = Labetalol, Nifedipine, Methyldopa, Hydralazine. Contraindicated = ACE inhibitors, ARBs.

GDM, CARDIAC, THROMBOPHILIA, ICP, ANEMIA, PROM & TWINS

- **Gestational Diabetes Mellitus (GDM):**
  • *Most common fetal complication of uncontrolled maternal DM:* **Macrosomia** (Exam 3 Q27; mediated by fetal hyperinsulinemia), whereas the *most specific* congenital anomaly of pregestational DM is **Caudal regression syndrome (sacral agenesis)** and most common is VSD/cardiac (Gestational Diabetes - StatPearls).
  • *If diet & exercise fail to control GDM:* Start **Insulin** (gold standard 1st-line pharmacotherapy; Exam 1 Q43).
  • *Postpartum GDM Follow-up Screening:* **75g 2-hour OGTT at 6–12 weeks postpartum** (Exam 1 Q50).
- **Cardiac Disease in Pregnancy:**
  • **WHO Class IV (Contraindicated in pregnancy): Severe pulmonary arterial hypertension / Eisenmenger syndrome** (Exam 1 Q26).
  • **Mitral Stenosis (most common rheumatic lesion):** Highest risk of acute pulmonary edema / heart failure is **late 3rd trimester, intrapartum, and immediate (1st day) postpartum** due to autotransfusion and increased stroke volume/cardiac output (Exam 1 Q44; Book55 Q1).
  • **Diagnostic sign of true valvular heart disease in pregnancy: Diastolic murmur** (Exam 3 Q10; soft systolic ejection murmurs are physiologic in pregnancy).
  • **Mechanical Heart Valve Anticoagulation: LMWH or Unfractionated Heparin** (Exam 1 Q25, Exam 3 Q29).
- **Intrahepatic Cholestasis of Pregnancy (ICP):** 3rd-trimester intense pruritus on **palms and soles worse at night + elevated serum bile acids** (no rash) → treat with **Ursodeoxycholic acid (UDCA) + close fetal monitoring** (Exam 1 Q59).
- **Anemia & Folic Acid:** Iron deficiency anemia is the most common anemia in pregnancy, diagnosed when **Hb <11 g/dL in 1st & 3rd trimesters (or <10.5 g/dL in 2nd trimester)** (Exam 1 Q65). High-dose **Folic Acid 5 mg/day** is given for history of spina bifida/NTD (Exam 1 Q64).
- **PROM, Pyelonephritis, Puerperal Pyrexia & Twins:**
  • **Antenatal Steroids in PROM: Reduce neonatal RDS** (Exam 1 Q69, Exam 3 Q17).
  • **Acute Pyelonephritis:** 3rd-trimester high spiking fever (102°F), chills, flank/back pain, bacteriuria/pyuria (Exam 3 Q3).
  • **Puerperal Pyrexia Trap (Exam 1 Q32):** Defined as fever ≥38°C within the first **10–14 days** (excluding first 24 hrs), NOT "within 6 weeks" (which makes Option A the "non-related/incorrect" statement in Exam 1 Q32!).
  • **Dichorionic Diamniotic (DCDA) Twins:** Have risk for preeclampsia, FGR, and PPH, **EXCEPT Twin-to-Twin Transfusion Syndrome (TTTS)**, which occurs exclusively in **Monochorionic** twins (Exam 1 Q30, Exam 2 Q29).

5. Realistic Hour-by-Hour 3-Day (72-Hour) Emergency Study Schedule

This schedule is engineered for maximum score conversion: **11.5 net study hours per day**, **7.5 hours of protected sleep** (memory consolidation and clinical reasoning collapse without sleep), meal/prayer breaks, and **active MCQ testing built into every block**.

DAY 1 (Hours 0–24): Gynecology Unfinished High-Yield Blitz (p.100–228) + Endocrinology/Contraception Consolidation

Time Window	Duration	Study Block & Exact Source Pages	Execution Method & Deliverable Used
08:00 – 11:00	3.0 hrs	**Block 1A (NEW): Gynecologic Oncology** — Endometrial Cancer, Cervical Cancer/CIN, Ovarian Tumors, VIN/Paget (*Gyn Book p.164–197*)	Study Master Plan Summary Cards G1–G3 + drill all Oncology questions in *Progressive MCQ Bank (Levels 1–4)* and *Pathology MCQs*.
11:00 – 11:30	0.5 hr	Break & Hydration	Step away from screens; brief walk.
11:30 – 14:00	2.5 hrs	**Block 1B (NEW): Benign Gyn Conditions** — AUB, Fibroids, Adenomyosis, Endometriosis (*Gyn Book p.137–163*)	Study Summary Card G5 + focus on LNG-IUS vs COCs (vWD), Fibroid degeneration, Adenomyosis vs Endometriosis laparoscopy.
14:00 – 15:00	1.0 hr	Lunch & Power Rest	Full meal + 20-minute eyes-closed rest.
15:00 – 17:30	2.5 hrs	**Block 1C (NEW): PID, Vulvar Ulcers, Prolapse, Urinary Incontinence & Genitourinary Fistula** (*Gyn Book p.100–136*)	Study Summary Cards G7–G8 + DeLancey levels, Enterocele, SUI vs Detrusor overactivity, VVF, Syphilis vs Chancroid vs Gonorrhea.
17:30 – 18:00	0.5 hr	Afternoon Break	Coffee/tea + light stretch.

Time Window	Duration	Study Block & Exact Source Pages	Execution Method & Deliverable Used
18:00 – 20:30	2.5 hrs	**Block 1D (CONSOLIDATION p.1–100): Amenorrhea, DSD (Turner/MRKH/CAIS/CAH), PCOS, Hirsutism, Infertility & Contraception** (*Gyn Book p.24–91*)	Study Summary Cards G4 & G6. Do NOT re-read textbook chapters — go straight to diagnostic tables and active recall.
20:30 – 21:30	1.0 hr	Dinner Break	Relax and recharge before night MCQ drill.
21:30 – 23:30	2.0 hrs	**Block 1E (ACTIVE RECALL):** Solve all Gynecology questions in *Progressive MCQ Bank (Unsolved) + Mock Exam 3 (Final Gynecology Paper, 40 MCQs)*	Grade immediately using *Solved Bank* & *Mock Exam Answer Key*. Circle every missed trap.
23:30 – 07:30	8.0 hrs	**Protected Sleep**	Mandatory hippocampal consolidation of Day 1 Gynecology material.

DAY 2 (Hours 24–48): Obstetrics Unfinished High-Yield Blitz (p.100–182) + Haemorrhage/Medical Disorders Consolidation

Time Window	Duration	Study Block & Exact Source Pages	Execution Method & Deliverable Used
08:00 – 11:00	3.0 hrs	**Block 2A (NEW): Malpresentations, Abnormal/Obstructed Labor, Shoulder Dystocia, Perineal Tears & Forceps/Vacuum** (*Obs Book p.96–123, 159–173*)	Study Summary Cards O1 & O2. Master Face (mentum posterior), Breech, Cord prolapse, Shoulder dystocia maneuvers, Vacuum vs Forceps, Cephalohematoma.
11:00 – 11:30	0.5 hr	Morning Break	Walk & hydrate.
11:30 – 14:00	2.5 hrs	**Block 2B (NEW): Postpartum Hemorrhage (PPH), 3rd Stage, Retained Placenta, Uterine Inversion, PROM, Preterm Labor & Puerperium** (*Obs Book p.124–142, 153–158*)	Study Summary Card O3 + PROM steroids, PPH atony vs accreta hysterectomy, Uterine inversion from premature cord traction.

Time Window	Duration	Study Block & Exact Source Pages	Execution Method & Deliverable Used
14:00 – 15:00	1.0 hr	Lunch & Power Rest	Full meal + 20-minute rest.
15:00 – 17:30	2.5 hrs	**Block 2C (CONSOLIDATION p.27–50): Early Pregnancy Bleeding (Abortion, Ectopic, Molar/GTD) & Antepartum Hemorrhage (Previa, Abruption, Accreta, Vasa Previa)**	Study Summary Cards O4 & O5. Focus on Previa vs Abruption table, Complete vs Partial Mole, Ectopic MTX vs Laparoscopy, Blighted ovum 25 mm.
17:30 – 18:00	0.5 hr	Afternoon Break	Light snack & stretch.
18:00 – 20:30	2.5 hrs	**Block 2D (CONSOLIDATION p.51–72 + Priority B Sweep): Preeclampsia/MgSO4, GDM, Cardiac/Valves, ICP, Anemia, Folic Acid, Twins & Rh**	Study Summary Cards O6–O8. Drill MgSO4 toxicity, GDM insulin & 6–12 wk screening, Mitral stenosis, Mechanical valves, DCDA vs MCDA twins.
20:30 – 21:30	1.0 hr	Dinner Break	Unwind before night exam simulation.
21:30 – 23:30	2.0 hrs	**Block 2E (ACTIVE RECALL):** Complete all Obstetrics questions in *Progressive MCQ Bank (Unsolved) + Mock Exam 2 (Final Obstetrics Paper, 40 MCQs)*	Grade immediately and review explanations for every incorrect option.
23:30 – 07:30	8.0 hrs	**Protected Sleep**	Full night's sleep before Final-Day Revision.

DAY 3 (Hours 48–72 — Final 24-Hour Rescue Revision & Full Mock Simulation)

Time Window	Duration	Study Block & Deliverable Focus	Execution Method
08:00 – 10:30	2.5 hrs	**Block 3A: Full Timed Simulation — Mock Exam 1 (Combined End-Round 50 MCQs) + Re-test Missed Questions from Mock Exams 2 & 3**	Take *Mock Exam 1 Unsolved* under strict exam conditions (60 mins), then spend 90 mins reviewing every explanation in *Mock Exams Solved*.
10:30 – 11:00	0.5 hr	Break	Hydrate & reset.
11:00 – 14:00	3.0 hrs	**Block 3B: Past Exam Verbatim Audit (Last 4 Exams 2026 & Final Gyn BSNU)**	Rapid-fire pass through all 173 questions of *آخر امتحانات نسا ٢٠٢٦ ءpdf.* (covered in our Progressive Bank & Mock Exams) so you recognize every recycled stem in 5 seconds.
14:00 – 15:00	1.0 hr	Lunch & Rest	Nourishing meal + 20-minute nap.
15:00 – 18:00	3.0 hrs	**Block 3C: Final 24-Hour Rescue Revision Sheet — Part 1 (Numbers, Cutoffs, FIGO Staging, Tumor Bodies & Diagnostic Criteria)**	Read *Final_24Hour_Emergency_Revision_Sheet.md* Sections 1–4 aloud, testing yourself on every number and classification table.
18:00 – 18:30	0.5 hr	Break	Light walk.

Time Window	Duration	Study Block & Deliverable Focus	Execution Method
18:30 – 21:00	2.5 hrs	**Block 3D: Final 24-Hour Rescue Revision Sheet — Part 2 (Management Algorithms, Commonly Confused Pairs & Top 30 Trap Drills)**	Finish Sections 5–8 of *Final_24Hour_Emergency_Revision_Sheet.md*. Do NOT open any new textbook chapters!
21:00 – 22:30	1.5 hrs	Light Dinner & Final 30-Minute Flash Review of Your Personal Weak-Spot List	Prepare exam ID/stationery; stop studying by 22:30.
22:30 – 06:30	8.0 hrs	**Pre-Exam Sleep**	Enter the exam hall rested, sharp, and locked onto exam traps.

6. Index of Your Complete 6-File Rescue Deliverable Suite

File #	Deliverable Filename	Contents & How to Use It
1	**OBGYN_3Day_Emergency_Rescue_Master_Plan.html**	This Master Strategy Report: Exam Forensics, Priority A/B/C Syllabus Matrix, 16 Priority A Clinical Deep-Dive Summaries with NCBI StatPearls links, and the 72-Hour Schedule.

File #	Deliverable Filename	Contents & How to Use It
2	**Progressive_MCQ_Rescue_Bank_SOLVED.md**	**Version A (SOLVED):** 80 high-yield progressive MCQs arranged across Level 1 (Recall), Level 2 (Differentiation), Level 3 (Clinical Vignettes), and Level 4 (Advanced Traps) with full answers, explanations, why distractors fail, source tags, and takeaways.
3	**Progressive_MCQ_Rescue_Bank_UNSOLVED.md**	**Version B (UNSOLVED):** Exact same 80 progressive MCQs in identical order and numbering with zero answers or hints for active self-testing.
4	**OBGYN_Mock_Exams_1_2_3_UNSOLVED.md**	**3 Full-Length Unsolved Mock Exams (130 MCQs total):** Mock Exam 1 (Combined OB/GYN End-Round Style, 50 MCQs), Mock Exam 2 (Final Obstetrics Paper Style, 40 MCQs), and Mock Exam 3 (Final Gynecology Paper Style, 40 MCQs). Every question is explicitly tagged `[ACTUAL PAST EXAM]` or `[NEW PATTERN-MATCHED]`.

File #	Deliverable Filename	Contents & How to Use It
5	**OBGYN_Mock_Exams_1_2_3_SOLVED_and_Answer_Keys.md**	**Separate Quick-Correction Answer Key Grids + Full Solved Explanations** for all 130 questions across Mock Exams 1, 2, and 3.
6	**Final_24Hour_Emergency_Revision_Sheet.md**	**Last-Day 24-Hour Concentrated Rescue Package:** High-yield numbers & cutoffs, FIGO staging tables, diagnostic criteria, management algorithms, commonly confused conditions, pathology bodies, and top exam traps.