VERSION A (SOLVED MASTER EDITION) • BSNU / KASR AL AINY 2025–2026 SYLLABUS

Progressive MCQ Rescue Bank – SOLVED (80 Questions)

80 High-Yield Progressive MCQs arranged across 4 Difficulty Levels with verified correct answers, full clinical explanations, distractor rationales, high-yield clinical takeaways, exact textbook page numbers, and NCBI StatPearls citations. Includes transparent editorial documentation of the Progressive Q74 historical exam key discrepancy.

80 MCQs
100% Actual Past Exams

4 Levels
Recall to Exam Traps

40 GYN / 40 OB
Balanced Specialty Split

Q74 Note
Key Discrepancy Preserved

STRUCTURE & DIFFICULTY PROGRESSION

Level 1 (Q1–Q20): Basic Recall & Essential Facts

Level 2 (Q21–Q40): Understanding & Differentiation

Level 3 (Q41–Q60): Clinical Scenarios & Application

Level 4 (Q61–Q80): Advanced Clinical Reasoning & Exam Traps

Quick-Reference Master Answer Key Grid (Q1–Q80)

Question : Key	Question : Key	Question : Key	Question : Key
Q1: C (Gyn)	**Q2**: C (Gyn)	**Q3**: C (Gyn)	**Q4**: C (Gyn)
Q5: A (Gyn)	**Q6**: B (Gyn)	**Q7**: A (Gyn)	**Q8**: A (Gyn)
Q9: D (Gyn)	**Q10**: A (Gyn)	**Q11**: A (Obs)	**Q12**: C (Obs)
Q13: A (Obs)	**Q14**: B (Obs)	**Q15**: B (Obs)	**Q16**: A (Obs)
Q17: B (Obs)	**Q18**: B (Obs)	**Q19**: C (Obs)	**Q20**: C (Gyn)
Q21: C (Gyn)	**Q22**: E (Gyn)	**Q23**: C (Gyn)	**Q24**: C (Gyn)
Q25: D (Gyn)	**Q26**: C (Gyn)	**Q27**: A (Gyn)	**Q28**: B (Gyn)
Q29: A (Gyn)	**Q30**: B (Gyn)	**Q31**: B (Obs)	**Q32**: B (Obs)

Question : Key	Question : Key	Question : Key	Question : Key
Q33: A (Obs)	**Q34**: C (Obs)	**Q35**: B (Obs)	**Q36**: C (Obs)
Q37: B (Obs)	**Q38**: A (Obs)	**Q39**: B (Obs)	**Q40**: D (Obs)
Q41: B (Gyn)	**Q42**: B (Gyn)	**Q43**: B (Gyn)	**Q44**: B (Gyn)
Q45: B (Gyn)	**Q46**: A (Gyn)	**Q47**: B (Gyn)	**Q48**: C (Gyn)
Q49: D (Gyn)	**Q50**: B (Gyn)	**Q51**: B (Obs)	**Q52**: A (Obs)
Q53: B (Obs)	**Q54**: B (Obs)	**Q55**: C (Obs)	**Q56**: A (Obs)
Q57: C (Obs)	**Q58**: C (Obs)	**Q59**: B (Obs)	**Q60**: B (Obs)
Q61: C (Gyn)	**Q62**: A (Gyn)	**Q63**: A (Gyn)	**Q64**: C (Gyn)
Q65: D (Gyn)	**Q66**: D (Gyn)	**Q67**: A (Gyn)	**Q68**: A (Gyn)
Q69: A (Gyn)	**Q70**: A (Gyn)	**Q71**: C (Obs)	**Q72**: C (Obs)
Q73: D (Obs)	**Q74**: A (Obs)	**Q75**: A (Obs)	**Q76**: C (Obs)
Q77: B (Obs)	**Q78**: B (Obs)	**Q79**: B (Obs)	**Q80**: B (Gyn)

Level 1: Basic Recall & Essential Facts

Question 1 Gynecology Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q1 & Final Gyn BSNU Q27 | Gyn Book p.83

Which of the following is an absolute contraindication (WHO Category 4) to the use of the combined oral contraceptive pill (COC)?

☐ **A.** Prosthetic heart valves (uncomplicated)

☐ **B.** Sickle cell trait/disease

✓ **C. Active liver disease**

☐ **D.** Age under 14 years

☐ **E.** Bronchial asthma

Correct Answer: C (Active liver disease)

Explanation: Active viral hepatitis, severe cirrhosis, and benign/malignant liver tumors are WHO MEC Category 4 (absolute) contraindications to estrogen-containing combined oral contraceptives (Oral Contraceptive Pills - StatPearls). Why others are wrong: Young age (<14 yrs), bronchial asthma, and sickle cell trait are safe (MEC 1–2).

> **High-Yield Takeaway:** Active liver disease, breast cancer, VTE/PE history, migraine with aura, and smoking >=15 cig/day at age >=35 are the classic absolute contraindications to COCs.

Question 2 Gynecology Level 1

ACTUAL PAST EXAM — Final Gyn BSNU Q3 | Gyn Book p.66

What is the standard clinical definition of infertility in a woman under 35 years of age?

☐ **A.** Inability to conceive after 3 months of unprotected intercourse

☐ **B.** Inability to conceive after 6 months of unprotected intercourse

✓ **C. Inability to conceive after 12 months of regular, unprotected intercourse**

☐ **D.** Inability to conceive after 24 months of regular, unprotected intercourse

Correct Answer: C (Inability to conceive after 12 months of regular, unprotected intercourse)

Explanation: Infertility is defined as the failure to achieve a clinical pregnancy after 12 months of regular, unprotected sexual intercourse in women under 35 years of age (Female Infertility - StatPearls). Why B is wrong: 6 months is the cutoff for evaluation in women aged >=35 years.

> **High-Yield Takeaway:** Infertility workup starts at 12 months if age <35 years, and at 6 months if age >=35 years.

Question 3 Gynecology Level 1

ACTUAL PAST EXAM — Final Gyn BSNU Q5 | Gyn Book p.116

Which pelvic structure provides the primary apical support (DeLancey Level I support) to the uterus and upper vaginal vault?

☐ **A.** Pubocervical fascia

☐ **B.** Rectovaginal fascia

✓ **C. Cardinal–uterosacral ligament complex**

☐ **D.** Levator ani muscle

☐ **E.** Perineal body

Correct Answer: C (Cardinal–uterosacral ligament complex)

Explanation: According to DeLancey's three levels of pelvic floor support, Level I (apical suspension of the uterus and vaginal apex) is provided by the cardinal (transverse cervical /

Mackenrodt's) and uterosacral ligament complex (Pelvic Organ Prolapse - NCBI). Why A & B are wrong: Pubocervical and rectovaginal fascia provide Level II (mid-vaginal lateral) support; perineal body provides Level III support.

> **High-Yield Takeaway:** Level I = Cardinal-uterosacral complex (apical prolapse); Level II = Pubocervical/rectovaginal fascia (cystocele/rectocele); Level III = Perineal body.

Question 4 Gynecology Level 1

ACTUAL PAST EXAM — Final Gyn BSNU Q6 | Gyn Book p.64

What is the most common cause of hirsutism in women of reproductive age?

☐ **A.** Cushing's syndrome

☐ **B.** Congenital adrenal hyperplasia (CAH)

✓ **C. Polycystic ovary syndrome (PCOS)**

☐ **D.** Androgen-secreting ovarian tumor

☐ **E.** Acromegaly

Correct Answer: C (Polycystic ovary syndrome (PCOS))

Explanation: PCOS accounts for 70% to 80% of all cases of hirsutism in reproductive-aged women, followed by idiopathic hirsutism (PCOS - StatPearls). Androgen-secreting tumors are rare and present with rapid onset and virilization.

> **High-Yield Takeaway:** Gradual hirsutism + oligomenorrhea = PCOS (most common); rapid-onset hirsutism + virilization (clitoromegaly/deep voice) = Androgen-secreting tumor.

Question 5 Gynecology Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q21 | Gyn Book p.144

What is the most common clinical presentation of uterine leiomyoma (fibroid)?

✓ **A. Asymptomatic**

☐ **B.** Metrorrhagia

☐ **C.** Severe acute pelvic pain

☐ **D.** Pedunculated torsion

☐ **E.** Urinary retention from impaction

Correct Answer: A (Asymptomatic)

Explanation: The majority of uterine leiomyomas (50% to 70%) are completely asymptomatic and discovered incidentally on exam or ultrasound (Uterine Leiomyomata - StatPearls). When symptomatic, heavy/prolonged menstrual bleeding (menorrhagia) is the most common symptom.

> **High-Yield Takeaway:** Watch the wording: 'Most common presentation overall' = Asymptomatic; 'Most common symptom when symptomatic' = Heavy menstrual bleeding (menorrhagia).

Question 6 Gynecology Level 1

ACTUAL PAST EXAM — Final Gyn BSNU Q16 | Gyn Book p.70

Which of the following is the gold standard diagnostic technique for evaluating tubal patency and pelvic adhesions?

☐ **A.** Hysterosalpingography (HSG)

✓ **B. Diagnostic laparoscopy with chromopertubation**

☐ **C.** Saline infusion sonography (SIS)

☐ **D.** Pelvic MRI

☐ **E.** Transvaginal ultrasound

Correct Answer: B (Diagnostic laparoscopy with chromopertubation)

Explanation: While HSG is the initial screening test for tubal patency, diagnostic laparoscopy with methylene blue dye test (chromopertubation) is the gold standard because it directly visualizes both tubal patency and peritubal adhesions/endometriosis (Female Infertility - StatPearls).

> **High-Yield Takeaway:** Initial screening test for tubal patency = HSG; Gold standard = Laparoscopy with chromopertubation.

Question 7 Gynecology Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q45 | Gyn Book p.46

What is the single most common cause of primary amenorrhea?

✓ **A. Gonadal dysgenesis (Turner syndrome, 45,X0)**

☐ **B.** Müllerian agenesis (MRKH syndrome)

☐ **C.** Kallmann syndrome

☐ **D.** Complete androgen insensitivity syndrome (CAIS)

☐ **E.** Imperforate hymen

Correct Answer: A (Gonadal dysgenesis (Turner syndrome, 45,X0))

Explanation: Chromosomal gonadal dysgenesis—most commonly Turner syndrome (45,X0)—accounts for ~43–50% of all cases of primary amenorrhea, followed by Müllerian agenesis (MRKH, ~15%) (Primary Amenorrhea - StatPearls).

> **High-Yield Takeaway:** 1st most common cause of primary amenorrhea = Gonadal dysgenesis (Turner 45,X); 2nd most common = Müllerian agenesis (MRKH 46,XX).

Question 8 Gynecology Level 1

ACTUAL PAST EXAM — Final Gyn BSNU Q19 | Gyn Book p.36

Regarding the physiological stages of female puberty, what is the most common chronological order of events?

✓ **A. Gonadarche, thelarche, pubarche, menarche**

☐ **B.** Gonadarche, menarche, thelarche, pubarche

☐ **C.** Thelarche, gonadarche, pubarche, menarche

☐ **D.** Pubarche, thelarche, gonadarche, menarche

Correct Answer: A (Gonadarche, thelarche, pubarche, menarche)

Explanation: Endocrine activation of the hypothalamic-pituitary-gonadal axis (gonadarche) occurs first, triggering breast budding (thelarche, ~9.8–10 yrs), followed by pubic/axillary hair (pubarche/adrenarche, ~10.5–11 yrs), peak height velocity, and finally first menstruation (menarche, ~12–12.5 yrs).

> **High-Yield Takeaway:** Endocrine event first (Gonadarche), then clinical breast bud (Thelarche) -> Pubarche -> Peak Growth -> Menarche last.

Question 9 Gynecology Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q10 | Gyn Book p.81

Toxic shock syndrome (TSS) has been classically associated with which of the following contraceptive methods?

☐ **A.** Combined oral contraceptive pills

☐ **B.** Progestin-only pill (mini-pill)

☐ **C.** Male latex condoms

✓ **D. Cervical cap / diaphragm / contraceptive sponge**

☐ **E.** Levonorgestrel intrauterine system

Correct Answer: D (Cervical cap / diaphragm / contraceptive sponge)

Explanation: Prolonged retention of female barrier methods (cervical cap, diaphragm, or vaginal sponge) promotes Staphylococcus aureus overgrowth and Toxic Shock Syndrome toxin-1 (TSST-1) production (Contraception - StatPearls).

> **High-Yield Takeaway:** Female barrier devices (cervical cap/diaphragm/sponge) left in place >24 hours carry a risk of Staphylococcal Toxic Shock Syndrome.

Question 10 Gynecology Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q27 | Gyn Book p.179

What is the most common presenting symptom of Vulvar Intraepithelial Neoplasia (VIN)?

✓ **A. Persistent vulvar pruritus (itching)**

☐ **B.** A large painless exophytic mass

☐ **C.** Heavy vaginal bleeding

☐ **D.** Inguinal lymph node ulceration

Correct Answer: A (Persistent vulvar pruritus (itching))

Explanation: Persistent, intractable pruritus vulvae is the hallmark symptom in >60% of women with VIN and vulvar dystrophies (Gyn Book p.179).

> **High-Yield Takeaway:** Any chronic vulvar itching or white/red plaque refractory to topical therapy requires vulvar punch biopsy to rule out VIN or vulvar carcinoma.

Question 11 Obstetrics Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q67 | Obs Book p.82

How is the first stage of labor clinically defined?

✓ **A. From the onset of true regular labor contractions until full cervical dilatation (10 cm)**

☐ **B.** From full cervical dilatation (10 cm) until delivery of the fetus

☐ **C.** From delivery of the fetus until delivery of the placenta

☐ **D.** From rupture of membranes until crowning of the fetal head

Correct Answer: A (From the onset of true regular labor contractions until full cervical dilatation (10 cm))

Explanation: Stage 1 of labor begins with regular uterine contractions that efface and dilate the cervix and ends at full (10 cm) cervical dilatation (Normal Labor - StatPearls). Stage 2 is 10 cm to fetal delivery; Stage 3 is fetal delivery to placental delivery.

> **High-Yield Takeaway:** Stage 1 = Onset of true labor to 10 cm; Stage 2 = 10 cm to baby delivered; Stage 3 = Baby delivered to placenta delivered.

Question 12 Obstetrics Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 3 Q5 | Obs Book p.27

What is the single most common cause of sporadic spontaneous pregnancy loss (miscarriage) in the first trimester?

☐ **A.** Maternal TORCH infection

☐ **B.** Tobacco exposure

✓ **C. Fetal genetic / chromosomal abnormalities**

☐ **D.** Gestational diabetes mellitus

☐ **E.** Maternal hypothyroidism

Correct Answer: C (Fetal genetic / chromosomal abnormalities)

Explanation: Fetal chromosomal abnormalities (principally autosomal trisomies such as Trisomy 16, monosomy X [45,X], and polyploidy) account for >50% to 60% of sporadic first-trimester abortions (Obs Book p.27).

> **High-Yield Takeaway:** First-trimester miscarriage is most commonly due to fetal chromosomal aneuploidy (especially autosomal trisomy); second-trimester painless loss is classically cervical incompetence or uterine anomaly.

Question 13 Obstetrics Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q5 & Exam 2 Q9 | Obs Book p.19

Pregnancy should be avoided for at least 1 month after receiving which of the following vaccinations?

✓ **A. Measles, mumps, and rubella (MMR)**

☐ **B.** Inactivated influenza vaccine

☐ **C.** Hepatitis B vaccine

☐ **D.** Tetanus toxoid / Tdap

☐ **E.** Pneumococcal polysaccharide vaccine

Correct Answer: A (Measles, mumps, and rubella (MMR))

Explanation: MMR is a live attenuated viral vaccine that is contraindicated during pregnancy and requires women to avoid conception for at least 28 days (1 month) post-vaccination due to theoretical congenital rubella risk (Obs Book p.19). Influenza (inactivated), Hepatitis B, and Tetanus/Tdap are safe during pregnancy.

> **High-Yield Takeaway:** Live attenuated vaccines (MMR, Varicella, Live Intranasal Flu) are contraindicated in pregnancy; avoid pregnancy for 1 month after MMR.

Question 14 Obstetrics Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q53 | Obs Book p.54

A pregnant woman with eclampsia continues to experience generalized tonic-clonic convulsions. Which medication is the drug of choice to arrest seizures and prevent recurrent attacks?

☐ **A.** Intravenous Diazepam

✓ **B. Magnesium sulfate (MgSO4)**

☐ **C.** Intravenous Labetalol

☐ **D.** Phenytoin

☐ **E.** Oral Nifedipine

Correct Answer: B (Magnesium sulfate (MgSO4))

Explanation: Magnesium sulfate is the gold-standard anticonvulsant for both prophylaxis (in severe preeclampsia) and treatment of eclamptic seizures, superior to diazepam and phenytoin (Preeclampsia - StatPearls). Labetalol controls blood pressure but does not stop seizures.

> **High-Yield Takeaway:** MgSO4 stops and prevents eclamptic convulsions; Labetalol/Hydralazine/Nifedipine lower severe hypertension (>=160/110 mmHg).

Question 15 Obstetrics Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q64 & Exam 2 Q37 | Obs Book p.17

All pregnant women are advised to take 0.4 mg (400 mcg) of folic acid daily. Which group of women is recommended to take a high-dose folic acid supplement (5 mg daily) pre-conceptionally and through the first trimester?

☐ **A.** Maternal BMI of 26

✓ **B. History of spina bifida (neural tube defect) in the partner's family or a prior child**

☐ **C.** Mild iron-deficiency anemia

☐ **D.** History of previous preeclampsia

☐ **E.** History of previous preterm delivery

Correct Answer: B (History of spina bifida (neural tube defect) in the partner's family or a prior child)

Explanation: High-dose folic acid (4–5 mg/day) starting at least 1–3 months before conception through 12 weeks' gestation is indicated for women with a personal/partner/prior pregnancy history of neural tube defects (spina bifida/anencephaly), pre-existing diabetes, or antiepileptic drug therapy (Obs Book p.17).

> **High-Yield Takeaway:** Standard folic acid = 0.4 mg (400 mcg)/day; High-risk NTD history / epilepsy drugs / DM = 5 mg/day.

Question 16 Obstetrics Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 3 Q9 | Obs Book p.89

Which of the following triads represents the classic clinical signs of placental separation during the third stage of labor?

✓ **A. A sudden gush of blood, change in uterine shape from discoid to globular, and lengthening of the umbilical cord**

☐ **B.** Descent of the uterine fundus into the pelvis, blanching of the cord, and maternal bradycardia

☐ **C.** Darkening of the perineum, softening of the uterus, and retraction of the cord

☐ **D.** A rise in maternal BP by 20 mmHg, disappearance of contractions, and cervical closure

Correct Answer: A (A sudden gush of blood, change in uterine shape from discoid to globular, and lengthening of the umbilical cord)

Explanation: Placental separation in the third stage is signaled by: (1) a gush of blood from the vagina, (2) the uterus becoming firm, globular, and rising in the abdomen (Calkin's sign), and (3) permanent lengthening of the umbilical cord outside the vulva (Obs Book p.89).

> **High-Yield Takeaway:** Never apply cord traction before observing the 3 signs of placental separation (globular firm fundus, gush of blood, cord lengthening).

Question 17 Obstetrics Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 3 Q2 | Obs Book p.98

Extreme hyperextension of the fetal head during labor is the defining feature of which presentation?

☐ **A.** Vertex presentation

✓ **B. Face presentation**

☐ **C.** Shoulder presentation

☐ **D.** Frank breech presentation

☐ **E.** Brow presentation

Correct Answer: B (Face presentation)

Explanation: Complete hyperextension of the fetal neck so that the occiput touches the fetal back and the chin (mentum) is the presenting denominator defines Face presentation (Obs Book p.98). Partial extension midway between flexion and hyperextension is Brow presentation.

> **High-Yield Takeaway:** Complete flexion = Vertex (occiput); Partial extension = Brow (frontum); Complete hyperextension = Face (mentum).

Question 18 Obstetrics Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q50 | Obs Book p.59

A woman with Gestational Diabetes Mellitus (GDM) delivers a healthy infant at term. When should she undergo postpartum screening for persistent diabetes?

☐ **A.** 1 to 2 weeks postpartum

✓ **B. 6 to 12 weeks postpartum**

☐ **C.** 6 months postpartum

☐ **D.** 1 year postpartum

Correct Answer: B (6 to 12 weeks postpartum)

Explanation: Women with GDM must undergo a 75-gram, 2-hour oral glucose tolerance test (OGTT) at 6 to 12 weeks postpartum once the diabetogenic placental hormones have cleared (Gestational Diabetes - StatPearls).

> **High-Yield Takeaway:** Postpartum GDM follow-up = 75g 2-hour OGTT at 6–12 weeks postpartum (not HbA1c, as RBC turnover in pregnancy/postpartum alters HbA1c).

Question 19 Obstetrics Level 1

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q69 & Exam 3 Q17 | Obs Book p.136

What is the proven benefit of administering antenatal corticosteroids in cases of preterm Premature Rupture of Membranes (PROM)?

☐ **A.** It is strictly contraindicated due to maternal sepsis

☐ **B.** It markedly increases neonatal mortality

✓ **C. It significantly reduces the incidence of neonatal Respiratory Distress Syndrome (RDS)**

☐ **D.** It directly seals the membranes and prolongs gestation by 6 weeks

Correct Answer: C (It significantly reduces the incidence of neonatal Respiratory Distress Syndrome (RDS))

Explanation: Antenatal corticosteroids (betamethasone or dexamethasone between 24 and 34 weeks) accelerate fetal type II pneumocyte surfactant production, reducing neonatal RDS, intraventricular hemorrhage (IVH), and necrotizing enterocolitis (NEC) without increasing maternal/neonatal infection (Obs Book p.136).

> **High-Yield Takeaway:** In preterm PROM (<34 wks without chorioamnionitis), always give antenatal corticosteroids (reduces RDS/IVH/NEC) + latency antibiotics (erythromycin/ampicillin).

Question 20 Gynecology Level 1

ACTUAL PAST EXAM — Final Gyn BSNU Q14 | Gyn Book p.126

What is the most common underlying cause of genuine stress urinary incontinence (SUI) in women?

☐ **A.** Chronic constipation

☐ **B.** Congenital absence of the internal sphincter

✓ **C. Childbirth trauma and vaginal delivery weakening pelvic floor support**

☐ **D.** Multiple sclerosis

☐ **E.** Vesicovaginal fistula

Correct Answer: C (Childbirth trauma and vaginal delivery weakening pelvic floor support)

Explanation: Vaginal childbirth trauma damages the endopelvic fascia, pubourethral ligaments, and levator ani (pubococcygeus) muscle, leading to urethral hypermobility and loss of bladder neck support (Gyn Book p.126).

> **High-Yield Takeaway:** Stress incontinence = urethral hypermobility from childbirth trauma (treated with Kegel exercises / mid-urethral sling TVT/TOT); Fistula = continuous true incontinence.

Level 2: Understanding & Differentiation

Question 21 Gynecology Level 2

ACTUAL PAST EXAM — Final Gyn BSNU Q20 & Exam 1 Q33 | Gyn Book p.48

An 18-year-old patient presents with primary amenorrhea. Examination reveals normal female breast development (Tanner stage 4), scant/absent pubic and axillary hair, a blind-ending vaginal pouch, and an absent uterus on ultrasound. Which single laboratory test is most useful to differentiate Complete Androgen Insensitivity Syndrome (CAIS) from Müllerian Agenesis (MRKH)?

☐ **A.** Serum FSH level

☐ **B.** Serum estradiol level

✓ **C. Serum total testosterone level (or karyotype)**

☐ **D.** MRI of the pituitary sella

☐ **E.** Serum prolactin level

Correct Answer: C (Serum total testosterone level (or karyotype))

Explanation: Both MRKH (46,XX) and CAIS (46,XY) present with primary amenorrhea, normal breasts, and an absent uterus. However, in CAIS the gonads are testes producing male-range serum testosterone, whereas in MRKH the gonads are normal ovaries with normal female-range serum testosterone (Primary Amenorrhea - StatPearls).

> **High-Yield Takeaway:** Absent uterus + normal breasts: check Serum Testosterone & Karyotype! Normal female testosterone + pubic hair present (46,XX) = MRKH; Male-range testosterone + absent pubic hair (46,XY) = CAIS.

Question 22 Gynecology Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q37, Q39, Q40 & Patho Q861, Q870 | Gyn Book p.183–192

Which of the following pairings between an ovarian neoplasm and its characteristic microscopic histopathological feature is INCORRECT?

☐ **A.** Serous cystadenocarcinoma — Concentric calcified Psammoma bodies

☐ **B.** Granulosa cell tumor — Call-Exner bodies and coffee-bean grooved nuclei

☐ **C.** Endodermal sinus (yolk sac) tumor — Schiller-Duval glomeruloid bodies

☐ **D.** Brenner tumor — Nests of transitional (urothelial) epithelium

✓ **E. Dysgerminoma — Mucin-filled signet-ring cells in fibrous stroma**

Correct Answer: E (Dysgerminoma — Mucin-filled signet-ring cells in fibrous stroma)

Explanation: Mucin-filled signet-ring cells in ovarian stroma are pathognomonic of a metastatic Krukenberg tumor (typically from gastric carcinoma; Patho Q875, Q916), whereas Dysgerminoma shows sheets of large clear polygonal germ cells separated by fibrous septa infiltrated by lymphocytes (Nonepithelial Ovarian Cancer - NCBI). Options A–D are all 100% correct classic matches.

> **High-Yield Takeaway:** Memorize the 5 ovarian pathology signatures: Psammoma = Serous; Call-Exner = Granulosa; Schiller-Duval = Yolk sac (AFP); Transitional urothelium = Brenner; Signet-ring = Krukenberg.

Question 23 Gynecology Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q35 | Gyn Book p.98–112

Which of the following conditions is NOT an etiological cause of vulvar ulcers?

☐ **A.** Primary syphilis (chancre)

☐ **B.** Chancroid (Haemophilus ducreyi)

✓ **C. Gonorrhea (Neisseria gonorrhoeae)**

☐ **D.** Cutaneous tuberculosis

☐ **E.** Basal cell carcinoma (rodent ulcer)

Correct Answer: C (Gonorrhea (Neisseria gonorrhoeae))

Explanation: Neisseria gonorrhoeae cannot penetrate intact stratified squamous epithelium of the adult vulva or vagina; it selectively infects columnar/transitional epithelium (endocervix, urethra, Skene's/Bartholin's ducts, fallopian tubes) causing purulent discharge and PID, NOT vulvar ulcers (Gyn Book p.109). Syphilis (painless indurated chancre), chancroid (painful soft ulcer), TB, and rodent ulcer all cause vulvar ulceration.

> **High-Yield Takeaway:** Gonorrhea infects columnar epithelium (cervix/urethra/tubes), NEVER intact adult stratified squamous vulvar skin—so it does NOT cause vulvar ulcers.

Question 24 Gynecology Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q17 & Exam 2 Q21 | Gyn Book p.166, 174

When comparing endometrial carcinoma to carcinoma of the cervix, which of the following statements is CORRECT?

☐ **A.** Endometrial carcinoma occurs at an average age 10 years younger than cervical cancer

☐ **B.** The main primary modality of treatment for Stage I endometrial carcinoma is radical radiotherapy

✓ **C. The overall prognosis of endometrial carcinoma is better than that of cervical carcinoma**

☐ **D.** Endometrial carcinoma is strongly caused by persistent HPV 16 and 18 infection

Correct Answer: C (The overall prognosis of endometrial carcinoma is better than that of cervical carcinoma)

Explanation: Endometrial carcinoma presents early with postmenopausal vaginal bleeding when still confined to the uterine corpus (Stage I in >75% of cases), giving it a significantly better overall 5-year survival (~85–90%) than cervical cancer (Endometrial Cancer - StatPearls). Surgery (TAH+BSO) is the primary treatment for endometrial cancer.

> **High-Yield Takeaway:** Endometrial cancer presents early via postmenopausal bleeding -> diagnosed at Stage I -> treated primarily by surgery (TAH+BSO) -> better overall prognosis than cervical or ovarian cancer.

Question 25 Gynecology Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q20 & Exam 2 Q24 | Gyn Book p.118

Which statement best characterizes an enterocele compared with other forms of pelvic organ prolapse?

☐ **A.** It is not considered a true hernia

☐ **B.** It is a herniation of the bladder floor through the anterior vaginal wall

☐ **C.** It is a complete eversion of the uterus outside the introitus

✓ **D. It is a true hernia involving protrusion of the pelvic peritoneal sac (Pouch of Douglas) and upper posterior vaginal wall into the vagina**

Correct Answer: D (It is a true hernia involving protrusion of the pelvic peritoneal sac (Pouch of Douglas) and upper posterior vaginal wall into the vagina)

Explanation: An enterocele is the ONLY pelvic organ prolapse that is a true peritoneal hernia because it contains a peritoneal sac (the cul-de-sac / Pouch of Douglas, often containing small intestine or omentum) dissecting between the rectovaginal septum and upper posterior vaginal wall (Gyn Book p.118). Option B describes a cystocele; Option C describes procidentia.

> **High-Yield Takeaway:** Enterocele = true hernia of the Pouch of Douglas (peritoneal sac + small bowel) through the upper posterior vaginal fornix.

Question 26 Gynecology Level 2

ACTUAL PAST EXAM — Patho Solved MCQs Q844 | Gyn Book p.168

What is the single most important histopathological criterion that differentiates a malignant uterine leiomyosarcoma from a benign cellular leiomyoma?

☐ **A.** Gross tumor diameter >5 cm

☐ **B.** Presence of hyaline degeneration

✓ **C. Number of mitotic figures per 10 high-power fields (coupled with tumor cell necrosis and nuclear atypia)**

☐ **D.** Subserosal vs intramural location

☐ **E.** Presence of whorled smooth muscle bundles

Correct Answer: C (Number of mitotic figures per 10 high-power fields (coupled with tumor cell necrosis and nuclear atypia))

Explanation: Histological differentiation between benign leiomyoma and malignant leiomyosarcoma relies on the Stanford criteria, with the mitotic index (typically >=10 mitoses per 10 HPF), coagulative tumor cell necrosis, and moderate-to-severe cytologic atypia being decisive (Patho Q844).

> **High-Yield Takeaway:** Leiomyosarcoma vs Leiomyoma on pathology = Mitotic count (per 10 HPF) + coagulative necrosis + nuclear atypia.

Question 27 Gynecology Level 2

ACTUAL PAST EXAM — Final Gyn BSNU Q28 | Gyn Book p.131

Which of the following statements regarding genitourinary fistula is INCORRECT?

✓ **A. Congenital fistula is the most common etiological cause in current clinical practice**

☐ **B.** Pelvic tuberculosis or radiation necrosis can be an etiological factor

☐ **C.** FIGO Stage IVA carcinoma of the cervix may invade the bladder and cause a vesicovaginal fistula

☐ **D.** Vesicovaginal fistula (VVF) is the most common anatomical type

Correct Answer: A (Congenital fistula is the most common etiological cause in current clinical practice)

Explanation: Congenital genitourinary fistulas are exceedingly rare. Almost all cases are acquired—most commonly from prolonged obstructed labor (ischemic pressure necrosis in developing countries) or gynecological surgery (abdominal/radical hysterectomy injury in surgical practice) (Gyn Book p.131).

> **High-Yield Takeaway:** Vesicovaginal fistula (VVF) is the most common type; acquired causes (obstructed labor & hysterectomy) dominate, while congenital VVF is extremely

rare.

Question 28 Gynecology Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q62 | Gyn Book p.20, 69

A woman with recurrent second-trimester pregnancy loss undergoes 3D coronal ultrasound of the uterus, which reveals two distinct endometrial cavities and an external fundal cleft/indentation measuring 1.5 cm deep. What is the diagnosis?

☐ **A.** Septate uterus

✓ **B. Bicornuate uterus**

☐ **C.** Unicornuate uterus

☐ **D.** Arcuate uterus

☐ **E.** Asherman syndrome

Correct Answer: B (Bicornuate uterus)

Explanation: Incomplete fusion of the two Müllerian ducts produces a bicornuate uterus, diagnosed on coronal 3D US or MRI/laparoscopy by two endometrial horns AND an external fundal serosal indentation >=1.0 cm (here 1.5 cm) (The Role of Ultrasound in Women's Health - IntechOpen). By contrast, a septate uterus (failure of resorption) has a normal convex/flat external fundal contour (<1 cm cleft).

> **High-Yield Takeaway:** External fundal cleft >=1 cm (e.g. 1.5 cm) = Bicornuate uterus (fusion defect); Normal flat external fundus + internal partition = Septate uterus (resorption defect, highest abortion rate, treated by hysteroscopic septal resection).

Question 29 Gynecology Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 2 Q23 | Gyn Book p.49

A 29-year-old woman underwent vigorous sharp dilation and curettage (D&C) for postpartum hemorrhage 6 months ago. She now presents with Asherman syndrome. Which menstrual symptom is most typical of this condition?

✓ **A. Hypomenorrhea (or secondary amenorrhea)**

☐ **B.** Heavy regular menorrhagia

☐ **C.** Continuous intermenstrual metrorrhagia

☐ **D.** Precocious puberty

Correct Answer: A (Hypomenorrhea (or secondary amenorrhea))

Explanation: Asherman syndrome (intrauterine adhesions/synechiae obliterating the basal layer of the endometrium after curettage or endometritis) presents with markedly reduced menstrual flow (hypomenorrhea) or secondary amenorrhea despite normal ovulatory hormone profiles (Secondary Amenorrhea - StatPearls).

> **High-Yield Takeaway:** Post-D&C hypomenorrhea/secondary amenorrhea + negative estrogen-progesterone withdrawal bleed = Asherman syndrome (diagnosed & treated via Hysteroscopy).

Question 30 Gynecology Level 2

ACTUAL PAST EXAM — Final Gyn BSNU Q8 | Gyn Book p.151

By what primary mechanism does mild-to-moderate pelvic endometriosis cause female infertility?

☐ **A.** By causing complete bilateral cornual occlusion in 100% of patients

✓ **B. Through pelvic adhesions, distorted tubo-ovarian anatomy, and chronic pro-inflammatory cytokines/macrophages that impair oocyte quality and sperm transport**

☐ **C.** By permanently destroying hypothalamic GnRH neurons

☐ **D.** By causing hyperprolactinemia from pituitary compression

Correct Answer: B (Through pelvic adhesions, distorted tubo-ovarian anatomy, and chronic pro-inflammatory cytokines/macrophages that impair oocyte quality and sperm transport)

Explanation: Endometriosis causes infertility both mechanically (peritubal/ovarian adhesions impairing ovum pick-up) and immunologically (activated peritoneal macrophages, elevated IL-1, TNF-alpha, and reactive oxygen species toxic to gametes and embryos) (Immunology at the Maternal-Fetal Interface - StatPearls).

> **High-Yield Takeaway:** Endometriosis impairs fertility via both anatomical distortion (adhesions) and a toxic inflammatory peritoneal microenvironment.

Question 31 Obstetrics Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 3 Q13 & Exam 2 Q25 | Obs Book p.44–49

A woman at 30 weeks' gestation presents to the emergency department with third-trimester vaginal bleeding. Which clinical finding correlates with Placenta Previa rather than Placental Abruption?

☐ **A.** Woody, board-like tender uterus

✓ **B. Painless, bright-red recurrent vaginal bleeding with a soft non-tender uterus**

☐ **C.** Severe fetal bradycardia and early DIC

☐ **D.** Maternal hypovolemic shock out of proportion to the visible blood loss

☐ **E.** Associated severe preeclampsia

Correct Answer: B (Painless, bright-red recurrent vaginal bleeding with a soft non-tender uterus)

Explanation: Placenta previa classically presents with painless, unprovoked, bright-red vaginal bleeding, a soft relaxed uterus, and hemodynamic changes strictly proportional to visible blood loss (Placenta Previa - StatPearls). Painful dark bleeding, woody tender uterus, preeclampsia association, fetal distress, DIC, and shock out of proportion to visible bleeding are all hallmarks of Placental Abruption (Placental Abruption - StatPearls).

> **High-Yield Takeaway:** Painless + soft uterus + proportional shock = Placenta Previa; Painful + woody tender uterus + shock out of proportion + DIC + HTN = Placental Abruption.

Question 32 Obstetrics Level 2

ACTUAL PAST EXAM — Comprehensive Bank p.70, p.211 Q69 & Patho Q847–848 | Obs Book p.39–41

Which feature correctly distinguishes a Partial Hydatidiform Mole from a Complete Hydatidiform Mole?

☐ **A.** Complete mole has a 69,XXY triploid karyotype and contains fetal red blood cells

✓ **B. Partial mole has a 69,XXY or 69,XXX triploid karyotype, focal villous edema, and identifiable fetal/embryonic tissue**

☐ **C.** Partial mole carries a higher (50%) risk of progressing to invasive choriocarcinoma than complete mole

☐ **D.** Complete mole is caused by dispermic fertilization of a normal haploid ovum with maternal chromosomes retained

Correct Answer: B (Partial mole has a 69,XXY or 69,XXX triploid karyotype, focal villous edema, and identifiable fetal/embryonic tissue)

Explanation: A partial mole results from fertilization of a normal haploid ovum (23,X) by two sperm (resulting in 69,XXY or 69,XXX triploidy) and features focal hydropic villi alongside fetal parts/fetal RBCs (Hydatidiform Mole - StatPearls). A complete mole is diploid (46,XX or 46,XY, entirely paternal androgenetic), has diffuse villous swelling, NO fetal tissue, and a much higher (~15–20%) risk of post-molar GTN.

> **High-Yield Takeaway:** Complete mole = 46,XX (all paternal), NO fetus, snowstorm US, high hCG, 15–20% GTN; Partial mole = 69,XXY (triploid), fetus present, focal villous edema, <5% GTN.

Question 33 Obstetrics Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q30 & Exam 2 Q29 | Obs Book p.108

Dichorionic diamniotic (DCDA) twin pregnancies are at increased risk for all of the following obstetric complications EXCEPT:

✓ **A. Twin-to-twin transfusion syndrome (TTTS)**

☐ **B.** Preeclampsia

☐ **C.** Selective fetal growth restriction

☐ **D.** Postpartum hemorrhage (from uterine overdistention)

☐ **E.** Preterm labor

Correct Answer: A (Twin-to-twin transfusion syndrome (TTTS))

Explanation: Twin-to-twin transfusion syndrome (TTTS) results from unbalanced deep arteriovenous vascular anastomoses within a shared single placenta and therefore occurs almost exclusively in Monochorionic (MCDA/MCMA) twin pregnancies, NOT dichorionic twins (Obs Book p.108).

> **High-Yield Takeaway:** TTTS (oligohydramnios/donor + polyhydramnios/recipient) is unique to Monochorionic twins; all twins have increased risk of PPH, preeclampsia, preterm birth, and malpresentation.

Question 34 Obstetrics Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 3 Q30 & Exam 1 Q42 | Obs Book p.151, 169

Which of the following statements is TRUE regarding fetal cephalohematoma?

☐ **A.** It is a subcutaneous serosanguinous fluid collection that crosses skull suture lines

☐ **B.** It requires immediate surgical incision and drainage in the delivery room

✓ **C. It is a subperiosteal collection of blood between the periosteum and skull bone that never crosses suture lines**

☐ **D.** It is exclusively caused by forceps delivery and never occurs with vacuum extraction

Correct Answer: C (It is a subperiosteal collection of blood between the periosteum and skull bone that never crosses suture lines)

Explanation: Cephalohematoma is a subperiosteal hemorrhage (typically over the parietal bone, strongly associated with vacuum extraction; Exam 1 Q42) that is strictly bounded by the periosteal attachments at the cranial suture lines (Obs Book p.151). Aspiration is contraindicated due to infection risk; it resolves spontaneously over 2–8 weeks (may cause neonatal jaundice).

> **High-Yield Takeaway:** Cephalohematoma = subperiosteal blood, does NOT cross sutures, associated with Vacuum; Caput succedaneum = subcutaneous edema, CROSSES sutures.

Question 35 Obstetrics Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q68 & Exam 3 Q14 | Obs Book p.121, 164

A perineal laceration after vaginal delivery involves the vaginal mucosa, perineal skin, and the muscles of the perineal body (transverse perineal muscles), while the anal sphincter complex remains completely intact. How is this tear classified, and what is its surgical equivalent?

☐ **A.** First-degree tear; equivalent to a labial graze

✓ **B. Second-degree perineal tear; anatomically equivalent to a mediolateral episiotomy**

☐ **C.** Third-degree perineal tear; requires overlapping sphincteroplasty

☐ **D.** Fourth-degree perineal tear; involves rectal mucosa

Correct Answer: B (Second-degree perineal tear; anatomically equivalent to a mediolateral episiotomy)

Explanation: A second-degree perineal tear involves the perineal skin, vaginal epithelium, and perineal body muscles without injuring the external or internal anal sphincter, making it anatomically equivalent to a standard episiotomy (Exam 1 Q68, Exam 3 Q14; Obs Book p.121).

> **High-Yield Takeaway:** 1st degree = skin/mucosa; 2nd degree = perineal muscles (= episiotomy); 3rd degree = anal sphincter; 4th degree = rectal mucosa.

Question 36 Obstetrics Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 3 Q1 | Obs Book p.82–84

Regarding the physiological differences between a primigravida and a multipara during normal labor, which statement is CORRECT?

☐ **A.** Cervical dilatation and effacement occur simultaneously in a primigravida

☐ **B.** The fetal head always engages only during the second stage in a primigravida

✓ **C. The duration of the third stage of labor is approximately equal in both primigravida and multipara**

☐ **D.** The latent phase is significantly shorter in a primigravida than in a multipara

Correct Answer: C (The duration of the third stage of labor is approximately equal in both primigravida and multipara)

Explanation: While the first and second stages of labor are longer in a primigravida (where cervical effacement typically completes before dilatation, vs simultaneously in multipara), the duration of the third stage of labor (placental separation and expulsion, ~5–15 minutes with active management, up to 30 minutes) is equal in primigravida and multipara (Obs Book p.84).

> **High-Yield Takeaway:** Primigravida effaces then dilates; Multipara effaces and dilates simultaneously; 3rd stage duration (15–30 min) is EQUAL in both!

Question 37 Obstetrics Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q41, Q48 | Obs Book p.168–169

Regarding operative vaginal delivery using the Vacuum Extractor (Ventouse), which of the following statements is CORRECT?

☐ **A.** It can be safely used in preterm deliveries at 31 weeks' gestation

✓ **B. The cup should be centered over the flexion point, 3 cm posterior to the anterior fontanelle (3 cm anterior to the posterior fontanelle) along the sagittal suture**

☐ **C.** It is the instrument of choice for mentum-anterior face presentation

☐ **D.** It may be applied at 7 cm cervical dilatation to speed up a prolonged active phase

Correct Answer: B (The cup should be centered over the flexion point, 3 cm posterior to the anterior fontanelle (3 cm anterior to the posterior fontanelle) along the sagittal suture)

Explanation: Correct placement of the vacuum cup over the flexion point (on the sagittal suture 3 cm anterior to the posterior fontanelle / 3 cm posterior to the anterior fontanelle) promotes flexion and presents the smallest suboccipitobregmatic diameter (9.5 cm) (Obs Book p.168). Vacuum is contraindicated before 34 weeks (Exam 1 Q41), in face/breech presentations, and before full (10 cm) cervical dilatation (except historic/obsolete myths).

> **High-Yield Takeaway:** Vacuum flexion point = sagittal suture 3 cm anterior to posterior fontanelle (3 cm posterior to anterior fontanelle); Contraindicated <34 weeks and in Face/Breech.

Question 38 Obstetrics Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 3 Q19 | Obs Book p.129

What is the most dangerous, life-threatening acute complication of applying forceful umbilical cord traction before signs of placental separation have

occurred?

✓ **A. Acute uterine inversion with profound neurogenic and hemorrhagic shock**

☐ **B.** Vasa previa rupture

☐ **C.** Amniotic fluid embolism

☐ **D.** Cephalohematoma

Correct Answer: A (Acute uterine inversion with profound neurogenic and hemorrhagic shock)

Explanation: Pulling on the umbilical cord before the placenta has separated—especially when combined with fundal pressure on a relaxed uterus with a fundally implanted placenta—turns the uterus inside-out (acute uterine inversion), causing severe hemorrhage and vagal/neurogenic shock out of proportion to blood loss (Postpartum Hemorrhage - StatPearls).

> **High-Yield Takeaway:** Premature cord traction + fundal pressure on relaxed uterus -> Acute Uterine Inversion -> immediate manual replacement (Johnson maneuver) under tocolysis.

Question 39 Obstetrics Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 3 Q10 & Exam 1 Q26, Q44 | Obs Book p.62

Which clinical finding in a pregnant woman strongly indicates true organic valvular heart disease rather than normal physiological cardiovascular adaptation of pregnancy?

☐ **A.** A soft grade 1–2 midsystolic ejection murmur at the left sternal border

✓ **B. A diastolic murmur (such as the mid-diastolic rumble of mitral stenosis)**

☐ **C.** Mild dependent ankle edema in the third trimester

☐ **D.** A physiological third heart sound (S3) and bounding pulse

Correct Answer: B (A diastolic murmur (such as the mid-diastolic rumble of mitral stenosis))

Explanation: Increased blood volume and cardiac output during normal pregnancy frequently produce a physiological S3, bounding pulse, and a soft grade 1–2 systolic ejection murmur. However, ANY diastolic murmur (e.g., mitral stenosis) or pansystolic murmur >=grade 3/6 is pathological and diagnostic of organic valvular disease (Obs Book p.62).

> **High-Yield Takeaway:** Soft systolic murmur & S3 = normal in pregnancy; Diastolic murmur = ALWAYS pathological (Mitral stenosis is the most common rheumatic lesion in pregnancy).

Question 40 Obstetrics Level 2

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 2 Q1 | Obs Book p.50

All of the following are recognized risk factors for Vasa Previa EXCEPT:

☐ **A.** Bilobed or succenturiate lobe placenta

☐ **B.** Conception via In Vitro Fertilization (IVF)

☐ **C.** Multifetal (twin/triplet) gestation

✓ **D. Photocoagulopathy**

☐ **E.** Second-trimester low-lying placenta

Correct Answer: D (Photocoagulopathy)

Explanation: Vasa previa (fetal vessels running through the membranes across the internal os) is strongly associated with velamentous cord insertion, bilobed/succenturiate placentas, IVF pregnancies, multiple gestation, and low-lying placentas (Obs Book p.50). 'Photocoagulopathy' is a distractor term and is not a risk factor (Exam 2 Q1).

> **High-Yield Takeaway:** Vasa previa risk factors = Bilobed/succenturiate placenta, velamentous cord insertion, IVF, and multiple pregnancy.

Level 3: Clinical Scenarios & Application

Question 41 Gynecology Level 3

ACTUAL PAST EXAM — Final Gyn BSNU Q1 | Gyn Book p.166

A 60-year-old postmenopausal woman undergoes total abdominal hysterectomy, bilateral salpingo-oophorectomy, and bilateral pelvic and para-aortic lymphadenectomy for endometrial carcinoma. Final histopathology reveals Grade 2 endometrioid adenocarcinoma invading 65% (more than half) of the myometrial thickness. The cervical stroma, serosa, adnexa, and all lymph nodes are negative for malignancy. What is her FIGO stage?

☐ **A.** Stage IA

✓ **B. Stage IB**

☐ **C.** Stage II

☐ **D.** Stage IIIA

☐ **E.** Stage IIIC1

Correct Answer: B (Stage IB)

Explanation: According to FIGO staging of endometrial carcinoma, tumor confined to the corpus uteri with <50% myometrial invasion is Stage IA, whereas >=50% myometrial invasion (here 65%) with negative cervix/adnexa/nodes is Stage IB (Endometrial Cancer Treatment (PDQ) - NCBI). Notice how in Exam 1 Q2, when the tumor extended into the cervical stroma with negative nodes, the stage became Stage II!

> **High-Yield Takeaway:** Endometrial cancer FIGO: <50% myometrium = IA; >=50% myometrium = IB; Cervical stroma = II; Serosa/Adnexa = IIIA; Vagina/Parametrium = IIIB; Nodes = IIIC.

Question 42 Gynecology Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q13 & Exam 2 Q17 | Gyn Book p.185

An asymptomatic 57-year-old postmenopausal woman is found incidentally on pelvic ultrasound to have a simple, unilateral, thin-walled unilocular ovarian cyst measuring 4.5 cm in diameter with no solid components or ascites. Her serum CA-125 is 10 IU/L (normal <35 IU/L). What is the most appropriate first-line management?

☐ **A.** Immediate discharge with no further imaging

✓ **B. Conservative follow-up with repeat transvaginal ultrasound in 4 months**

☐ **C.** Laparoscopic bilateral salpingo-oophorectomy

☐ **D.** Percutaneous ultrasound-guided cyst aspiration

☐ **E.** Total abdominal hysterectomy and bilateral salpingo-oophorectomy

Correct Answer: B (Conservative follow-up with repeat transvaginal ultrasound in 4 months)

Explanation: In a postmenopausal woman who is asymptomatic and has a simple, unilocular, thin-walled cyst <5 cm (here 4.5 cm) alongside a normal CA-125 (<35 IU/L), the risk of malignancy is <1% (RMI <25). RCOG/department guidelines recommend conservative management with repeat ultrasound + CA-125 in 4 months (Exam 1 Q13). Aspiration is contraindicated in postmenopausal cysts.

> **High-Yield Takeaway:** Postmenopausal simple unilocular cyst <5 cm + normal CA-125 + asymptomatic = Conservative follow-up ultrasound in 4 months.

Question 43 Gynecology Level 3

ACTUAL PAST EXAM — Final Gyn BSNU Q13 | Gyn Book p.153

A 34-year-old multiparous woman presents with heavy menstrual bleeding, irregular spotting, and progressively worsening secondary dysmenorrhea over the past 6 months. On bimanual pelvic examination, the uterus is symmetrically

enlarged (10-week size), globular, boggy, and mildly tender. What is the most likely diagnosis?

☐ **A.** Subserosal pedunculated leiomyoma

✓ **B. Adenomyosis**

☐ **C.** Asherman syndrome

☐ **D.** Cervical intraepithelial neoplasia (CIN 3)

☐ **E.** Ovarian fibroma

Correct Answer: B (Adenomyosis)

Explanation: Adenomyosis (ectopic endometrial glands and stroma deep within the myometrium) classically presents in multiparous women in their 30s–40s with heavy menstrual bleeding (menorrhagia), painful menses (secondary dysmenorrhea), and a uniformly/symmetrically enlarged, globular, soft/tender uterus (Gyn Book p.153). By contrast, uterine fibroids produce an asymmetrically enlarged, firm, nodular/irregular uterus.

> **High-Yield Takeaway:** Symmetrically enlarged, globular, tender uterus + menorrhagia + dysmenorrhea = Adenomyosis; Asymmetrically enlarged, firm, nodular uterus = Fibroids.

Question 44 Gynecology Level 3

ACTUAL PAST EXAM — Final Gyn BSNU Q18 & Exam 1 Q61 | Gyn Book p.186

A 26-year-old nulligravid woman presents to the emergency department with sudden-onset, severe, sharp right lower quadrant pain associated with nausea and vomiting. Her last menstrual period was 2 weeks ago and her urine pregnancy test is negative. Transvaginal Doppler ultrasound reveals an enlarged 8 cm right ovary with absent intra-ovarian venous/arterial flow, a twisted pedicle ('whirlpool sign'), and scant free fluid in the cul-de-sac. What is the most likely diagnosis?

☐ **A.** Ruptured ectopic pregnancy

✓ **B. Ovarian torsion**

☐ **C.** Chronic pelvic inflammatory disease

☐ **D.** Degenerating uterine leiomyoma

☐ **E.** Polycystic ovary syndrome

Correct Answer: B (Ovarian torsion)

Explanation: Acute colicky/sharp unilateral pelvic pain with nausea/vomiting, negative pregnancy test, enlarged edematous ovary, absent Doppler flow, and the pathognomonic 'whirlpool sign' of the twisted infundibulopelvic pedicle confirm acute ovarian torsion (Final Gyn Q18, Exam 1 Q61).

> **High-Yield Takeaway:** Sudden unilateral pain + vomiting + negative hCG + enlarged avascular ovary / Whirlpool sign = Ovarian Torsion -> urgent laparoscopic detorsion.

Question 45 Gynecology Level 3

ACTUAL PAST EXAM — Final Gyn BSNU Q25 | Gyn Book p.195

A 55-year-old postmenopausal woman presents with vaginal bleeding and a palpable unilateral solid-cystic adnexal mass. Endometrial biopsy demonstrates complex endometrial hyperplasia. Which ovarian neoplasm is most likely responsible for her clinical picture?

☐ **A.** Serous cystadenocarcinoma

✓ **B. Granulosa cell tumor**

☐ **C.** Dysgerminoma

☐ **D.** Brenner tumor

☐ **E.** Sertoli-Leydig cell tumor

Correct Answer: B (Granulosa cell tumor)

Explanation: Granulosa cell tumor (and thecoma) is a sex cord-stromal tumor that secretes high levels of unopposed estradiol, stimulating the postmenopausal endometrium and causing endometrial hyperplasia or endometrioid adenocarcinoma in 25–50% of patients (Final Gyn Q25; Patho Q865).

> **High-Yield Takeaway:** Estrogen-secreting ovarian tumor = Granulosa-theca cell tumor (causes precocious pseudopuberty in children or PMB + endometrial hyperplasia/cancer in postmenopausal women).

Question 46 Gynecology Level 3

ACTUAL PAST EXAM — Final Gyn BSNU Q12 & Exam 1 Q47, Q54 | Gyn Book p.50

A 4-year-old girl presents with early onset of pubic hair, clitoromegaly, and accelerated linear growth. Her blood pressure and serum electrolytes are normal. Which enzyme deficiency is most consistent with this 'simple virilizing' presentation, and what is its specific diagnostic screening marker?

✓ **A. 21-hydroxylase deficiency — elevated serum 17-hydroxyprogesterone (17-OHP)**

☐ **B.** 11-beta-hydroxylase deficiency — decreased serum ACTH

☐ **C.** 17-alpha-hydroxylase deficiency — elevated estradiol

☐ **D.** 5-alpha-reductase deficiency — elevated cortisol

Correct Answer: A (21-hydroxylase deficiency — elevated serum 17-hydroxyprogesterone (17-OHP))

Explanation: 21-hydroxylase deficiency accounts for >90% of Congenital Adrenal Hyperplasia (CAH). Impaired conversion of 17-hydroxyprogesterone to 11-deoxycortisol leads to marked elevation of serum 17-OHP (diagnostic screening test; Exam 1 Q47) and shunting of precursors into adrenal androgens, causing ambiguous genitalia in 46,XX neonates (Exam 1 Q54) or simple virilizing precocious pubarche in childhood (Final Gyn Q12). Note: 11-beta-hydroxylase deficiency causes virilization PLUS hypertension.

> **High-Yield Takeaway:** 21-hydroxylase deficiency = most common CAH, screened by elevated 17-OHP; 11-beta-hydroxylase = virilization + HTN; 17-alpha-hydroxylase = sexual infantilism + HTN.

Question 47 Gynecology Level 3

ACTUAL PAST EXAM — Final Gyn BSNU Q10 | Gyn Book p.111

A 24-year-old woman presents with a single, painless, indurated (hard-based) ulcer on her labia majora and non-tender, rubbery bilateral inguinal lymphadenopathy. Which organism is the most likely cause?

☐ **A.** Herpes simplex virus type 2 (HSV-2)

✓ **B. Treponema pallidum**

☐ **C.** Haemophilus ducreyi

☐ **D.** Chlamydia trachomatis serovar L1–L3

☐ **E.** Klebsiella granulomatis

Correct Answer: B (Treponema pallidum)

Explanation: A solitary, painless, indurated ulcer with a clean base (hard chancre) accompanied by painless rubbery inguinal lymphadenopathy is the classic primary lesion of syphilis, caused by the spirochete Treponema pallidum (diagnosed via dark-field microscopy and VDRL/RPR + treponemal tests; Treated with Benzathine Penicillin G) (Gyn Book p.111).

> **High-Yield Takeaway:** Painless indurated ulcer (chancre) + painless nodes = Treponema pallidum (Syphilis); Painful soft ulcer + suppurative nodes = Haemophilus ducreyi (Chancroid); Grouped painful vesicles = HSV-2.

Question 48 Gynecology Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q66 | Gyn Book p.156

A 7-year-old girl is brought to the clinic with intense vulvar itching and soreness. Examination reveals thin, wrinkled, porcelain-white plaques in a figure-of-eight

distribution around the vulva and perianal skin with focal subepithelial ecchymoses. The hymenal ring is normal. What is the most appropriate first-line treatment?

☐ **A.** Immediate surgical vulvectomy

☐ **B.** Oral broad-spectrum antibiotics

✓ **C. Super-potent topical corticosteroid ointment (Clobetasol propionate 0.05%)**

☐ **D.** Immediate reporting as confirmed sexual abuse without medical therapy

☐ **E.** Topical testosterone cream

Correct Answer: C (Super-potent topical corticosteroid ointment (Clobetasol propionate 0.05%))

Explanation: This is the classic presentation of vulvar Lichen Sclerosus, which has a bimodal peak in prepubertal girls and postmenopausal women. Fragile atrophic skin with purpura/ecchymosis in a figure-of-eight pattern can mimic trauma, so recognizing it prevents misdiagnosis of abuse, and first-line therapy is a super-potent topical corticosteroid (Clobetasol propionate 0.05% ointment; Exam 1 Q66).

> **High-Yield Takeaway:** White 'cigarette-paper' figure-of-8 vulvar/perianal plaques + itching + ecchymosis = Lichen Sclerosus -> treat with super-potent topical Clobetasol propionate 0.05%.

Question 49 Gynecology Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q3 & Exam 2 Q7 | Gyn Book p.139

A 16-year-old girl with known von Willebrand disease presents with severe heavy menstrual bleeding since menarche. Which of the following is an effective first-line medical therapy?

☐ **A.** Endometrial thermal ablation

☐ **B.** Sharp dilatation and curettage (D&C)

☐ **C.** Nonsteroidal anti-inflammatory drugs (NSAIDs / Mefenamic acid)

✓ **D. Combined oral contraceptive pills (COCs)**

Correct Answer: D (Combined oral contraceptive pills (COCs))

Explanation: In patients with inherited bleeding disorders such as von Willebrand disease, Combined Oral Contraceptive Pills (COCs) (or tranexamic acid / desmopressin / LNG-IUS) are effective first-line therapy because estrogen elevates circulating factor VIII and vWF levels while progestin induces endometrial atrophy (Exam 1 Q3). NSAIDs are strictly contraindicated in bleeding disorders because they inhibit platelet cyclooxygenase and worsen bleeding!

> **High-Yield Takeaway:** Heavy menstrual bleeding + von Willebrand disease -> give COCs (or tranexamic acid); NEVER give NSAIDs (inhibit platelet aggregation) or perform endometrial ablation in adolescents!

Question 50 Gynecology Level 3

ACTUAL PAST EXAM — Final Gyn BSNU Q24 | Gyn Book p.209

During an outpatient dilation and curettage (D&C), what is the classic intraoperative sign that uterine perforation has occurred?

☐ **A.** Sudden decrease in maternal abdominal girth

✓ **B. Sudden loss of resistance ('give') with the surgical instrument passing beyond the expected uterine sounding depth**

☐ **C.** Development of a high fever within 5 minutes of cervical dilation

☐ **D.** Profuse watery discharge from the urethra

Correct Answer: B (Sudden loss of resistance ('give') with the surgical instrument passing beyond the expected uterine sounding depth)

Explanation: Uterine perforation during a blind intrauterine procedure (sound, dilator, or curette) is recognized clinically when the operator feels a sudden loss of resistance and the instrument advances deeper than the expected length of the uterine cavity (Final Gyn Q24; Gyn Book p.209). Risk is highest in pregnant/postpartum soft uteri, postmenopausal atrophic uteri, and marked retroversion/anteflexion.

> **High-Yield Takeaway:** Instrument passes deeper than expected uterine cavity length with sudden loss of resistance = Uterine Perforation -> stop procedure immediately!

Question 51 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q19 | Obs Book p.28

A 20-year-old primigravida presents with mild vaginal spotting and lower abdominal cramping after 7 weeks of amenorrhea. Pelvic examination shows a closed internal cervical os, and transvaginal ultrasound reveals a single intrauterine gestational sac containing a fetal pole with regular cardiac pulsations. What is the diagnosis?

☐ **A.** Inevitable abortion

✓ **B. Threatened abortion**

☐ **C.** Incomplete abortion

☐ **D.** Missed abortion

☐ **E.** Complete abortion

Correct Answer: B (Threatened abortion)

Explanation: First-trimester vaginal bleeding with a closed cervix and ultrasound confirmation of a live intrauterine embryo (cardiac pulsations present) is the textbook definition of Threatened Abortion (Exam 1 Q19; Obs Book p.28). Management is reassurance, avoidance of strenuous activity, and anti-D immunoglobulin if Rh-negative.

> **High-Yield Takeaway:** Closed cervix + live fetus on US = Threatened abortion; Closed cervix + dead embryo or sac >=25 mm with no embryo = Missed abortion / Blighted ovum; Open cervix = Inevitable/Incomplete abortion.

Question 52 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q16 & Exam 2 Q20 | Obs Book p.49

A primigravida at 37 weeks' gestation is diagnosed on ultrasound with central (complete) placenta previa totally covering the internal cervical os. What is the mandatory mode of delivery?

✓ **A. Elective Cesarean section**

☐ **B.** Spontaneous vaginal delivery

☐ **C.** Induction of labor with intravenous oxytocin

☐ **D.** Artificial rupture of membranes (amniotomy)

Correct Answer: A (Elective Cesarean section)

Explanation: Central (complete or partial major) placenta previa completely obstructs the birth canal; any attempt at vaginal delivery, oxytocin induction, or amniotomy will tear the placental sinuses and cause fatal maternal-fetal hemorrhage (Placenta Previa - StatPearls). Planned Cesarean section at 36–37 weeks is mandatory.

> **High-Yield Takeaway:** Central / Major Placenta Previa = Absolute indication for Cesarean section (and NEVER perform digital vaginal exam!).

Question 53 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q52 | Obs Book p.112, 117

A 22-year-old primigravida at 39 weeks' gestation is in the active phase of labor. Over the past 4 hours, her cervical dilatation has remained unchanged at 6 cm with no descent of the fetal head, despite strong, regular uterine contractions (>200 Montevideo units). What is the most likely cause of this secondary arrest of active labor?

☐ **A.** Placenta previa

✓ **B. Cephalopelvic disproportion (CPD)**

☐ **C.** Umbilical cord prolapse

☐ **D.** Hypotonic uterine inertia

Correct Answer: B (Cephalopelvic disproportion (CPD))

Explanation: Secondary arrest of active-phase cervical dilatation (>=6 cm with no change for >=4 hours despite adequate contractions) accompanied by failure of descent is classically caused by mechanical obstruction / Cephalopelvic Disproportion (CPD) or malposition (Exam 1 Q52; Obs Book p.112). Because contractions are already strong, oxytocin is contraindicated and delivery is by Cesarean section.

> **High-Yield Takeaway:** Active-phase arrest (>=4 hrs at >=6 cm) WITH strong contractions = Cephalopelvic Disproportion (CPD) -> Cesarean section (do NOT give oxytocin in obstructed labor/CPD!).

Question 54 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q49 | Obs Book p.95, 163

A laboring patient receiving oxytocin augmentation develops uterine contractions occurring every 1 minute, each lasting up to 90 seconds (>5 contractions in 10 minutes), accompanied by recurrent late decelerations on cardiotocography (CTG). How is this clinical picture best described?

☐ **A.** Normal active-phase labor progression

✓ **B. Uterine hyperstimulation (Tachysystole) with uteroplacental insufficiency**

☐ **C.** Hypotonic uterine dysfunction

☐ **D.** Early physiological head compression

Correct Answer: B (Uterine hyperstimulation (Tachysystole) with uteroplacental insufficiency)

Explanation: More than 5 contractions in 10 minutes (or contractions lasting >=90 seconds with <60 seconds relaxation) defines uterine tachysystole; when coupled with non-reassuring fetal heart rate changes (late decelerations from uteroplacental insufficiency), it is termed uterine hyperstimulation (Exam 1 Q49). Immediate management: stop oxytocin, left lateral position, IV fluids, oxygen, and tocolytic (terbutaline) if persistent.

> **High-Yield Takeaway:** >5 contractions in 10 min (or lasting 90s every 1 min) + late decelerations = Uterine Hyperstimulation (Tachysystole) -> STOP oxytocin immediately!

Question 55 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q59 | Obs Book p.65

A pregnant woman at 32 weeks' gestation complains of severe generalized pruritus concentrated on the palms of her hands and soles of her feet that worsens markedly at night. Examination shows excoriations without a primary rash. Laboratory testing reveals elevated serum total bile acids and mildly elevated transaminases. What is the most appropriate management?

☐ **A.** Reassurance and cold baths only until 42 weeks

☐ **B.** Immediate emergency Cesarean section at 32 weeks

✓ **C. Ursodeoxycholic acid (UDCA) therapy with close fetal surveillance (and planned delivery at 37–38 weeks)**

☐ **D.** High-dose systemic oral corticosteroids for 8 weeks

Correct Answer: C (Ursodeoxycholic acid (UDCA) therapy with close fetal surveillance (and planned delivery at 37–38 weeks))

Explanation: Third-trimester palmar-plantar nocturnal pruritus without a primary rash + elevated serum bile acids (>10 micromol/L) is diagnostic of Intrahepatic Cholestasis of Pregnancy (ICP) (Obs Book p.65). Because bile acids cross the placenta and can cause sudden fetal arrhythmia/IUFD, first-line treatment is Ursodeoxycholic acid (UDCA) to lower bile acids alongside close fetal monitoring and planned delivery at 37 weeks (or earlier if bile acids >100 micromol/L).

> **High-Yield Takeaway:** Pruritus of palms & soles worse at night + elevated serum bile acids = Intrahepatic Cholestasis of Pregnancy (ICP) -> treat with Ursodeoxycholic acid (UDCA) + fetal monitoring.

Question 56 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q43 | Obs Book p.59

A pregnant woman diagnosed with Gestational Diabetes Mellitus (GDM) at 26 weeks fails to achieve target blood glucose levels (fasting <95 mg/dL, 1-hr postprandial <140 mg/dL, 2-hr <120 mg/dL) after 2 weeks of medical nutrition therapy (diet) and exercise. What is the gold-standard next step in pharmacologic management?

✓ **A. Initiate subcutaneous Insulin therapy**

☐ **B.** Initiate Glibenclamide (Glyburide) as preferred first-line over insulin

☐ **C.** Start strict fasting ketogenic diet

☐ **D.** Immediate termination of pregnancy

Correct Answer: A (Initiate subcutaneous Insulin therapy)

Explanation: When diet and exercise fail to achieve glycemic targets in GDM (converting Class A1GDM to Class A2GDM), Insulin is the gold-standard first-line pharmacologic therapy because it does not cross the placenta (Gestational Diabetes - StatPearls).

> **High-Yield Takeaway:** GDM diet/exercise failure -> Insulin is the gold-standard first-line pharmacologic agent (targets: Fasting <95, 1-hr <140, 2-hr <120 mg/dL).

Question 57 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q44 & Book55 Q1 | Obs Book p.62

A pregnant patient with rheumatic mitral stenosis is at the highest risk of developing acute left ventricular failure and severe pulmonary edema during which period?

☐ **A.** Early first trimester (6–10 weeks)

☐ **B.** Early second trimester (14–16 weeks)

✓ **C. Late third trimester, intrapartum, and the immediate postpartum period (first 24–48 hours of puerperium)**

☐ **D.** 6 months after delivery

Correct Answer: C (Late third trimester, intrapartum, and the immediate postpartum period (first 24–48 hours of puerperium))

Explanation: In mitral stenosis, the narrowed left atrioventricular valve cannot accommodate rapid increases in preload, stroke volume, and heart rate. Peak hemodynamic stress occurs in the late third trimester, during labor (pain/tachycardia), and immediately postpartum when uterine contraction and release of caval compression autotransfuse ~500 mL of blood into the central venous circulation (Exam 1 Q44; Obs Book p.62).

> **High-Yield Takeaway:** Mitral stenosis in pregnancy: highest risk of pulmonary edema = Late 3rd trimester, labor, and immediate postpartum (autotransfusion + increased stroke volume).

Question 58 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 3 Q3 | Obs Book p.63

A woman in the early third trimester presents with acute onset of high fever (102°F / 38.9°C), rigors/chills, nausea, vomiting, and right costovertebral angle (loin/back) tenderness. Urinalysis reveals numerous bacteria, WBC casts, and pyuria. What is the most likely diagnosis?

☐ **A.** Acute appendicitis

☐ **B.** Ruptured uterus

✓ **C. Acute pyelonephritis of pregnancy**

☐ **D.** Placental abruption

☐ **E.** Round ligament pain

Correct Answer: C (Acute pyelonephritis of pregnancy)

Explanation: Progesterone-induced ureteric smooth muscle relaxation and dextrorotation of the gravid uterus compress the right ureter, predisposing pregnant women (especially those with untreated asymptomatic bacteriuria) to right-sided acute pyelonephritis (high fever, chills, flank pain, bacteriuria/pyuria; Exam 3 Q3). Requires inpatient hospitalization and IV cephalosporins (e.g., ceftriaxone).

> **High-Yield Takeaway:** High spiking fever + chills + flank/back pain + pyuria/bacteriuria in 2nd/3rd trimester = Acute Pyelonephritis (more common on the RIGHT side; admit for IV antibiotics; increases preterm labor/ARDS risk).

Question 59 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q29 & Exam 3 Q23, Q24 | Obs Book p.36–38

A 27-year-old woman presents with 6 weeks of amenorrhea, mild vaginal spotting, cervical motion tenderness, and fullness in the cul-de-sac. Her serum beta-hCG is 2,400 mIU/mL. Transvaginal ultrasound reveals an empty uterine cavity and an unruptured 2.5 cm right adnexal mass with no fetal cardiac activity and no free peritoneal fluid. She is hemodynamically stable. What is the most cost-effective medical treatment?

☐ **A.** Laparotomy with bilateral salpingectomy

✓ **B. Systemic intramuscular Methotrexate**

☐ **C.** Oral Mifepristone alone

☐ **D.** Hysteroscopic resection

Correct Answer: B (Systemic intramuscular Methotrexate)

Explanation: In a hemodynamically stable patient with an unruptured tubal ectopic pregnancy (<3.5–4 cm, no fetal cardiac activity, beta-hCG <5,000 mIU/mL, normal liver/renal function), systemic intramuscular Methotrexate (folic acid antagonist) is the most cost-effective, fertility-preserving treatment (Exam 1 Q29, Exam 2 Q28) (Ectopic Pregnancy - StatPearls).

> **High-Yield Takeaway:** Unruptured stable ectopic (<3.5 cm, no fetal heartbeat, hCG <5000) -> Systemic Methotrexate; Ruptured / unstable ectopic -> Emergency surgical salpingectomy.

Question 60 Obstetrics Level 3

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q56 & Exam 2 Q35 | Obs Book p.32

In a patient with cervical insufficiency (incompetence), what is the specific clinical indication for performing a transabdominal cervico-isthmic cerclage rather than a standard transvaginal cerclage?

☐ **A.** First-trimester threatened abortion at 7 weeks

✓ **B. Failure of a previous transvaginal cerclage (or congenital/surgical absence of the vaginal ectocervix)**

☐ **C.** Routine twin pregnancy with normal cervical length

☐ **D.** Active chorioamnionitis at 22 weeks

Correct Answer: B (Failure of a previous transvaginal cerclage (or congenital/surgical absence of the vaginal ectocervix))

Explanation: Transabdominal cerclage placed at the cervico-isthmic junction (requiring subsequent delivery by Cesarean section) is specifically reserved for women who have experienced a failed prior transvaginal cerclage or who have an anatomically absent/severely amputated cervix after radical trachelectomy/conization (Exam 1 Q56, Exam 2 Q35).

> **High-Yield Takeaway:** Indication for Abdominal Cerclage = Failed previous transvaginal cerclage or absent/amputated vaginal cervix (delivery must be by Cesarean section).

Level 4: Advanced Clinical Reasoning & Exam Traps

Question 61 Gynecology Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q38 & Exam 2 Q32 | Gyn Book p.139

A 34-year-old multiparous woman presents with heavy menstrual bleeding for the past 6 months. She has Crohn's disease maintained on oral sulfasalazine. Pelvic examination and ultrasound show a normal uterus with no structural pathology, and she does not desire future fertility. Despite requesting a hysterectomy, what is the most appropriate next step in management according to evidence-based guidelines?

☐ **A.** Immediate total abdominal hysterectomy

☐ **B.** Depot medroxyprogesterone acetate (DMPA) injection

✓ **C. Levonorgestrel-releasing intrauterine system (LNG-IUS)**

☐ **D.** Bilateral uterine artery embolization

Correct Answer: C (Levonorgestrel-releasing intrauterine system (LNG-IUS))

Explanation: TRAP ALERT: Even though the stem states the patient 'does not desire future fertility and requests a hysterectomy,' NICE and department guidelines mandate offering the Levonorgestrel-releasing Intrauterine System (LNG-IUS / Mirena) as the first-line treatment for heavy menstrual bleeding with no structural uterine pathology (>80–90% blood loss reduction, safe in inflammatory bowel disease/Crohn's) before resorting to major surgery (Exam 1 Q38, Exam 2 Q32).

> **High-Yield Takeaway:** TRAP: In HMB with a normal uterus, even if the patient asks for a hysterectomy, the correct exam answer for first-line management is ALWAYS Levonorgestrel-releasing IUS (LNG-IUS).

Question 62 Gynecology Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q63 | Gyn Book p.165

A 59-year-old postmenopausal woman presents to the gynecology clinic complaining of painless vaginal spotting for the past month. Which of the following is the MOST LIKELY (most common) underlying cause of this patient's bleeding?

✓ **A. Endometrial atrophy (senile atrophic endometritis/vaginitis)**

☐ **B.** Endometrial adenocarcinoma

☐ **C.** Endometrial hyperplasia

☐ **D.** Endometrial polyp

☐ **E.** Cervical squamous cell carcinoma

Correct Answer: A (Endometrial atrophy (senile atrophic endometritis/vaginitis))

Explanation: TRAP ALERT: Students reflexively pick 'Endometrial adenocarcinoma' whenever they see postmenopausal bleeding. However, endometrial cancer is the most SERIOUS cause to rule out (~10% of cases), whereas Endometrial / Vaginal Atrophy is the MOST COMMON cause (~60–80% of cases) (Exam 1 Q63, Final Gyn Q29).

> **High-Yield Takeaway:** TRAP: Most COMMON cause of postmenopausal bleeding = Endometrial atrophy (~60–80%); Most SERIOUS cause that must be excluded first via TVUS/biopsy = Endometrial carcinoma (~10%).

Question 63 Gynecology Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q34 | Gyn Book p.50

A 25-year-old woman presents with galactorrhea and secondary amenorrhea of 8 weeks' duration accompanied by irregular spotting. Which of the following serum

assays should be performed INITIALLY?

✓ **A. Serum beta-hCG (pregnancy test)**

☐ **B.** Serum progesterone

☐ **C.** Serum prolactin

☐ **D.** Serum FSH

☐ **E.** Pituitary MRI

Correct Answer: A (Serum beta-hCG (pregnancy test))

Explanation: TRAP ALERT: Although the stem mentions 'galactorrhea' to tempt you into choosing Serum Prolactin, pregnancy is the most common cause of secondary amenorrhea PLUS breast secretion/spotting in a reproductive-aged woman! Therefore, Serum beta-hCG must ALWAYS be ordered FIRST before prolactin or FSH (Exam 1 Q34).

> **High-Yield Takeaway:** TRAP: Even when 'galactorrhea' is in the stem of a woman with secondary amenorrhea, the FIRST initial test is ALWAYS Serum beta-hCG (pregnancy test)!

Question 64 Gynecology Level 4

ACTUAL PAST EXAM — Final Gyn BSNU Q9 | Gyn Book p.51

A 31-year-old woman develops agalactorrhea (failure to lactate), secondary amenorrhea, loss of pubic/axillary hair, hypotension, and fatigue following a massive postpartum hemorrhage (Sheehan's syndrome). Which hormone replacement is the MOST IMPORTANT and must be initiated FIRST?

☐ **A.** Conjugated estrogens

☐ **B.** Oral medroxyprogesterone

✓ **C. Cortisone (Glucocorticoid / Hydrocortisone)**

☐ **D.** Levothyroxine (Thyroid extract)

☐ **E.** Recombinant FSH/LH

Correct Answer: C (Cortisone (Glucocorticoid / Hydrocortisone))

Explanation: TRAP ALERT: In panhypopituitarism / Sheehan's syndrome, Cortisone (hydrocortisone) is the most life-saving hormone and MUST be administered BEFORE thyroid hormone replacement. Giving thyroid extract first accelerates basal metabolic clearance of the remaining cortisol and precipitates a fatal acute adrenal (Addisonian) crisis (Final Gyn Q9).

> **High-Yield Takeaway:** TRAP: In Sheehan syndrome, ALWAYS replace Cortisone (glucocorticoids) FIRST before Levothyroxine to prevent fatal acute adrenal crisis!

Question 65 Gynecology Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q11 & Exam 2 Q14 | Gyn Book p.89

Regarding emergency postcoital contraception, which of the following statements is NOT true?

☐ **A.** It may include insertion of a copper intrauterine device (Cu-IUD) within 5 days

☐ **B.** It may be administered as oral levonorgestrel contraceptive pills in one or two doses

☐ **C.** Oral levonorgestrel emergency contraception is most effective when taken within 72 hours of unprotected intercourse

✓ **D. Oral emergency contraceptive pills reduce the pregnancy rate by 99%**

Correct Answer: D (Oral emergency contraceptive pills reduce the pregnancy rate by 99%)

Explanation: TRAP ALERT: The Copper IUD reduces pregnancy rate by >99% when inserted within 5 days, whereas oral emergency contraceptive pills (levonorgestrel / Yuzpe regimen) reduce the expected pregnancy rate by ~75% to 85% (NOT 99%), making D the false statement in Exam 1 Q11 & Exam 2 Q14.

> **High-Yield Takeaway:** TRAP: Copper IUD is >99% effective for emergency contraception; oral levonorgestrel EC pills are ~75–85% effective (so 'reduces pregnancy rate by 99%' is FALSE for pills).

Question 66 Gynecology Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q12 & Exam 2 Q15 | Gyn Book p.172

Diagnostic/therapeutic conization of the cervix would be INAPPROPRIATE in which of the following clinical situations?

☐ **A.** When there is a discrepancy between a high-grade Pap smear and a negative punch biopsy

☐ **B.** When colposcopy is unsatisfactory/inadequate (transformation zone not fully visualized)

☐ **C.** When microinvasive carcinoma (Stage IA1) is suspected on biopsy to determine depth/margins

✓ **D. When frankly / deeply invasive cervical carcinoma is already demonstrated on punch biopsy**

☐ **E.** For excisional treatment of biopsy-proven CIN III

Correct Answer: D (When frankly / deeply invasive cervical carcinoma is already demonstrated on punch biopsy)

Explanation: If a cervical punch biopsy already proves frankly/deeply invasive cervical cancer, diagnostic conization is unnecessary and contraindicated because it causes severe hemorrhage, infection, and delays definitive staging/radical hysterectomy or chemoradiation (Exam 1 Q12, Exam 2 Q15). By contrast, conization IS indicated for CIN III, microinvasion (to measure exact depth in mm), Pap-biopsy disparity, or unsatisfactory colposcopy.

> **High-Yield Takeaway:** Conization is indicated for CIN 2/3, microinvasion (IA1), unsatisfactory colposcopy, or Pap-biopsy discrepancy—but CONTRAINDICATED once deeply invasive cancer is proven on biopsy!

Question 67 Gynecology Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q18 & Exam 2 Q22 | Gyn Book p.74

A 28-year-old infertile woman with PCOS develops severe Ovarian Hyperstimulation Syndrome (OHSS) 5 days after hCG trigger, presenting with tense ascites, ovaries measuring 11 cm bilaterally, hematocrit 48%, and oliguria. Which of the following is NOT used in the management of OHSS?

✓ **A. Laparoscopic ovarian drilling**

☐ **B.** Ultrasound-guided paracentesis for tense ascites/dyspnea

☐ **C.** Careful intravenous fluid and albumin resuscitation

☐ **D.** Prophylactic anticoagulation (LMWH) for thromboembolism prevention

Correct Answer: A (Laparoscopic ovarian drilling)

Explanation: In acute OHSS, the ovaries are hugely enlarged, hypervascular, and friable; surgical manipulation or laparoscopic ovarian drilling is strictly contraindicated due to life-threatening ovarian hemorrhage (unless emergency torsion/rupture occurs) (Exam 1 Q18). Ovarian drilling is an elective treatment for clomiphene-resistant anovulatory PCOS, NEVER for acute OHSS.

> **High-Yield Takeaway:** Acute OHSS management = IV fluids/albumin + LMWH thromboprophylaxis + paracentesis for tense ascites + cabergoline; NEVER perform ovarian drilling in OHSS!

Question 68 Gynecology Level 4

ACTUAL PAST EXAM — Comprehensive Bank p.114 Q26 & Patho Q865, Q879 | Gyn Book p.181, 195

A 5-year-old girl is brought to the pediatric gynecology clinic with bilateral breast enlargement (isosexual precocious pseudopuberty), vaginal bleeding, suppressed serum FSH/LH, elevated estradiol, and a solid 8 cm left ovarian mass on ultrasound. Which diagnosis is most likely?

✓ **A. Juvenile Granulosa cell tumor of the ovary**

☐ **B.** Embryonal rhabdomyosarcoma (Sarcoma botryoides) of the vagina

☐ **C.** Sertoli-Leydig cell tumor

☐ **D.** Complete hydatidiform mole

☐ **E.** Dysgerminoma

Correct Answer: A (Juvenile Granulosa cell tumor of the ovary)

Explanation: DISTINCTION TRAP: Both Juvenile Granulosa Cell Tumor and Sarcoma Botryoides can cause vaginal bleeding in a young girl (<8 yrs). However, Breast enlargement (precocious pseudopuberty) + an ovarian mass + high estradiol is classic for an estrogen-secreting Juvenile Granulosa Cell Tumor (Comp Bank p.114 Q26), whereas a grape-like polypoid mass protruding from the vagina without breast development is Sarcoma Botryoides (Embryonal rhabdomyosarcoma; Patho Q879, Q891).

> **High-Yield Takeaway:** Child with vaginal bleeding + BREAST enlargement + OVARIAN mass = Granulosa cell tumor; Child with vaginal bleeding + GRAPE-LIKE VAGINAL mass = Sarcoma botryoides (Embryonal rhabdomyosarcoma).

Question 69 Gynecology Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q51 | Gyn Book p.64, 196

A 27-year-old woman presents with a rapid onset of severe hirsutism over the past 3 months, accompanied by male-pattern temporal balding, deepening of the voice, and clitoromegaly. What is the most likely underlying etiology?

✓ **A. Androgen-secreting ovarian or adrenal tumor (e.g., Sertoli-Leydig cell tumor)**

☐ **B.** Idiopathic hirsutism

☐ **C.** Mild polycystic ovary syndrome (PCOS)

☐ **D.** Hypothyroidism

Correct Answer: A (Androgen-secreting ovarian or adrenal tumor (e.g., Sertoli-Leydig cell tumor))

Explanation: While PCOS is the most common cause of gradual hirsutism starting around puberty, a RAPID onset (<6–12 months) of severe hirsutism accompanied by frank virilization (clitoromegaly, deep voice, male muscularity, temporal balding, serum testosterone >150–200 ng/dL or DHEA-S >700 mcg/dL) is the classic red flag for an androgen-secreting neoplasm (Sertoli-Leydig cell tumor or adrenal carcinoma; Exam 1 Q51).

> **High-Yield Takeaway:** Rapid onset (<6 months) + Virilization (clitoromegaly, voice deepening) = Androgen-secreting tumor (Sertoli-Leydig / adrenal tumor), NOT PCOS!

Question 70 Gynecology Level 4

ACTUAL PAST EXAM — Comprehensive Bank p.6 Q6 | Gyn Book p.212

Among the following types of hysterectomy, which carries the highest statistical risk of intraoperative urinary bladder and ureteral injury?

✓ **A. Radical hysterectomy (Wertheim's operation) / Laparoscopic hysterectomy depending on series, vs Vaginal hysterectomy in benign series**

☐ **B.** Subtotal (supracervical) abdominal hysterectomy

☐ **C.** Hysteroscopic myomectomy

☐ **D.** Endometrial ablation

Correct Answer: A (Radical hysterectomy (Wertheim's operation) / Laparoscopic hysterectomy depending on series, vs Vaginal hysterectomy in benign series)

Explanation: In gynecologic oncology, Radical Hysterectomy (Wertheim's) carries the highest overall risk of ureteric injury because the ureter must be dissected out of the parametrial tunnel ('water under the bridge' beneath the uterine artery, 1.5 cm lateral to the internal os). Among benign hysterectomy options listed in Formative A2 2022 Q6 (vaginal vs abdominal vs supracervical vs laparoscopic), laparoscopic hysterectomy has the highest ureteral thermal/transection injury rate while supracervical has the lowest (Comp Bank p.6 Q6).

> **High-Yield Takeaway:** Anatomical trap: The ureter passes UNDER the uterine artery ('water under the bridge') 1.5 cm lateral to the supravaginal cervix—the #1 site of ureteric injury during clamping of the uterine vessels.

Question 71 Obstetrics Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q22, Exam 2 Q26 & Exam 3 Q8 | Obs Book p.99, 115

You are examining a term patient in active labor and palpate fetal facial landmarks (orbital ridges, nose, mouth, and chin). Which of the following fetal positions is INCOMPATIBLE with spontaneous vaginal delivery and mandates Cesarean section?

☐ **A.** Occiput anterior

☐ **B.** Occiput posterior

✓ **C. Mentum posterior (Persistent mento-posterior face presentation)**

☐ **D.** Occiput transverse

☐ **E.** Mentum anterior

Correct Answer: C (Mentum posterior (Persistent mento-posterior face presentation))

Explanation: In a Mentum Posterior face presentation, the fetal neck is already maximally extended against the maternal sacrum and is shorter than the anterior surface of the sacrum (12 cm); to deliver beneath the symphysis pubis, the already hyperextended neck would have to extend even further, which is anatomically impossible (Obs Book p.99). Thus, persistent mentum posterior (and brow presentation / transverse lie) cannot deliver vaginally and causes obstructed labor (Exam 1 Q22, Exam 3 Q8). By contrast, Mentum Anterior CAN deliver vaginally by flexion!

> **High-Yield Takeaway:** Mentum Anterior face presentation = vaginal delivery possible (by flexion); Mentum Posterior face presentation = IMPOSSIBLE to deliver vaginally -> mandatory Cesarean section.

Question 72 Obstetrics Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q58, Q60 & Exam 3 Q7 | Obs Book p.114

During vaginal delivery of a 4.3 kg infant of a diabetic mother, the fetal head delivers but retracts tightly against the perineum ('turtle sign'), and gentle downward traction fails to deliver the anterior shoulder (shoulder dystocia). Which of the following maneuvers is STRICTLY CONTRAINDICATED?

☐ **A.** McRoberts maneuver (sharp hyperflexion and abduction of maternal thighs)

☐ **B.** Woods' corkscrew maneuver

✓ **C. Application of firm maternal fundal pressure**

☐ **D.** Delivery of the posterior fetal arm

☐ **E.** Zavanelli maneuver (cephalic replacement followed by emergency CS)

Correct Answer: C (Application of firm maternal fundal pressure)

Explanation: TRAP ALERT: This question appeared in 3 of the 4 2026 exams (Exam 1 Q60, Exam 2 Q36, Exam 3 Q7)! In shoulder dystocia, applying fundal pressure drives the impacted anterior shoulder even harder against the maternal symphysis pubis, causing brachial plexus injury (Erb's palsy), clavicular/humeral fracture, and uterine rupture. Always use suprapubic pressure + McRoberts maneuver instead.

> **High-Yield Takeaway:** In shoulder dystocia: Suprapubic pressure + McRoberts = YES (1st line); Fundal pressure = NEVER (strictly contraindicated!).

Question 73 Obstetrics Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q4 & Exam 2 Q8 | Obs Book p.83, 112

A 31-year-old G2P1 woman at 40 weeks' gestation in spontaneous labor progresses from 5 cm to 7 cm cervical dilatation over a 2-hour period. How is her labor best classified?

☐ **A.** Prolonged latent phase

☐ **B.** Prolonged active phase (protraction disorder)

☐ **C.** Secondary arrest of active phase

✓ **D. Normal labor progression**

Correct Answer: D (Normal labor progression)

Explanation: TRAP ALERT: Many students overthink this vignette and pick 'prolonged active phase.' At >=5–6 cm, the patient is in the active phase of the first stage of labor. Progressing from 5 cm to 7 cm in 2 hours equals 1.0 cm/hour, which meets the normal active-phase dilatation threshold (>=1.0 cm/hr on the WHO partograph) (Exam 1 Q4, Exam 2 Q8).

> **High-Yield Takeaway:** 5 cm to 7 cm in 2 hours (= 1 cm/hr) is NORMAL active-phase labor! Arrest of active phase requires >=4 hours of NO cervical change at >=6 cm with adequate contractions.

Question 74 Obstetrics Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q28 & Exam 2 Q2 | Obs Book p.67

An asymptomatic pregnant woman presents for her first antenatal visit at 10 weeks' gestation. Her personal medical history and physical examination are completely unremarkable, but she reports that her sister previously suffered a calf deep vein thrombosis (DVT). How is this exact scenario keyed in your 2026 exam files?

✓ **A. In Exam 1 Q28: Test for inherited thrombophilia (vs Reassurance in Exam 2 Q2 — know both exam keys!)**

☐ **B.** Immediate therapeutic IV unfractionated heparin infusion

☐ **C.** Inferior vena cava (IVC) filter placement

☐ **D.** Immediate termination of pregnancy

Correct Answer: A (In Exam 1 Q28: Test for inherited thrombophilia (vs Reassurance in Exam 2 Q2 — know both exam keys!))

Explanation: EXAM KEY DISCREPANCY ALERT: This exact question appeared in both Exam 1 Q28 (p.9–10) and Exam 2 Q2 (p.23) of ٤ آخر امتحانات نسا ٢٠٢٦.pdf with the exact same options: A) Reassurance, B) Initiate LMWH, C) Initiate Low-Dose Aspirin, D) Test for inherited thrombophilia. In Exam 1 Q28, the marked answer key is D (Test for inherited thrombophilia because of a 1st-degree relative with VTE), whereas in Exam 2 Q2 the marked key is A (Reassurance). Neither starts LMWH or Aspirin immediately. If this question appears on your

exam, check whether the stem emphasizes screening a 1st-degree relative with unprovoked DVT (pick D: Test for inherited thrombophilia per End Round B 2026 official key).

High-Yield Takeaway: Know the exact 2026 exam key note: Sister with calf DVT in asymptomatic pregnant woman -> End Round B 2026 (Exam 1 Q28) keys 'D) Test for inherited thrombophilia' (never start LMWH/Aspirin empirically without testing/risk score).

⚠ EDITORIAL REVIEW NOTE (Known Historical Key Discrepancy): This exact question stem appeared in both End Round B 2026 Exam 1 Q28 (p.9–10) and Exam 2 Q2 (p.23) of '٢٠٢٦ امتحانات نسا ٤ آخر.pdf' with identical options: A) Reassurance, B) Initiate LMWH, C) Initiate Low-Dose Aspirin, D) Test for inherited thrombophilia. In Exam 1 Q28, the official marked key was D (Test for inherited thrombophilia due to a first-degree relative with VTE), whereas in Exam 2 Q2 the marked key was A (Reassurance). Neither key initiates empirical LMWH or Aspirin. Both historical keys are preserved transparently here so students recognize this discrepancy if the stem recurs.

Question 75 Obstetrics Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q32 | Obs Book p.155

Which of the following statements is INCORRECT (non-related) regarding puerperal pyrexia?

✓ **A. It is defined as a temperature >=38.0°C occurring at any time within 6 weeks after delivery**

☐ **B.** Puerperal endometritis is the most common infectious cause

☐ **C.** Acute breast engorgement and puerperal mastitis can cause puerperal pyrexia

☐ **D.** Prolonged rupture of membranes (PROM) and repeated vaginal exams are major risk factors

Correct Answer: A (It is defined as a temperature >=38.0°C occurring at any time within 6 weeks after delivery)

Explanation: TRAP ALERT: While the puerperium itself lasts 6 weeks (42 days), Puerperal Pyrexia is strictly defined in the textbook as a temperature of >=38.0°C (100.4°F) on any 2 of the first 10 days (or within the first 14 days) postpartum, excluding the first 24 hours (Obs Book p.155). Therefore, stating 'within 6 weeks' is the incorrect/false definition tested in Exam 1 Q32!

High-Yield Takeaway: TRAP: The puerperium lasts 6 weeks, but Puerperal Pyrexia is defined within the first 10–14 days postpartum (excluding the first 24 hours)—so 'within 6 weeks' is FALSE (Exam 1 Q32)!

Question 76 Obstetrics Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 2 Q3 | Obs Book p.58

Which of the following is NOT a risk factor that would prompt gestational diabetes mellitus (GDM) screening in a pregnant woman?

☐ **A.** Maternal BMI > 30 kg/m²

☐ **B.** Previous delivery of a macrosomic infant (>=4.0–4.5 kg)

✓ **C. Pre-existing known history of Type 2 Diabetes Mellitus**

☐ **D.** First-degree relative with diabetes mellitus

Correct Answer: C (Pre-existing known history of Type 2 Diabetes Mellitus)

Explanation: TRAP ALERT: Why is 'History of Type 2 DM' NOT an indication for *screening* for gestational diabetes (Exam 2 Q3)? Because a woman who ALREADY has known Type 2 Diabetes Mellitus has *pre-gestational (overt) diabetes*, NOT gestational diabetes—she does not undergo an OGTT screening test (which could cause severe hyperglycemia) and instead goes straight to diabetic management!

> **High-Yield Takeaway:** TRAP: Known pre-existing Type 1 or Type 2 DM is NOT screened for GDM with an OGTT—she already has pre-gestational diabetes!

Question 77 Obstetrics Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 1 Q25 & Exam 3 Q29 & Comp Bank p.88 | Obs Book p.62, 68

A pregnant woman with a mechanical prosthetic mitral valve requires therapeutic anticoagulation. Which regimen is safe for the fetus (does not cross the placenta) and recommended in the first trimester (weeks 6–12) and late third trimester?

☐ **A.** Oral Warfarin 10 mg daily throughout all three trimesters

✓ **B. Low-Molecular-Weight Heparin (LMWH) or Unfractionated Heparin (UFH)**

☐ **C.** Low-dose Aspirin monotherapy

☐ **D.** Oral Dabigatran or Rivaroxaban

Correct Answer: B (Low-Molecular-Weight Heparin (LMWH) or Unfractionated Heparin (UFH))

Explanation: Neither Unfractionated Heparin (UFH) nor Low-Molecular-Weight Heparin (LMWH) crosses the placenta, making them safe for the fetus (Exam 1 Q25, Exam 3 Q29). By contrast, Warfarin crosses the placenta and causes Warfarin embryopathy (nasal hypoplasia, stippled epiphyses) between weeks 6 and 12 and fetal intracranial hemorrhage near delivery; DOACs (Dabigatran) are contraindicated in pregnancy and mechanical valves.

> **High-Yield Takeaway:** LMWH and UFH do NOT cross the placenta (safe for fetus); Warfarin crosses the placenta (teratogenic in weeks 6–12; switch prosthetic valve patient to heparin at 6–12 wks and at 36 wks).

Question 78 Obstetrics Level 4

ACTUAL PAST EXAM — Comprehensive Bank p.105 Q45–46 | Obs Book p.54

A patient with severe preeclampsia is receiving a continuous intravenous infusion of Magnesium Sulfate (MgSO4). On hourly assessment, her patellar (knee-jerk) reflex is absent and her respiratory rate has dropped to 10 breaths/minute. What is the immediate management?

☐ **A.** Double the infusion rate of Magnesium Sulfate

✓ **B. Stop the Magnesium Sulfate infusion immediately and administer intravenous 10% Calcium Gluconate (10 mL over 10 minutes)**

☐ **C.** Administer intravenous Diazepam

☐ **D.** Administer intravenous Potassium Chloride

Correct Answer: B (Stop the Magnesium Sulfate infusion immediately and administer intravenous 10% Calcium Gluconate (10 mL over 10 minutes))

Explanation: Magnesium sulfate toxicity progresses in a strict dose-dependent sequence: loss of patellar reflexes occurs first (at 8–10 mEq/L), followed by respiratory depression (<12–16/min at >12 mEq/L), and cardiac arrest (>15–25 mEq/L). Whenever reflexes disappear or respiratory depression occurs, stop MgSO4 immediately, support ventilation/oxygen, and give the specific physiological antagonist: 10 mL of 10% Calcium Gluconate IV slowly over 10 minutes (Obs Book p.54).

> **High-Yield Takeaway:** MgSO4 toxicity: 1st sign = loss of patellar reflex; next = respiratory depression; Antidote = 10% Calcium Gluconate (10 mL IV slowly over 10 min).

Question 79 Obstetrics Level 4

ACTUAL PAST EXAM — Last 4 Exams 2026 Exam 2 Q39 & Exam 3 Q6 | Obs Book p.50, 127

What are the two most common indications for performing an emergency peripartum (postpartum) hysterectomy in modern obstetric practice?

☐ **A.** Uterine inversion and first-degree perineal tear

✓ **B. Placenta accreta spectrum (accreta/increta/percreta) and refractory uterine atony**

☐ **C.** Cervical intraepithelial neoplasia (CIN 3) and placenta circumvallata

☐ **D.** Red infarction of the placenta and mild preeclampsia

Correct Answer: B (Placenta accreta spectrum (accreta/increta/percreta) and refractory uterine atony)

Explanation: Abnormal placentation (Placenta Accreta Spectrum: accreta, increta, percreta—especially in women with placenta previa and prior Cesarean scar) and refractory uterine atony unresponsive to medical/conservative surgical measures are the top two indications for emergency postpartum hysterectomy (Exam 2 Q39, Exam 3 Q6).

> **High-Yield Takeaway:** Top 2 causes of Emergency Peripartum Hysterectomy = Placenta Accreta Spectrum (PAS) and refractory Uterine Atony.

Question 80 Gynecology Level 4

ACTUAL PAST EXAM — Comprehensive Bank p.621 Q38 & Obs Book p.36

A 26-year-old woman presents with 6 weeks of amenorrhea and mild pelvic pain. At what serum beta-hCG level ('discriminatory zone') does the absence of an intrauterine gestational sac on transvaginal ultrasound (TVUS) indicate a >90% probability of an ectopic pregnancy (or abnormal gestation)?

☐ **A.** > 50 mIU/mL

✓ **B. > 1,500 to 2,000 mIU/mL (or >6,000 mIU/mL on transabdominal ultrasound)**

☐ **C.** > 100,000 mIU/mL

☐ **D.** < 5 mIU/mL

Correct Answer: B (> 1,500 to 2,000 mIU/mL (or >6,000 mIU/mL on transabdominal ultrasound))

Explanation: The beta-hCG discriminatory zone is the threshold above which a normal intrauterine gestational sac should always be visible on ultrasound: 1,500 to 2,000 mIU/mL for Transvaginal Ultrasound (TVUS) and 6,000 to 6,500 mIU/mL for Transabdominal Ultrasound (TAUS) (Obs Book p.36; Comp Bank p.621 Q38). Empty uterus above this level strongly indicates an ectopic pregnancy.

> **High-Yield Takeaway:** Beta-hCG Discriminatory Zone: TVUS = 1,500–2,000 mIU/mL; TAUS = 6,000–6,500 mIU/mL.