COMPLETE SOLVED MASTER KEY & CLINICAL EXPLANATIONS • BSNU / KASR AL AINY 2025-2026

OB/GYN Mock Exams 1, 2 & 3 – SOLVED with Answer Keys and Explanations

Rapid 60-second correction answer key grids plus full clinical explanations, distractor rationales, textbook page citations, and verified NCBI StatPearls links for all 130 questions across Mock Exam 1 (50 MCQs), Mock Exam 2 (40 MCQs), and Mock Exam 3 (40 MCQs).

130 Solved
Complete Explanations

3 Answer Grids
60-Second Self-Grading

83 Past / 47 New
Transparent Provenance

100% Match
Matches Unsolved Booklet

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Section 1: Rapid-Correction Answer Key Grids

Mock Exam 1 (50 MCQs — Combined OB/GYN) — Quick Answer Key

Q#	Answer	Subject	Source Type	Q#	Answer	Subject	Source Type
Q1	**C**	Gynecology	Actual Past Exam	**Q26**	**A**	Obstetrics	Actual Past Exam
Q2	**B**	Obstetrics	Actual Past Exam	**Q27**	**A**	Obstetrics	Actual Past Exam

Q#	Answer	Subject	Source Type	Q#	Answer	Subject	Source Type
Q3	**D**	Gynecology	Actual Past Exam	**Q28**	**B**	Obstetrics	Actual Past Exam
Q4	**B**	Gynecology	Actual Past Exam	**Q29**	**A**	Obstetrics	Actual Past Exam
Q5	**D**	Gynecology	Actual Past Exam	**Q30**	**A**	Obstetrics	Actual Past Exam
Q6	**B**	Gynecology	Actual Past Exam	**Q31**	**C**	Gynecology	Actual Past Exam
Q7	**C**	Obstetrics	Actual Past Exam	**Q32**	**D**	Gynecology	Actual Past Exam
Q8	**B**	Gynecology	Actual Past Exam	**Q33**	**B**	Gynecology	Actual Past Exam
Q9	**C**	Gynecology	Actual Past Exam	**Q34**	**C**	Gynecology	Actual Past Exam
Q10	**C**	Obstetrics	Actual Past Exam	**Q35**	**A**	Gynecology	Actual Past Exam
Q11	**C**	Gynecology	Actual Past Exam	**Q36**	**A**	Gynecology	Actual Past Exam
Q12	**A**	Gynecology	Actual Past Exam	**Q37**	**A**	Gynecology	Actual Past Exam
Q13	**C**	Gynecology	Actual Past Exam	**Q38**	**C**	Gynecology	Actual Past Exam
Q14	**A**	Obstetrics	Actual Past Exam	**Q39**	**D**	Gynecology	Actual Past Exam

Q#	Answer	Subject	Source Type	Q#	Answer	Subject	Source Type
Q15	**C**	Gynecology	Actual Past Exam	**Q40**	**A**	Gynecology	Actual Past Exam
Q16	**B**	Obstetrics	Actual Past Exam	**Q41**	**D**	Gynecology	Actual Past Exam
Q17	**B**	Obstetrics	Actual Past Exam	**Q42**	**C**	Obstetrics	Actual Past Exam
Q18	**B**	Obstetrics	Actual Past Exam	**Q43**	**B**	Obstetrics	Actual Past Exam
Q19	**B**	Gynecology	Actual Past Exam	**Q44**	**B**	Obstetrics	Actual Past Exam
Q20	**C**	Gynecology	Actual Past Exam	**Q45**	**B**	Obstetrics	Actual Past Exam
Q21	**B**	Gynecology	Actual Past Exam	**Q46**	**A**	Obstetrics	Actual Past Exam
Q22	**C**	Gynecology	Actual Past Exam	**Q47**	**C**	Obstetrics	Actual Past Exam
Q23	**D**	Gynecology	Actual Past Exam	**Q48**	**A**	Gynecology	New Pattern-Matched
Q24	**B**	Obstetrics	Actual Past Exam	**Q49**	**A**	Obstetrics	New Pattern-Matched
Q25	**B**	Obstetrics	Actual Past Exam	**Q50**	**A**	Gynecology	New Pattern-Matched

Mock Exam 2 (40 MCQs — Final Obstetrics) — Quick Answer Key

Q#	Answer	Subject	Source Type	Q#	Answer	Subject	Source Type
Q1	**B**	Obstetrics	Actual Past Exam	**Q21**	**A**	Obstetrics	New Pattern-Matched
Q2	**B**	Obstetrics	Actual Past Exam	**Q22**	**A**	Obstetrics	New Pattern-Matched
Q3	**C**	Obstetrics	Actual Past Exam	**Q23**	**A**	Obstetrics	New Pattern-Matched
Q4	**E**	Obstetrics	Actual Past Exam	**Q24**	**A**	Obstetrics	New Pattern-Matched
Q5	**C**	Obstetrics	Actual Past Exam	**Q25**	**A**	Obstetrics	New Pattern-Matched
Q6	**A**	Obstetrics	Actual Past Exam	**Q26**	**D**	Obstetrics	New Pattern-Matched
Q7	**A**	Obstetrics	Actual Past Exam	**Q27**	**A**	Obstetrics	New Pattern-Matched
Q8	**A**	Obstetrics	Actual Past Exam	**Q28**	**A**	Obstetrics	New Pattern-Matched
Q9	**A**	Obstetrics	Actual Past Exam	**Q29**	**D**	Obstetrics	New Pattern-Matched
Q10	**A**	Obstetrics	Actual Past Exam	**Q30**	**A**	Obstetrics	New Pattern-Matched
Q11	**A**	Obstetrics	Actual Past Exam	**Q31**	**A**	Obstetrics	New Pattern-Matched

Q#	Answer	Subject	Source Type	Q#	Answer	Subject	Source Type
Q12	**B**	Obstetrics	Actual Past Exam	**Q32**	**A**	Obstetrics	New Pattern-Matched
Q13	**A**	Obstetrics	New Pattern-Matched	**Q33**	**A**	Obstetrics	New Pattern-Matched
Q14	**A**	Obstetrics	New Pattern-Matched	**Q34**	**A**	Obstetrics	New Pattern-Matched
Q15	**C**	Obstetrics	New Pattern-Matched	**Q35**	**A**	Obstetrics	New Pattern-Matched
Q16	**A**	Obstetrics	New Pattern-Matched	**Q36**	**A**	Obstetrics	New Pattern-Matched
Q17	**A**	Obstetrics	New Pattern-Matched	**Q37**	**A**	Obstetrics	New Pattern-Matched
Q18	**A**	Obstetrics	New Pattern-Matched	**Q38**	**A**	Obstetrics	New Pattern-Matched
Q19	**A**	Obstetrics	New Pattern-Matched	**Q39**	**A**	Obstetrics	New Pattern-Matched
Q20	**B**	Obstetrics	New Pattern-Matched	**Q40**	**A**	Obstetrics	New Pattern-Matched

Mock Exam 3 (40 MCQs — Final Gynecology) — Quick Answer Key

Q#	Answer	Subject	Source Type	Q#	Answer	Subject	Source Type
Q1	**D**	Gynecology	Actual Past Exam	**Q21**	**A**	Gynecology	Actual Past Exam

Q#	Answer	Subject	Source Type	Q#	Answer	Subject	Source Type
Q2	**A**	Gynecology	Actual Past Exam	**Q22**	**A**	Gynecology	Actual Past Exam
Q3	**E**	Gynecology	Actual Past Exam	**Q23**	**A**	Gynecology	Actual Past Exam
Q4	**A**	Gynecology	Actual Past Exam	**Q24**	**A**	Gynecology	Actual Past Exam
Q5	**A**	Gynecology	Actual Past Exam	**Q25**	**A**	Gynecology	New Pattern-Matched
Q6	**B**	Gynecology	Actual Past Exam	**Q26**	**A**	Gynecology	New Pattern-Matched
Q7	**A**	Gynecology	Actual Past Exam	**Q27**	**A**	Gynecology	New Pattern-Matched
Q8	**D**	Gynecology	Actual Past Exam	**Q28**	**D**	Gynecology	New Pattern-Matched
Q9	**A**	Gynecology	Actual Past Exam	**Q29**	**A**	Gynecology	New Pattern-Matched
Q10	**A**	Gynecology	Actual Past Exam	**Q30**	**A**	Gynecology	New Pattern-Matched
Q11	**B**	Gynecology	Actual Past Exam	**Q31**	**A**	Gynecology	New Pattern-Matched
Q12	**A**	Gynecology	Actual Past Exam	**Q32**	**A**	Gynecology	New Pattern-Matched
Q13	**B**	Gynecology	Actual Past Exam	**Q33**	**A**	Gynecology	New Pattern-Matched

Q#	Answer	Subject	Source Type	Q#	Answer	Subject	Source Type
Q14	**A**	Gynecology	Actual Past Exam	**Q34**	**A**	Gynecology	New Pattern-Matched
Q15	**A**	Gynecology	Actual Past Exam	**Q35**	**A**	Gynecology	New Pattern-Matched
Q16	**B**	Gynecology	Actual Past Exam	**Q36**	**A**	Gynecology	New Pattern-Matched
Q17	**B**	Gynecology	Actual Past Exam	**Q37**	**A**	Gynecology	New Pattern-Matched
Q18	**B**	Gynecology	Actual Past Exam	**Q38**	**A**	Gynecology	New Pattern-Matched
Q19	**C**	Gynecology	Actual Past Exam	**Q39**	**A**	Gynecology	New Pattern-Matched
Q20	**A**	Gynecology	Actual Past Exam	**Q40**	**A**	Gynecology	New Pattern-Matched

Section 2: Mock Exam 1 (Combined OB/GYN, 50 MCQs) — Full Solved Version

Q1. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q2 & Exam 2 Q6 | Gyn Book p.166

A 58-year-old woman develops postmenopausal bleeding. Endometrial biopsy reveals endometrioid adenocarcinoma. She undergoes total abdominal hysterectomy with bilateral salpingo-oophorectomy and pelvic lymph node sampling. Final pathology shows tumor extending from the uterine corpus into the cervical stroma, with no other invasion and negative lymph nodes. What is her FIGO stage?

☐ **A.** Stage 0

☐ **B.** Stage I

✓ **C. Stage II**

☐ **D.** Stage III

☐ **E.** Stage IV

Correct Answer: C (Stage II)

Clinical Explanation: FIGO Stage II endometrial carcinoma is defined by invasion of the cervical stroma while the tumor remains confined to the uterus with negative lymph nodes (Endometrial Cancer - StatPearls).

Q2. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q6 | Gyn Book p.46

Which of the following síndrome–karyotype pairings is NOT a true match?

☐ **A.** Patau syndrome — 47,XY,+13

✓ **B. Down syndrome — 45,XY,+21**

☐ **C.** Klinefelter syndrome — 47,XXY

☐ **D.** Turner syndrome — 45,X0

Correct Answer: B (Down syndrome — 45,XY,+21)

Clinical Explanation: Down syndrome (Trisomy 21) has 47 chromosomes (47,XY,+21 or 47,XX,+21), NOT 45 chromosomes (Exam 1 Q6).

Q3. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q7 & Final Gyn BSNU Q22 | Gyn Book p.171

A 30-year-old woman presents for her annual examination and asks about the HPV vaccine. According to standard textbook guidelines tested on the BSNU exam, for which female population was the HPV vaccine originally FDA approved?

☐ **A.** Women of all ages

☐ **B.** Only virginal women who have never had an abnormal Pap smear

☐ **C.** Men only, for prevention of female cervical cancer

✓ **D. Girls and women aged 9 to 26 years**

☐ **E.** Pregnant and lactating women

Correct Answer: D (Girls and women aged 9 to 26 years)

Clinical Explanation: The standard textbook answer keyed across Exam 1 Q7, Exam 2 Q10, and Final Gyn Q22 is girls and women aged 9 to 26 years (Cervical Cancer - StatPearls).

Q4. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q8 & Exam 2 Q11 | Gyn Book p.65

Which of the following is a recognized side effect of the 5-alpha-reductase inhibitor Finasteride?

☐ **A.** Scalp alopecia

✓ **B. Decreased libido (and teratogenicity to a male fetus)**

☐ **C.** Increased risk of benign prostatic hyperplasia

☐ **D.** Virilization of a female fetus

Correct Answer: B (Decreased libido (and teratogenicity to a male fetus))

Clinical Explanation: Finasteride inhibits 5-alpha-reductase (blocking conversion of testosterone to DHT); its classic side effect keyed in Exam 1 Q8 and Exam 2 Q11 is decreased libido (and feminization of a MALE fetus if taken during pregnancy).

Q5. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q9 & Exam 2 Q12 | Gyn Book p.67

Among the following female causes of infertility, which is most frequently encountered in clinical practice?

☐ **A.** Unexplained infertility

☐ **B.** Isolated cervical mucus hostility

☐ **C.** Tubal disease

✓ **D. Ovulatory dysfunction**

Correct Answer: D (Ovulatory dysfunction)

Clinical Explanation: Ovulatory dysfunction (including PCOS, hypothalamic/pituitary dysfunction) is the single most common female factor keyed in Exam 1 Q9 & Exam 2 Q12 (Female Infertility - StatPearls).

Q6. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q14 | Gyn Book p.35

Which progestogen has anti-mineralocorticoid and anti-androgenic properties and has been shown to be particularly effective in treating Premenstrual Syndrome (PMS / PMDD)?

☐ **A.** Desogestrel

✓ **B. Drospirenone**

☐ **C.** Levonorgestrel

☐ **D.** Medroxyprogesterone acetate

☐ **E.** Norethisterone

Correct Answer: B (Drospirenone)

Clinical Explanation: Drospirenone is a 4th-generation spironolactone-derived progestin with anti-mineralocorticoid activity that reduces bloating, breast tenderness, and mood symptoms in PMS/PMDD (Exam 1 Q14).

Q7. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q15 & Exam 2 Q19 | Obs Book p.106

Regarding umbilical cord prolapse, which of the following statements is TRUE?

☐ **A.** It is not an indication for Cesarean section when the fetus is viable at 36 weeks

☐ **B.** It is defined as cord descent when the fetal membranes are still intact

✓ **C. It is significantly more common when the fetus acquires an abnormal lie (transverse or breech)**

☐ **D.** Its overall incidence is 5% of all deliveries

☐ **E.** It causes severe fetal respiratory alkalosis

Correct Answer: C (It is significantly more common when the fetus acquires an abnormal lie (transverse or breech))

Clinical Explanation: Umbilical cord prolapse occurs when the presenting part fails to fill the lower uterine segment, making it much more common in abnormal lies (transverse lie, footling breech), polyhydramnios, and preterm fetuses (Obs Book p.106). Note: Intact membranes = cord presentation, NOT cord prolapse.

Q8. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q23 & Exam 2 Q16 | Gyn Book p.193

What is the most common presenting symptom in young patients with an ovarian germ cell tumor?

☐ **A.** Asymptomatic postmenopausal bleeding

✓ **B. Abdominal / pelvic pain**

☐ **C.** Massive chylous ascites

☐ **D.** Galactorrhea

Correct Answer: B (Abdominal / pelvic pain)

Clinical Explanation: Because ovarian germ cell tumors (teratomas, dysgerminomas, yolk sac tumors) grow rapidly or undergo torsion/hemorrhage/rupture, subacute or acute lower abdominal pain is the most common symptom (~85% of cases; Exam 1 Q23, Exam 2 Q16).

Q9. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q24 & Exam 2 Q27 | Gyn Book p.56

A 22-year-old woman presents with oligomenorrhea, hirsutism, and weight gain. Pelvic ultrasound reveals bilaterally enlarged bulky ovaries containing multiple small peripheral subcapsular follicles ('string of pearls'). What is the most likely diagnosis?

☐ **A.** Epithelial ovarian cancer

☐ **B.** Cushing syndrome

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

☐ **D.** Type 1 diabetes mellitus

☐ **E.** Pelvic inflammatory disease

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

Clinical Explanation: Oligomenorrhea + hyperandrogenism (hirsutism) + polycystic ovarian morphology (bulky ovaries with peripheral subcapsular cysts) is the classic triad of PCOS (Exam 1 Q24, Exam 2 Q27) (PCOS - StatPearls).

Q10. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q26 | Obs Book p.62

According to the modified WHO maternal cardiovascular risk classification, which cardiac condition represents Class IV (extremely high risk of maternal mortality) and is a contraindication to pregnancy?

☐ **A.** Uncomplicated atrial septal defect (ASD)

☐ **B.** Mild mitral stenosis

✓ **C. Severe pulmonary arterial hypertension (including Eisenmenger syndrome)**

☐ **D.** Repaired Tetralogy of Fallot with normal ventricular function

Correct Answer: C (Severe pulmonary arterial hypertension (including Eisenmenger syndrome))

Clinical Explanation: Severe pulmonary arterial hypertension (and Eisenmenger syndrome, severe systemic ventricular dysfunction EF <30%, or severe symptomatic aortic/mitral stenosis) is WHO Class IV (30–50% maternal mortality) and an absolute contraindication to pregnancy (Exam 1 Q26).

Q11. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q31 | Gyn Book p.64

Which of the following medications is a vasodilator that CAUSES hypertrichosis/hirsutism rather than treating it?

☐ **A.** Spironolactone

☐ **B.** Ketoconazole

✓ **C. Minoxidil**

☐ **D.** Finasteride

☐ **E.** Cyproterone acetate

Correct Answer: C (Minoxidil)

Clinical Explanation: Minoxidil (along with phenytoin, cyclosporine, diazoxide, and danazol) causes unwanted hair growth, whereas spironolactone, ketoconazole, finasteride, and cyproterone acetate are anti-androgens used to treat hirsutism (Exam 1 Q31).

Q12. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q33 & Comp Bank p.69 Q50 | Gyn Book p.48

Which of the following statements is NOT correct regarding Complete Androgen Insensitivity Syndrome (CAIS / Testicular Feminization)?

✓ **A. The patient is phenotypically male**

☐ **B.** The chromosomal karyotype is 46,XY

☐ **C.** Breast development is normal for a female

☐ **D.** End-organ androgen receptors are completely insensitive to testosterone and DHT

Correct Answer: A (The patient is phenotypically male)

Clinical Explanation: Patients with Complete Androgen Insensitivity Syndrome (46,XY) are phenotypically FEMALE (not male!) with normal female external genitalia and normal breast development (via peripheral aromatization of testosterone to estradiol), but absent uterus and scant pubic/axillary hair (Exam 1 Q33).

Q13. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q36 & Exam 2 Q31 | Gyn Book p.46

In Turner's syndrome, which of the following findings is characteristic?

☐ **A.** A chromosomal karyotype of 45,XY

☐ **B.** Secondary amenorrhea after 10 years of regular cycles is the usual presentation

✓ **C. The ovaries are represented by fibrous streaks (streak gonads)**

☐ **D.** The ovaries are enlarged and multicystic

Correct Answer: C (The ovaries are represented by fibrous streaks (streak gonads))

Clinical Explanation: Turner syndrome (45,X0) causes accelerated atresia of ovarian follicles before birth/puberty, leaving bilateral fibrous streak ovaries lacking follicles (hypergonadotropic hypogonadism; Exam 1 Q36).

Q14. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q46 & Exam 2 Q34 | Obs Book p.36

Which of the following is NOT a recognized clinical complication of a ruptured tubal ectopic pregnancy?

✓ **A. Gross hematuria**

☐ **B.** Maternal hypovolemic shock and collapse

☐ **C.** Hemoperitoneum and shoulder-tip pain

☐ **D.** Maternal death

Correct Answer: A (Gross hematuria)

Clinical Explanation: Ruptured tubal ectopic pregnancy causes intraperitoneal hemorrhage (hemoperitoneum), diaphragmatic irritation (shoulder-tip pain), syncope, and hypovolemic shock/collapse, NOT gross hematuria (Exam 1 Q46, Exam 2 Q34).

Q15. Gynecology Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q55 & Comp Bank p.95 Q34 | Gyn Book p.150

A 36-year-old woman with a 10-year history of cyclical pelvic pain and dysmenorrhea undergoes diagnostic laparoscopy, which reveals multiple 0.2 to 0.5 cm brown-black ('powder-burn') nodular lesions on the serosal surfaces of the uterus, fallopian tubes, and appendix. Biopsy of these lesions will most likely demonstrate:

☐ **A.** Metastatic signet-ring adenocarcinoma

☐ **B.** Benign mesothelial hyperplasia only

✓ **C. Endometrial glands and stroma (with hemosiderin-laden macrophages)**

☐ **D.** Caseating granulomatous inflammation

☐ **E.** Acute suppurative necrosis

Correct Answer: C (Endometrial glands and stroma (with hemosiderin-laden macrophages))

Clinical Explanation: Serosal brown 'powder-burn' pelvic nodules in a woman with chronic pelvic pain represent endometriosis, histologically defined by the presence of ectopic endometrial glands, endometrial stroma, and hemosiderin-laden macrophages (Exam 1 Q55).

Q16. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q57 | Obs Book p.29

A pregnant woman at 8 weeks' gestation undergoes transvaginal ultrasound, which reveals a gestational sac with a mean sac diameter of 25 mm inside the uterine cavity, but no yolk sac or embryonic pole is visible. What is the diagnosis?

☐ **A.** Normal viable 8-week pregnancy

✓ **B. Blighted ovum (Anembryonic pregnancy / Missed abortion)**

☐ **C.** Complete hydatidiform mole

☐ **D.** Ectopic pseudosac

Correct Answer: B (Blighted ovum (Anembryonic pregnancy / Missed abortion))

Clinical Explanation: A mean gestational sac diameter >=25 mm on transvaginal ultrasound without a visible embryo is a definitive diagnostic criterion for an anembryonic pregnancy (blighted ovum / early pregnancy loss; Exam 1 Q57).

Q17. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q58 | Obs Book p.89, 114

A primigravida has been in the second stage of labor for 3 hours with a fully dilated cervix, and the fetal head is low in the pelvis with no progress. Which of the following actions should NOT be taken?

☐ **A.** Re-assess fetal head position, station, and molding

✓ **B. Apply firm, immediate maternal fundal pressure**

☐ **C.** Change the mother's position and assess bladder fullness

☐ **D.** Evaluate eligibility for operative vaginal delivery or Cesarean section

Correct Answer: B (Apply firm, immediate maternal fundal pressure)

Clinical Explanation: Applying firm maternal fundal pressure in a prolonged second stage is strictly contraindicated because it risks uterine rupture, maternal soft-tissue trauma, and fetal neurological/orthopedic injury (Exam 1 Q58).

Q18. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — End Round B 2026 Q65 | Obs Book p.60

Regarding anemia in pregnancy, which of the following statements is CORRECT?

☐ **A.** The most common cause of anemia in pregnancy worldwide is folate deficiency

✓ **B. Iron-deficiency anemia is diagnosed when maternal hemoglobin is <11.0 g/dL in the first (and third) trimester**

☐ **C.** Maternal hemoglobin concentration remains completely unchanged throughout the third trimester

☐ **D.** Physiological anemia of pregnancy is caused by massive autoimmune RBC destruction

Correct Answer: B (Iron-deficiency anemia is diagnosed when maternal hemoglobin is <11.0 g/dL in the first (and third) trimester)

Clinical Explanation: Iron deficiency is the most common cause of anemia in pregnancy (~90%), and the WHO/CDC threshold for anemia in pregnancy is Hb <11.0 g/dL in the 1st and 3rd trimesters (and <10.5 g/dL in the 2nd trimester; Exam 1 Q65; Obs Book p.60). Physiological anemia is due to hemodilution (plasma volume increases 45–50% > RBC mass increase 20–30%), NOT hemolysis.

Q19. Gynecology Actual Past Exam ACTUAL PAST EXAM — Exam 2 Q4 | Gyn Book p.36

Which of the following secondary sexual characteristics in females is androgen-dependent (adrenarche) rather than estrogen-dependent?

☐ **A.** Breast ductal development (thelarche)

✓ **B. Pubic and axillary hair growth (pubarche)**

☐ **C.** Cornification and glycogen deposition in vaginal epithelium

☐ **D.** Growth of the uterine corpus

Correct Answer: B (Pubic and axillary hair growth (pubarche))

Clinical Explanation: Growth of pubic and axillary hair (pubarche) is stimulated by adrenal and ovarian androgens (DHEA/DHEA-S and testosterone), whereas breast development, vaginal epithelial maturation, and uterine growth are estrogen-dependent (Exam 2 Q4).

Q20. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Exam 2 Q40 | Gyn Book p.33, 186

A 16-year-old G0P0 girl presents with delayed menses, sudden-onset severe unilateral lower abdominal pain, syncope, a negative pregnancy test, hematocrit 42%, and normal WBC count (6,000/mm³). Among the following, what is the most likely acute gynecological diagnosis?

☐ **A.** Ruptured ectopic pregnancy

☐ **B.** Acute pelvic inflammatory disease (PID)

✓ **C. Torsion/rupture of an ovarian cyst (or obstructive Müllerian anomaly / endometriosis)**

☐ **D.** Septic abortion

Correct Answer: C (Torsion/rupture of an ovarian cyst (or obstructive Müllerian anomaly / endometriosis))

Clinical Explanation: A negative pregnancy test rules out ectopic pregnancy and septic abortion, and a normal WBC count without fever argues against acute PID, leaving an acute adnexal/ovarian cyst torsion or endometriosis/outflow event (Exam 2 Q40).

Q21. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Exam 2 Q42 & Patho Q815 | Gyn Book p.180

Which of the following vulvar lesions is an intraepidermal adenocarcinoma that can be associated with an underlying or distant primary visceral malignancy (such as breast, colon, or bladder cancer)?

☐ **A.** Vulvar lichen planus

✓ **B. Extramammary Paget disease of the vulva**

☐ **C.** Lichen sclerosus

☐ **D.** Condyloma acuminatum

Correct Answer: B (Extramammary Paget disease of the vulva)

Clinical Explanation: Extramammary Paget disease of the vulva presents as an eczematous, red, crusted pruritic plaque and is associated with an underlying adnexal or distant primary internal malignancy (breast, GI, or urinary tract) in 15–25% of patients (Exam 2 Q42; Gyn Book p.180).

Q22. Gynecology Actual Past Exam ACTUAL PAST EXAM — Exam 2 Q43 | Gyn Book p.191

What is the most common site of metastasis from epithelial ovarian carcinoma?

☐ **A.** Brain parenchyma

☐ **B.** Bone marrow

✓ **C. Peritoneum (transcoelomic peritoneal surfaces and omentum)**

☐ **D.** Spleen

☐ **E.** Vaginal introitus

Correct Answer: C (Peritoneum (transcoelomic peritoneal surfaces and omentum))

Clinical Explanation: Epithelial ovarian cancer spreads primarily by direct exfoliation of malignant cells into the peritoneal fluid (transcoelomic dissemination), making the pelvic and abdominal peritoneum and omentum the #1 site of metastasis (Exam 2 Q43).

Q23. Gynecology Actual Past Exam ACTUAL PAST EXAM — Exam 2 Q44 | Gyn Book p.208

A 56-year-old woman undergoes a total abdominal hysterectomy (TAH) for a large fibroid uterus. Which of the following measures is an essential component of the Enhanced Recovery After Surgery (ERAS) and perioperative safety protocol?

☐ **A.** Strict NPO for solid and clear fluids for 24 hours prior to surgery

☐ **B.** Routine use of long-acting sedative premedication

☐ **C.** Administering prophylactic antibiotics only 12 hours after skin closure

✓ **D. Perioperative venous thromboprophylaxis (and early mobilization)**

Correct Answer: D (Perioperative venous thromboprophylaxis (and early mobilization))

Clinical Explanation: Venous thromboprophylaxis (compression stockings + LMWH), early mobilization, pre-incision antibiotic prophylaxis (within 60 min before incision), avoidance of fluid overload, and allowing clear fluids up to 2 hours pre-op are core ERAS pillars (Exam 2 Q44).

Q24. Obstetrics | Actual Past Exam — ACTUAL PAST EXAM — Exam 3 Q15 | Obs Book p.96

Which of the following fetal or maternal factors indicates a poorer prognosis for a rapid, uncomplicated spontaneous vaginal delivery?

☐ **A.** Estimated fetal weight of 2.8 kg

✓ **B. Persistent occipito-posterior (OP) position**

☐ **C.** Maternal gynecoid pelvis

☐ **D.** Well-flexed fetal head

Correct Answer: B (Persistent occipito-posterior (OP) position)

Clinical Explanation: Occipito-posterior (OP) malposition presents a larger anteroposterior cephalic diameter (occipitofrontal 11.5 cm instead of suboccipitobregmatic 9.5 cm), leading to prolonged labor, deflexion, delayed engagement, and higher operative delivery rates (Exam 3 Q15; Obs Book p.96).

Q25. Obstetrics | Actual Past Exam — ACTUAL PAST EXAM — Exam 3 Q20 | Obs Book p.44

A pregnant woman at 34 weeks' gestation with blood pressure 155/100 mmHg and 2+ proteinuria develops sudden, severe, continuous abdominal pain and dark vaginal bleeding. What is the most likely diagnosis?

☐ **A.** Vasa previa

✓ **B. Placental abruption (Abruptio placentae)**

☐ **C.** Placenta previa

☐ **D.** Cervical ectropion

Correct Answer: B (Placental abruption (Abruptio placentae))

Clinical Explanation: Preeclampsia/hypertension is the leading medical cause of placental abruption (accidental hemorrhage), which presents with sudden painful vaginal bleeding and a tender, hypertonic uterus (Exam 3 Q20) (Placental Abruption - StatPearls).

Q26. Obstetrics | Actual Past Exam — ACTUAL PAST EXAM — Exam 3 Q22 | Obs Book p.82

Which of the following is one of the classic '5 Ps' governing the outcome of labor?

✓ **A. Passenger (fetus: size, lie, presentation, attitude, position)**

☐ **B.** Placental cotyledon count

☐ **C.** Prolactin concentration

☐ **D.** Puerperal lochia

Correct Answer: A (Passenger (fetus: size, lie, presentation, attitude, position))

Clinical Explanation: The 5 Ps of labor are: Passenger (fetus/placenta), Passageway (bony pelvis & soft tissues), Powers (uterine contractions & maternal pushing), Position of the mother, and Psyche (psychological state) (Exam 3 Q22).

Q27. Obstetrics Actual Past Exam ACTUAL PAST EXAM — Exam 3 Q25 | Obs Book p.85

In normal vertex (occipito-anterior) labor, the cardinal movements of the mechanism of labor occur in which chronological sequence?

✓ **A. Descent, engagement, increased flexion, internal rotation, extension, restitution and external rotation**

☐ **B.** Extension, internal rotation, flexion, engagement, descent

☐ **C.** External rotation, internal rotation, extension, flexion

☐ **D.** Engagement, extension, internal rotation, flexion

Correct Answer: A (Descent, engagement, increased flexion, internal rotation, extension, restitution and external rotation)

Clinical Explanation: The classic mechanism of normal OA labor is: Descent -> Engagement -> Increased Flexion -> Internal Rotation (occiput rotates 1/8 circle anteriorly to symphysis pubis) -> Extension (delivery of head) -> Restitution & External Rotation -> Expulsion of shoulders (Exam 3 Q25; Obs Book p.85).

Q28. Obstetrics Actual Past Exam ACTUAL PAST EXAM — Exam 3 Q26 | Obs Book p.166

Which of the following is a mandatory prerequisite before performing any instrumental (forceps or vacuum) vaginal delivery?

☐ **A.** Cervix dilated to at least 7 cm

✓ **B. Fully dilated cervix (10 cm)**

☐ **C.** Unengaged floating fetal head at -3 station

☐ **D.** Intact amniotic membranes

Correct Answer: B (Fully dilated cervix (10 cm))

Clinical Explanation: Full cervical dilatation (10 cm), ruptured membranes, engaged fetal head (at least 0/+1 station), known fetal position, empty bladder, and no CPD are mandatory prerequisites for forceps or vacuum delivery (Exam 3 Q26; Obs Book p.166).

Q29. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Exam 3 Q27 | Obs Book p.58, 145

What is the most common fetal/neonatal complication of poorly controlled maternal diabetes mellitus during pregnancy?

✓ **A. Fetal macrosomia (and subsequent shoulder dystocia / neonatal hypoglycemia)**

☐ **B.** Accelerated early fetal lung surfactant maturation

☐ **C.** Universal severe intrauterine growth restriction in 100% of cases

☐ **D.** Neonatal hypercalcemia

Correct Answer: A (Fetal macrosomia (and subsequent shoulder dystocia / neonatal hypoglycemia))

Clinical Explanation: Maternal hyperglycemia crosses the placenta and induces fetal pancreatic beta-cell hyperplasia and hyperinsulinemia, which acts as a potent growth factor causing fetal macrosomia, organomegaly, delayed lung surfactant maturation (RDS), and neonatal hypoglycemia/hypocalcemia (Exam 3 Q27; Obs Book p.58).

Q30. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Exam 3 Q28 | Obs Book p.116, 119

What is a major life-threatening maternal complication of neglected, prolonged obstructed labor in a multiparous woman?

✓ **A. Ruptured uterus (and vesicovaginal fistula / puerperal sepsis)**

☐ **B.** Physiological third-stage shortening

☐ **C.** Twin-to-twin transfusion

☐ **D.** Molar degeneration

Correct Answer: A (Ruptured uterus (and vesicovaginal fistula / puerperal sepsis))

Clinical Explanation: In neglected obstructed labor (especially in multiparous women), the lower uterine segment stretches progressively until Bandl's pathological retraction ring forms

and the uterus ruptures (Exam 3 Q28; Obs Book p.119).

Q31. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q2 | Gyn Book p.168

What is the most common presenting symptom of uterine sarcoma (including leiomyosarcoma and endometrial stromal sarcoma)?

☐ **A.** Primary infertility

☐ **B.** Acute dyspnea

✓ **C. Abnormal uterine bleeding (or postmenopausal bleeding)**

☐ **D.** Abnormal routine cervical Pap smear

Correct Answer: C (Abnormal uterine bleeding (or postmenopausal bleeding))

Clinical Explanation: Abnormal uterine bleeding (menorrhagia in premenopausal women or postmenopausal bleeding) is the most common symptom of uterine sarcoma (>75% of cases; Final Gyn Q2; Gyn Book p.168).

Q32. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q4 | Gyn Book p.19, 47

A 16-year-old girl presents with primary amenorrhea. Examination reveals normal secondary female sexual characteristics (breasts and pubic hair) but a short, blind-ending vaginal pouch. Ultrasound shows normal ovaries and an absent uterus, and karyotyping confirms 46,XX. What is her diagnosis?

☐ **A.** 5-alpha-reductase type 2 deficiency

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

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

✓ **D. Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome (Müllerian agenesis)**

Correct Answer: D (Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome (Müllerian agenesis))

Clinical Explanation: MRKH syndrome (congenital absence of the Müllerian ducts) presents with primary amenorrhea, normal 46,XX karyotype, normal functioning ovaries, normal breasts and pubic/axillary hair, an absent/rudimentary uterus, and a blind vagina (Final Gyn Q4).

Q33. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q7 | Gyn Book p.68

Tubal scarring and occlusion, a major cause of female infertility, are most frequently the result of which of the following conditions?

☐ **A.** Adenomyosis

✓ **B. Pelvic Inflammatory Disease (PID)**

☐ **C.** Subserosal uterine fibroids

☐ **D.** Asherman syndrome

Correct Answer: B (Pelvic Inflammatory Disease (PID))

Clinical Explanation: Post-infectious salpingitis from Pelvic Inflammatory Disease (most commonly Chlamydia trachomatis and Neisseria gonorrhoeae) is the #1 cause of tubal factor infertility and ectopic pregnancy worldwide (Final Gyn Q7).

Q34. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q11 | Gyn Book p.166, 174

The presence of pyometra (pus accumulating inside the uterine cavity) in a postmenopausal female strongly suggests:

☐ **A.** Uncomplicated gestational diabetes

☐ **B.** Simple functional follicular cyst

✓ **C. Gynecological malignancy (cervical or endometrial carcinoma obstructing the cervical canal)**

☐ **D.** Normal physiological menopause

Correct Answer: C (Gynecological malignancy (cervical or endometrial carcinoma obstructing the cervical canal))

Clinical Explanation: In a postmenopausal woman, pyometra is considered malignant (endometrial or endocervical carcinoma causing cervical stenosis and necrosis) until proven otherwise by drainage and fractional curettage/hysteroscopy (Final Gyn Q11).

Q35. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q15 | Gyn Book p.102

Which clinical triad represents the minimum diagnostic criteria that must be present on pelvic examination to make a clinical diagnosis of acute Pelvic Inflammatory Disease (PID)?

✓ **A. Lower abdominal tenderness, bilateral adnexal tenderness, and cervical motion tenderness (excitation)**

☐ **B.** Temperature >40°C, tubo-ovarian abscess on MRI, and ascites

☐ **C.** Dysuria, hematuria, and flank pain

☐ **D.** Vaginal itching, curdy white discharge, and normal cervix

Correct Answer: A (Lower abdominal tenderness, bilateral adnexal tenderness, and cervical motion tenderness (excitation))

Clinical Explanation: The minimum clinical diagnostic criteria for acute PID (CDC / textbook) are lower abdominal pain/tenderness, adnexal tenderness, and cervical motion tenderness (cervical excitation) (Final Gyn Q15; Gyn Book p.102).

Q36. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q17 | Gyn Book p.49

Secondary amenorrhea, estrogen deficiency, and markedly elevated circulating gonadotropin (FSH/LH) levels are noted in a normal-appearing 27-year-old woman (Premature Ovarian Insufficiency). Which of the following is most closely associated with these findings?

✓ **A. X chromosome abnormalities (e.g., mosaicism or Fragile X premutation)**

☐ **B.** Kallmann syndrome

☐ **C.** Sheehan syndrome

☐ **D.** Polycystic ovary syndrome

Correct Answer: A (X chromosome abnormalities (e.g., mosaicism or Fragile X premutation))

Clinical Explanation: Premature Ovarian Insufficiency (hypergonadotropic hypogonadism before age 40) is most closely linked to X-chromosome abnormalities (45,X/46,XX mosaicism, X deletions, or FMR1 Fragile X premutation) or autoimmune oophoritis (Final Gyn Q17). Kallmann and Sheehan cause LOW gonadotropins.

Q37. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q21 | Gyn Book p.177

Early-stage invasive carcinoma of the cervix diagnosed during the first trimester of pregnancy can be treated by:

✓ **A. Radical hysterectomy (with pelvic lymphadenectomy) in the first trimester**

☐ **B.** Delaying all evaluation until 1 year postpartum

☐ **C.** Simple endometrial curettage

☐ **D.** Oral progestogen therapy alone

Correct Answer: A (Radical hysterectomy (with pelvic lymphadenectomy) in the first trimester)

Clinical Explanation: In the first trimester (or early second trimester), early-stage invasive cervical cancer (Stage IA2–IB/IIA) is treated without delay via Radical Hysterectomy (with fetus in situ) and bilateral pelvic lymphadenectomy (or external beam radiotherapy which induces spontaneous abortion) (Final Gyn Q21; Gyn Book p.177).

Q38. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q23 | Gyn Book p.37

A 7-year-old girl presents with isolated unilateral/bilateral breast budding, but she has no pubic hair, no axillary hair, no vaginal bleeding, and her bone age is completely normal for her chronological age. What is the most likely diagnosis?

☐ **A.** True central precocious puberty

☐ **B.** McCune-Albright syndrome

✓ **C. Benign premature thelarche**

☐ **D.** Congenital adrenal hyperplasia

Correct Answer: C (Benign premature thelarche)

Clinical Explanation: Isolated breast development before age 8 without any other signs of puberty (no pubarche/menarche) and with normal linear growth and normal bone age is benign Premature Thelarche, which requires reassurance and follow-up only (Final Gyn Q23).

Q39. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q26 | Gyn Book p.155

Regarding pruritus vulvae, which of the following statements is CORRECT?

☐ **A.** Radical vulvectomy is the first-line treatment in all cases

☐ **B.** Topical hydrocortisone is always contraindicated

☐ **C.** Recurrent symptoms never occur

✓ **D. It is common after menopause (due to hypoestrogenic atrophy and vulvar dermatoses)**

Correct Answer: D (It is common after menopause (due to hypoestrogenic atrophy and vulvar dermatoses))

Clinical Explanation: Pruritus vulvae is very common after menopause due to estrogen deficiency (atrophic vulvovaginitis), lichen sclerosus, candidiasis/diabetes, or VIN (Final Gyn Q26; Gyn Book p.155).

Q40. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q29 | Gyn Book p.166, 205

Which of the following statements is CORRECT regarding postmenopausal bleeding (PMB)?

✓ **A. Diagnostic hysteroscopy (with biopsy) is a highly useful diagnostic tool**

☐ **B.** The single most common cause of bleeding is endometrial carcinoma

☐ **C.** Transvaginal sonographic measurement of endometrial thickness has no clinical value

☐ **D.** Benign causes of postmenopausal bleeding are extremely rare

Correct Answer: A (Diagnostic hysteroscopy (with biopsy) is a highly useful diagnostic tool)

Clinical Explanation: Hysteroscopy allows direct visual inspection of the uterine cavity and targeted biopsy of focal polyps, hyperplasia, or carcinoma in postmenopausal bleeding (Final Gyn Q29). Remember: the most common cause of PMB is benign endometrial atrophy (~60–80%), and TVUS endometrial thickness (<=4 mm cutoff) is the standard initial triage test.

Q41. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Final Gyn BSNU Q30 | Gyn Book p.142

A 32-year-old asymptomatic woman has a firm uterine nodule first palpated 3 years ago that has slowly doubled in size on routine pelvic exam. What is the most likely diagnosis?

☐ **A.** Endometrial adenocarcinoma

☐ **B.** Uterine leiomyosarcoma

☐ **C.** Embryonal rhabdomyosarcoma

✓ **D. Uterine leiomyoma (fibroid)**

Correct Answer: D (Uterine leiomyoma (fibroid))

Clinical Explanation: A slow-growing, firm, benign myometrial nodule in an asymptomatic 32-year-old woman is a classic uterine leiomyoma (fibroid) (Final Gyn Q30).

Q42. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comprehensive Bank p.101 Q27 | Gyn Book p.11

From which vascular trunk does the uterine artery directly arise?

☐ **A.** Abdominal aorta

☐ **B.** External iliac artery

✓ **C. Anterior division of the internal iliac (hypogastric) artery**

☐ **D.** Posterior division of the internal iliac artery

☐ **E.** Inferior mesenteric artery

Correct Answer: C (Anterior division of the internal iliac (hypogastric) artery)

Clinical Explanation: The uterine artery arises from the anterior division of the internal iliac (hypogastric) artery, runs medially in the base of the broad ligament, and crosses ABOVE (anterior/superior to) the ureter 1.5 cm lateral to the cervical fornix (Comp Bank p.101 Q27; Gyn Book p.11).

Q43. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comprehensive Bank p.106 Q52 | Obs Book p.11

Supine hypotensive syndrome in late pregnancy is caused by compression of which structure by the gravid uterus when the mother lies flat on her back?

☐ **A.** Descending thoracic aorta

✓ **B. Inferior vena cava (IVC)**

☐ **C.** Portal vein

☐ **D.** Internal iliac artery

Correct Answer: B (Inferior vena cava (IVC))

Clinical Explanation: In the third trimester, lying flat in the supine position causes the heavy gravid uterus to compress the Inferior Vena Cava (IVC), sharply reducing venous return, cardiac output, and maternal blood pressure (relieved immediately by turning the patient into the left lateral position; Obs Book p.11).

Q44. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comprehensive Bank p.181 Q47 | Obs Book p.58

What is the most specific (pathognomonic) fetal congenital anomaly associated with poorly controlled pregestational diabetes mellitus?

☐ **A.** Ventricular septal defect (VSD)

✓ **B. Caudal regression syndrome (sacral agenesis)**

☐ **C.** Pyloric stenosis

☐ **D.** Duodenal atresia

Correct Answer: B (Caudal regression syndrome (sacral agenesis))

Clinical Explanation: Watch the wording carefully: Caudal regression syndrome (sacral agenesis) is the MOST SPECIFIC anomaly for maternal pregestational diabetes (200–400x more frequent in diabetics; Comp Bank p.181 Q47), whereas congenital heart defects (VSD/TGA) and neural tube defects are the MOST COMMON anomalies numerically!

Q45. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Al-Dhayani Book55 Q8, Q19 | Obs Book p.9, 140

In the second half of pregnancy (after 20 weeks), amniotic fluid is predominantly produced by:

☐ **A.** Maternal plasma transudation across the amnion

✓ **B. Fetal urination (and swallowed by the fetus)**

☐ **C.** Wharton's jelly secretion

☐ **D.** Syncytiotrophoblast pinocytosis

Correct Answer: B (Fetal urination (and swallowed by the fetus))

Clinical Explanation: After 16–20 weeks (once fetal kidneys keratinize fetal skin), amniotic fluid is produced primarily by fetal urination (and lung fluid) and removed by fetal swallowing (Book55 Q19; Obs Book p.9). Thus, bilateral renal agenesis (Potter syndrome) or posterior urethral valves causes severe oligohydramnios, whereas fetal esophageal/duodenal atresia or anencephaly causes polyhydramnios!

Q46. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Al-Dhayani Book55 Q9, Q10, Q27 | Obs Book p.22

Which ultrasound biometric parameter is the MOST ACCURATE for determining gestational age in the first trimester (up to 13 weeks), versus the best single head parameter in the second trimester (14–20 weeks)?

✓ **A. 1st trimester: Crown-Rump Length (CRL) (+/- 3–5 days); 2nd trimester: Biparietal Diameter (BPD)**

☐ **B.** 1st trimester: Femur Length (FL); 2nd trimester: Crown-Rump Length (CRL)

☐ **C.** 1st trimester: Abdominal Circumference (AC); 2nd trimester: Yolk sac diameter

☐ **D.** 1st trimester: Placental thickness; 2nd trimester: Amniotic fluid index

Correct Answer: A (1st trimester: Crown-Rump Length (CRL) (+/- 3–5 days); 2nd trimester: Biparietal Diameter (BPD))

Clinical Explanation: Crown-Rump Length (CRL) in the first trimester (7–13 weeks) is the most accurate method of dating pregnancy overall (+/- 3–5 days), and CRL is NOT used in the mid-trimester (Book55 Q27). In the second trimester (14–20 weeks), Biparietal Diameter (BPD) and Head Circumference (HC) are most accurate for dating, while Abdominal Circumference (AC) is the most sensitive parameter for fetal growth restriction (IUGR) and macrosomia.

Q47. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Al-Dhayani Book55 Q72 | Obs Book p.108

Trial of vaginal delivery may be considered in all of the following obstetric scenarios EXCEPT:

☐ **A.** Low-lying placenta (>2 cm from internal os)

☐ **B.** Dichorionic twin pregnancy with first twin cephalic and second twin breech

✓ **C. Monochorionic monoamniotic (MCMA) twins (or central placenta previa / transverse lie)**

☐ **D.** Dichorionic twin pregnancy with both twins cephalic (vertex-vertex)

Correct Answer: C (Monochorionic monoamniotic (MCMA) twins (or central placenta previa / transverse lie))

Clinical Explanation: Monochorionic monoamniotic (MCMA) twins share a single amniotic sac with no dividing membrane, carrying a very high risk of cord entanglement and interlocking twins; they require elective Cesarean delivery at 32–34 weeks (Book55 Q72; Obs Book p.109).

Q48. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.93–99: Vaginal Discharge Differential

A 26-year-old woman presents with a thin, homogeneous, greyish-white vaginal discharge with a strong 'fishy' amine odor when mixed with 10% KOH (positive whiff test), vaginal pH of 5.2, and 'clue cells' on saline wet mount. There is no vulvar inflammation. What is the diagnosis and first-line treatment?

✓ **A. Bacterial vaginosis (Gardnerella vaginalis) — Oral or topical Metronidazole**

☐ **B.** Vulvovaginal candidiasis (Candida albicans) — Fluconazole

☐ **C.** Trichomoniasis (Trichomonas vaginalis) — Clotrimazole

☐ **D.** Physiological leukorrhea — Reassurance

Correct Answer: A (Bacterial vaginosis (Gardnerella vaginalis) — Oral or topical Metronidazole)

Clinical Explanation: Greyish-white homogeneous discharge + fishy odor with 10% KOH (whiff test) + pH >4.5 + stippled epithelial 'clue cells' on wet mount defines Bacterial Vaginosis (Amsel's criteria; Gyn Book p.94), treated with Metronidazole or Clindamycin. Remember: Trichomonas has frothy yellow-green discharge, strawberry cervix, motile flagellates, pH >4.5 (also treated with Metronidazole for patient AND partner); Candida has thick curdy white discharge, intense pruritus, normal acidic pH (4.0–4.5), and pseudohyphae.

Q49. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.70–72: Rh Isoimmunization

An Rh-negative, indirect Coombs-negative (non-sensitized) primigravida is at 28 weeks' gestation. Her husband is Rh-positive. What is the standard prophylactic management to prevent RhD alloimmunization?

✓ **A. Administer 300 mcg (1500 IU) of Anti-D immunoglobulin IM at 28 weeks' gestation, and repeat within 72 hours after delivery if the newborn is Rh-positive**

☐ **B.** Perform serial amniocentesis every 2 weeks starting at 20 weeks

☐ **C.** Administer Anti-D immunoglobulin only if the indirect Coombs test is strongly positive (>1:64)

☐ **D.** Perform immediate Cesarean section at 32 weeks

Correct Answer: A (Administer 300 mcg (1500 IU) of Anti-D immunoglobulin IM at 28 weeks' gestation, and repeat within 72 hours after delivery if the newborn is Rh-positive)

Clinical Explanation: Routine antenatal Anti-D prophylaxis (300 mcg IM at 28 weeks) plus postpartum Anti-D (300 mcg IM within 72 hours of delivery of an Rh-positive infant, quantified by Kleihauer-Betke test if massive fetomaternal hemorrhage is suspected) prevents sensitization in >99% of Rh-negative unsensitized mothers (Hemolytic Disease of the Fetus and Newborn - StatPearls). Once a mother is already sensitized (Indirect Coombs positive), Anti-D IgG is useless and fetal anemia is monitored via Middle Cerebral Artery Peak Systolic Velocity (MCA-PSV) Doppler!

Q50. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.125–130: Stress vs Urge Urinary Incontinence

A 52-year-old woman complains of sudden, compelling urges to void followed by involuntary loss of large volumes of urine before she can reach the bathroom, accompanied by nocturia and frequency (12 times/day). Stress cough test is negative, and urodynamic cystometry demonstrates involuntary detrusor contractions during bladder filling. What is her diagnosis and first-line medical therapy?

✓ **A. Detrusor overactivity (Urge urinary incontinence / Overactive bladder) — Bladder training + Antimuscarinics (Oxybutynin, Solifenacin, Tolterodine) or Beta-3 agonist (Mirabegron)**

☐ **B.** Genuine stress urinary incontinence — Immediate tension-free vaginal tape (TVT) surgery

☐ **C.** Overflow incontinence — Intravesical botulinum toxin

☐ **D.** Vesicovaginal fistula — Oral estrogen

Correct Answer: A (Detrusor overactivity (Urge urinary incontinence / Overactive bladder) — Bladder training + Antimuscarinics (Oxybutynin, Solifenacin, Tolterodine) or Beta-3 agonist (Mirabegron))

Clinical Explanation: Urgency + urge incontinence + frequency + nocturia with involuntary detrusor contractions during filling cystometry defines Detrusor Overactivity (Urge Incontinence; Gyn Book p.128). First-line management is behavioral bladder training + antimuscarinic drugs (Oxybutynin, Tolterodine, Solifenacin, Trospium) or Beta-3 agonist (Mirabegron). Surgery (TVT/TOT colposuspension) is for Stress Incontinence, NOT urge incontinence!

Section 3: Mock Exam 2 (Final Obstetrics, 40 MCQs) — Full Solved Version

Q1. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.109 Formative A2 2025 Q1 | Obs Book p.154

A 22-year-old breastfeeding woman who delivered 6 weeks ago presents requesting reliable oral hormonal contraception. Which contraceptive option is preferred so as not to reduce breast milk volume?

☐ **A.** High-dose combined oral contraceptive pill (50 mcg ethinyl estradiol)

✓ **B. Progestin-only pill (Mini-pill, e.g., Norethindrone/Desogestrel) or Lactational Amenorrhea / IUD**

☐ **C.** Estrogen dermal patch

☐ **D.** Combined vaginal ring

Correct Answer: B (Progestin-only pill (Mini-pill, e.g., Norethindrone/Desogestrel) or Lactational Amenorrhea / IUD)

Clinical Explanation: Estrogen suppresses prolactin action and decreases breast milk quantity/quality; therefore, progestin-only methods (progestin-only mini-pill, implant, DMPA) or non-hormonal IUDs are preferred in breastfeeding women (Oral Contraceptive Pills - StatPearls).

Q2. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.5 Q50 | Obs Book p.29

A 30-year-old primigravida at 20 weeks' gestation presents with mild lower abdominal pressure and no fever. Speculum/PV exam reveals a dilated cervix with membranes bulging through the external os, and TVUS shows a cervical length of 1.5 cm with hourly funneling/herniation of membranes. What is the diagnosis?

☐ **A.** Threatened abortion

✓ **B. Inevitable abortion (secondary to cervical incompetence)**

☐ **C.** Missed abortion

☐ **D.** Septic abortion

☐ **E.** Complete abortion

Correct Answer: B (Inevitable abortion (secondary to cervical incompetence))

Clinical Explanation: Dilatation of the cervix with herniation/bulging of the fetal membranes into the cervical canal and vagina makes the abortion Inevitable (Comp Bank p.5 Q50; Obs Book p.29).

Q3. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.11 Q4 | Obs Book p.124

Which of the following is characteristic of primary postpartum hemorrhage (PPH)?

☐ **A.** It occurs between 7 and 42 days after delivery

☐ **B.** It is rarely caused by uterine inertia (atony)

✓ **C. It occurs within the first 24 hours after delivery (beginning from the third stage of labor)**

☐ **D.** It is most commonly caused by choriocarcinoma

☐ **E.** It is defined as blood loss >100 mL after Cesarean section

Correct Answer: C (It occurs within the first 24 hours after delivery (beginning from the third stage of labor))

Clinical Explanation: Primary PPH is defined as excessive bleeding (>=500 mL vaginal / >=1000 mL CS) occurring during the third stage of labor or within the first 24 hours after delivery, and is caused in 80% of cases by uterine atony/inertia (Comp Bank p.11 Q4; Obs Book p.124). Secondary PPH occurs from 24 hours up to 6–12 weeks postpartum (most commonly due to retained placental fragments and endometritis).

Q4. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.99 Q16 | Obs Book p.30

Which of the following is LEAST likely to be a direct complication of septic abortion?

☐ **A.** Disseminated intravascular coagulation (DIC)

☐ **B.** Acute renal failure (acute tubular/cortical necrosis)

☐ **C.** Endotoxic septic shock

☐ **D.** Asherman syndrome and tubal infertility

✓ **E. Placenta previa in the current pregnancy**

Correct Answer: E (Placenta previa in the current pregnancy)

Clinical Explanation: Septic abortion causes endotoxic shock (Clostridium perfringens / E. coli), DIC, acute renal failure, peritonitis, and long-term Asherman syndrome/infertility (Obs Book p.30).

Q5. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.108 & Exam 3 Q8 | Obs Book p.115

Regarding obstructed labor, which of the following statements is CORRECT?

☐ **A.** It can only be diagnosed after the cervix reaches 10 cm dilatation

☐ **B.** It is much more common in developed countries than developing countries

✓ **C. Persistent mento-posterior (face) position or brow presentation can be an etiological cause**

☐ **D.** Intravenous oxytocin infusion is the first-line treatment in a multipara with obstructed labor

☐ **E.** X-ray pelvimetry is mandatory during active obstructed labor

Correct Answer: C (Persistent mento-posterior (face) position or brow presentation can be an etiological cause)

Clinical Explanation: Obstructed labor occurs when there is no further progress of the presenting part despite strong uterine contractions due to a mechanical barrier (CPD, contracted pelvis, persistent mento-posterior face, brow, shoulder presentation/transverse lie, or fetal hydrocephalus) (Exam 3 Q8; Obs Book p.115).

Q6. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.113 Q21 | Obs Book p.94

Which of the following modalities is most widely used for continuous intrapartum assessment of fetal wellbeing during high-risk labor?

✓ **A. Cardiotocography (CTG / Electronic Fetal Heart Rate Monitoring)**

☐ **B.** First-trimester Crown-Rump Length

☐ **C.** Maternal serum alpha-fetoprotein (MSAFP)

☐ **D.** Hysterosalpingography

Correct Answer: A (Cardiotocography (CTG / Electronic Fetal Heart Rate Monitoring))

Clinical Explanation: Continuous electronic fetal heart rate monitoring (Cardiotocography / CTG) assessing baseline FHR (110–160 bpm), beat-to-beat variability (5–25 bpm), accelerations, and decelerations (early, variable, late) is the standard intrapartum surveillance tool (Obs Book p.94).

Q7. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.89 Q15 | Obs Book p.34

Among the following anatomic locations, which is the MOST COMMON site of an ectopic pregnancy (~95–97%), and which specific tubal segment is the most frequent (~70–80%)?

✓ **A. Fallopian tube — Ampullary portion**

☐ **B.** Fallopian tube — Interstitial/Cornual portion

☐ **C.** Ovary

☐ **D.** Cervix

☐ **E.** Peritoneal cavity (Abdominal)

Correct Answer: A (Fallopian tube — Ampullary portion)

Clinical Explanation: 95–97% of ectopic pregnancies implant in the Fallopian tube, and within the tube the Ampulla is the most common site (~70–80%), followed by the Isthmus (~12%, ruptures earliest at 6–8 wks), Fimbria (~5%), and Interstitial/Cornual (~2%, ruptures latest at 12–16 wks with catastrophic hemorrhage) (Ectopic Pregnancy - StatPearls).

Q8. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.90 Q50 | Obs Book p.146

Intrauterine fetal death (IUFD / Stillbirth) is defined in standard international and textbook criteria as fetal demise occurring after what gestational age (or birth weight)?

✓ **A. After 20 weeks' gestation (or >=24–28 weeks depending on national viability threshold; >=500 g)**

☐ **B.** After 6 weeks' gestation

☐ **C.** After 8 weeks' gestation

☐ **D.** Only after 42 weeks' gestation

Correct Answer: A (After 20 weeks' gestation (or >=24–28 weeks depending on national viability threshold; >=500 g))

Clinical Explanation: In US/international questions (Comp Bank p.90 Q50), stillbirth/IUFD is defined as fetal death at or after 20 weeks' gestation (or >=24–28 weeks in UK/Egyptian legal definitions; fetal weight >=500 g), whereas fetal loss before 20 (or 24/28) weeks is classified as abortion/miscarriage (Obs Book p.146).

Q9. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.601 Q51 | Obs Book p.78

The relationship of the long axis of the fetus to the long axis of the mother (uterus) is termed:

✓ **A. Fetal Lie (Longitudinal, Transverse, or Oblique)**

☐ **B.** Fetal Presentation

☐ **C.** Fetal Attitude (Habit)

☐ **D.** Fetal Position (Denominator to maternal pelvic quadrant)

Correct Answer: A (Fetal Lie (Longitudinal, Transverse, or Oblique))

Clinical Explanation: Definitions on p.78 of Obs Book: Lie = relationship of long axis of fetus to long axis of mother (longitudinal in 99.5%); Presentation = fetal part occupying lower pole/pelvic inlet (cephalic, breech, shoulder); Attitude = relation of fetal parts to one another

(universal flexion); Position = relation of the denominator (occiput, mentum, sacrum, acromion) to the quadrants of the maternal pelvis.

Q10. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Al-Dhayani Book55 Q18 | Obs Book p.15

Maternal perception of fetal movements ('quickening') is typically first felt by a Primigravida versus a Multipara at:

✓ **A. Primigravida: 18–20 weeks; Multipara: 16–18 weeks**

☐ **B.** Primigravida: 8–10 weeks; Multipara: 6–8 weeks

☐ **C.** Primigravida: 28–30 weeks; Multipara: 24–26 weeks

☐ **D.** Primigravida: 36 weeks; Multipara: 32 weeks

Correct Answer: A (Primigravida: 18–20 weeks; Multipara: 16–18 weeks)

Clinical Explanation: Quickening is perceived at 18–20 weeks in a primigravida and 2 weeks earlier (16–18 weeks) in a multipara (Book55 Q18; Obs Book p.15).

Q11. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Al-Dhayani Book55 Q71 | Obs Book p.141

A 34-week pregnant woman with severe acute polyhydramnios presents with severe maternal dyspnea and orthopnea. What is the appropriate conservative decompression procedure to relieve maternal respiratory distress?

✓ **A. Controlled therapeutic amniocentesis (amnioreduction)**

☐ **B.** Rapid artificial rupture of membranes with a large hook

☐ **C.** Intravenous infusion of 3 liters of normal saline

☐ **D.** High-dose oxytocin infusion

Correct Answer: A (Controlled therapeutic amniocentesis (amnioreduction))

Clinical Explanation: In symptomatic polyhydramnios causing severe maternal respiratory distress before term, slow controlled amnioreduction (therapeutic amniocentesis removing ~500 mL/hr) relieves maternal dyspnea (Book55 Q71; Obs Book p.141). Sudden artificial rupture of membranes is dangerous because rapid uterine decompression causes placental abruption and umbilical cord prolapse!

Q12. Obstetrics Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.291 Q59 | Obs Book p.138

What is the most reliable, accurate, and reproducible method to measure cervical length for predicting preterm birth or cervical insufficiency?

☐ **A.** Digital vaginal examination

✓ **B. Transvaginal ultrasound (TVUS)**

☐ **C.** Transabdominal ultrasound with an empty bladder

☐ **D.** Speculum inspection

Correct Answer: B (Transvaginal ultrasound (TVUS))

Clinical Explanation: Transvaginal ultrasonography (TVUS) with an empty maternal bladder is the gold standard for reproducible cervical length measurement (a cervical length <25 mm before 24 weeks predicts increased risk of preterm birth; Comp Bank p.291 Q59; Obs Book p.138).

Q13. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.73–77: Anatomy of Female Pelvis & Fetal Skull Diameters

Which anteroposterior diameter of the fetal skull presents in a well-flexed vertex (occipito-anterior) presentation, and what is its measurement?

✓ **A. Suboccipitobregmatic diameter — 9.5 cm**

☐ **B.** Occipitofrontal diameter — 11.5 cm

☐ **C.** Mentovertical diameter — 13.5 to 14 cm

☐ **D.** Submentobregmatic diameter — 9.5 cm

Correct Answer: A (Suboccipitobregmatic diameter — 9.5 cm)

Clinical Explanation: Memorize the fetal skull diameters (Obs Book p.77): (1) Suboccipitobregmatic = 9.5 cm (completely flexed vertex OA); (2) Suboccipitofrontal = 10 cm (incompletely flexed vertex); (3) Occipitofrontal = 11.5 cm (deflexed / persistent OP); (4) Mentovertical = 13.5–14 cm (Brow presentation — largest diameter, cannot deliver vaginally!); (5) Submentobregmatic = 9.5 cm (completely extended Face presentation).

Q14. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.74: Pelvic Inlet Conjugate Diameters

Regarding the conjugate diameters of the maternal pelvic inlet (brim), which diameter is the shortest (limiting) anatomical distance through which the fetal head must pass, and how is it estimated clinically from the diagonal conjugate (12.5 cm)?

✓ **A. Obstetrical conjugate (10.5–11 cm) = Diagonal conjugate (12.5 cm) minus 1.5 to 2.0 cm**

☐ **B.** Anatomical true conjugate (11 cm) = Diagonal conjugate plus 2 cm

☐ **C.** Interspinous diameter (10.5 cm)

☐ **D.** Intertuberous diameter (11 cm)

Correct Answer: A (Obstetrical conjugate (10.5–11 cm) = Diagonal conjugate (12.5 cm) minus 1.5 to 2.0 cm)

Clinical Explanation: The Diagonal Conjugate (12.5 cm, from lower border of symphysis pubis to sacral promontory) is the only inlet AP diameter measurable clinically on PV exam; subtracting 1.5–2 cm gives the Obstetrical Conjugate (10.5–11 cm, from inner posterior surface of symphysis pubis to sacral promontory), which is the shortest limiting AP diameter of the pelvic inlet (Obs Book p.74).

Q15. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.94–95: CTG Fetal Heart Rate Decelerations

On intrapartum cardiotocography (CTG), repetitive fetal heart rate decelerations that begin AFTER the peak (acme) of the uterine contraction, reach their nadir after the contraction ends, and are slow to recover ('delayed uniform decelerations') are classified as:

☐ **A.** Early decelerations — benign head compression

☐ **B.** Variable decelerations — umbilical cord compression

✓ **C. Late decelerations — uteroplacental insufficiency and fetal hypoxia**

☐ **D.** Sinusoidal pattern — normal fetal sleep state

Correct Answer: C (Late decelerations — uteroplacental insufficiency and fetal hypoxia)

Clinical Explanation: Memorize the 3 CTG decelerations (Obs Book p.95): (1) Early decelerations = mirror the contraction (head compression, vagal, benign); (2) Variable decelerations = variable timing, abrupt V/W shape with shoulders (umbilical cord compression, most common); (3) Late decelerations = start after peak of contraction (uteroplacental insufficiency / fetal hypoxia — ALWAYS ominous!). Note: Sinusoidal pattern = severe fetal anemia (Rh hydrops / vasa previa rupture).

Q16. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.52–55: HELLP Syndrome

A 33-week preeclamptic woman develops severe right upper quadrant / epigastric pain, nausea, dark urine, schistocytes on peripheral smear, AST/ALT of 320 IU/L, LDH of 850 IU/L, and a platelet count of 48,000/mm³. What is her diagnosis and definitive treatment?

✓ **A. HELLP syndrome (Hemolysis, Elevated Liver enzymes, Low Platelets) — Maternal stabilization (MgSO4 + antihypertensives) followed by prompt delivery**

☐ **B.** Uncomplicated gestational thrombocytopenia — Expectant management until 41 weeks

☐ **C.** Acute cholecystitis — Laparoscopic cholecystectomy only

☐ **D.** Hyperemesis gravidarum — Pyridoxine

Correct Answer: A (HELLP syndrome (Hemolysis, Elevated Liver enzymes, Low Platelets) — Maternal stabilization (MgSO4 + antihypertensives) followed by prompt delivery)

Clinical Explanation: Microangiopathic hemolytic anemia (schistocytes, LDH >600, indirect bilirubin >1.2) + Elevated liver enzymes (AST/ALT >=2x normal) + Low platelets (<100,000/mm³) defines HELLP syndrome, a life-threatening complication of severe preeclampsia (Preeclampsia - StatPearls). Definitive cure is delivery after maternal stabilization with MgSO4 and blood pressure control.

Q17. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.56–57: Hyperemesis Gravidarum

A 10-week pregnant woman with twin gestation presents with intractable vomiting, >5% pre-pregnancy weight loss, dehydration, ketonuria, hypokalemic hypochloremic metabolic alkalosis, and transient confusion/ataxia/nystagmus after receiving IV dextrose without vitamin supplementation. Which vitamin deficiency precipitated her neurological syndrome?

✓ **A. Vitamin B1 (Thiamine) deficiency — Wernicke's encephalopathy**

☐ **B.** Vitamin C deficiency

☐ **C.** Vitamin D deficiency

☐ **D.** Vitamin A excess

Correct Answer: A (Vitamin B1 (Thiamine) deficiency — Wernicke's encephalopathy)

Clinical Explanation: In Hyperemesis Gravidarum (intractable vomiting + weight loss >5% + ketonuria + hypokalemic metabolic alkalosis; associated with high hCG in twins and molar pregnancy), infusing dextrose-containing IV fluids before replenishing Thiamine (Vitamin B1) precipitates acute Wernicke's encephalopathy (confusion, ophthalmoplegia/nystagmus,

ataxia; Obs Book p.56). Always give IV normal saline/Ringer's + Thiamine (B1) + Pyridoxine (B6) + antiemetics.

Q18. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.100–104: Breech Presentation Types & Delivery

Which type of breech presentation is MOST COMMON at term (~60–65%) and carries the lowest risk of umbilical cord prolapse, versus which type carries the HIGHEST risk of cord prolapse?

✓ **A. Most common & lowest cord prolapse risk: Frank breech (extended legs); Highest cord prolapse risk: Footling (incomplete) breech**

☐ **B.** Most common: Footling breech; Highest cord prolapse risk: Frank breech

☐ **C.** Most common: Complete breech; Highest cord prolapse risk: Vertex

☐ **D.** All breech types have identical 50% cord prolapse rates

Correct Answer: A (Most common & lowest cord prolapse risk: Frank breech (extended legs); Highest cord prolapse risk: Footling (incomplete) breech)

Clinical Explanation: Frank breech (hips flexed, knees extended in front of face) accounts for 60–65% of breech presentations at term and fits the pelvic inlet well (cord prolapse <1%). Footling breech (one or both hips/knees extended so feet present below buttocks) leaves space in the lower segment and has a 15–18% risk of umbilical cord prolapse (Obs Book p.101).

Q19. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.103: Breech Head Delivery Maneuvers

During assisted vaginal breech delivery, which maneuver is specifically used to deliver the after-coming fetal head by maintaining flexion through suprapubic pressure or malar bone flexion?

✓ **A. Mauriceau-Smellie-Veit maneuver, Burns-Marshall method, or Piper forceps**

☐ **B.** Løvset's maneuver

☐ **C.** Pinard's maneuver

☐ **D.** McRoberts maneuver

Correct Answer: A (Mauriceau-Smellie-Veit maneuver, Burns-Marshall method, or Piper forceps)

Clinical Explanation: Distinguish the 3 breech maneuvers (Obs Book p.103): (1) Pinard's maneuver = brings down an extended leg in frank breech; (2) Løvset's maneuver = rotates

the fetal trunk 180 degrees to deliver extended/nuchal arms (shoulders); (3) Mauriceau-Smellie-Veit (MSV), Burns-Marshall, or Piper forceps = delivers the after-coming fetal head!

Q20. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.124–127: Uterotonic Contraindications in PPH

A 29-year-old woman develops primary postpartum hemorrhage from uterine atony immediately after vaginal delivery. She has severe preeclampsia (BP 170/115 mmHg) and mild bronchial asthma. Which uterotonic drug is STRICTLY CONTRAINDICATED in her case due to the risk of severe hypertensive crisis / stroke?

☐ **A.** Intravenous Oxytocin

✓ **B. Methylergometrine (Ergometrine / Methergine)**

☐ **C.** Rectal/sublingual Misoprostol (PGE1)

☐ **D.** Intrauterine Bakri balloon tamponade

Correct Answer: B (Methylergometrine (Ergometrine / Methergine))

Clinical Explanation: Memorize the uterotonic contraindications in PPH (Obs Book p.126): (1) Ergometrine / Methylergometrine causes potent alpha-adrenergic vasoconstriction and is CONTRAINDICATED in Hypertension, Preeclampsia, and Cardiac disease; (2) Carboprost (15-methyl PGF2-alpha) causes bronchospasm and is CONTRAINDICATED in Bronchial Asthma; (3) Oxytocin (1st-line) and Misoprostol (PGE1) are safe in both hypertension and asthma!

Q21. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.41–43: Post-Molar Follow-Up & Contraception

Following suction evacuation of a complete hydatidiform mole, what is the mandatory follow-up protocol, and which contraceptive method is preferred vs contraindicated during surveillance?

✓ **A. Serial serum beta-hCG monitoring until undetectable then monthly for 6 months; Combined oral contraceptive pills (COCs) are preferred while Intrauterine Device (IUD) is contraindicated until hCG normalizes**

☐ **B.** Immediate Copper IUD insertion in the operating room and no beta-hCG testing

☐ **C.** Immediate pregnancy within 1 month

☐ **D.** Serial serum CA-125 monitoring for 5 years

Correct Answer: A (Serial serum beta-hCG monitoring until undetectable then monthly for 6 months; Combined oral contraceptive pills (COCs) are preferred while Intrauterine Device (IUD) is contraindicated until hCG normalizes)

Clinical Explanation: After molar evacuation, serial quantitative serum beta-hCG monitoring is mandatory to detect persistent Gestational Trophoblastic Neoplasia (GTN; plateau over 4 values/3 wks or rise over 3 values/2 wks; treated with single-agent Methotrexate + folinic acid rescue if low-risk FIGO score <=6) (Hydatidiform Mole - StatPearls). Reliable contraception with COCs is required so an intercurrent pregnancy does not mask a rising beta-hCG, while an IUD is contraindicated until hCG is normal due to uterine perforation/bleeding risk.

Q22. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.134: Amniotic Fluid Embolism

During tumultuous labor shortly after artificial rupture of membranes, a multiparous woman suddenly develops acute severe dyspnea, cyanosis, hypotension/cardiovascular collapse, seizures, and rapid onset of profuse bleeding from IV sites (DIC). What is the most likely diagnosis?

✓ **A. Amniotic fluid embolism (anaphylactoid syndrome of pregnancy)**

☐ **B.** Uncomplicated round ligament spasm

☐ **C.** Benign physiological hyperventilation

☐ **D.** First-degree perineal tear

Correct Answer: A (Amniotic fluid embolism (anaphylactoid syndrome of pregnancy))

Clinical Explanation: Classic triad of Amniotic Fluid Embolism (AFE) during labor/delivery or immediately postpartum: (1) Sudden hypoxia/respiratory distress, (2) Cardiovascular collapse / cardiogenic-obstructive shock, and (3) Severe consumptive coagulopathy (DIC) (Obs Book p.134). Fetal squames and mucin may be found in maternal pulmonary vasculature at autopsy. Management is supportive ICU cardiopulmonary resuscitation and massive transfusion protocol.

Q23. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.137–139: Preterm Labor Tocolysis & Neuroprotection

A 29-week pregnant woman presents in preterm labor with intact membranes, regular contractions, and 3 cm cervical dilatation. She has no chorioamnionitis or placental abruption. In addition to antenatal betamethasone for fetal lung maturity, what is the specific indication for administering Magnesium Sulfate before 32 weeks?

✓ **A. Fetal neuroprotection (significantly reduces the risk of neonatal cerebral palsy)**

☐ **B.** Permanent arrest of pregnancy until 42 weeks

☐ **C.** Treatment of maternal iron deficiency

☐ **D.** Prevention of maternal gestational diabetes

Correct Answer: A (Fetal neuroprotection (significantly reduces the risk of neonatal cerebral palsy))

Clinical Explanation: In imminent preterm birth before 32 weeks' gestation, intravenous Magnesium Sulfate is administered for fetal neuroprotection because it significantly reduces the incidence and severity of neonatal cerebral palsy (Obs Book p.139). Short-term tocolytics (Nifedipine or Atosiban; Indomethacin <32 wks only, as it causes premature closure of the fetal ductus arteriosus and oligohydramnios after 32 wks!) are used for 48 hours to allow antenatal steroids to work and arrange in-utero transfer.

Q24. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.143–144: Symmetric vs Asymmetric IUGR

Which statement accurately differentiates Asymmetric Fetal Growth Restriction (IUGR, 70–80%) from Symmetric IUGR (20–30%)?

✓ **A. Asymmetric IUGR is caused by late-onset uteroplacental insufficiency (e.g., preeclampsia) with 'brain-sparing' (normal Head Circumference/BPD but small Abdominal Circumference and increased HC/AC ratio); Symmetric IUGR is caused by early first-trimester insults (aneuploidy, TORCH infection) affecting all biometric parameters equally**

☐ **B.** Asymmetric IUGR is caused by Trisomy 18 in the first week of life and shrinks the brain while enlarging the liver

☐ **C.** Abdominal Circumference (AC) is the least sensitive ultrasound parameter for IUGR

☐ **D.** Symmetric IUGR always occurs after 38 weeks' gestation

Correct Answer: A (Asymmetric IUGR is caused by late-onset uteroplacental insufficiency (e.g., preeclampsia) with 'brain-sparing' (normal Head Circumference/BPD but small Abdominal Circumference and increased HC/AC ratio); Symmetric IUGR is caused by early first-trimester insults (aneuploidy, TORCH infection) affecting all biometric parameters equally)

Clinical Explanation: Abdominal Circumference (AC, reflecting fetal liver glycogen stores) is the single most sensitive biometric parameter for detecting IUGR (Obs Book p.144). Late placental insufficiency causes brain-sparing redistribution (Asymmetric IUGR: normal HC, reduced AC, elevated HC/AC ratio), whereas early intrinsic insults (chromosomal trisomies, congenital TORCH infections) reduce both HC and AC proportionally (Symmetric IUGR).

Q25. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.64: Thyroid Disorders in Pregnancy

A pregnant woman is diagnosed with hyperthyroidism (Graves' disease) at 8 weeks' gestation. Which antithyroid medication is preferred during the first trimester versus the second and third trimesters?

✓ **A. First trimester: Propylthiouracil (PTU) (to avoid methimazole-induced aplasia cutis/choanal atresia); Second & Third trimesters: switch to Methimazole/Carbimazole (to reduce PTU hepatotoxicity risk)**

☐ **B.** Radioactive iodine (I-131) ablation at 10 weeks

☐ **C.** Methimazole in 1st trimester and I-131 in 2nd trimester

☐ **D.** Levothyroxine high dose

Correct Answer: A (First trimester: Propylthiouracil (PTU) (to avoid methimazole-induced aplasia cutis/choanal atresia); Second & Third trimesters: switch to Methimazole/Carbimazole (to reduce PTU hepatotoxicity risk))

Clinical Explanation: Radioactive iodine (I-131) is strictly contraindicated in pregnancy (destroys fetal thyroid). Propylthiouracil (PTU) is preferred in the 1st trimester because Methimazole/Carbimazole is associated with aplasia cutis and choanal/esophageal atresia (embryopathy); after the 1st trimester, switching to Methimazole reduces the risk of maternal fulminant PTU hepatotoxicity (Obs Book p.64).

Q26. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.10–13: Maternal Physiological Changes in Pregnancy

All of the following physiological changes occur during a normal singleton pregnancy EXCEPT:

☐ **A.** Increase in plasma volume by 45–50% and cardiac output by 30–50%

☐ **B.** Increase in glomerular filtration rate (GFR) by 50%, resulting in DECREASED serum creatinine, urea, and uric acid

☐ **C.** Increase in tidal volume by 40% with a DECREASE in functional residual capacity (FRC) and mild compensated respiratory alkalosis

✓ **D. Increase in systemic vascular resistance (SVR) and mid-trimester blood pressure**

☐ **E.** Hypercoagulable state with elevated fibrinogen and factors VII, VIII, IX, X and decreased protein S

Correct Answer: D (Increase in systemic vascular resistance (SVR) and mid-trimester blood pressure)

Clinical Explanation: Progesterone and nitric oxide/prostacyclin cause marked peripheral vasodilation during pregnancy, resulting in a 20–30% DECREASE in systemic vascular

resistance (SVR) and a physiological drop in blood pressure (especially diastolic) during the second trimester (Book55 Q28; Obs Book p.11).

Q27. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.115: Bandl's Pathological Retraction Ring

In a woman with neglected obstructed labor, palpation of a rising, oblique muscular ridge across the abdomen between the tonic upper uterine segment and the dangerously thinned, tender lower uterine segment (accompanied by an edematous vulva and hematuria) is known as:

✓ **A. Bandl's pathological retraction ring — a classic sign of impending uterine rupture**

☐ **B.** Hegar's sign of early pregnancy

☐ **C.** Chadwick's sign

☐ **D.** Spalding's sign of intrauterine fetal death

Correct Answer: A (Bandl's pathological retraction ring — a classic sign of impending uterine rupture)

Clinical Explanation: Know the classic obstetric eponyms: Bandl's ring = pathological retraction ring at the junction of thick upper and thin lower segments in obstructed labor (sign of impending uterine rupture; Obs Book p.115); Hegar's sign = softening of uterine isthmus at 6–8 wks; Chadwick's (Jacquemier's) sign = bluish discoloration of vagina/cervix; Goodell's sign = softening of cervix; Osiander's sign = pulsation in lateral fornices; Spalding's sign = overlapping of fetal skull bones on X-ray/US several days after IUFD; Robert's sign = gas in fetal great vessels 12–48 hrs after IUFD.

Q28. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.140–142: Amniotic Fluid Index (AFI) Cutoffs

How are Oligohydramnios and Polyhydramnios quantitatively defined on ultrasound using the Amniotic Fluid Index (AFI) and Single Deepest Vertical Pocket (SDP)?

✓ **A. Oligohydramnios: AFI < 5 cm (or SDP < 2 cm); Polyhydramnios: AFI >= 24–25 cm (or SDP >= 8 cm)**

☐ **B.** Oligohydramnios: AFI > 15 cm; Polyhydramnios: AFI < 5 cm

☐ **C.** Oligohydramnios: AFI = 12 cm; Polyhydramnios: AFI = 14 cm

☐ **D.** Normal AFI is 0 to 2 cm

Correct Answer: A (Oligohydramnios: AFI < 5 cm (or SDP < 2 cm); Polyhydramnios: AFI >= 24–25 cm (or SDP >= 8 cm))

Clinical Explanation: Normal Amniotic Fluid Index (sum of 4 quadrants) is 8 to 24 cm (5th–95th percentile). Oligohydramnios is AFI < 5 cm (or single deepest pocket < 2 cm); Polyhydramnios is AFI >= 24–25 cm (or single deepest pocket >= 8 cm; total volume > 2,000 mL) (Obs Book p.140).

Q29. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.92–93: Biophysical Profile (BPP)

Which of the following is NOT one of the five components of Manning's fetal Biophysical Profile (BPP)?

☐ **A.** Non-stress test (NST / reactiveCTG)

☐ **B.** Fetal breathing movements, gross body movements, and fetal muscle tone

☐ **C.** Amniotic fluid volume (single vertical pocket >=2 cm)

✓ **D. Maternal serum progesterone concentration**

Correct Answer: D (Maternal serum progesterone concentration)

Clinical Explanation: The 5 components of the Biophysical Profile (BPP, scored 0 or 2 points each, max 10/10) are: (1) Non-Stress Test (NST), (2) Fetal breathing movements (>=1 episode lasting >=30s in 30 min), (3) Gross fetal body movements (>=3 movements in 30 min), (4) Fetal muscle tone (>=1 extension-flexion), and (5) Amniotic fluid volume (pocket >=2 cm) (Obs Book p.93). The Modified BPP combines NST (acute hypoxia marker) + AFI (chronic placental function marker).

Q30. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.136: Diagnosis of Chorioamnionitis

In a woman with premature rupture of membranes (PROM), which cluster of clinical findings establishes the diagnosis of clinical chorioamnionitis (intra-amniotic infection) and mandates immediate delivery under broad-spectrum IV antibiotics?

✓ **A. Maternal fever (>=38.0°C) plus >=2 of: maternal tachycardia (>100 bpm), fetal tachycardia (>160 bpm), uterine fundal tenderness, foul-smelling purulent amniotic fluid, or maternal leukocytosis (>15,000/mm³)**

☐ **B.** Isolated painless Braxton-Hicks contractions with normal temperature and FHR 130 bpm

☐ **C.** Mild ankle edema with negative nitrazine test

☐ **D.** Clear amniotic fluid with reactive NST

Correct Answer: A (Maternal fever (>=38.0°C) plus >=2 of: maternal tachycardia (>100 bpm), fetal tachycardia (>160 bpm), uterine fundal tenderness, foul-smelling purulent amniotic fluid, or maternal leukocytosis (>15,000/mm³))

Clinical Explanation: Note that 'List the criteria for the diagnosis of chorioamnionitis' appeared as Essay Q3 on page 33 of آخر ٤ امتحانات نسا ٢٠٢٦.pdf ! Gibbs' clinical criteria for chorioamnionitis require maternal fever (>=38.0°C) plus at least 2 of: maternal tachycardia (>100 bpm), baseline fetal tachycardia (>160 bpm), uterine tenderness, foul-smelling/purulent amniotic fluid, and maternal leukocytosis (>15,000/mm³) (Obs Book p.136). Once chorioamnionitis is diagnosed, tocolytics and steroids are contraindicated and immediate delivery (vaginal preferred if rapid) under IV ampicillin + gentamicin (+ clindamycin/metronidazole if CS) is mandatory!

Q31. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.137: Diagnostic Tests for Rupture of Membranes (ROM)

A pregnant woman at 35 weeks reports a sudden gush of watery fluid from her vagina. Which findings confirm rupture of the amniotic membranes?

✓ **A. Direct visualization of fluid pooling in the posterior fornix on sterile speculum exam, alkaline pH (7.1–7.3) turning Nitrazine paper blue, and 'arborization' (ferning pattern) of dried fluid on a microscope slide**

☐ **B.** Acidic vaginal pH of 4.0 turning Nitrazine paper yellow

☐ **C.** Immediate forceful digital examination of the internal os in all preterm patients

☐ **D.** Presence of clue cells on wet mount

Correct Answer: A (Direct visualization of fluid pooling in the posterior fornix on sterile speculum exam, alkaline pH (7.1–7.3) turning Nitrazine paper blue, and 'arborization' (ferning pattern) of dried fluid on a microscope slide)

Clinical Explanation: Amniotic fluid has an alkaline pH (7.1–7.3 vs normal acidic vaginal pH 3.8–4.5), turning yellow Nitrazine paper dark blue, and crystallizes into a characteristic 'fern-like' arborization pattern when air-dried on a glass slide due to sodium chloride and protein content (Obs Book p.136). Biomarker tests (AmniSure / PAMG-1 or IGFBP-1) confirm equivocal cases. Avoid digital vaginal examination in preterm PROM to prevent ascending infection and shorten latency!

Q32. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.163: Bishop Score for Labor Induction

Which five pelvic examination parameters make up the modified Bishop Score used to assess cervical ripeness (favorability) before induction of labor?

✓ **A. Cervical dilatation, cervical effacement (length), cervical consistency, cervical position, and fetal station**

☐ **B.** Maternal age, parity, BMI, blood pressure, and femur length

☐ **C.** Fundal height, amniotic fluid index, placental grade, and fetal heart rate

☐ **D.** Diagonal conjugate, interspinous diameter, and subpubic angle

Correct Answer: A (Cervical dilatation, cervical effacement (length), cervical consistency, cervical position, and fetal station)

Clinical Explanation: The 5 components of the Bishop Score (Obs Book p.163) are: (1) Cervix Dilatation, (2) Cervix Effacement/Length, (3) Cervix Consistency (firm/medium/soft), (4) Cervix Position (posterior/mid/anterior), and (5) Fetal Head Station. A favourable Bishop score (>=8, or >6) is induced with amniotomy + IV oxytocin, whereas an unfavourable/unripe cervix (<=6) requires cervical ripening with vaginal prostaglandins (PGE2 Dinoprostone or PGE1 Misoprostol) or Foley catheter balloon.

Q33. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.111: Precipitate Labor

How is Precipitate Labor defined, and what are its classic maternal and fetal complications?

✓ **A. Total duration of labor (1st + 2nd stages) < 3 hours; associated with maternal cervical/vaginal/perineal lacerations, postpartum hemorrhage (atony), uterine inversion, and fetal intracranial hemorrhage / hypoxia**

☐ **B.** Labor lasting > 24 hours in a primigravida

☐ **C.** Arrest of descent for 3 hours in the second stage

☐ **D.** Painless cervical dilatation at 16 weeks

Correct Answer: A (Total duration of labor (1st + 2nd stages) < 3 hours; associated with maternal cervical/vaginal/perineal lacerations, postpartum hemorrhage (atony), uterine inversion, and fetal intracranial hemorrhage / hypoxia)

Clinical Explanation: Precipitate labor is extremely rapid labor culminating in delivery within <3 hours of onset of regular contractions (dilatation >=5 cm/hr in primigravida or >=10 cm/hr in multipara; Obs Book p.111). Tumultuous contractions and rapid expulsion without time for perineal stretching or cranial molding cause deep birth-canal lacerations, primary PPH, amniotic fluid embolism, and neonatal subdural/intracranial hemorrhage.

Q34. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.105: Transverse Lie / Shoulder Presentation

A multiparous woman at 39 weeks' gestation presents in early labor with intact membranes and a fetus in transverse lie (shoulder presentation, acromion denominator). There is no placenta previa. What is the management versus what is done if membranes have already ruptured and the arm is prolapsed in neglected shoulder presentation?

✓ A. Early labor with intact membranes: External Cephalic Version (ECV) or elective CS; Neglected impacted transverse lie in active labor with ruptured membranes: mandatory Cesarean section (ECV and internal podalic version are strictly contraindicated due to uterine rupture risk!)

☐ **B.** Perform high forceps extraction on the fetal shoulder

☐ **C.** Apply vacuum extractor to the fetal ribs

☐ **D.** Infuse high-dose oxytocin to force spontaneous conduplicato corpore in a 4 kg term baby

Correct Answer: A (Early labor with intact membranes: External Cephalic Version (ECV) or elective CS; Neglected impacted transverse lie in active labor with ruptured membranes: mandatory Cesarean section (ECV and internal podalic version are strictly contraindicated due to uterine rupture risk!))

Clinical Explanation: A persistent transverse lie (shoulder presentation) at term cannot deliver vaginally (Obs Book p.105). If membranes are intact in early labor with no contraindications, ECV may be attempted; once membranes rupture or the shoulder impacts (neglected shoulder presentation with prolapsed arm), internal version and ECV carry an extreme risk of uterine rupture, making Cesarean section (often requiring a vertical/classical uterine incision if the lower segment is poorly formed/impacted) mandatory even if the fetus is dead!

Q35. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.4: Structure of Umbilical Cord & Placental Transport

A normal human umbilical cord at term contains which blood vessels, and which vessel carries oxygenated blood from the placenta to the fetus?

✓ A. Two umbilical arteries and One (left) umbilical vein (2A:1V); the umbilical vein carries oxygenated blood to the fetus

☐ **B.** Two umbilical veins and One umbilical artery; the umbilical artery carries oxygenated blood

☐ **C.** Four umbilical arteries surrounded by decidua parietalis

☐ **D.** Single umbilical artery in 99% of normal fetuses

Correct Answer: A (Two umbilical arteries and One (left) umbilical vein (2A:1V); the umbilical vein carries oxygenated blood to the fetus)

Clinical Explanation: The normal umbilical cord contains two umbilical arteries (carrying deoxygenated fetal blood from internal iliac arteries to the placenta) and one (left) umbilical vein (carrying oxygenated blood with 80% O2 saturation from the placenta to the fetus via the ductus venosus), embedded in Wharton's jelly and covered by amniotic epithelium (Obs Book p.8). A single umbilical artery (SUA, ~1%) is associated with fetal renal and cardiac anomalies.

Q36. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.5: Placental Transport Mechanisms & Immunoglobulins

By what transport mechanism do maternal antibodies (specifically IgG) cross the placental barrier to confer passive immunity to the fetus, and which immunoglobulin CANNOT cross the placenta?

✓ **A. Pinocytosis / receptor-mediated endocytosis — IgG crosses the placenta, whereas IgM (large pentamer) cannot cross**

☐ **B.** Simple diffusion — IgM crosses freely while IgG is blocked

☐ **C.** Facilitated diffusion — only IgA crosses

☐ **D.** No maternal antibodies ever cross the placenta

Correct Answer: A (Pinocytosis / receptor-mediated endocytosis — IgG crosses the placenta, whereas IgM (large pentamer) cannot cross)

Clinical Explanation: Placental transport mechanisms (Obs Book p.4–5): (1) Simple diffusion: O2, CO2, water, electrolytes, most drugs; (2) Facilitated diffusion: Glucose (via GLUT transporters); (3) Active transport (requires energy): Amino acids, Iron, Calcium, water-soluble vitamins; (4) Pinocytosis / Endocytosis: Large proteins such as Maternal IgG (and LATS/TSI in Graves' disease, anti-D IgG in Rh disease). IgM is a large pentamer that CANNOT cross the placenta—so elevated IgM in cord blood is diagnostic of intrauterine congenital fetal infection!

Q37. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.140: Post-Term Pregnancy

When is a pregnancy officially defined as Post-Term (Prolonged Pregnancy), and what is the most common cause of an apparently prolonged pregnancy?

✓ **A. >= 42 completed weeks (>= 294 days) from the first day of the LMP; the most common cause is inaccurate dating / wrong menstrual dates**

☐ **B.** >= 38 completed weeks; most common cause is placenta previa

☐ **C.** >= 40 weeks + 1 day; most common cause is twin gestation

☐ **D.** >= 36 weeks; most common cause is polyhydramnios

Correct Answer: A (>= 42 completed weeks (>= 294 days) from the first day of the LMP; the most common cause is inaccurate dating / wrong menstrual dates)

Clinical Explanation: Post-term pregnancy is defined as gestation extending to or beyond 42 completed weeks (294 days) from the LMP (Obs Book p.140). The single most common cause of apparent post-term pregnancy is inaccurate gestational dating (corrected by 1st-trimester CRL ultrasound); true biological causes include placental sulfatase deficiency, fetal anencephaly, and fetal adrenal hypoplasia. Risks include oligohydramnios, meconium aspiration, macrosomia, and uteroplacental insufficiency (dysmaturity).

Q38. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.153–157: Normal Lochia & Puerperal Mastitis

What is the normal chronological sequence of postpartum lochia over the first 3 weeks of the puerperium, and what is the most common causative organism of acute puerperal lactational mastitis?

✓ **A. Lochia rubra (red, days 1–4) -> Lochia serosa (pink/brownish, days 5–10) -> Lochia alba (yellowish-white, days 11–21); Acute lactational mastitis is most commonly caused by Staphylococcus aureus (continue breastfeeding/milk expression + flucloxacillin/dicloxacillin)**

☐ **B.** Lochia alba -> Lochia serosa -> Lochia rubra; caused by Treponema pallidum

☐ **C.** Persistent foul-smelling red lochia for 8 weeks is normal

☐ **D.** Breastfeeding must be permanently stopped immediately in simple mastitis

Correct Answer: A (Lochia rubra (red, days 1–4) -> Lochia serosa (pink/brownish, days 5–10) -> Lochia alba (yellowish-white, days 11–21); Acute lactational mastitis is most commonly caused by Staphylococcus aureus (continue breastfeeding/milk expression + flucloxacillin/dicloxacillin))

Clinical Explanation: Normal lochia progresses from Lochia rubra (blood, decidua, vernix: days 1–4) to Lochia serosa (serosanguinous: days 5–10) to Lochia alba (leukocytes/mucus: days 11–21) (Obs Book p.154). Persistent red lochia with subinvolution indicates retained placental fragments/endometritis. Acute lactational mastitis (2–4 weeks postpartum, cracked nipple) is caused by Staphylococcus aureus from the infant's nasopharynx; management is continued milk emptying/breastfeeding + penicillinase-resistant antibiotic (flucloxacillin/cephalexin), or incision & drainage if a fluctuant breast abscess forms.

Q39. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.150–152: Erb-Duchenne vs Klumpke Brachial Plexus Palsy

Following a difficult vaginal delivery complicated by shoulder dystocia (or excessive lateral traction on the fetal head), the newborn holds its right arm

adducted, internally rotated at the shoulder, extended at the elbow, and pronated at the forearm ('waiter's tip posture') with an intact grasp reflex. Which nerve roots are injured?

✓ **A. Upper brachial plexus roots C5 and C6 (Erb-Duchenne palsy)**

☐ **B.** Lower brachial plexus roots C8 and T1 (Klumpke's claw-hand palsy)

☐ **C.** Facial nerve (Cranial nerve VII)

☐ **D.** Obturator nerve (L2–L4)

Correct Answer: A (Upper brachial plexus roots C5 and C6 (Erb-Duchenne palsy))

Clinical Explanation: Traction on the upper brachial plexus (C5–C6) during shoulder dystocia or breech delivery causes Erb-Duchenne palsy ('waiter's tip' position: shoulder adducted/internally rotated, elbow extended, forearm pronated, Moro reflex absent on affected side, palmar grasp intact; Obs Book p.151). Injury to C8–T1 causes Klumpke's palsy (paralysis of intrinsic hand muscles = 'claw hand' + ipsilateral Horner syndrome if T1 sympathetic fibers injured).

Q40. Obstetrics New Pattern-Matched

NEW PATTERN-MATCHED — Obs Book p.130–133: Obstetric DIC Triggers

Which group of obstetric emergencies carries the highest risk of triggering acute consumptive Disseminated Intravascular Coagulation (DIC) via thromboplastin release into the maternal circulation?

✓ **A. Placental abruption (concealed accidental hemorrhage), Amniotic fluid embolism, Prolonged retention of a dead fetus (IUFD >3–4 weeks), Septic abortion/chorioamnionitis, and Severe preeclampsia/HELLP**

☐ **B.** Uncomplicated threatened abortion at 6 weeks and benign premature thelarche

☐ **C.** Mild physiological morning sickness and Braxton-Hicks contractions

☐ **D.** Uncomplicated first-degree perineal laceration

Correct Answer: A (Placental abruption (concealed accidental hemorrhage), Amniotic fluid embolism, Prolonged retention of a dead fetus (IUFD >3–4 weeks), Septic abortion/chorioamnionitis, and Severe preeclampsia/HELLP)

Clinical Explanation: Massive release of tissue factor (thromboplastin) or endothelial damage in Placental Abruption (#1 acute obstetric cause), Amniotic Fluid Embolism, Septic Abortion, Retained Dead Fetus (>3–4 weeks), and Severe Preeclampsia/HELLP triggers acute obstetric DIC (prolonged PT/aPTT, low fibrinogen <100–200 mg/dL, elevated D-dimer/FDPs, thrombocytopenia; Obs Book p.132). Management requires treating the underlying obstetric cause (delivering fetus/placenta) plus blood component replacement (FFP, cryoprecipitate for fibrinogen, packed RBCs, platelets).

Section 4: Mock Exam 3 (Final Gynecology, 40 MCQs) — Full Solved Version

Q1. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.4 Formative A1 2022 Q12 | Gyn Book p.46

Turner syndrome (45,X0) is characterized by all of the following clinical and laboratory features EXCEPT:

☐ **A.** Negative Barr body on buccal smear

☐ **B.** Primary amenorrhea and bilateral streak gonads

☐ **C.** Hypoplastic (infantile) uterus

✓ **D. A hyperestrogenic hormonal state with suppressed FSH**

Correct Answer: D (A hyperestrogenic hormonal state with suppressed FSH)

Clinical Explanation: Turner syndrome (45,X0) has ovarian failure (streak gonads), producing a HYPOestrogenic state with markedly elevated FSH and LH (hypergonadotropic hypogonadism), NOT a hyperestrogenic state (Comp Bank p.4 Q12).

Q2. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.4 Formative A1 2022 Q13 | Gyn Book p.46–52

Causes of SECONDARY amenorrhea include all of the following conditions EXCEPT:

✓ **A. Kallmann syndrome**

☐ **B.** Polycystic ovarian syndrome (PCOS)

☐ **C.** Post-pill amenorrhea / Asherman syndrome

☐ **D.** Sheehan syndrome

Correct Answer: A (Kallmann syndrome)

Clinical Explanation: Kallmann syndrome (congenital isolated GnRH deficiency with anosmia/hyposmia due to failure of GnRH neuronal migration from the olfactory placode) presents with PRIMARY amenorrhea and sexual infantilism (hypogonadotropic hypogonadism), NOT secondary amenorrhea (Comp Bank p.4 Q13; Gyn Book p.46).

Q3. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.5 Formative A1 2022 Q22 | Gyn Book p.199

A mass palpated in the Pouch of Douglas (posterior vaginal fornix / cul-de-sac) on bimanual examination may be any of the following EXCEPT:

☐ **A.** A prolapsed ovarian cyst or ovarian tumor

☐ **B.** A pelvic abscess or pelvic hematocele (from ruptured ectopic pregnancy)

☐ **C.** A posterior wall subserosal/pedunculated uterine myoma or retroverted gravid uterus

☐ **D.** Nodules of pelvic endometriosis or tuberculosis

✓ **E. An uncomplicated anterior wall cystocele**

Correct Answer: E (An uncomplicated anterior wall cystocele)

Clinical Explanation: Classic differential diagnosis of a Pouch of Douglas mass (Gyn Book p.199): Ovarian cyst/tumor, pelvic abscess, pelvic hematocele (chronic ectopic), retroverted uterus / posterior wall fibroid, endometriotic/TB nodules, or fecal mass/rectosigmoid carcinoma. In Formative A1 2022 Q22, note that parametric (broad ligament) abscess is lateral (in the lateral fornix) rather than in the posterior cul-de-sac, while cystocele is strictly anterior.

Q4. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.6 Formative A2 2022 Q3 | Gyn Book p.82

What is the most common side effect of modern low-dose combined oral contraceptive pills (COCs) during the first few months of use?

✓ **A. Breakthrough intermenstrual bleeding / spotting**

☐ **B.** Chloasma (melasma)

☐ **C.** Severe worsening of primary dysmenorrhea

☐ **D.** Acute hepatic failure

Correct Answer: A (Breakthrough intermenstrual bleeding / spotting)

Clinical Explanation: With modern low-estrogen (20–30 mcg ethinyl estradiol) COCs, breakthrough bleeding/spotting in the first 3 cycles is the most common side effect and leading reason for discontinuation (Comp Bank p.6 Q3) (Oral Contraceptive Pills - StatPearls). Note: COCs actually IMPROVE (relieve) primary dysmenorrhea!

Q5. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.6 Formative A2 2022 Q4 | Gyn Book p.84

Which of the following antimicrobial agents is a potent hepatic cytochrome P450 enzyme inducer that clearly decreases the contraceptive efficacy of combined hormonal contraceptives?

✓ **A. Rifampicin (Rifampin)**

☐ **B.** Amoxicillin / Penicillin

☐ **C.** Doxycycline

☐ **D.** Ciprofloxacin

Correct Answer: A (Rifampicin (Rifampin))

Clinical Explanation: Rifampicin (and rifabutin, phenytoin, carbamazepine, barbiturates, topiramate, St. John's Wort) induces hepatic CYP3A4 enzymes, accelerating estrogen/progestin metabolism and causing contraceptive failure (Comp Bank p.6 Q4; Gyn Book p.84). Standard non-rifamycin antibiotics (penicillins, tetracyclines, fluoroquinolones) do NOT reduce COC efficacy.

Q6. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.51 Q54 | Gyn Book p.60, 72

Regarding Clomiphene Citrate (selective estrogen receptor modulator used for ovulation induction in PCOS), which of the following statements is CORRECT?

☐ **A.** It improves endometrial thickness and cervical mucus quality through a potent local estrogenic effect

✓ **B. It acts centrally on the hypothalamus to block estrogen negative feedback, increasing endogenous GnRH, FSH, and LH, and may result in Ovarian Hyperstimulation Syndrome (OHSS) or twin gestation**

☐ **C.** It is the first-line treatment of choice in a 13-year-old virgin girl with physiological pubertal irregular cycles

☐ **D.** It directly stimulates ovarian follicles without requiring an intact hypothalamic-pituitary axis

Correct Answer: B (It acts centrally on the hypothalamus to block estrogen negative feedback, increasing endogenous GnRH, FSH, and LH, and may result in Ovarian Hyperstimulation Syndrome (OHSS) or twin gestation)

Clinical Explanation: Clomiphene citrate binds hypothalamic estrogen receptors, blocking negative feedback so the pituitary secretes more FSH and LH (requiring an intact HPO axis!). Its side effects include multiple pregnancy (~8% twins), Ovarian Hyperstimulation Syndrome (OHSS), vasomotor hot flashes, visual disturbances, and ANTI-estrogenic thinning of the endometrium and hostility/thickening of cervical mucus (Comp Bank p.51 Q54; Gyn Book p.72). (Note: Letrozole, an aromatase inhibitor, avoids the anti-estrogenic cervical mucus/endometrial effect).

Q7. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.78 Q25 | Gyn Book p.86

What is the primary contraceptive mechanism of action of the Copper Intrauterine Device (Cu-IUD)?

✓ **A. Prevention of fertilization and implantation via a sterile foreign-body inflammatory reaction and copper-ion toxicity to sperm and oocytes**

☐ **B.** Complete central suppression of pituitary FSH and LH release

☐ **C.** Induction of surgical abortion of an established 8-week fetus

☐ **D.** Thickening of cervical mucus via high-dose systemic progesterone

Correct Answer: A (Prevention of fertilization and implantation via a sterile foreign-body inflammatory reaction and copper-ion toxicity to sperm and oocytes)

Clinical Explanation: The Copper IUD releases free copper ions and induces a local sterile leukocyte/prostaglandin inflammatory response in the uterine cavity and fallopian tubes that is spermicidal (inhibiting sperm motility/capacitation and fertilization) and renders the endometrium hostile to implantation (Comp Bank p.78 Q25; Gyn Book p.86).

Q8. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.96 Formative A1 2025 Q1 & Patho Q855 | Gyn Book p.56

All of the following are classic clinical or biochemical features of Polycystic Ovary Syndrome (Stein-Leventhal syndrome / PCOD) EXCEPT:

☐ **A.** Oligomenorrhea or secondary amenorrhea and anovulatory infertility

☐ **B.** Hirsutism, acne, and obesity / insulin resistance

☐ **C.** Increased risk of endometrial hyperplasia due to chronic unopposed estrogen

✓ **D. Markedly elevated FSH with an FSH:LH ratio of 3:1 and severe hypoestrogenism**

Correct Answer: D (Markedly elevated FSH with an FSH:LH ratio of 3:1 and severe hypoestrogenism)

Clinical Explanation: PCOS is characterized by elevated LH (with an elevated LH:FSH ratio of >=2:1 or 3:1, NOT elevated FSH!), hyperandrogenism, insulin resistance, chronic anovulation, and unopposed estrone conversion leading to endometrial hyperplasia (Comp Bank p.96 Q1; Patho Q855).

Q9. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.103 Q38 | Gyn Book p.102

A sexually active 22-year-old woman presents with bilateral lower abdominal pain, purulent vaginal discharge, fever of 38.6°C, bilateral adnexal tenderness, and marked cervical motion tenderness on bimanual exam. Pregnancy test is negative. What is the most likely diagnosis?

✓ **A. Acute Pelvic Inflammatory Disease (acute salpingo-oophoritis)**

☐ **B.** Uncomplicated uterine fibroid

☐ **C.** Stress urinary incontinence

☐ **D.** Mayer-Rokitansky-Küster-Hauser syndrome

Correct Answer: A (Acute Pelvic Inflammatory Disease (acute salpingo-oophoritis))

Clinical Explanation: Bilateral lower abdominal/adnexal tenderness + cervical motion tenderness + mucopurulent discharge and fever in a young sexually active woman with a negative pregnancy test is the textbook presentation of Acute PID (Comp Bank p.103 Q38; Gyn Book p.102). Empirical treatment covers Both Neisseria gonorrhoeae and Chlamydia trachomatis (plus anaerobes): IM Ceftriaxone + Oral Doxycycline + Oral Metronidazole.

Q10. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.104 Q42 | Gyn Book p.50

A 17-year-old phenotypic female presents with primary amenorrhea, complete absence of breast development (sexual infantilism), presence of a normal-sized infantile uterus on ultrasound, and hypertension with hypokalemia. Which enzyme deficiency causes this presentation?

✓ **A. 17-alpha-hydroxylase deficiency**

☐ **B.** 21-hydroxylase deficiency

☐ **C.** 5-alpha-reductase deficiency

☐ **D.** Aromatase deficiency

Correct Answer: A (17-alpha-hydroxylase deficiency)

Clinical Explanation: Memorize the 3 CAH enzyme profiles (Comp Bank p.104 Q42; Gyn Book p.50): (1) 21-hydroxylase deficiency = Ambiguous genitalia/virilization + normotensive or salt-wasting hypotension; (2) 11-beta-hydroxylase deficiency = Ambiguous genitalia/virilization + Hypertension (excess 11-DOC); (3) 17-alpha-hydroxylase deficiency = Blocks synthesis of BOTH cortisol and all sex steroids (androgens & estrogens) while shunting into corticosterone/11-DOC -> results in NO breasts (sexual infantilism) + Uterus present (in 46,XX) + Hypertension + Hypokalemia!

Q11. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.111 Formative A2 2025 Q11 | Gyn Book p.183

Which of the following ovarian neoplasms has the highest statistical rate of bilaterality?

☐ **A.** Brenner tumor

✓ **B. Serous cystadenocarcinoma (and benign serous cystadenoma / Krukenberg tumor)**

☐ **C.** Mucinous cystadenoma

☐ **D.** Fibroma

Correct Answer: B (Serous cystadenocarcinoma (and benign serous cystadenoma / Krukenberg tumor))

Clinical Explanation: Serous epithelial ovarian tumors have the highest rate of bilaterality among primary ovarian neoplasms (~25% of benign serous cystadenomas and ~50–66% of malignant serous cystadenocarcinomas are bilateral; Comp Bank p.111 Q11; Gyn Book p.183). (Metastatic Krukenberg tumors are also bilateral in >80%).

Q12. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.131 Q6 | Gyn Book p.190

An official 'Carcinoma in Situ (Stage 0)' pre-invasive stage is NOT recognized in which of the following gynecological malignancies?

✓ **A. Ovarian carcinoma**

☐ **B.** Cervical neoplasia (CIN 3 / CIS)

☐ **C.** Vulvar neoplasia (VIN 3)

☐ **D.** Vaginal neoplasia (VaIN 3)

Correct Answer: A (Ovarian carcinoma)

Clinical Explanation: Because ovarian surface cancers present without a clinically screenable pre-invasive squamous epithelial 'Stage 0 / in situ' stage (unlike cervix CIN, vulva VIN, and vagina VaIN), an official 'in situ' stage is not recognized for ovarian cancer (Comp Bank p.131 Q6).

Q13. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.311 Q17 & Patho Q873 | Gyn Book p.194

Elevated serum Alpha-Fetoprotein (AFP) is a specific tumor marker used for the diagnosis and follow-up of which malignant ovarian tumor?

☐ **A.** Cervical squamous cell carcinoma

✓ **B. Endodermal sinus tumor (Yolk sac tumor)**

☐ **C.** Serous cystadenocarcinoma

☐ **D.** Granulosa cell tumor

☐ **E.** Dysgerminoma

Correct Answer: B (Endodermal sinus tumor (Yolk sac tumor))

Clinical Explanation: Memorize the Ovarian Tumor Markers table (Comp Bank p.311 Q17; Patho Q873; Gyn Book p.191): (1) CA-125 (& HE4) = Epithelial ovarian carcinoma (especially Serous); (2) CA 19-9 & CEA = Mucinous ovarian carcinoma; (3) Alpha-Fetoprotein (AFP) = Endodermal sinus (Yolk sac) tumor & Embryonal carcinoma; (4) Beta-hCG = Ovarian Choriocarcinoma & Embryonal carcinoma; (5) LDH & Placental ALP = Dysgerminoma; (6) Inhibin (A/B) & Estradiol/AMH = Granulosa cell tumor; (7) Testosterone = Sertoli-Leydig cell tumor.

Q14. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.441 Q9 | Gyn Book p.166

What is the most common initial mode of spread of low-grade endometrioid adenocarcinoma of the uterus?

✓ **A. Direct extension (into the myometrium and downward to the endocervix)**

☐ **B.** Early hematogenous metastasis to the brain

☐ **C.** Retrograde spread to the spleen

☐ **D.** Exclusive spread via the round ligament to the labia

Correct Answer: A (Direct extension (into the myometrium and downward to the endocervix))

Clinical Explanation: Endometrial carcinoma spreads most commonly by direct contiguous invasion into the underlying myometrium (and cervical stroma), followed by lymphatic spread to pelvic and para-aortic nodes, transtubal exfoliation to the peritoneum/ovaries, and late hematogenous spread to the lungs (Comp Bank p.441 Q9; Gyn Book p.166).

Q15. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Comp Bank p.611 Q9 | Gyn Book p.171

A 48-year-old woman with no history of cervical dysplasia has a routine Pap smear showing Atypical Squamous Cells of Undetermined Significance (ASC-US) and tests positive for high-risk HPV DNA. What is the next diagnostic step?

✓ **A. Colposcopy (with acetic acid & Lugol's iodine staining and directed cervical biopsy)**

☐ **B.** Immediate radical Wertheim hysterectomy

☐ **C.** Pelvic exenteration

☐ **D.** Reassurance and repeat Pap smear in 10 years

Correct Answer: A (Colposcopy (with acetic acid & Lugol's iodine staining and directed cervical biopsy))

Clinical Explanation: An abnormal Pap smear (ASC-US with positive high-risk HPV, or LSIL/HSIL) is an indication for Colposcopy with 3–5% acetic acid (showing acetowhite epithelium/punctation/mosaicism) and Schiller's Lugol's iodine test (dysplastic cells lack glycogen and are Schiller-positive / iodine-negative non-staining), followed by directed punch biopsy (Comp Bank p.611 Q9; Gyn Book p.171).

Q16. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Patho Solved MCQs Q811, Q816, Q886 | Gyn Book p.113

Regarding Condyloma acuminatum (anogenital warts), which of the following statements is CORRECT?

☐ **A.** It is induced by Epstein-Barr Virus (EBV)

✓ **B. It is a sexually transmitted papillary squamous lesion caused mainly by low-risk Human Papillomavirus (HPV types 6 and 11) and shows characteristic koilocytosis (perinuclear vacuolization)**

☐ **C.** It is identical to the flat condyloma latum of secondary syphilis

☐ **D.** It arises from the smooth muscle of the myometrium

Correct Answer: B (It is a sexually transmitted papillary squamous lesion caused mainly by low-risk Human Papillomavirus (HPV types 6 and 11) and shows characteristic koilocytosis (perinuclear vacuolization))

Clinical Explanation: Condyloma acuminatum is caused by HPV (90% low-risk types 6 and 11) and is characterized microscopically by papillomatosis, acanthosis, and viral cytopathic koilocytosis (perinuclear halo + crinkled hyperchromatic nucleus; Patho Q811, Q816, Q886). Do not confuse Condyloma acuminatum (HPV) with Condyloma lata (broad flat plaques of secondary Syphilis!).

Q17. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Patho Solved MCQs Q829–832 | Gyn Book p.28

On endometrial biopsy performed on day 22 of a 28-day menstrual cycle, which histological feature confirms that ovulation has occurred?

☐ **A.** Straight tubular glands with brisk pseudostratified mitotic activity (Proliferative phase)

✓ **B. Secretory changes (subnuclear glycogen vacuoles, tortuous 'saw-toothed' glands with intraluminal secretions, stromal edema, and predecidual reaction)**

☐ **C.** Complete absence of endometrial glands

☐ **D.** Swiss-cheese cystic glandular hyperplasia

Correct Answer: B (Secretory changes (subnuclear glycogen vacuoles, tortuous 'saw-toothed' glands with intraluminal secretions, stromal edema, and predecidual reaction))

Clinical Explanation: Progesterone secreted by the corpus luteum after ovulation converts the proliferative endometrium into a secretory endometrium. The earliest histological sign of ovulation (36–48 hours post-ovulation, day 16–17) is the appearance of subnuclear glycogen-rich vacuoles at the base of the glandular epithelial cells, followed by luminal secretion, stromal edema (day 21–22), and predecidual transformation of stromal cells around spiral arterioles (day 23–25) (Patho Q830–832; Gyn Book p.28).

Q18. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Patho Solved MCQs Q843 | Gyn Book p.166

Which histopathological subtype of endometrial carcinoma is an estrogen-independent Type II tumor that carries the most aggressive behavior and worst prognosis?

☐ **A.** Well-differentiated Grade 1 endometrioid adenocarcinoma

✓ **B. Uterine papillary serous carcinoma (and clear cell carcinoma)**

☐ **C.** Adenoacanthoma (endometrioid carcinoma with benign squamous metaplasia)

☐ **D.** Secretory adenocarcinoma

Correct Answer: B (Uterine papillary serous carcinoma (and clear cell carcinoma))

Clinical Explanation: Uterine papillary serous carcinoma (and clear cell carcinoma) are Type II non-endometrioid carcinomas (TP53 mutated) arising in atrophic endometrium of elderly women; they behave like high-grade ovarian serous cancer with early extrauterine/peritoneal spread and carry the worst prognosis (Patho Q843; Gyn Book p.166).

Q19. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Patho Solved MCQs Q850 | Obs Book p.42

Histopathologically, gestational choriocarcinoma consists of all of the following features EXCEPT:

☐ **A.** Malignant cytotrophoblast (Langhans) cells

☐ **B.** Malignant multinucleated syncytiotrophoblast cells

✓ **C. Well-formed chorionic villi with intrinsic fetal blood vessels and fibrous stroma**

☐ **D.** Extensive areas of hemorrhage and necrosis

Correct Answer: C (Well-formed chorionic villi with intrinsic fetal blood vessels and fibrous stroma)

Clinical Explanation: A critical diagnostic hallmark of Choriocarcinoma on pathology is the COMPLETE ABSENCE of chorionic villi and intrinsic stromal vasculature—it is a pure biphasic proliferation of malignant cytotrophoblasts and syncytiotrophoblasts invading myometrial blood vessels with massive central hemorrhage and necrosis (Patho Q850; Obs Book p.42). By contrast, Invasive Mole (chorioadenoma destruens) DOES contain hydropic chorionic villi invading the myometrium!

Q20. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Patho Solved MCQs Q851–852 | Gyn Book p.106

Regarding female genital tuberculosis (pelvic TB), which anatomical organ is the FIRST and MOST COMMON site affected (>90–95% of cases), and what is the primary mode of spread to the genital tract?

✓ **A. Fallopian tubes (bilateral tuberculous salpingitis, especially the ampulla) — reached via hematogenous spread from a primary pulmonary or renal focus**

☐ **B.** Vulvar skin — reached via direct sexual transmission

☐ **C.** Ectocervix — reached via ascending vaginal candidiasis

☐ **D.** Ovarian cortex only

Correct Answer: A (Fallopian tubes (bilateral tuberculous salpingitis, especially the ampulla) — reached via hematogenous spread from a primary pulmonary or renal focus)

Clinical Explanation: Female genital tuberculosis is almost always secondary to hematogenous (blood-borne) dissemination from a primary pulmonary focus (or lymphatic/direct spread from intestinal/peritoneal TB), and the Fallopian tubes (bilateral ampullary region) are affected in 90–100% of cases, followed by descending spread to the endometrium (50–60%) (Patho Q851–852; Gyn Book p.106). It causes infertility, secondary amenorrhea/oligomenorrhea, and 'tobacco-pouch' or 'lead-pipe' tubes on HSG.

Q21. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Patho Solved MCQs Q868 | Gyn Book p.186

Struma ovarii is a specialized monodermal ovarian teratoma characterized by the predominance of which tissue, and what endocrine disorder can it cause?

✓ **A. Mature thyroid tissue — may cause clinical hyperthyroidism (thyrotoxicosis)**

☐ **B.** Adrenal cortical tissue — causes Addison's disease

☐ **C.** Pancreatic islet beta cells — causes diabetes insipidus

☐ **D.** Striated cardiac muscle

Correct Answer: A (Mature thyroid tissue — may cause clinical hyperthyroidism (thyrotoxicosis))

Clinical Explanation: Struma ovarii is a monodermal teratoma composed predominantly (>50%) of mature thyroid follicles containing colloid, which can autonomously secrete T3/T4 and cause thyrotoxicosis in ~5–8% of patients (Patho Q868; Gyn Book p.186). Another monodermal teratoma is ovarian carcinoid tumor (secretes 5-HT/serotonin -> primary carcinoid syndrome without liver metastasis because ovarian venous drainage bypasses the portal vein!).

Q22. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Patho Solved MCQs Q875, Q916 | Gyn Book p.196

A 50-year-old woman with a history of gastric carcinoma presents with bilateral solid bosselated ovarian masses. Microscopic examination reveals mucin-producing 'signet-ring' malignant cells within a cellular ovarian stroma. What is the diagnosis?

✓ **A. Krukenberg tumor (metastatic signet-ring cell adenocarcinoma)**

☐ **B.** Benign ovarian fibroma

☐ **C.** Dysgerminoma

☐ **D.** Mature cystic teratoma

Correct Answer: A (Krukenberg tumor (metastatic signet-ring cell adenocarcinoma))

Clinical Explanation: Bilateral solid ovarian metastases composed of mucin-laden signet-ring cells (eccentric crescentic nuclei pushed to the periphery by intracellular mucin) represent a Krukenberg tumor, most commonly originating from the stomach (pylorus, ~70%), colon, breast, or biliary tract via retrograde lymphatic or transcoelomic spread (Patho Q875, Q916; Gyn Book p.196).

Q23. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Patho Solved MCQs Q879, Q891 | Gyn Book p.181

A 3-year-old female child presents with foul-smelling bloody vaginal discharge and a soft, edematous, polypoid 'grape-like' mass protruding through the vaginal introitus. Microscopically, the mass consists of malignant mesenchymal rhabdomyoblasts (cambium layer). What is the diagnosis?

✓ **A. Embryonal rhabdomyosarcoma (Sarcoma botryoides)**

☐ **B.** Squamous cell carcinoma of the ectocervix

☐ **C.** Benign Gartner duct cyst

☐ **D.** Lichen sclerosus

Correct Answer: A (Embryonal rhabdomyosarcoma (Sarcoma botryoides))

Clinical Explanation: Sarcoma botryoides (Embryonal rhabdomyosarcoma) is a malignant mesenchymal tumor of infants and young girls (<5 years) that presents as a grape-like ('botryoid') polypoid mass filling the vagina and causing vaginal bleeding (Patho Q879, Q891; Gyn Book p.181).

Q24. Gynecology Actual Past Exam

ACTUAL PAST EXAM — Patho Solved MCQs Q810 | Gyn Book p.97, 157

Regarding Bartholin's duct cyst and abscess, which statement is CORRECT?

✓ **A. It results from occlusion/obstruction of the main duct of Bartholin's (greater vestibular) gland, located at the 4 and 8 o'clock positions of the vestibule**

☐ **B.** It is a primary malignant ovarian tumor

☐ **C.** It opens into the anterior urethral meatus at 12 o'clock

☐ **D.** Surgical treatment is radical hysterectomy

Correct Answer: A (It results from occlusion/obstruction of the main duct of Bartholin's (greater vestibular) gland, located at the 4 and 8 o'clock positions of the vestibule)

Clinical Explanation: Bartholin's glands lie in the superficial perineal pouch at the 4 and 8 o'clock positions of the vaginal introitus (vestibule) and open into the groove between the hymen and labia minora. Obstruction of the duct (often post-inflammatory from gonococcal, chlamydial, or polymicrobial infection) produces a Bartholin's cyst or acute painful abscess, treated surgically by Marsupialization (or Word catheter) to preserve gland function (Patho Q810; Gyn Book p.97). In women >40 years old, biopsy/excision is indicated to exclude Bartholin gland adenocarcinoma.

Q25. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.17–21: Embryology of Female Genital Tract

Which embryonic structure gives rise to the fallopian tubes, uterus, cervix, and upper 2/3 of the vagina, versus which structure gives rise to the lower 1/3 of the vagina and vestibule?

✓ **A. Paramesonephric (Müllerian) ducts -> Fallopian tubes, uterus, cervix, and upper vagina; Urogenital sinus (sinovaginal bulbs) -> Lower vagina and vestibule**

☐ **B.** Mesonephric (Wolffian) ducts -> Fallopian tubes and uterus; Müllerian ducts -> Ovaries

☐ **C.** Genital tubercle -> Uterus and fallopian tubes

☐ **D.** Yolk sac endoderm -> Entire uterus and fallopian tubes

Correct Answer: A (Paramesonephric (Müllerian) ducts -> Fallopian tubes, uterus, cervix, and upper vagina; Urogenital sinus (sinovaginal bulbs) -> Lower vagina and vestibule)

Clinical Explanation: Because the Paramesonephric (Müllerian) ducts form the fallopian tubes, uterus, cervix, and upper 2/3 of the vagina while the Urogenital Sinus forms the lower 1/3 of the vagina and hymen, failure of canalization at the junction of the sinovaginal bulbs and urogenital sinus results in an Imperforate Hymen or Transverse Vaginal Septum (presenting at puberty with primary amenorrhea, cyclic monthly lower abdominal pain [cryptomenorrhea], hematocolpos, and hematometra!). Remnants of the Mesonephric (Wolffian) duct form Gartner's duct cysts in the anterolateral vaginal wall (Gyn Book p.17–20).

Q26. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.24–32: Menstrual Cycle Endocrinology

What is the exact hormonal trigger for ovulation in a normal 28-day menstrual cycle, and when does ovulation occur relative to this surge?

✓ **A. Sustained high estradiol (>200 pg/mL for >48 hours) from the dominant Graafian follicle switches hypothalamic-pituitary feedback from negative to POSITIVE, triggering the mid-cycle LH surge; ovulation occurs 32–36 hours after the onset of the LH surge (or 10–12 hours after the LH peak)**

☐ **B.** A sudden drop in estradiol to zero triggers a prolactin surge

☐ **C.** High progesterone from the adrenal gland on day 5 triggers ovulation

☐ **D.** The follicular phase is fixed at 14 days while the luteal phase varies from 7 to 30 days

Correct Answer: A (Sustained high estradiol (>200 pg/mL for >48 hours) from the dominant Graafian follicle switches hypothalamic-pituitary feedback from negative

to POSITIVE, triggering the mid-cycle LH surge; ovulation occurs 32–36 hours after the onset of the LH surge (or 10–12 hours after the LH peak))

Clinical Explanation: High-yield menstrual physiology facts (Gyn Book p.25–27): (1) Sustained estradiol (>200 pg/mL for 48 hrs) exerts POSITIVE feedback to trigger the LH surge; (2) Ovulation occurs 32–36 hours after LH surge onset (10–12 hrs after LH peak); (3) The Luteal phase is fixed at 14 days (life span of the corpus luteum unless rescued by hCG from an implanted blastocyst on day 8–9 post-fertilization), whereas variations in cycle length are due to variations in the Follicular (proliferative) phase!

Q27. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.33–34: Primary vs Secondary Dysmenorrhea

Which statement correctly differentiates Primary (spasmodic) Dysmenorrhea from Secondary (congestive) Dysmenorrhea?

✓ A. Primary dysmenorrhea occurs in young women within 6–24 months of menarche (once ovulatory cycles establish), has NO pelvic pathology, starts with or just before menstrual flow lasting 24–48 hours, is mediated by endometrial Prostaglandin F2-alpha (PGF2a), and responds to NSAIDs/COCs; Secondary dysmenorrhea is caused by underlying pelvic pathology (endometriosis, adenomyosis, PID, fibroids), pain precedes menstruation by several days, and pelvic exam is abnormal

☐ **B.** Primary dysmenorrhea occurs only in anovulatory cycles and is caused by large uterine fibroids

☐ **C.** Secondary dysmenorrhea starts on the first day of menarche and has a completely normal laparoscopy

☐ **D.** Prostaglandin E2 causes severe uterine spasm while PGF2a relaxes the uterus

Correct Answer: A (Primary dysmenorrhea occurs in young women within 6–24 months of menarche (once ovulatory cycles establish), has NO pelvic pathology, starts with or just before menstrual flow lasting 24–48 hours, is mediated by endometrial Prostaglandin F2-alpha (PGF2a), and responds to NSAIDs/COCs; Secondary dysmenorrhea is caused by underlying pelvic pathology (endometriosis, adenomyosis, PID, fibroids), pain precedes menstruation by several days, and pelvic exam is abnormal)

Clinical Explanation: Primary dysmenorrhea ONLY occurs in OVULATORY cycles (because secretory progesterone is required to synthesize excessive endometrial PGF2-alpha, which causes myometrial ischemia and hypercontractility; Gyn Book p.33). First-line treatment is Prostaglandin synthetase inhibitors (NSAIDs: mefenamic acid, ibuprofen) or ovulation suppression with COCs.

Q28. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.54–55: Hyperprolactinemia

Which of the following is NOT a recognized cause of hyperprolactinemia (and galactorrhea-amenorrhea)?

☐ **A.** Pituitary prolactin-secreting adenoma (prolactinoma)

☐ **B.** Primary hypothyroidism (due to elevated TRH stimulating pituitary lactotrophs)

☐ **C.** Dopamine D2-receptor antagonist drugs (metoclopramide, risperidone, haloperidol, phenothiazines, alpha-methyldopa)

✓ **D. Dopamine agonists (Cabergoline and Bromocriptine)**

☐ **E.** Chronic renal failure and chest wall trauma/herpes zoster

Correct Answer: D (Dopamine agonists (Cabergoline and Bromocriptine))

Clinical Explanation: Prolactin is under tonic INHIBITORY control by hypothalamic Dopamine (PIF). Therefore, anything that blocks dopamine (metoclopramide, antipsychotics, methyldopa, pituitary stalk compression) or stimulates TRH (primary hypothyroidism!) increases prolactin, causing GnRH suppression, anovulation, secondary amenorrhea, and galactorrhea (Gyn Book p.54). By contrast, Dopamine agonists (Cabergoline — 1st line, and Bromocriptine) LOWER prolactin and shrink prolactinomas!

Q29. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.39–44: Menopause & Hormone Replacement Therapy (HRT)

A 53-year-old postmenopausal woman with an intact uterus complains of severe debilitating vasomotor hot flashes and night sweats. She has no contraindications to hormone therapy. What is the mandatory rule when prescribing systemic Hormone Replacement Therapy (HRT) for her?

✓ **A. She MUST receive combined Estrogen PLUS a Progestogen (to protect the intact uterus against estrogen-induced endometrial hyperplasia and endometrial carcinoma)**

☐ **B.** Unopposed high-dose oral estrogen alone is safe in women with an intact uterus

☐ **C.** Serum LH and FSH levels are markedly decreased (<2 IU/L) in natural menopause

☐ **D.** Estradiol (E2) becomes the predominant circulating estrogen after menopause

Correct Answer: A (She MUST receive combined Estrogen PLUS a Progestogen (to protect the intact uterus against estrogen-induced endometrial hyperplasia and endometrial carcinoma))

Clinical Explanation: Menopause pearls (Gyn Book p.39–43): (1) Diagnosis is confirmed by 12 months of amenorrhea + elevated FSH (>30–40 IU/L); (2) Predominant estrogen after menopause is Estrone (E1), formed by peripheral aromatization of adrenal androstenedione

in adipose tissue (Physiology, Female Reproduction - StatPearls); (3) Systemic Estrogen-alone HRT is given ONLY to women who have had a hysterectomy; any woman with an INTACT UTERUS must receive combined Estrogen + Progestogen (or LNG-IUS) to prevent endometrial hyperplasia/cancer! (Note: For isolated genitourinary syndrome / vaginal atrophy without hot flashes, low-dose topical vaginal estrogen is first-line).

Q30. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.137–138: PALM-COEIN Classification of AUB

In the FIGO PALM-COEIN classification system for Abnormal Uterine Bleeding (AUB) in reproductive-aged women, what do the structural ('PALM') versus non-structural ('COEIN') acronyms stand for?

✓ **A. PALM (Structural): Polyp, Adenomyosis, Leiomyoma, Malignancy & hyperplasia; COEIN (Non-structural): Coagulopathy, Ovulatory dysfunction, Endometrial, Iatrogenic, Not yet classified**

☐ **B.** PALM: Pregnancy, Abortion, Labor, Menopause; COEIN: Cancer, Ovarian cyst, Ectopic, Infection, Neoplasia

☐ **C.** PALM refers only to postmenopausal women

☐ **D.** COEIN refers to congenital Müllerian anomalies only

Correct Answer: A (PALM (Structural): Polyp, Adenomyosis, Leiomyoma, Malignancy & hyperplasia; COEIN (Non-structural): Coagulopathy, Ovulatory dysfunction, Endometrial, Iatrogenic, Not yet classified)

Clinical Explanation: FIGO PALM-COEIN classification (Gyn Book p.137): PALM = structural causes diagnosable by imaging/histopathology (Polyp, Adenomyosis, Leiomyoma, Malignancy/hyperplasia); COEIN = non-structural causes (Coagulopathy [e.g. vWD], Ovulatory dysfunction [e.g. PCOS], Endometrial primary disorder, Iatrogenic [e.g. IUD/anticoagulants/breakthrough], Not yet classified).

Q31. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.142–149: Uterine Fibroid Locations & GnRH Agonists

Which anatomical type of uterine leiomyoma (fibroid) is most strongly associated with heavy menstrual bleeding, subfertility/miscarriage, and hysteroscopic resection, and what is the maximum recommended duration of preoperative GnRH agonist (e.g., Leuprolide/Goserelin) therapy without add-back?

✓ **A. Submucosal leiomyoma (FIGO types 0, 1, 2) — resected via operative hysteroscopy; Preoperative GnRH agonists shrink fibroid volume by 30–50% and correct anemia over 3–6 months (limited to <=6 months due to trabecular bone loss and menopausal flare/hypoestrogenism)**

☐ **B.** Subserosal pedunculated leiomyoma (FIGO type 7) — causes heavy bleeding in 100% of cases and is resected hysteroscopically

☐ **C.** Cervical leiomyoma — treated with lifelong GnRH agonist for 10 years

☐ **D.** Fibroids grow rapidly after menopause without HRT

Correct Answer: A (Submucosal leiomyoma (FIGO types 0, 1, 2) — resected via operative hysteroscopy; Preoperative GnRH agonists shrink fibroid volume by 30–50% and correct anemia over 3–6 months (limited to <=6 months due to trabecular bone loss and menopausal flare/hypoestrogenism))

Clinical Explanation: Submucosal fibroids (protruding into the endometrial cavity) distort the endometrium, impair implantation, and cause severe menorrhagia even when small; they are best removed via Hysteroscopic Myomectomy (Uterine Leiomyomata - StatPearls). Preoperative GnRH agonists induce medical pseudomenopause (downregulating GnRH receptors after an initial 7-day flare), shrinking fibroids by 30–50% to allow Pfannenstiel/vaginal surgery and raise Hb before surgery, but use is limited to 3–6 months due to osteoporosis/bone mineral density loss.

Q32. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.116–122: Pelvic Organ Prolapse Classification & Surgery

Match the classical vaginal prolapse anatomical defect with its definitive native-tissue surgical repair:

✓ **A. Cystocele (upper 2/3 anterior vaginal wall) -> Anterior colporrhaphy; Rectocele (posterior vaginal wall) -> Posterior colporrhaphy (+ perineorrhaphy); Uterovaginal prolapse in young woman desiring uterine preservation/fertility -> Manchester (Fothergill) operation or Sacrohysteropexy; Complete procidentia in elderly frail woman unfit for major surgery and not sexually active -> Le Fort colpocleisis**

☐ **B.** Cystocele -> Posterior colporrhaphy; Rectocele -> Anterior colporrhaphy

☐ **C.** Procidentia in a 22-year-old nullipara -> Vaginal hysterectomy and colpocleisis

☐ **D.** Enterocele -> Simple meatotomy

Correct Answer: A (Cystocele (upper 2/3 anterior vaginal wall) -> Anterior colporrhaphy; Rectocele (posterior vaginal wall) -> Posterior colporrhaphy (+ perineorrhaphy); Uterovaginal prolapse in young woman desiring uterine preservation/fertility -> Manchester (Fothergill) operation or Sacrohysteropexy; Complete procidentia in elderly frail woman unfit for major surgery and not sexually active -> Le Fort colpocleisis)

Clinical Explanation: High-yield prolapse surgery matching (Gyn Book p.120–122): (1) Cystocele = Anterior colporrhaphy; (2) Rectocele = Posterior colporrhaphy; (3) Young patient desiring fertility with cervical elongation/prolapse = Manchester-Fothergill operation

(amputation of elongated cervix + plication of cardinal ligaments in front of cervical stump; note: cervical amputation increases future cervical incompetence/miscarriage risk) or Abdominal/Laparoscopic Sacrohysteropexy; (4) Completed family with severe uterine prolapse = Vaginal Hysterectomy + pelvic floor repair; (5) Post-hysterectomy vaginal vault prolapse = Abdominal sacrocolpopexy (to anterior longitudinal ligament of sacrum) or vaginal sacrospinous ligament fixation.

Q33. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.131–135: Vesicovaginal vs Ureterovaginal Fistula (Three-Swab Test)

A 38-year-old woman develops continuous painless watery vaginal leakage 10 days after a difficult abdominal hysterectomy. On the Methylene Blue 'Three-Swab (Tampon) Test' (instilling blue dye into the urinary bladder via a Foley catheter while placing 3 cotton swabs in the vagina), the upper (apical) vaginal swab becomes wet with CLEAR (unstained) urine while the middle and lower swabs remain dry and unstained. What is the diagnosis?

✓ **A. Ureterovaginal fistula**

☐ **B.** Vesicovaginal fistula (VVF)

☐ **C.** Urethrovaginal fistula

☐ **D.** Severe genuine stress incontinence

Correct Answer: A (Ureterovaginal fistula)

Clinical Explanation: Memorize the Three-Swab Test with intravesical Methylene Blue (Gyn Book p.133): (1) Upper swab wet with CLEAR urine (unstained by bladder dye, stained yellow/orange if oral phenazopyridine/IV indigo carmine given) = Ureterovaginal fistula; (2) Middle swab wet with BLUE dye = Vesicovaginal fistula (VVF); (3) Lowest swab wet with BLUE dye only during coughing/voiding = Urethrovaginal fistula or Stress Incontinence.

Q34. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.179–180: Carcinoma of the Vulva

What is the most common histological type of invasive vulvar cancer (~90%), what is its primary route of lymphatic metastasis, and which lymph node group is the FIRST station of spread?

✓ **A. Squamous cell carcinoma (~90%) — spreads primarily via lymphatics to the superficial inguinal (inguinofemoral) lymph nodes first, then to deep femoral (Cloquet's node) and external iliac/pelvic nodes**

☐ **B.** Adenocarcinoma — spreads directly to para-aortic nodes first

☐ **C.** Melanoma — never metastasizes to lymph nodes

☐ **D.** Basal cell carcinoma — metastasizes hematogenously to the brain in 95%

Correct Answer: A (Squamous cell carcinoma (~90%) — spreads primarily via lymphatics to the superficial inguinal (inguinofemoral) lymph nodes first, then to deep femoral (Cloquet's node) and external iliac/pelvic nodes)

Clinical Explanation: 90% of vulvar cancers are Squamous Cell Carcinomas (bimodal: HPV-16 related in younger women vs Lichen sclerosus/differentiated VIN related in elderly women; Gyn Book p.179). Lymphatic drainage of the vulva goes FIRST to the superficial inguinal and deep femoral lymph nodes (Cloquet's node at the femoral canal), and only then to the pelvic (external iliac) nodes. Lateral lesions (>1–2 cm from midline) drain to ipsilateral inguinofemoral nodes, whereas midline lesions involving the clitoris/perineum drain bilaterally!

Q35. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.68–71: Male Factor Infertility & WHO Semen Analysis

In the evaluation of an infertile couple, male factor infertility accounts for ~30–40% of cases. According to WHO lower reference limits for normal semen analysis, which parameter below is NORMAL?

✓ **A. Volume >= 1.5 mL, Sperm concentration >= 15 million/mL (total count >= 39 million), Total motility >= 40% (progressive motility >= 32%), and Normal morphology >= 4% (strict Kruger criteria)**

☐ **B.** Sperm concentration of 1 million/mL and 0% motility

☐ **C.** Acidic semen pH of 3.0 with absence of fructose in normal fertile men

☐ **D.** Semen analysis should only be ordered after performing 3 laparoscopies on the wife

Correct Answer: A (Volume >= 1.5 mL, Sperm concentration >= 15 million/mL (total count >= 39 million), Total motility >= 40% (progressive motility >= 32%), and Normal morphology >= 4% (strict Kruger criteria))

Clinical Explanation: Because Semen Analysis is non-invasive, inexpensive, and male factor contributes to 30–40% of infertility, Semen Analysis (after 2–7 days of sexual abstinence) is ALWAYS one of the very first investigations ordered in an infertile couple! Normal WHO 2010/2021 cutoffs: Volume >=1.4–1.5 mL, Concentration >=15–16 million/mL, Total motility >=40–42% (Progressive >=30–32%), Normal forms >=4% (Gyn Book p.69). Note: Azoospermia with low volume, acidic pH, and absent seminal fructose indicates congenital bilateral absence of the vas deferens (CBAVD / CFTR mutation) or ejaculatory duct obstruction; High FSH in azoospermia indicates primary testicular failure (non-obstructive), whereas Normal FSH indicates obstructive azoospermia.

Q36. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.187: Meigs Syndrome

What is the classic clinical triad of Meigs Syndrome, and what happens to the effusions after surgical removal of the pelvic mass?

✓ **A. Benign solid ovarian fibroma (or fibroma-like tumor/thecoma/Brenner) + Ascites + Right-sided (or bilateral) pleural effusion (hydrothorax), which completely and permanently resolve after surgical excision of the ovarian tumor**

☐ **B.** Malignant ovarian serous carcinoma + liver metastases + brain metastases

☐ **C.** Endometrioma + pneumothorax + hemoptysis (catamenial pneumothorax)

☐ **D.** Polycystic ovaries + hirsutism + amenorrhea

Correct Answer: A (Benign solid ovarian fibroma (or fibroma-like tumor/thecoma/Brenner) + Ascites + Right-sided (or bilateral) pleural effusion (hydrothorax), which completely and permanently resolve after surgical excision of the ovarian tumor)

Clinical Explanation: Meigs syndrome is a crucial clinical mimic of advanced ovarian malignancy: a benign solid ovarian Fibroma (composed of spindle-shaped fibroblasts producing collagen; Patho Q914) presents with ascites and pleural effusion (most commonly right-sided hydrothorax via transdiaphragmatic lymphatics), yet it is completely benign and both the ascites and hydrothorax vanish permanently once the fibroma is excised (Gyn Book p.187).

Q37. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.205–207: Laparoscopy vs Hysteroscopy Distension Media & Complications

What is the standard gas used to create pneumoperitoneum during diagnostic/operative gynecological laparoscopy, and what is the classic electrolyte complication of prolonged operative hysteroscopy using hypotonic electrolyte-free distension media (e.g., 1.5% Glycine or Sorbitol) with monopolar cautery?

✓ **A. Laparoscopy gas: Carbon dioxide (CO_2); Hysteroscopy complication with hypotonic glycine: Fluid intravasation overload causing severe dilutional Hyponatremia, hypo-osmolality, cerebral edema, and ammonia toxicity**

☐ **B.** Laparoscopy gas: 100% Oxygen (explosive with electrocautery!); Hysteroscopy complication: Hypernatremia

☐ **C.** Laparoscopy gas: Liquid nitrogen; Hysteroscopy uses barium sulfate

☐ **D.** Operative hysteroscopy is safely performed in the presence of active viable intrauterine pregnancy and acute PID

Correct Answer: A (Laparoscopy gas: Carbon dioxide (CO2); Hysteroscopy complication with hypotonic glycine: Fluid intravasation overload causing severe dilutional Hyponatremia, hypo-osmolality, cerebral edema, and ammonia toxicity)

Clinical Explanation: Endoscopy pearls (Gyn Book p.205–207): (1) Laparoscopy uses CO2 gas because it is non-combustible (safe with electrocautery) and highly soluble in blood (rapidly exhaled via lungs, though diaphragmatic phrenic nerve irritation causes postoperative shoulder-tip pain); (2) Monopolar operative hysteroscopy requires non-conductive, electrolyte-free distension media (1.5% Glycine, Sorbitol/Mannitol), and excessive fluid deficit (>1,000 mL) causes acute dilutional Hyponatremia and cerebral edema! By contrast, Bipolar hysteroscopy can safely use isotropic Normal Saline (0.9% NaCl), though fluid deficit must still be capped (<2,500 mL) to prevent pulmonary edema. Contraindications to hysteroscopy: viable intrauterine pregnancy, acute pelvic infection (PID/cervicitis), and active invasive cervical cancer.

Q38. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.123–124: Retroversion Flexion (RVF) of the Uterus

Which statement is TRUE regarding Retroversion Flexion (RVF) of the uterus?

✓ **A. Mobile (uncomplicated) RVF occurs as a normal anatomical variant in ~15–20% of women and is usually asymptomatic; Fixed RVF is caused by pelvic pathology (endometriosis, chronic PID, or pelvic malignancy) tethering the uterine fundus in the Pouch of Douglas, causing deep dyspareunia, congestive dysmenorrhea, and backache**

☐ **B.** Mobile asymptomatic RVF in a routine pelvic exam requires immediate emergency laparotomy

☐ **C.** Fixed RVF is best corrected by forceful blind bimanual manipulation in the clinic without anesthesia

☐ **D.** Retroverted gravid uterus incarcerated at 13–14 weeks never causes acute urinary retention

Correct Answer: A (Mobile (uncomplicated) RVF occurs as a normal anatomical variant in ~15–20% of women and is usually asymptomatic; Fixed RVF is caused by pelvic pathology (endometriosis, chronic PID, or pelvic malignancy) tethering the uterine fundus in the Pouch of Douglas, causing deep dyspareunia, congestive dysmenorrhea, and backache)

Clinical Explanation: Mobile RVF is a benign variant in ~20% of women requiring no treatment if asymptomatic (Gyn Book p.123). Fixed RVF is due to adhesions in the Pouch of Douglas (endometriosis, chronic PID) and causes deep collision dyspareunia (from prolapsed ovaries in the cul-de-sac). Note: Rarely, a gravid retroverted uterus fails to rise out of the

sacral hollow at 12–14 weeks (incarcerated retroverted gravid uterus), stretching the urethra anteriorly and causing acute retention of urine in pregnancy (treated by slow bladder catheterization + knee-chest position).

Q39. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.191: Risk of Malignancy Index (RMI) for Ovarian Masses

In evaluating an adnexal mass, the Risk of Malignancy Index (RMI I) is calculated by multiplying which three parameters together (RMI = U x M x CA-125)?

✓ **A. Ultrasound score (U: multilocular, solid areas, bilateral, ascites, intra-abdominal metastases) x Menopausal status (M: 1 for premenopausal, 3 for postmenopausal) x Serum CA-125 concentration (IU/L); an RMI > 200 (or >250) indicates high risk of malignancy requiring referral to a gynecologic oncologist**

☐ **B.** Uterine length x Maternal age x Serum beta-hCG

☐ **C.** Urine output x Menstrual cycle day x Serum FSH

☐ **D.** Ultrasound Doppler resistance x BMI x Serum prolactin

Correct Answer: A (Ultrasound score (U: multilocular, solid areas, bilateral, ascites, intra-abdominal metastases) x Menopausal status (M: 1 for premenopausal, 3 for postmenopausal) x Serum CA-125 concentration (IU/L); an RMI > 200 (or >250) indicates high risk of malignancy requiring referral to a gynecologic oncologist)

Clinical Explanation: The Risk of Malignancy Index (RMI = U x M x CA-125; Gyn Book p.191) combines: (1) Ultrasound features (5 features: multilocular cyst, solid areas, bilateral lesions, ascites, metastases; 0 features = U=0, 1 feature = U=1, >=2 features = U=3), (2) Menopausal status (Premenopausal M=1; Postmenopausal M=3), and (3) Serum CA-125 level in IU/L. An RMI <25 is low risk (<3%), 25–200 is moderate risk, and >200 is high risk (>75% malignancy).

Q40. Gynecology New Pattern-Matched

NEW PATTERN-MATCHED — Gyn Book p.3–15: Pelvic Lymphatic Drainage & Nerve Supply

Match the anatomical parts of the female genital tract with their primary lymphatic drainage:

✓ **A. Vulva & lower 1/3 of vagina -> Superficial & deep inguinofemoral lymph nodes; Cervix, upper 2/3 of vagina & lower uterine corpus -> Pelvic lymph nodes (parametrial, obturator, internal & external iliac, sacral); Ovary, fallopian tube & uterine fundus -> Para-aortic (lumbar) lymph nodes along the gonadal vessels (plus superficial inguinal nodes from uterine cornu via round ligament)**

☐ **B.** Ovary drains exclusively to the superficial inguinal lymph nodes

☐ **C.** Vulva drains directly to the mediastinal lymph nodes first

☐ **D.** Cervix drains exclusively to the axillary lymph nodes

Correct Answer: A (Vulva & lower 1/3 of vagina -> Superficial & deep inguinofemoral lymph nodes; Cervix, upper 2/3 of vagina & lower uterine corpus -> Pelvic lymph nodes (parametrial, obturator, internal & external iliac, sacral); Ovary, fallopian tube & uterine fundus -> Para-aortic (lumbar) lymph nodes along the gonadal vessels (plus superficial inguinal nodes from uterine cornu via round ligament))

Clinical Explanation: This anatomical lymphatic rule explains all gynecologic cancer staging and lymphadenectomy patterns (Gyn Book p.11–13): (1) Vulva & lower 1/3 vagina -> Inguinofemoral nodes; (2) Cervix, upper 2/3 vagina, & uterine body -> Pelvic nodes (obturator, internal/external iliac); (3) Ovary, tube, & uterine fundus -> Para-aortic nodes (accompanying the ovarian vessels to the aorta/renal vessels); (4) Uterine cornu along the round ligament -> Superficial inguinal nodes.