FINAL YEAR MBBS · SINGLE BEST ANSWER

Gynaecology MCQs for MBBS

Clinical-scenario SBAs with full explanations
Based on *Gynaecology by Ten Teachers*

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Published by Prof. Zahid Mahmood · professorzahid.com · 0300-4130159
800 MCQs in 16 chapters

How to use this book

Each question starts with a clinical scenario followed by five options (A–E). Choose the single best answer, then read the explanation. Every explanation covers why the key is correct, why each other option is wrong, a key point to remember, and a reference.

Questions are marked **Easy**, **Moderate** or **Hard**, with cognitive level C2 (understanding) or C3 (application). Practise the same questions online, in timed exam mode, at **professorzahid.com**.

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CHAPTER 1

Anatomy and Development

MCQ 1 · Pelvic Anatomy · **Moderate** · C2

A 46-year-old woman had a total abdominal hysterectomy for a large fibroid uterus. On the second postoperative day she develops left loin pain and a temperature of 38.2°C. Her creatinine has risen from 70 to 135 µmol/L. Ultrasound shows a dilated left renal pelvis and ureter.

Which structure was most likely injured while the uterine vessels were being clamped?

A. Genitofemoral nerve
B. Internal iliac vein
C. Obturator nerve
D. Ovarian vein
E. Ureter

Answer: E. Ureter

The ureter passes beneath the uterine artery about 1.5–2 cm lateral to the cervix ("water under the bridge"). Clamping the uterine vessels too low or too lateral can catch or kink it, giving hydronephrosis, loin pain and rising creatinine.

Why not the others

- **A:** Genitofemoral nerve injury causes groin or labial numbness, not hydronephrosis.
- **B:** Internal iliac vein injury presents with intraoperative bleeding.
- **C:** Obturator nerve injury causes weak thigh adduction and medial thigh numbness.
- **D:** The ovarian vein lies in the infundibulopelvic ligament, away from the uterine pedicle, and does not obstruct the kidney.

Key point: Identify the ureter before clamping the infundibulopelvic ligament and the uterine pedicle. These are the two commonest sites of ureteric injury at hysterectomy.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Gynaecological surgery

MCQ 2 · Lymphatic Drainage · **Easy** · C2

A 70-year-old woman has a 2 cm ulcerated lesion on the right labium majus, 3 cm from the midline. Biopsy confirms squamous cell carcinoma. The surgeon plans sentinel lymph node assessment.

Which group of lymph nodes is the first to receive drainage from this lesion?

A. Deep inguinal nodes
B. External iliac nodes
C. Internal iliac nodes
D. Para-aortic nodes
E. Superficial inguinal nodes

Answer: E. Superficial inguinal nodes

The vulva drains first to the superficial inguinal nodes, then to the deep inguinal (femoral) nodes, and then to the external iliac nodes. A lateral lesion drains mainly to the ipsilateral groin.

Why not the others

- **A:** Deep inguinal (femoral) nodes are the second station, after the superficial nodes.
- **B:** External iliac nodes are reached only after the inguinofemoral nodes.
- **C:** Internal iliac nodes drain the cervix and upper vagina, not the vulva.
- **D:** Para-aortic nodes drain the ovaries and fundus of the uterus.

Key point: Vulva → superficial inguinal → deep inguinal → external iliac nodes.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Lymphatic drainage

MCQ 3 · Lymphatic Drainage · **Moderate** · C2

A 55-year-old woman is diagnosed with epithelial ovarian cancer. Staging CT shows enlarged lymph nodes. The ovarian lymphatics travel with the ovarian vessels in the infundibulopelvic ligament.

Which nodes receive the primary lymphatic drainage of the ovary?

A. Deep inguinal nodes
B. External iliac nodes
C. Obturator nodes
D. Para-aortic nodes
E. Superficial inguinal nodes

Answer: D. Para-aortic nodes

Ovarian lymphatics follow the ovarian vessels up to the para-aortic (lumbar) nodes at the level of the renal vessels, because the ovary develops on the posterior abdominal wall and descends into the pelvis.

Why not the others

- **A:** Deep inguinal nodes drain the lower limb and vulva.
- **B:** External iliac nodes are a secondary route via the broad ligament, not the primary one.
- **C:** Obturator nodes drain the cervix.
- **E:** Superficial inguinal nodes drain the vulva and lower vagina.

Key point: Ovary and testis both drain to para-aortic nodes because both gonads start near the kidneys.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Malignant disease of the ovary

MCQ 4 · Venous Drainage · **Moderate** · C2

A 32-year-old woman (para 4) has a dull pelvic ache for a year that is worse after prolonged standing and at the end of the day. Pelvic examination is normal. Doppler ultrasound shows a dilated left ovarian vein with reflux, suggesting pelvic congestion syndrome.

Into which vessel does the left ovarian vein drain?

A. Inferior vena cava
B. Left common iliac vein
C. Left internal iliac vein
D. Left renal vein
E. Left suprarenal vein

Answer: D. Left renal vein

The left ovarian vein drains into the left renal vein at a right angle, while the right ovarian vein drains directly into the inferior vena cava. This is why left-sided ovarian vein reflux and varicocele-type problems are more common.

Why not the others

- **A:** The right ovarian vein, not the left, drains into the IVC.
- **B:** The common iliac vein receives the internal and external iliac veins.
- **C:** The internal iliac vein drains the uterus via the uterine veins, not the ovary.
- **E:** The left suprarenal vein also drains into the left renal vein but does not receive the ovarian vein.

Key point: Right ovarian vein → IVC; left ovarian vein → left renal vein.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Chronic pelvic pain

MCQ 5 · Arterial Supply · **Easy** · C2

During a laparoscopic right oophorectomy, there is brisk bleeding from the infundibulopelvic ligament after the ovarian pedicle slips from a clip.

From which vessel does the bleeding artery arise?

A. Abdominal aorta
B. Common iliac artery
C. External iliac artery
D. Internal iliac artery
E. Renal artery

Answer: A. Abdominal aorta

The ovarian artery arises from the front of the abdominal aorta just below the renal arteries. It runs down in the infundibulopelvic (suspensory) ligament to reach the ovary.

Why not the others

- **B:** The common iliac artery gives only the internal and external iliac arteries.
- **C:** The external iliac artery supplies the lower limb.
- **D:** The internal iliac artery gives the uterine artery, not the ovarian artery.
- **E:** The renal artery supplies the kidney; the ovarian artery arises just below it, from the aorta.

Key point: Ovarian artery comes from the aorta; uterine artery comes from the internal iliac.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis

MCQ 6 · Arterial Supply · **Easy** · C2

A 40-year-old woman with symptomatic fibroids is treated by uterine artery embolisation. The radiologist passes a catheter from the femoral artery and selectively cannulates the uterine artery on each side.

The uterine artery is a branch of which vessel?

A. Anterior division of the internal iliac artery
B. Common iliac artery
C. External iliac artery
D. Inferior epigastric artery
E. Posterior division of the internal iliac artery

Answer: A. Anterior division of the internal iliac artery

The uterine artery arises from the anterior division of the internal iliac artery. It runs medially in the base of the broad ligament, crosses above the ureter, and ascends along the side of the uterus.

Why not the others

- **B:** The common iliac artery divides into internal and external iliac arteries; it has no uterine branch.
- **C:** The external iliac artery supplies the lower limb.
- **D:** The inferior epigastric artery supplies the anterior abdominal wall.
- **E:** The posterior division gives the iliolumbar, lateral sacral and superior gluteal arteries.

Key point: Visceral pelvic arteries (uterine, vesical, middle rectal, internal pudendal) come from the anterior division of the internal iliac artery.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Benign conditions of the uterus

MCQ 7 · Nerve Supply · **Easy** · C2

A 30-year-old woman needs a vulval procedure under regional anaesthesia. A pudendal nerve block is given transvaginally. The operator palpates a bony landmark on the lateral vaginal wall and injects just medial and posterior to it.

Which bony landmark is used?

A. Coccyx
B. Ischial spine
C. Ischial tuberosity
D. Obturator foramen
E. Sacral promontory

Answer: B. Ischial spine

The pudendal nerve passes behind the ischial spine and sacrospinous ligament as it re-enters the pelvis through the lesser sciatic foramen. The ischial spine is felt through the lateral vaginal wall and guides the block.

Why not the others

- **A:** The coccyx lies in the midline posteriorly and is not related to the nerve.
- **C:** The ischial tuberosity is used as a landmark for the transperineal approach, not the transvaginal one.
- **D:** The obturator foramen transmits the obturator nerve.
- **E:** The sacral promontory is not palpable vaginally and is far above the nerve.

Key point: Pudendal block: palpate the ischial spine, inject behind the sacrospinous ligament.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis

MCQ 8 · Nerve Supply · **Easy** · C2

A 45-year-old woman develops numbness of the perineum and faecal urgency after pelvic surgery. Examination shows reduced sensation over the vulva and perineum and a weak anal sphincter squeeze. A pudendal neuropathy is suspected.

From which spinal nerve roots does the pudendal nerve arise?

A. L1
B. L1–L2
C. L4–L5
D. S1–S2
E. S2–S4

Answer: E. S2–S4

The pudendal nerve arises from the ventral rami of S2, S3 and S4. It supplies the external anal and urethral sphincters, the perineal muscles and the skin of the vulva and perineum.

Why not the others

- **A:** L1 forms the ilioinguinal and iliohypogastric nerves.
- **B:** L1–L2 form the genitofemoral nerve.
- **C:** L4–L5 contribute to the lumbosacral trunk and sciatic nerve.
- **D:** S1–S2 contribute to the sciatic and gluteal nerves.

Key point: "S2, 3, 4 keeps the faeces off the floor": pudendal nerve and pelvic floor.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis

MCQ 9 · Nerve Injury · **Moderate** · C2

A 48-year-old woman underwent radical hysterectomy with pelvic lymphadenectomy for cervical cancer. On the first postoperative day she finds it difficult to cross her legs. There is numbness over a small area of the medial thigh. Knee extension is normal.

Which nerve has most likely been injured?

A. Femoral nerve
B. Genitofemoral nerve
C. Ilioinguinal nerve
D. Obturator nerve
E. Sciatic nerve

Answer: D. Obturator nerve

The obturator nerve runs along the lateral pelvic wall within the obturator fossa, where obturator nodes are cleared. Injury causes weak thigh adduction and numbness of the medial thigh.

Why not the others

- **A:** Femoral nerve injury causes weak knee extension and anterior thigh numbness.
- **B:** Genitofemoral injury causes numbness of the labium majus and upper anterior thigh without weakness.
- **C:** Ilioinguinal injury causes groin and labial pain or numbness, not weakness.
- **E:** Sciatic injury causes foot drop and weak knee flexion.

Key point: Obturator nerve = thigh adduction. Look for it before clearing obturator nodes.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Gynaecological surgery

MCQ 10 · Nerve Injury · **Moderate** · C3

A 52-year-old thin woman had an abdominal hysterectomy through a Pfannenstiel incision with a large self-retaining retractor in place for 3 hours. Next day she cannot straighten her knee to climb into bed and has numbness over the front of her thigh. The patellar reflex is absent.

Which nerve has most likely been injured?

A. Femoral nerve
B. Genitofemoral nerve
C. Lateral cutaneous nerve of thigh
D. Obturator nerve
E. Sciatic nerve

Answer: A. Femoral nerve

The lateral blades of a self-retaining retractor can compress the femoral nerve against the psoas muscle, especially in thin women and long operations. This weakens quadriceps (knee extension), abolishes the knee jerk and numbs the anterior thigh.

Why not the others

- **B:** The genitofemoral nerve is sensory only and does not affect the knee.
- **C:** The lateral cutaneous nerve of thigh gives lateral thigh numbness (meralgia paraesthetica) without weakness.
- **D:** Obturator nerve injury weakens adduction, not knee extension.
- **E:** Sciatic injury weakens knee flexion and the foot.

Key point: Prevent femoral nerve injury: use short lateral retractor blades and check they are not resting on psoas.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 11 · Nerve Injury · **Hard** · C3

A 35-year-old woman complains of burning pain near the lateral end of her Pfannenstiel scar for 4 months after a hysterectomy. The pain radiates to the labium majus and the upper medial thigh. Pressing a point just medial to the anterior superior iliac spine reproduces the pain.

Which nerve is most likely entrapped?

A. Genitofemoral nerve
B. Iliohypogastric nerve
C. Ilioinguinal nerve
D. Lateral cutaneous nerve of thigh
E. Obturator nerve

Answer: C. Ilioinguinal nerve

The ilioinguinal nerve (L1) can be caught in the lateral angle of a Pfannenstiel closure. It supplies the skin of the mons, labium majus and upper medial thigh, so entrapment causes burning pain in that area with a trigger point near the scar.

Why not the others

- **A:** The genitofemoral nerve runs on psoas and is not usually caught in the scar.
- **B:** The iliohypogastric nerve supplies the suprapubic skin and does not reach the labium.
- **D:** The lateral cutaneous nerve of thigh causes lateral thigh pain.
- **E:** The obturator nerve lies deep in the pelvis and causes medial thigh symptoms with weak adduction.

Key point: Burning scar pain radiating to the labium after Pfannenstiel = ilioinguinal or iliohypogastric entrapment; a local anaesthetic block confirms it.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Chronic pelvic pain

MCQ 12 · Laparoscopic Anatomy · **Moderate** · C2

During laparoscopic ovarian cystectomy, a 5 mm port is inserted in the left lower quadrant, just lateral to the edge of the rectus muscle. At the end of the operation a large haematoma develops in the abdominal wall at this port site.

Which vessel is most likely injured?

A. Deep circumflex iliac artery
B. Inferior epigastric artery
C. Superficial circumflex iliac artery
D. Superficial epigastric artery
E. Superior epigastric artery

Answer: B. Inferior epigastric artery

The inferior epigastric artery runs upward deep to the rectus muscle along its lateral part. Lateral ports should be placed under direct vision, lateral to the vessels, which can be seen laparoscopically lateral to the medial umbilical fold.

Why not the others

- **A:** The deep circumflex iliac artery runs near the iliac crest, well lateral to port sites.
- **C:** The superficial circumflex iliac artery is a small vessel near the inguinal ligament.
- **D:** The superficial epigastric artery lies in subcutaneous fat and usually causes minor bleeding.
- **E:** The superior epigastric artery is in the upper abdomen.

Key point: Transilluminate the abdominal wall and look for the inferior epigastric vessels before placing lateral ports.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Laparoscopy

MCQ 13 · Pelvic Support · **Easy** · C2

A 62-year-old woman (para 6) has a uterine prolapse with the cervix reaching the introitus. At vaginal hysterectomy, the surgeon secures the main ligaments that give level I (apical) support to the cervix and upper vagina.

Which ligament gives the main support to the cervix along with the uterosacral ligaments?

A. Broad ligament
B. Cardinal ligament
C. Ovarian ligament
D. Round ligament
E. Suspensory ligament of ovary

Answer: B. Cardinal ligament

The cardinal (transverse cervical, Mackenrodt's) ligaments and the uterosacral ligaments form the level I support of the cervix and vaginal vault. Weakness here causes uterine or vault prolapse.

Why not the others

- **A:** The broad ligament is a peritoneal fold that gives little support.
- **C:** The ovarian ligament attaches the ovary to the uterus.
- **D:** The round ligament maintains anteversion but does not prevent prolapse.
- **E:** The suspensory ligament carries the ovarian vessels.

Key point: Level I support: cardinal and uterosacral ligaments. Level II: paravaginal attachments. Level III: perineal body.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Pelvic organ prolapse

MCQ 14 · Pelvic Ligaments · **Easy** · C2

A 28-year-old woman has a soft, painless, non-reducible swelling in the right groin for 6 months. It does not have a cough impulse. Ultrasound shows a thin-walled cyst within the inguinal canal extending towards the labium majus. A cyst of the canal of Nuck is diagnosed.

With which structure is this cyst associated?

A. Broad ligament
B. Ovarian ligament
C. Round ligament of uterus
D. Suspensory ligament of ovary
E. Uterosacral ligament

Answer: C. Round ligament of uterus

The round ligament passes from the uterine cornu through the deep ring and inguinal canal to end in the labium majus. A persistent processus vaginalis along it (canal of Nuck) can form a hydrocele-like cyst in women.

Why not the others

- **A:** The broad ligament stays within the pelvis.
- **B:** The ovarian ligament joins the ovary to the uterus inside the pelvis.
- **D:** The suspensory ligament runs from the ovary to the pelvic side wall.
- **E:** The uterosacral ligament runs from the cervix to the sacrum.

Key point: In females, the round ligament is the content of the inguinal canal.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis

MCQ 15 · Vulval Anatomy · **Easy** · C2

A 25-year-old woman has a painful swelling in the vulva for 3 days and cannot sit comfortably. Examination shows a 4 cm tender, red, fluctuant swelling in the posterior part of the left labium majus at the 5 o'clock position of the vestibule.

What is the most likely diagnosis?

A. Bartholin abscess
B. Gartner duct cyst
C. Inclusion cyst
D. Sebaceous cyst
E. Skene duct cyst

Answer: A. Bartholin abscess

Bartholin glands lie at about 4 and 8 o'clock in the posterolateral vestibule and open between the hymen and labium minus. Blockage of the duct causes a cyst, and infection causes an abscess. Treatment is incision with marsupialisation or a Word catheter.

Why not the others

- **B:** A Gartner duct cyst lies in the anterolateral vaginal wall.
- **C:** An inclusion cyst follows trauma or episiotomy and is usually painless.
- **D:** A sebaceous cyst is in the skin of the labium majus, small and usually painless.
- **E:** Skene duct cysts lie beside the urethral meatus anteriorly.

Key point: In a woman over 40, biopsy a Bartholin mass to exclude carcinoma.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Conditions affecting the vulva and vagina

MCQ 16 · Embryology · **Moderate** · C2

A 32-year-old woman has a 2 cm smooth, non-tender cystic swelling in the anterolateral wall of the upper vagina, found at a routine examination. It does not involve the urethra. MRI confirms a simple cyst.

From which embryological structure does this cyst most likely arise?

A. Mesonephric (Wolffian) duct
B. Paramesonephric (Müllerian) duct
C. Pronephric duct
D. Urachus
E. Urogenital sinus

Answer: A. Mesonephric (Wolffian) duct

A Gartner duct cyst is a remnant of the mesonephric (Wolffian) duct, which normally regresses in the female. It lies along the anterolateral vaginal wall and needs treatment only if symptomatic.

Why not the others

- **B:** The Müllerian ducts form the tubes, uterus and upper vagina; their remnants do not produce lateral wall cysts.
- **C:** The pronephros disappears early and leaves no remnant here.
- **D:** The urachus forms a midline cyst between the bladder and umbilicus.
- **E:** The urogenital sinus forms the lower vagina and vestibule; its glands give Bartholin and Skene cysts.

Key point: Female Wolffian remnants: Gartner duct, epoöphoron and paroöphoron.

Reference: Gynaecology by Ten Teachers — Development of the female reproductive tract

MCQ 17 · Müllerian Anomalies · **Hard** · C2

A 14-year-old girl has had monthly lower abdominal pain for 6 months but has never menstruated. She has normal breast and pubic hair development. The hymen is normal, but the vagina ends blindly 3 cm from the introitus. MRI shows a distended upper vagina and uterus filled with blood above a thin membrane.

What developmental error explains this finding?

A. Failure of lateral fusion of the Müllerian ducts
B. Failure of resorption of the uterine septum
C. Failure of the urogenital sinus to canalise the hymen
D. Failure of vertical fusion between the Müllerian duct and urogenital sinus
E. Failure of Wolffian duct regression

Answer: D. Failure of vertical fusion between the Müllerian duct and urogenital sinus

The upper vagina comes from the Müllerian ducts and the lower vagina from the urogenital sinus (sinovaginal bulbs). Failure of these to fuse and canalise gives a transverse vaginal septum, here causing haematocolpos with a normal hymen.

Why not the others

- **A:** Failure of lateral fusion gives bicornuate or didelphys uterus.
- **B:** Failure of septal resorption gives a septate uterus.
- **C:** Failure of hymen canalisation gives an imperforate hymen, which bulges at the introitus.
- **E:** Persistent Wolffian remnants give Gartner duct cysts, not obstruction.

Key point: Transverse septum: blind vagina above a normal hymen. Imperforate hymen: bulging bluish membrane at the introitus.

Reference: Gynaecology by Ten Teachers — Development of the female reproductive tract; Puberty and its disorders

MCQ 18 · Müllerian Anomalies · **Hard** · C3

A 29-year-old woman has had three consecutive miscarriages at 8–10 weeks. 3D ultrasound shows a uterus with a normal, convex external fundal contour and a thick midline septum extending from the fundus to the internal os. Parental karyotypes and antiphospholipid tests are normal.

What is the most appropriate management to improve her chance of a live birth?

A. Abdominal metroplasty (Strassman procedure)
B. Cervical cerclage at 12 weeks
C. Hysteroscopic resection of the septum
D. Laparoscopic excision of a rudimentary horn
E. Progesterone support alone in the next pregnancy

Answer: C. Hysteroscopic resection of the septum

A septate uterus has a normal external contour with a septum inside the cavity. The poorly vascularised septum is linked with miscarriage. Hysteroscopic resection is minimally invasive and is offered to women with recurrent miscarriage and no other cause.

Why not the others

- **A:** Abdominal metroplasty is for a bicornuate uterus and is rarely done now.
- **B:** Cerclage is for cervical weakness with second-trimester loss.
- **D:** Rudimentary horn excision applies to a unicornuate uterus.
- **E:** Progesterone does not correct a structural septum.

Key point: Normal fundal contour + internal septum = septate (treat hysteroscopically). Fundal cleft = bicornuate (usually no surgery).

Reference: Gynaecology by Ten Teachers — Development of the female reproductive tract; Recurrent miscarriage

MCQ 19 · Müllerian Anomalies · **Hard** · C3

A 15-year-old girl has severe cyclical pain on the right side of her pelvis since menarche 2 years ago, not relieved by NSAIDs. Her periods are regular. MRI shows a left unicornuate uterus and a separate right rudimentary horn containing functional endometrium and blood, with no connection to the main cavity.

What is the most appropriate management?

A. Combined oral contraceptive pill
B. Hysteroscopic septum resection
C. Laparoscopic excision of the rudimentary horn
D. Observation until she wants pregnancy
E. Total abdominal hysterectomy

Answer: C. Laparoscopic excision of the rudimentary horn

A non-communicating rudimentary horn with functional endometrium causes haematometra, endometriosis and a risk of horn pregnancy, which can rupture catastrophically. Laparoscopic excision of the horn, with the ipsilateral tube, is recommended while preserving the unicornuate uterus.

Why not the others

- **A:** The pill may reduce pain temporarily but does not remove the rupture risk.
- **B:** There is no septum; the horn is separate.
- **D:** Waiting risks a horn pregnancy with rupture.
- **E:** Hysterectomy is unnecessary; the unicornuate uterus can carry a pregnancy.

Key point: Always check the kidneys in Müllerian anomalies; renal agenesis is often on the side of the horn.

Reference: Gynaecology by Ten Teachers — Development of the female reproductive tract

MCQ 20 · Müllerian Anomalies · **Moderate** · C3

A 17-year-old girl is diagnosed with Mayer–Rokitansky–Küster–Hauser syndrome after investigation of primary amenorrhoea. She has normal breasts, a 46,XX karyotype and normal ovaries.

Which further investigation is most important?

A. Audiometry
B. Echocardiography
C. Renal tract ultrasound
D. Serum testosterone
E. Spinal X-ray

Answer: C. Renal tract ultrasound

The Müllerian and mesonephric systems develop together, so MRKH is linked with renal anomalies (such as unilateral agenesis or pelvic kidney) in about a third of cases. Renal ultrasound is essential.

Why not the others

- **A:** Hearing loss occurs in a few cases but is not the priority.
- **B:** Cardiac anomalies are uncommon.
- **D:** Testosterone is normal for a female; it is measured if androgen insensitivity is suspected.
- **E:** Skeletal (vertebral) anomalies occur, but renal anomalies are commoner and more important.

Key point: Any Müllerian anomaly → check the kidneys.

Reference: Gynaecology by Ten Teachers — Development of the female reproductive tract; Puberty and its disorders

MCQ 21 · Developmental Anomalies · **Easy** · C3

A 13-year-old girl has had cyclical lower abdominal pain for 4 months and now cannot pass urine. She has normal breast development but no periods. Examination shows a lower abdominal mass and a tense, bulging, bluish membrane at the introitus.

What is the most appropriate management?

A. Cruciate incision of the hymen
B. Diagnostic laparoscopy
C. Needle aspiration through the hymen
D. Observation until menarche
E. Vaginoplasty with skin graft

Answer: A. Cruciate incision of the hymen

This is imperforate hymen with haematocolpos causing urinary retention. A cruciate (or elliptical) incision of the hymen under anaesthesia drains the old blood and is curative.

Why not the others

- **B:** Laparoscopy is not needed; the diagnosis is clinical.
- **C:** Needle aspiration risks infection (pyocolpos) and re-accumulation.
- **D:** She has already passed menarche functionally; waiting causes more pain and retention.
- **E:** Vaginoplasty is for vaginal agenesis, not an imperforate hymen.

Key point: Bulging bluish membrane + cyclic pain + amenorrhoea = imperforate hymen.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Development of the female reproductive tract

MCQ 22 · Vaginal Physiology · **Easy** · C2

A 26-year-old woman has a thin, grey, fishy-smelling vaginal discharge without itching. Vaginal pH is 5.5 and the whiff test with potassium hydroxide is positive. Microscopy shows clue cells.

Loss of which normal vaginal organism underlies this condition?

A. Candida albicans
B. Gardnerella vaginalis
C. Lactobacillus species
D. Mycoplasma hominis
E. Streptococcus agalactiae

Answer: C. Lactobacillus species

Lactobacilli convert glycogen in the oestrogenised vaginal epithelium to lactic acid, keeping the pH at 3.8–4.5. In bacterial vaginosis lactobacilli fall and anaerobes overgrow, raising the pH.

Why not the others

- **A:** Candida causes thick white discharge with itch and normal pH.
- **B:** Gardnerella overgrows in bacterial vaginosis; it is not lost.
- **D:** Mycoplasma hominis also increases in bacterial vaginosis.
- **E:** Group B streptococcus is a commensal relevant in pregnancy, not the protective organism.

Key point: Normal vaginal pH is 3.8–4.5, maintained by lactobacilli.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Infections in gynaecology

MCQ 23 · Cervical Anatomy · **Easy** · C2

A 22-year-old woman on the combined pill has occasional postcoital bleeding. Speculum examination shows a red, velvety area surrounding the external os that does not bleed easily. Chlamydia and gonorrhoea swabs are negative and her cervical screening is up to date and normal.

What is the most likely diagnosis?

A. Cervical carcinoma
B. Cervical ectropion
C. Cervical polyp
D. Chlamydial cervicitis
E. Nabothian follicles

Answer: B. Cervical ectropion

In ectropion the columnar epithelium of the endocervix is everted onto the ectocervix, giving a red area. It is common with the pill, in pregnancy and in adolescents, and is physiological. Treat only if troublesome.

Why not the others

- **A:** Carcinoma is unlikely with normal screening and no friable or ulcerated lesion.
- **C:** A polyp is a pedunculated lesion from the canal.
- **D:** Swabs are negative, making cervicitis unlikely.
- **E:** Nabothian follicles are small yellowish cysts, not a red area.

Key point: Postcoital bleeding always needs examination of the cervix, even with normal screening.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Premalignant disease of the cervix

MCQ 24 · Cervical Anatomy · **Moderate** · C2

A 30-year-old woman has colposcopy for an abnormal screening result. After acetic acid is applied, the colposcopist examines the area between the original and the new squamocolumnar junction, where columnar epithelium has been replaced by metaplastic squamous epithelium.

Where does cervical intraepithelial neoplasia most commonly arise?

A. Ectocervical squamous epithelium
B. Endocervical canal above the internal os
C. Original squamocolumnar junction only
D. Transformation zone
E. Vaginal fornix

Answer: D. Transformation zone

Metaplastic cells in the transformation zone are vulnerable to HPV, so CIN and cervical cancer arise here. Colposcopy aims to see the whole transformation zone, and LLETZ removes it.

Why not the others

- **A:** Mature ectocervical squamous epithelium is less vulnerable.
- **B:** Disease above the internal os is uncommon and is outside the transformation zone.
- **C:** The original junction is only the outer edge of the zone.
- **E:** Vaginal intraepithelial neoplasia is far less common.

Key point: The transformation zone moves outward in puberty and pregnancy and inward after menopause, so colposcopy may be unsatisfactory in older women.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Premalignant disease of the cervix

MCQ 25 · Peritoneal Anatomy · **Easy** · C2

A 27-year-old woman with 7 weeks of amenorrhoea presents with sudden lower abdominal pain and shoulder-tip pain. Pregnancy test is positive. Transvaginal ultrasound shows an empty uterus and free fluid behind the uterus.

In which space has the free fluid collected?

A. Morison's pouch
B. Paracolic gutter
C. Pouch of Douglas (rectouterine pouch)
D. Space of Retzius
E. Uterovesical pouch

Answer: C. Pouch of Douglas (rectouterine pouch)

The rectouterine pouch (pouch of Douglas) is the lowest part of the peritoneal cavity in the upright woman, so blood and fluid collect there first. It lies just behind the posterior vaginal fornix.

Why not the others

- **A:** Morison's pouch (hepatorenal) fills only with large volumes or when supine.
- **B:** Paracolic gutters fill later with larger bleeds.
- **D:** The space of Retzius is extraperitoneal, in front of the bladder.
- **E:** The uterovesical pouch lies in front of the uterus and is shallower.

Key point: Fluid in Morison's pouch on scan suggests a large haemoperitoneum.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Early pregnancy problems

MCQ 26 · Ureteric Anatomy · **Moderate** · C2

A 52-year-old woman is having an abdominal hysterectomy with bilateral salpingo-oophorectomy for severe endometriosis. Before clamping the infundibulopelvic ligament, the surgeon opens the peritoneum to identify the ureter.

Where is the ureter most at risk when the ovarian vessels are clamped?

A. At the pelvic brim
B. At the ureterovesical junction
C. In the broad ligament beside the round ligament
D. In the uterosacral ligament
E. Within the bladder wall

Answer: A. At the pelvic brim

The ureter crosses the pelvic brim over the bifurcation of the common iliac artery, lying just medial and close to the ovarian vessels in the infundibulopelvic ligament. A clamp placed blindly here can include the ureter.

Why not the others

- **B:** The ureterovesical junction is at risk during bladder dissection, not ovarian pedicle clamping.
- **C:** The round ligament is anterior and away from the ureter.
- **D:** The ureter lies lateral to the uterosacral ligament and is at risk during uterosacral suspension, not oophorectomy.
- **E:** The intramural ureter is at risk only in bladder surgery.

Key point: Two danger sites for the ureter: the pelvic brim (ovarian pedicle) and under the uterine artery (uterine pedicle).

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Gynaecological surgery

MCQ 27 · Nerve Supply · **Hard** · C2

A 38-year-old woman is having an outpatient hysteroscopy. The gynaecologist injects local anaesthetic into the cervix at the 3 and 9 o'clock positions (paracervical block) to reduce pain from cervical dilatation.

Pain fibres from the cervix travel mainly with which nerves?

A. Ilioinguinal nerve
B. Obturator nerve
C. Pelvic splanchnic nerves (S2–S4)
D. Pudendal nerve
E. Subcostal nerve

Answer: C. Pelvic splanchnic nerves (S2–S4)

Pain from the cervix and upper vagina is carried by afferent fibres running with the parasympathetic pelvic splanchnic nerves (S2–S4) through the uterovaginal plexus. Pain from the uterine body travels with sympathetic fibres to T10–L1.

Why not the others

- **A:** The ilioinguinal nerve supplies the skin of the mons and labium majus.
- **B:** The obturator nerve supplies the medial thigh.
- **D:** The pudendal nerve supplies the lower vagina, vulva and perineum, not the cervix.
- **E:** The subcostal nerve supplies the lower abdominal wall.

Key point: Cervix → S2–S4 (paracervical block). Uterine body → T10–L1. Vulva and perineum → pudendal (S2–S4).

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis

MCQ 28 · Lymphatic Drainage · **Hard** · C3

A 72-year-old woman has a 2 cm squamous cell carcinoma of the clitoris, invading 3 mm deep. CT shows no distant spread. The surgeon plans wide local excision and assessment of the groin nodes.

Which groin node assessment is required?

A. Bilateral inguinofemoral nodes
B. Internal iliac nodes first
C. Ipsilateral inguinofemoral nodes only
D. Obturator nodes first
E. Para-aortic nodes first

Answer: A. Bilateral inguinofemoral nodes

Midline vulval lesions (within 1 cm of the midline, including the clitoris) can drain to either groin, so both inguinofemoral groups must be assessed (sentinel nodes or lymphadenectomy) when invasion is more than 1 mm.

Why not the others

- **B:** Internal iliac nodes are not a first station for the vulva.
- **C:** Ipsilateral assessment alone is for well-lateralised lesions.
- **D:** Obturator nodes drain the cervix.
- **E:** Para-aortic nodes are far beyond the first station.

Key point: Lateral vulval lesion → ipsilateral groin. Midline or clitoral lesion → both groins.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Malignant disease of the vulva

MCQ 29 · Lymphatic Drainage · **Moderate** · C2

A 45-year-old woman is diagnosed with squamous cell carcinoma of the cervix. MRI is being reviewed for nodal disease before treatment is planned.

Which nodes form the first station of lymphatic drainage of the cervix?

A. Inguinal nodes
B. Mesenteric nodes
C. Para-aortic nodes
D. Parametrial and obturator nodes
E. Supraclavicular nodes

Answer: D. Parametrial and obturator nodes

The cervix drains first to the parametrial, obturator, internal and external iliac nodes, then to the common iliac and para-aortic nodes. This is why radical hysterectomy includes pelvic lymphadenectomy.

Why not the others

- **A:** Inguinal nodes drain the vulva and lower vagina.
- **B:** Mesenteric nodes drain the bowel.
- **C:** Para-aortic nodes are a later station; involvement means more advanced disease.
- **E:** Supraclavicular nodes are a distant site.

Key point: Para-aortic nodal spread in cervical cancer changes the radiotherapy field.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Malignant disease of the cervix

MCQ 30 · Sexual Differentiation · **Hard** · C2

A 16-year-old girl with primary amenorrhoea has well-developed breasts but scanty pubic and axillary hair. The vagina is short and blind-ending. Ultrasound shows no uterus, and gonads are seen in the inguinal canals. Karyotype is 46,XY and serum testosterone is in the male range.

Why is there no uterus in this patient?

A. Absence of androgen receptors in the Müllerian ducts
B. Anti-Müllerian hormone from fetal Sertoli cells
C. Excess oestrogen in fetal life
D. Lack of 5-alpha reductase
E. Testosterone from fetal Leydig cells

Answer: B. Anti-Müllerian hormone from fetal Sertoli cells

This is complete androgen insensitivity syndrome. The fetal testes still produce anti-Müllerian hormone from Sertoli cells, which causes the Müllerian ducts to regress, so there is no uterus, tubes or upper vagina.

Why not the others

- **A:** Androgen receptors are absent, but Müllerian regression does not depend on androgens.
- **C:** Oestrogen does not cause Müllerian regression.
- **D:** 5-alpha reductase deficiency affects external genitalia; it is a different condition.
- **E:** Testosterone maintains Wolffian ducts; it has no effect here because receptors are absent.

Key point: Testes make two hormones: AMH (removes Müllerian ducts) and testosterone (keeps Wolffian ducts and virilises).

Reference: Gynaecology by Ten Teachers — Development of the female reproductive tract; Disorders of sex development

MCQ 31 · Sexual Differentiation · **Hard** · C2

A 14-year-old raised as a girl has clitoral enlargement, deepening of the voice and increased muscle bulk starting at puberty. At birth the external genitalia looked mostly female. Gonads are palpable in the labioscrotal folds and there is no uterus. Karyotype is 46,XY.

What is the most likely diagnosis?

A. 5-alpha reductase deficiency
B. Complete androgen insensitivity syndrome
C. Congenital adrenal hyperplasia
D. Swyer syndrome
E. Turner syndrome

Answer: A. 5-alpha reductase deficiency

5-alpha reductase converts testosterone to dihydrotestosterone, which masculinises the external genitalia in fetal life. Deficiency gives female-looking genitalia at birth, but the surge of testosterone at puberty causes virilisation.

Why not the others

- **B:** Complete androgen insensitivity gives female development at puberty, with breasts and no virilisation.
- **C:** CAH in a 46,XX baby causes virilisation at birth with a uterus present.
- **D:** Swyer syndrome has streak gonads, a uterus and no virilisation.
- **E:** Turner syndrome is 45,X with short stature.

Key point: Virilisation at puberty in a 46,XY girl → think 5-alpha reductase deficiency.

Reference: Gynaecology by Ten Teachers — Development of the female reproductive tract; Disorders of sex development

MCQ 32 · Sexual Differentiation · **Moderate** · C2

A newborn has ambiguous genitalia with clitoromegaly and fused labia. On day 10 the baby vomits and becomes dehydrated with sodium 124 mmol/L and potassium 6.8 mmol/L. Karyotype is 46,XX and ultrasound shows a uterus. Serum 17-hydroxyprogesterone is very high.

Deficiency of which enzyme is most likely?

A. 11-beta hydroxylase
B. 17-alpha hydroxylase
C. 21-hydroxylase
D. 3-beta hydroxysteroid dehydrogenase
E. 5-alpha reductase

Answer: C. 21-hydroxylase

21-hydroxylase deficiency accounts for over 90% of congenital adrenal hyperplasia. Cortisol and aldosterone cannot be made, so ACTH drives excess androgens (virilisation) and salt wasting follows. 17-hydroxyprogesterone is raised.

Why not the others

- **A:** 11-beta hydroxylase deficiency causes virilisation with hypertension, not salt wasting.
- **B:** 17-alpha hydroxylase deficiency causes absent puberty and hypertension, without virilisation.
- **D:** 3-beta HSD deficiency is rare and causes mild virilisation in girls.
- **E:** 5-alpha reductase deficiency affects 46,XY males.

Key point: Ambiguous genitalia + salt-wasting crisis + raised 17-OHP = 21-hydroxylase deficiency.

Reference: Gynaecology by Ten Teachers — Development of the female reproductive tract; Disorders of sex development

MCQ 33 · Gonadal Dysgenesis · **Hard** · C3

A 17-year-old girl of normal height has primary amenorrhoea and no breast development. External genitalia are female and ultrasound shows a small uterus with streak gonads. FSH is 85 IU/L. Karyotype is 46,XY.

What is the most important next step in management?

A. Bilateral gonadectomy
B. Clomiphene citrate
C. Growth hormone therapy
D. Observation
E. Vaginal dilator therapy

Answer: A. Bilateral gonadectomy

This is Swyer syndrome (46,XY complete gonadal dysgenesis). The streak gonads contain Y material and carry a high risk of gonadoblastoma and dysgerminoma, so they should be removed. Oestrogen and later combined HRT induce puberty, and pregnancy is possible with donor eggs because the uterus is present.

Why not the others

- **B:** Clomiphene needs functioning ovaries; she has none.
- **C:** Growth hormone is used in Turner syndrome with short stature; her height is normal.
- **D:** Observation leaves the malignancy risk.
- **E:** She has a normal vagina and uterus; dilators are for vaginal agenesis.

Key point: Any Y chromosome with dysgenetic gonads → gonadectomy.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Disorders of sex development

MCQ 34 · Vaginal Agenesis · **Moderate** · C3

An 18-year-old woman with Mayer–Rokitansky–Küster–Hauser syndrome is engaged and wants to have sexual intercourse after marriage. The vaginal dimple is 2 cm deep. She is motivated and has had counselling.

What is the first-line treatment to create a functional vagina?

A. Hysteroscopic canalisation
B. Laparoscopic Vecchietti procedure
C. McIndoe vaginoplasty
D. Uterine transplantation
E. Vaginal dilator therapy

Answer: E. Vaginal dilator therapy

Self-dilation with graduated vaginal dilators is first line. It succeeds in most motivated women, avoids surgery and its complications, and should be offered before any operation.

Why not the others

- **A:** There is no uterus or upper vagina to canalise.
- **B:** The Vecchietti procedure is a surgical option when dilation fails.
- **C:** McIndoe vaginoplasty with a skin graft is a second-line surgical option.
- **D:** Uterine transplantation is experimental, for fertility, not for a vagina.

Key point: Support from a psychologist and a specialist centre is a key part of MRKH care.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Development of the female reproductive tract

MCQ 35 · Müllerian Anomalies · **Hard** · C2

A 13-year-old girl has had regular periods for a year but has worsening pelvic pain during each period. Examination shows a tender bulge in the right lateral vaginal wall. MRI shows two separate uteri and cervices, with the right hemivagina distended with blood, and the right kidney is absent.

What is the most likely diagnosis?

A. Bicornuate uterus
B. Imperforate hymen
C. OHVIRA syndrome
D. Septate uterus
E. Transverse vaginal septum

Answer: C. OHVIRA syndrome

OHVIRA (obstructed hemivagina with ipsilateral renal anomaly), also called Herlyn–Werner–Wunderlich syndrome, is a uterus didelphys with one blocked hemivagina and absent kidney on the same side. Periods occur from the open side, so the obstruction is missed. Treatment is excision of the vaginal septum.

Why not the others

- **A:** A bicornuate uterus has one cervix and no vaginal obstruction.
- **B:** Imperforate hymen gives amenorrhoea, not regular periods.
- **D:** A septate uterus has a single fundus and no obstruction.
- **E:** A complete transverse septum causes amenorrhoea.

Key point: Regular periods do not exclude an outflow obstruction when there are two systems.

Reference: Gynaecology by Ten Teachers — Development of the female reproductive tract

MCQ 36 · Pelvic Anatomy · **Moderate** · C2

A 44-year-old woman has a 10 cm fibroid growing laterally between the two layers of the left broad ligament. CT before surgery shows left hydronephrosis.

Which structure in the base of the broad ligament is displaced by this fibroid?

A. Internal iliac artery
B. Obturator nerve
C. Ovarian artery
D. Round ligament
E. Ureter

Answer: E. Ureter

The ureter runs forward in the base of the broad ligament, beneath the uterine artery, to reach the bladder. A broad ligament fibroid displaces and may compress it, so it must be identified before removing the fibroid.

Why not the others

- **A:** The internal iliac artery lies on the pelvic side wall, not in the broad ligament.
- **B:** The obturator nerve lies on the lateral pelvic wall.
- **C:** The ovarian artery is in the upper part of the broad ligament, not its base.
- **D:** The round ligament runs in the anterior fold and does not obstruct the kidney.

Key point: Broad ligament fibroid: open the peritoneum and trace the ureter before enucleation.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Benign conditions of the uterus

MCQ 37 · Uterine Position · **Easy** · C3

A 25-year-old woman has a pelvic scan for an unrelated reason. It reports a normal-sized retroverted uterus. She has no pain, no dyspareunia and regular periods. On examination the uterus is retroverted and fully mobile.

What is the most appropriate management?

A. Diagnostic laparoscopy
B. Hodge pessary
C. Reassurance
D. Vaginal hysterectomy
E. Ventrosuspension

Answer: C. Reassurance

About one woman in five has a retroverted uterus as a normal variant. A mobile retroverted uterus without symptoms needs no treatment. A fixed retroversion suggests endometriosis or adhesions.

Why not the others

- **A:** Laparoscopy is for a fixed retroverted uterus with symptoms.
- **B:** A Hodge pessary is not used for a normal mobile retroversion.
- **D:** Hysterectomy has no role.
- **E:** Ventrosuspension is an outdated operation with no benefit here.

Key point: Mobile retroversion = normal. Fixed retroversion = look for endometriosis or PID.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis

MCQ 38 · Nerve Supply · **Hard** · C2

A 34-year-old woman with a 6 cm left ovarian endometrioma adherent to the lateral pelvic wall complains of pain radiating down the inner side of her left thigh to the knee.

Irritation of which nerve best explains the referred pain?

A. Femoral nerve
B. Genitofemoral nerve
C. Lateral cutaneous nerve of thigh
D. Obturator nerve
E. Sciatic nerve

Answer: D. Obturator nerve

The ovary lies in the ovarian fossa on the lateral pelvic wall, whose floor contains the obturator nerve. Disease here can irritate the nerve, causing pain referred to the medial thigh.

Why not the others

- **A:** The femoral nerve lies outside the pelvis on iliacus and gives anterior thigh pain.
- **B:** The genitofemoral nerve gives groin and labial pain.
- **C:** The lateral cutaneous nerve gives lateral thigh pain.
- **E:** The sciatic nerve gives posterior leg pain.

Key point: Ovarian fossa: bounded by the external iliac vessels, ureter and internal iliac vessels, with the obturator nerve in its floor.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Endometriosis

MCQ 39 · Pelvic Floor · **Easy** · C2

A 58-year-old woman (para 5, with two prolonged second stages) has a vaginal bulge. Examination shows a wide genital hiatus and weak voluntary squeeze of the pelvic floor.

Damage to which muscle is the main cause of her pelvic floor weakness?

A. Bulbospongiosus
B. Ischiocavernosus
C. Levator ani
D. Obturator internus
E. Piriformis

Answer: C. Levator ani

The levator ani (pubococcygeus, puborectalis and iliococcygeus) forms most of the pelvic floor and supports the pelvic organs. Stretch and nerve injury during childbirth weaken it, leading to prolapse.

Why not the others

- **A:** Bulbospongiosus is a superficial perineal muscle around the vestibule.
- **B:** Ischiocavernosus covers the crus of the clitoris.
- **D:** Obturator internus lines the side wall and gives origin to levator ani, but is not the floor.
- **E:** Piriformis lies on the posterior wall and is not a support muscle.

Key point: Pelvic floor muscle training strengthens the levator ani and is first line for mild prolapse and stress incontinence.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Pelvic organ prolapse

MCQ 40 · Vulval Blood Supply · **Moderate** · C2

A 12-year-old girl falls astride the crossbar of her bicycle. Two hours later she has a large, tense, painful swelling of the right labium majus. She is passing urine and is haemodynamically stable.

Branches of which artery are most likely bleeding into this haematoma?

A. External pudendal artery
B. Inferior epigastric artery
C. Internal pudendal artery
D. Obturator artery
E. Uterine artery

Answer: C. Internal pudendal artery

The vulva and perineum are supplied mainly by the internal pudendal artery through its labial and perineal branches. Straddle injuries crush these against the pubic bone, causing vulval haematoma. Most are managed with ice and analgesia; large expanding ones need drainage.

Why not the others

- **A:** The external pudendal artery supplies the anterior labia but is a minor contributor to perineal haematoma.
- **B:** The inferior epigastric artery supplies the abdominal wall.
- **D:** The obturator artery supplies the medial thigh.
- **E:** The uterine artery supplies the uterus and upper vagina.

Key point: In a child with a genital injury, always consider the possibility of abuse and examine carefully.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Paediatric gynaecology

MCQ 41 · Pelvic Ligaments · **Easy** · C2

During a laparoscopic left salpingo-oophorectomy, the surgeon must seal and divide the ovarian artery and vein before removing the ovary.

In which structure do the ovarian vessels run?

A. Anterior leaf of the broad ligament
B. Infundibulopelvic (suspensory) ligament
C. Ovarian ligament
D. Round ligament
E. Uterosacral ligament

Answer: B. Infundibulopelvic (suspensory) ligament

The ovarian vessels, lymphatics and nerves reach the ovary in the infundibulopelvic (suspensory) ligament, which runs from the pelvic brim to the ovary.

Why not the others

- **A:** The broad ligament leaves cover the uterine vessels at its base, not the ovarian vessels.
- **C:** The ovarian ligament joins the ovary to the uterine cornu and carries a small branch of the uterine artery.
- **D:** The round ligament carries a small artery only.
- **E:** The uterosacral ligament runs from the cervix to the sacrum.

Key point: Clamping the infundibulopelvic ligament = taking the ovarian vessels; identify the ureter first.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Gynaecological surgery

MCQ 42 · Lymphatic Drainage · **Moderate** · C2

A 66-year-old woman has a 2 cm squamous cell carcinoma on the posterior wall of the lower third of the vagina, just above the hymen.

To which lymph nodes will this tumour first spread?

A. Inguinal nodes
B. Internal iliac nodes
C. Obturator nodes
D. Para-aortic nodes
E. Presacral nodes

Answer: A. Inguinal nodes

The lower third of the vagina drains like the vulva, to the inguinal nodes. The upper two-thirds drain like the cervix, to the obturator and iliac nodes.

Why not the others

- **B:** Internal iliac nodes drain the upper vagina.
- **C:** Obturator nodes drain the upper vagina and cervix.
- **D:** Para-aortic nodes are a later station.
- **E:** Presacral nodes drain the posterior upper vagina and rectum.

Key point: Lower vagina behaves like vulva (groin nodes); upper vagina behaves like cervix (pelvic nodes).

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Malignant disease of the vagina

MCQ 43 · Surgical Anatomy · **Moderate** · C2

A teaching hospital audits its urinary tract injuries during benign abdominal and laparoscopic hysterectomy over 5 years. The bladder and ureter are both recorded separately.

Which organ is most commonly injured during hysterectomy?

A. Bladder
B. Obturator nerve
C. Rectum
D. Ureter
E. Urethra

Answer: A. Bladder

The bladder is injured more often than the ureter, mostly while dissecting it off the cervix, especially after caesarean sections. Most injuries are recognised and repaired at the time with good results.

Why not the others

- **B:** Obturator nerve injury occurs mainly in lymphadenectomy and is rare.
- **C:** Rectal injury is uncommon except with severe endometriosis.
- **D:** The ureter is injured less often than the bladder but is more often missed.
- **E:** Urethral injury is very rare in hysterectomy.

Key point: Previous caesarean section increases bladder injury risk at hysterectomy.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 44 · Vulval Anatomy · **Hard** · C2

After a wide local excision of a lesion on the mons pubis, a 50-year-old woman notices numbness over the mons and the front of both labia majora. Sensation over the posterior labia and perineum is normal.

Which nerve supplies the sensation that has been lost?

A. Ilioinguinal nerve
B. Inferior rectal nerve
C. Obturator nerve
D. Perineal branch of posterior femoral cutaneous nerve
E. Perineal branch of pudendal nerve

Answer: A. Ilioinguinal nerve

The anterior vulva (mons and anterior labia majora) is supplied by the ilioinguinal nerve (L1) and the genital branch of the genitofemoral nerve. The posterior vulva and perineum are supplied by the pudendal nerve.

Why not the others

- **B:** The inferior rectal nerve supplies the anal skin and external sphincter.
- **C:** The obturator nerve supplies the medial thigh.
- **D:** The posterior femoral cutaneous nerve supplies the lateral perineum and posterior thigh.
- **E:** The perineal branch of the pudendal nerve supplies the posterior labia, which are intact.

Key point: Anterior vulva = L1 (ilioinguinal, genitofemoral). Posterior vulva = S2–S4 (pudendal).

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis

MCQ 45 · Uterine Anatomy · **Easy** · C2

A 24-year-old nulliparous woman attends for insertion of a copper intrauterine device. The doctor passes a uterine sound to measure the length of the uterine cavity and canal before insertion.

What is the expected sounding length in a normal nulliparous uterus?

A. 3–4 cm
B. 6–8 cm
C. 10–12 cm
D. 14–16 cm
E. 18–20 cm

Answer: B. 6–8 cm

The adult nulliparous uterus is about 7.5 cm long, with the cervix making up about a third. A sounding length of 6–8 cm is normal. Under 6 cm suggests a small cavity unsuitable for some devices; a longer length raises concern of perforation.

Why not the others

- **A:** 3–4 cm is the size of a prepubertal uterus or suggests the sound has not passed the internal os.
- **C:** 10–12 cm suggests an enlarged uterus such as with fibroids or perforation.
- **D:** 14–16 cm is far too long and suggests perforation.
- **E:** 18–20 cm is not compatible with a normal uterus.

Key point: Sounding the uterus guides the depth of IUD insertion and helps detect perforation.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Contraception

MCQ 46 · Tubal Anatomy · **Easy** · C2

A 30-year-old woman undergoes laparoscopy for a suspected tubal ectopic pregnancy. A swelling is found in the widest, longest part of the tube, lateral to the isthmus.

Which part of the tube is the commonest site of ectopic pregnancy?

A. Ampulla
B. Fimbrial end
C. Interstitial portion
D. Isthmus
E. Ovary

Answer: A. Ampulla

The ampulla is the commonest site of fertilisation and also of ectopic implantation (about 70–80% of tubal ectopics). It is wide and thin-walled, so ampullary ectopics often abort or rupture later than isthmic ones.

Why not the others

- **B:** Fimbrial ectopics are less common (about 10%).
- **C:** Interstitial ectopics are rare (2–4%) but dangerous.
- **D:** Isthmic ectopics (about 12%) rupture early because the lumen is narrow.
- **E:** The ovary is not part of the tube; ovarian ectopics are rare.

Key point: Tube parts from lateral to medial: fimbriae, infundibulum, ampulla, isthmus, interstitial (intramural).

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Early pregnancy problems

MCQ 47 · Tubal Anatomy · **Hard** · C2

A 31-year-old woman at 9 weeks collapses with severe abdominal pain. Pulse is 128/min and BP 80/50 mmHg. Before collapse, a scan had shown a gestational sac high in the left cornual region, eccentric to the cavity, with less than 5 mm of surrounding myometrium.

What is the most likely type of pregnancy?

A. Ampullary ectopic pregnancy
B. Angular pregnancy
C. Cervical ectopic pregnancy
D. Interstitial ectopic pregnancy
E. Ovarian ectopic pregnancy

Answer: D. Interstitial ectopic pregnancy

An interstitial ectopic implants in the part of the tube that runs through the myometrium. The muscle allows it to grow until 8–12 weeks, and then it ruptures with severe bleeding from the rich uterine and ovarian blood supply. A thin myometrial mantle (under 5 mm) is typical.

Why not the others

- **A:** An ampullary ectopic lies outside the uterus, lateral to it.
- **B:** An angular pregnancy is within the cavity at the cornual angle, with a thick myometrial mantle.
- **C:** A cervical ectopic lies in the cervical canal.
- **E:** An ovarian ectopic lies within the ovary.

Key point: Interstitial ectopic rupture causes heavy bleeding; it needs urgent surgery (cornual resection) when unstable.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; Anatomy of the female pelvis

MCQ 48 · Ovarian Physiology · **Hard** · C2

A 60-year-old woman has postmenopausal bleeding. Endometrial biopsy shows complex hyperplasia without atypia. Ultrasound shows a 7 cm solid right ovarian mass. Serum oestradiol is high for her age and inhibin is raised. A granulosa cell tumour is suspected.

Which enzyme in granulosa cells converts androgens into oestrogens?

A. 17-alpha hydroxylase
B. 21-hydroxylase
C. 3-beta hydroxysteroid dehydrogenase
D. 5-alpha reductase
E. Aromatase

Answer: E. Aromatase

In the two-cell model, theca cells make androgens under LH, and granulosa cells convert them to oestrogens using aromatase under FSH. A granulosa cell tumour makes excess oestrogen, causing endometrial hyperplasia and bleeding.

Why not the others

- **A:** 17-alpha hydroxylase works in the theca cell androgen pathway.
- **B:** 21-hydroxylase is an adrenal enzyme for cortisol and aldosterone.
- **C:** 3-beta HSD is an early step in steroid synthesis, not oestrogen formation.
- **D:** 5-alpha reductase converts testosterone to dihydrotestosterone.

Key point: Inhibin is a useful tumour marker for granulosa cell tumours.

Reference: Gynaecology by Ten Teachers — Physiology of the ovary; Malignant disease of the ovary

MCQ 49 · Clinical Examination · **Moderate** · C3

A 65-year-old woman, 15 years past menopause, has a routine bimanual examination before a minor procedure. A firm, mobile 3 cm mass is felt in the right adnexa. She has no symptoms.

What is the most appropriate next step?

A. CA-125 and transvaginal ultrasound
B. Diagnostic laparoscopy
C. Reassurance
D. Repeat examination in 1 year
E. Total hysterectomy and bilateral salpingo-oophorectomy

Answer: A. CA-125 and transvaginal ultrasound

After menopause the ovaries shrink and should not normally be palpable. A palpable adnexal mass needs transvaginal ultrasound and CA-125 to calculate the Risk of Malignancy Index, which decides further management.

Why not the others

- **B:** Laparoscopy comes after assessment of malignancy risk.
- **C:** Reassurance without investigation may miss ovarian cancer.
- **D:** Waiting a year could allow a cancer to spread.
- **E:** Major surgery is planned only after imaging and risk assessment.

Key point: A palpable ovary after menopause is abnormal until proved otherwise.

Reference: Gynaecology by Ten Teachers — Gynaecological history and examination; Malignant disease of the ovary

MCQ 50 · Urethral Anatomy · **Hard** · C2

A 42-year-old woman has had dysuria, post-void dribbling and pain during intercourse for a year, with three treated urinary infections. Examination shows a tender 2 cm swelling under the anterior vaginal wall, below the bladder neck. Pressing it expresses pus from the urethral meatus.

What is the most likely diagnosis?

A. Bartholin duct cyst
B. Gartner duct cyst
C. Skene duct cyst
D. Urethral caruncle
E. Urethral diverticulum

Answer: E. Urethral diverticulum

A urethral diverticulum is an outpouching of the urethra into the urethrovaginal septum, usually from an infected periurethral gland. The classic features are the "three Ds" (dysuria, dribbling, dyspareunia), recurrent UTI and pus expressed from the meatus. MRI confirms it and surgical excision treats it.

Why not the others

- **A:** A Bartholin cyst lies in the posterolateral vestibule.
- **B:** A Gartner duct cyst lies anterolaterally and does not communicate with the urethra.
- **C:** A Skene duct cyst lies beside the meatus at the vestibule, not under the mid-urethra, and does not discharge into it.
- **D:** A urethral caruncle is a small red fleshy lesion at the posterior lip of the meatus in older women.

Key point: Pus from the urethra on pressing an anterior vaginal wall swelling = urethral diverticulum.

Reference: Gynaecology by Ten Teachers — Anatomy of the female pelvis; Urogynaecology

CHAPTER 2

Puberty and Amenorrhoea

MCQ 51 · Primary Amenorrhoea · **Moderate** · C2

A 17-year-old girl is brought by her mother because she has never had a period. She is 160 cm tall with normal breast development and normal pubic and axillary hair. Examination shows a short, blind-ending vagina. Ultrasound shows normal ovaries but no uterus. Karyotype is 46,XX.

What is the most likely diagnosis?

A. Androgen insensitivity syndrome
B. Imperforate hymen
C. Mayer–Rokitansky–Küster–Hauser syndrome
D. Transverse vaginal septum
E. Turner syndrome

Answer: C. Mayer–Rokitansky–Küster–Hauser syndrome

MRKH syndrome is Müllerian agenesis: the uterus and upper vagina are absent, but the ovaries are normal. Oestrogen production gives normal breasts, and the 46,XX karyotype with normal pubic hair separates it from androgen insensitivity.

Why not the others

- **A:** Androgen insensitivity is 46,XY with scanty or absent pubic and axillary hair and testes in place of ovaries.
- **B:** Imperforate hymen gives cyclic pain and a bulging bluish membrane; the uterus is present.
- **D:** A transverse septum also has a uterus present, usually with haematocolpos and cyclic pain.
- **E:** Turner syndrome (45,X) gives short stature, streak ovaries and absent breast development.

Key point: Primary amenorrhoea with normal breasts: check for a uterus. No uterus → MRKH (46,XX) or androgen insensitivity (46,XY).

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Amenorrhoea

MCQ 52 · Secondary Amenorrhoea · **Hard** · C3

A 27-year-old woman has had no periods for 8 months. Ten months ago she had a surgical evacuation for retained products after a miscarriage, complicated by fever needing antibiotics. Pregnancy test is negative. FSH, LH, prolactin and TSH are normal. She has no withdrawal bleed after a progestogen challenge or after combined oestrogen and progestogen.

What is the most likely diagnosis?

A. Asherman syndrome
B. Hypothalamic amenorrhoea
C. Premature ovarian insufficiency
D. Prolactinoma
E. Sheehan syndrome

Answer: A. Asherman syndrome

Failure to bleed even after oestrogen plus progestogen means the endometrium cannot respond, an outflow (uterine) problem. Infected uterine curettage is the classic cause of intrauterine adhesions. Hysteroscopy confirms and treats with adhesiolysis.

Why not the others

- **B:** Hypothalamic amenorrhoea gives low or low-normal FSH/LH and a bleed after combined oestrogen and progestogen.
- **C:** Premature ovarian insufficiency gives raised FSH (above 25 IU/L on two occasions).
- **D:** A prolactinoma would raise serum prolactin.
- **E:** Sheehan syndrome follows massive postpartum haemorrhage and gives low pituitary hormones and failed lactation.

Key point: No bleed after oestrogen plus progestogen = outflow tract problem. Think Asherman syndrome after uterine instrumentation.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; Amenorrhoea

MCQ 53 · Normal Puberty · **Easy** · C2

A mother brings her 11-year-old daughter because she has noticed breast buds over the last 4 months. There is no pubic hair yet and she has not menstruated. Growth is along the 50th centile. Examination is otherwise normal.

What is the usual first sign of puberty in girls?

A. Axillary hair growth
B. Menarche
C. Peak height velocity
D. Pubic hair growth
E. Thelarche

Answer: E. Thelarche

Thelarche (breast budding, Tanner stage 2) is usually the first sign of puberty in girls, at about 8–13 years. It is followed by pubarche, the growth spurt, and menarche about 2–3 years after thelarche.

Why not the others

- **A:** Axillary hair appears later in puberty.
- **B:** Menarche is a late event, about 2 years after breast budding.
- **C:** Peak height velocity comes after thelarche, usually before menarche.
- **D:** Pubic hair usually follows breast development.

Key point: Order in girls: thelarche → pubarche → growth spurt → menarche.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 54 · Normal Puberty · **Moderate** · C2

A 12-year-old girl had her first period 2 months ago. Her mother is worried because she has grown 9 cm in the past year and now seems to be slowing down. She is at Tanner stage 4 for breasts.

What is the relationship between menarche and the pubertal growth spurt?

A. Growth continues at peak speed for 5 years after menarche
B. Growth stops completely at menarche
C. Menarche occurs before the growth spurt begins
D. Menarche usually occurs after peak height velocity
E. The growth spurt and menarche are unrelated

Answer: D. Menarche usually occurs after peak height velocity

In girls, peak height velocity occurs early in puberty, around Tanner stage 2–3, and menarche follows it. After menarche girls usually grow only another 5–7 cm as the epiphyses fuse under oestrogen.

Why not the others

- **A:** Growth slows after menarche; it does not stay at peak speed.
- **B:** Some growth (about 5–7 cm) continues after menarche.
- **C:** The growth spurt begins before menarche.
- **E:** Both are driven by rising oestrogen and follow a predictable sequence.

Key point: Girls reach peak height velocity earlier in puberty than boys.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 55 · Primary Amenorrhoea · **Easy** · C2

A 15-year-old girl has never had a period. She has normal breast development (Tanner stage 4) and pubic hair. Her mother is anxious and wants her investigated.

When should primary amenorrhoea be investigated in a girl with normal secondary sexual characteristics?

A. By age 12
B. By age 13
C. By age 15
D. By age 18
E. Only if she has cyclical pain

Answer: C. By age 15

Primary amenorrhoea is investigated if there are no periods by 15 in a girl with normal secondary sexual characteristics, or by 13 if there is no breast development. She should now be assessed.

Why not the others

- **A:** Age 12 is too early; many normal girls have not yet menstruated.
- **B:** Age 13 is the threshold when there is no breast development.
- **D:** Waiting until 18 delays diagnosis of treatable conditions.
- **E:** Cyclical pain suggests outflow obstruction and needs earlier assessment, but it is not required for investigation.

Key point: No periods by 15 with breasts, or no breasts by 13 → investigate.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Amenorrhoea

MCQ 56 · Turner Syndrome · **Easy** · C2

A 15-year-old girl has primary amenorrhoea and no breast development. She is 140 cm tall (below the 1st centile). She has a webbed neck, a wide carrying angle and widely spaced nipples. FSH and LH are markedly raised.

What is the most likely karyotype?

A. 45,X
B. 46,XX
C. 46,XY
D. 47,XXX
E. 47,XXY

Answer: A. 45,X

Turner syndrome (45,X or mosaic) causes gonadal dysgenesis with streak ovaries, so oestrogen is low and FSH/LH are high. Short stature, webbed neck, cubitus valgus and a shield chest are typical.

Why not the others

- **B:** 46,XX with these features would point to other causes such as Noonan syndrome, which has normal ovaries more often.
- **C:** 46,XY gonadal dysgenesis (Swyer) gives normal or tall stature.
- **D:** 47,XXX (triple X) gives tall stature and usually normal puberty.
- **E:** 47,XXY is Klinefelter syndrome in males.

Key point: Short stature + absent puberty + high FSH = Turner syndrome until proved otherwise.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 57 · Turner Syndrome · **Moderate** · C3

A 14-year-old girl with confirmed 45,X Turner syndrome attends the adolescent clinic. She is on growth hormone and is about to start oestrogen for pubertal induction.

Which associated condition must be screened for regularly throughout her life?

A. Aortic root dilatation
B. Congenital adrenal hyperplasia
C. Haemophilia
D. Polycystic kidney disease
E. Retinitis pigmentosa

Answer: A. Aortic root dilatation

Turner syndrome is linked with bicuspid aortic valve, coarctation and progressive aortic root dilatation, which can lead to dissection, especially in pregnancy. Regular echocardiography or cardiac MRI is needed. Other checks include thyroid, hearing, renal anatomy, glucose and BP.

Why not the others

- **B:** CAH is a separate enzyme disorder, not linked with Turner syndrome.
- **C:** Haemophilia is X-linked recessive, rare in females; it is not a recognised Turner screening item.
- **D:** Horseshoe kidney occurs in Turner syndrome, but polycystic kidney disease does not.
- **E:** Retinitis pigmentosa is not associated.

Key point: Pregnancy in Turner syndrome (usually by egg donation) needs cardiac assessment because of the risk of aortic dissection.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 58 · Delayed Puberty · **Moderate** · C2

A 16-year-old girl has no breast development and has never menstruated. She has never been able to smell flowers or food. Height is on the 25th centile. FSH and LH are low, and MRI of the pituitary is normal. Karyotype is 46,XX.

What is the most likely diagnosis?

A. Constitutional delay of puberty
B. Kallmann syndrome
C. Prolactinoma
D. Swyer syndrome
E. Turner syndrome

Answer: B. Kallmann syndrome

Kallmann syndrome is hypogonadotrophic hypogonadism with anosmia, due to failed migration of GnRH neurons and olfactory neurons from the olfactory placode. FSH and LH are low and the pituitary is normal.

Why not the others

- **A:** Constitutional delay does not cause anosmia and usually has a family history of late puberty.
- **C:** A prolactinoma would show on MRI and raise prolactin.
- **D:** Swyer syndrome is 46,XY with high FSH.
- **E:** Turner syndrome has high FSH and short stature.

Key point: Low FSH/LH + anosmia = Kallmann syndrome. Fertility is possible with pulsatile GnRH or gonadotrophins.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 59 · Delayed Puberty · **Moderate** · C3

A 14-year-old girl is brought because her friends have started their periods and she has only just developed breast buds. Her height is on the 10th centile and her bone age is 2 years behind her chronological age. Her mother started menstruating at 16. Examination is otherwise normal.

What is the most appropriate management?

A. Cyclical combined oral contraceptive
B. Gonadectomy
C. Pituitary MRI
D. Reassurance and review of growth and development
E. Start growth hormone

Answer: D. Reassurance and review of growth and development

Constitutional delay is the commonest cause of delayed puberty. A family history of late puberty, delayed bone age and the start of breast development support it. Reassurance and follow-up are appropriate; puberty will progress.

Why not the others

- **A:** The pill is not needed when puberty has started spontaneously.
- **B:** Gonadectomy is only for Y-chromosome dysgenesis.
- **C:** MRI is for low gonadotrophins without spontaneous progression or with neurological signs.
- **E:** Growth hormone is not indicated in constitutional delay.

Key point: Breast budding has begun, so puberty is under way; follow her rather than investigate extensively.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 60 · Precocious Puberty · **Moderate** · C2

A 6-year-old girl has breast development and pubic hair for 6 months, with rapid growth. Bone age is advanced by 3 years. Basal LH is raised and rises further after a GnRH stimulation test. Pelvic ultrasound shows an enlarged uterus.

What is the most likely type of precocious puberty?

A. Central (gonadotrophin-dependent) precocious puberty
B. Isolated premature adrenarche
C. Isolated premature thelarche
D. McCune–Albright syndrome
E. Oestrogen-secreting ovarian tumour

Answer: A. Central (gonadotrophin-dependent) precocious puberty

Central precocious puberty is driven by early activation of the hypothalamic–pituitary axis, shown by an LH rise after GnRH. In girls it is usually idiopathic, but an MRI of the brain is still needed. Treatment is with a GnRH agonist.

Why not the others

- **B:** Premature adrenarche gives pubic hair only, without breast growth or advanced bone age.
- **C:** Premature thelarche gives isolated breast development without growth acceleration.
- **D:** McCune–Albright gives peripheral precocity with suppressed LH.
- **E:** An ovarian tumour suppresses LH and FSH (peripheral precocity).

Key point: Puberty before age 8 in a girl is precocious. LH rise to GnRH = central.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 61 · Precocious Puberty · **Hard** · C2

A 5-year-old girl has had vaginal bleeding for a week and breast development for 2 months. She has large irregular café-au-lait patches on one side of her trunk with jagged "coast of Maine" borders. X-ray of the femur shows fibrous dysplasia. LH and FSH are suppressed.

What is the most likely diagnosis?

A. Central precocious puberty
B. Granulosa cell tumour
C. Hypothyroidism
D. McCune–Albright syndrome
E. Neurofibromatosis type 1

Answer: D. McCune–Albright syndrome

McCune–Albright syndrome is caused by a mosaic GNAS mutation. It gives the triad of peripheral precocious puberty (from autonomous ovarian cysts), café-au-lait patches with irregular edges, and polyostotic fibrous dysplasia.

Why not the others

- **A:** Central puberty gives raised, not suppressed, gonadotrophins.
- **B:** A granulosa tumour causes peripheral precocity but not skin patches or bone lesions.
- **C:** Severe hypothyroidism can cause precocity but with growth delay, not fibrous dysplasia.
- **E:** NF1 café-au-lait spots have smooth "coast of California" borders and do not cause fibrous dysplasia.

Key point: Café-au-lait + fibrous dysplasia + precocity = McCune–Albright.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 62 · Premature Thelarche · **Easy** · C3

A 20-month-old girl has had bilateral breast enlargement of about 2 cm for 3 months. There is no pubic hair, no vaginal bleeding and no growth acceleration. Her growth chart is normal and pelvic ultrasound shows a prepubertal uterus.

What is the most appropriate management?

A. Bone age and GnRH stimulation test now
B. Brain MRI
C. GnRH agonist treatment
D. Reassurance with clinical review
E. Surgical biopsy of the breast tissue

Answer: D. Reassurance with clinical review

This is isolated premature thelarche, common under age 2. It is benign and usually regresses. Without growth acceleration or other signs of puberty, reassurance and review are enough.

Why not the others

- **A:** Investigations are needed only if other signs of puberty or growth acceleration appear.
- **B:** MRI is for central precocious puberty.
- **C:** GnRH agonists treat central precocious puberty, which she does not have.
- **E:** Breast biopsy can damage the developing breast and is not indicated.

Key point: Never biopsy a breast bud in a child.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Paediatric gynaecology

MCQ 63 · Secondary Amenorrhoea · **Easy** · C3

A 23-year-old married woman has not had a period for 10 weeks. Her periods were previously regular. She has mild nausea and breast tenderness. She has no other symptoms.

What is the first investigation?

A. Pelvic ultrasound
B. Serum FSH and LH
C. Serum prolactin
D. Thyroid function tests
E. Urine pregnancy test

Answer: E. Urine pregnancy test

Pregnancy is the commonest cause of secondary amenorrhoea in women of reproductive age. A urine pregnancy test should always be done first.

Why not the others

- **A:** Ultrasound is useful later but is not the first test.
- **B:** FSH and LH are measured after excluding pregnancy.
- **C:** Prolactin is part of the work-up after pregnancy is excluded.
- **D:** Thyroid tests are also done after pregnancy is excluded.

Key point: Exclude pregnancy first in every woman with amenorrhoea.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 64 · Secondary Amenorrhoea · **Moderate** · C2

A 19-year-old university athlete running 80 km a week has not menstruated for 9 months. Her BMI is 17.5 kg/m². Pregnancy test is negative. FSH and LH are low, oestradiol is low, and prolactin and TSH are normal.

What is the most likely diagnosis?

A. Functional hypothalamic amenorrhoea
B. Polycystic ovary syndrome
C. Premature ovarian insufficiency
D. Prolactinoma
E. Sheehan syndrome

Answer: A. Functional hypothalamic amenorrhoea

Intense exercise, low body weight and stress suppress GnRH pulsatility, giving low FSH, LH and oestrogen. Low oestrogen causes bone loss. Treatment is to improve energy intake and reduce training, with HRT if needed.

Why not the others

- **B:** PCOS has normal or high LH and normal oestrogen.
- **C:** POI has high FSH.
- **D:** Prolactin is normal.
- **E:** Sheehan syndrome follows postpartum haemorrhage.

Key point: Female athlete triad: low energy availability, amenorrhoea and low bone density.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 65 · Hyperprolactinaemia · **Moderate** · C2

A 28-year-old woman has not menstruated for 6 months and has a milky nipple discharge. She has been taking risperidone for schizophrenia for a year. Pregnancy test is negative. Prolactin is 2,100 mIU/L (normal under 500). TSH is normal.

What is the most likely cause of her raised prolactin?

A. Hypothyroidism
B. Macroprolactinoma
C. Physiological stress
D. Polycystic ovary syndrome
E. Risperidone

Answer: E. Risperidone

Antipsychotics such as risperidone block dopamine D2 receptors, removing the dopamine brake on prolactin secretion. This causes galactorrhoea and amenorrhoea. The psychiatrist may change to a prolactin-sparing drug such as aripiprazole.

Why not the others

- **A:** TSH is normal, excluding hypothyroidism.
- **B:** Macroprolactinomas usually give much higher levels (often over 5,000 mIU/L); MRI is needed if levels stay high after stopping the drug.
- **C:** Stress gives only mild rises.
- **D:** PCOS may give slightly raised prolactin, not this level.

Key point: Always check the drug history in hyperprolactinaemia: antipsychotics, metoclopramide and domperidone are common causes.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 66 · Hyperprolactinaemia · **Moderate** · C3

A 26-year-old woman has amenorrhoea and galactorrhoea. Prolactin is 3,800 mIU/L. She takes no medication and thyroid function is normal. MRI shows a 7 mm pituitary adenoma. She wishes to conceive in the future.

What is the first-line treatment?

A. Cabergoline
B. Combined oral contraceptive pill
C. Observation only
D. Pituitary radiotherapy
E. Transsphenoidal surgery

Answer: A. Cabergoline

A dopamine agonist is first-line treatment for a microprolactinoma. Cabergoline is preferred because it is more effective and better tolerated than bromocriptine. It shrinks the tumour, normalises prolactin and restores ovulation.

Why not the others

- **B:** The pill restores bleeds but does not treat the tumour or restore fertility.
- **C:** She has symptoms and wants fertility, so observation is not appropriate.
- **D:** Radiotherapy is reserved for resistant tumours.
- **E:** Surgery is for drug intolerance or resistance.

Key point: Prolactinoma: medical treatment first, surgery rarely.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 67 · Pituitary Disorders · **Hard** · C2

A 31-year-old woman had a massive postpartum haemorrhage needing 10 units of blood 8 months ago. She was unable to breastfeed and has not menstruated since delivery. She feels tired, cold and has lost pubic and axillary hair.

What is the most likely diagnosis?

A. Asherman syndrome
B. Lactational amenorrhoea
C. Premature ovarian insufficiency
D. Prolactinoma
E. Sheehan syndrome

Answer: E. Sheehan syndrome

Sheehan syndrome is ischaemic necrosis of the enlarged pituitary after severe postpartum haemorrhage and hypotension. Failure of lactation is often the first sign, followed by amenorrhoea, hypothyroidism and adrenal insufficiency.

Why not the others

- **A:** Asherman syndrome causes amenorrhoea but not failed lactation, tiredness or hair loss.
- **B:** She is not breastfeeding, so lactation cannot explain the amenorrhoea.
- **C:** POI causes high FSH but does not stop lactation or cause hypothyroid symptoms.
- **D:** A prolactinoma causes galactorrhoea, not failed lactation.

Key point: Replace cortisol before thyroxine in hypopituitarism to avoid an adrenal crisis.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 68 · Premature Ovarian Insufficiency · **Easy** · C2

A 34-year-old woman has had no periods for 8 months, with hot flushes and vaginal dryness. Pregnancy test is negative. FSH is 68 IU/L, repeated 6 weeks later at 72 IU/L. Oestradiol is low.

What is the most likely diagnosis?

A. Functional hypothalamic amenorrhoea
B. Hyperprolactinaemia
C. Polycystic ovary syndrome
D. Premature ovarian insufficiency
E. Sheehan syndrome

Answer: D. Premature ovarian insufficiency

Premature ovarian insufficiency is loss of ovarian function before age 40, diagnosed by oligo/amenorrhoea for at least 4 months and an FSH above 25 IU/L on two occasions at least 4 weeks apart.

Why not the others

- **A:** Hypothalamic amenorrhoea has low FSH.
- **B:** Hyperprolactinaemia gives normal or low FSH.
- **C:** PCOS gives normal FSH.
- **E:** Sheehan syndrome gives low pituitary hormones.

Key point: POI: age under 40 + amenorrhoea + FSH over 25 IU/L twice.

Reference: Gynaecology by Ten Teachers — Amenorrhoea; The menopause

MCQ 69 · Premature Ovarian Insufficiency · **Moderate** · C3

A 32-year-old woman is diagnosed with premature ovarian insufficiency. She has hot flushes and is worried about her long-term health. She has no contraindications to hormones.

What is the most appropriate management?

A. Bisphosphonate alone
B. Clonidine for hot flushes
C. Hormone replacement until at least the age of natural menopause
D. No treatment unless fractures occur
E. Vaginal oestrogen only

Answer: C. Hormone replacement until at least the age of natural menopause

Women with POI should take oestrogen (HRT or the combined pill) at least until the average age of menopause (about 51). It controls symptoms and protects bones and the cardiovascular system. HRT at this age replaces what the body would normally make and does not carry the risks seen in older women.

Why not the others

- **A:** Bisphosphonates treat osteoporosis but do not replace oestrogen or relieve symptoms.
- **B:** Clonidine is a weak non-hormonal option and gives no bone or heart protection.
- **D:** Untreated oestrogen deficiency causes osteoporosis and cardiovascular disease.
- **E:** Vaginal oestrogen treats local symptoms only.

Key point: POI is not menopause: about 5–10% of women with POI still conceive spontaneously.

Reference: Gynaecology by Ten Teachers — Amenorrhoea; The menopause

MCQ 70 · Premature Ovarian Insufficiency · **Hard** · C3

A 30-year-old woman has premature ovarian insufficiency. She has no history of chemotherapy, radiotherapy or surgery. Her maternal uncle had a learning disability and her grandfather developed a tremor and ataxia in old age.

Which test is most appropriate to find the cause?

A. Anti-Müllerian hormone level
B. FMR1 premutation testing
C. Ovarian biopsy
D. Pelvic MRI
E. Serum testosterone

Answer: B. FMR1 premutation testing

FMR1 premutation (fragile X carrier) is a known cause of POI. The family history of learning disability (fragile X syndrome) and late-onset tremor and ataxia (FXTAS) is typical. Karyotype and adrenal antibodies are also part of the work-up.

Why not the others

- **A:** AMH reflects ovarian reserve and will be low, but does not show the cause.
- **C:** Ovarian biopsy is not helpful.
- **D:** MRI does not identify the cause.
- **E:** Testosterone is not relevant to finding the cause of POI.

Key point: POI work-up: karyotype, FMR1 premutation, adrenal (21-hydroxylase) and thyroid antibodies.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 71 · Investigation of Amenorrhoea · **Moderate** · C3

A 25-year-old woman has had no periods for 7 months. Pregnancy test is negative. Prolactin, TSH and FSH are normal. She is given a 5-day course of oral medroxyprogesterone and has a withdrawal bleed 4 days after stopping it.

What does the withdrawal bleed show?

A. Endometrium is absent
B. Oestrogen levels are adequate and the outflow tract is normal
C. Ovarian failure
D. Pituitary failure
E. The patient is pregnant

Answer: B. Oestrogen levels are adequate and the outflow tract is normal

A bleed after progestogen withdrawal shows that the endometrium has been primed by enough oestrogen and the outflow tract is patent. The problem is anovulation, as in PCOS.

Why not the others

- **A:** An absent or scarred endometrium would not bleed.
- **C:** Ovarian failure gives low oestrogen and no bleed.
- **D:** Pituitary failure gives low oestrogen and no bleed.
- **E:** Pregnancy is excluded by the negative test.

Key point: Progestogen bleed = oestrogen present. No bleed → give oestrogen + progestogen to test the endometrium.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 72 · Thyroid and Menstruation · **Easy** · C2

A 33-year-old woman has had scanty, infrequent periods for a year. She has gained weight, feels cold and tired, and is constipated. Pregnancy test is negative. Prolactin is slightly raised at 720 mIU/L.

Which investigation is most likely to reveal the cause?

A. Pelvic ultrasound
B. Pituitary MRI
C. Serum androgens
D. Serum FSH
E. Thyroid function tests

Answer: E. Thyroid function tests

Hypothyroidism causes menstrual disturbance and mild hyperprolactinaemia, because high TRH stimulates prolactin. Her symptoms suggest hypothyroidism, so TSH and free T4 should be checked.

Why not the others

- **A:** Ultrasound will not find the cause of her symptoms.
- **B:** MRI is not needed for a slight prolactin rise explained by hypothyroidism.
- **C:** Androgens are checked if hirsutism is present.
- **D:** FSH is useful, but her symptoms point to the thyroid.

Key point: Mildly raised prolactin + hypothyroid symptoms: treat the thyroid and recheck prolactin.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 73 · Adolescent Gynaecology · **Moderate** · C3

A 14-year-old girl attends the emergency department with very heavy bleeding since her second period started 8 days ago. Haemoglobin is 7.8 g/dL. She often has nosebleeds and her mother has heavy periods. Pregnancy test is negative.

Which investigation is most important to identify the cause?

A. Coagulation screen including von Willebrand factor
B. Pelvic MRI
C. Serum FSH and LH
D. Thyroid antibodies
E. Transvaginal ultrasound

Answer: A. Coagulation screen including von Willebrand factor

Heavy bleeding from menarche, nosebleeds and a family history suggest an inherited bleeding disorder. Von Willebrand disease is the commonest and is found in up to 20% of adolescents with heavy menstrual bleeding.

Why not the others

- **B:** Pelvic MRI is not needed initially.
- **C:** FSH and LH do not explain this bleeding.
- **D:** Thyroid disease can cause heavy periods but does not explain nosebleeds or family history.
- **E:** Transvaginal scanning is inappropriate in a young girl; structural causes are rare at this age.

Key point: Heavy periods from menarche → screen for von Willebrand disease.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Disorders of the menstrual cycle

MCQ 74 · Paediatric Gynaecology · **Easy** · C3

A 3-year-old girl is brought because her mother noticed that the opening of the vagina looks closed. The child has no symptoms and passes urine normally. Examination shows a thin, translucent midline line where the labia minora are joined.

What is the most appropriate management?

A. Examination under anaesthesia
B. Reassurance and watchful waiting
C. Referral to child protection
D. Surgical separation under anaesthesia
E. Topical steroid injection

Answer: B. Reassurance and watchful waiting

Labial adhesions are common in young girls because of low oestrogen. If there are no symptoms they need no treatment and usually separate by themselves, often at puberty. Topical oestrogen cream is used if there are urinary symptoms.

Why not the others

- **A:** An EUA is not needed for a clear clinical diagnosis.
- **C:** Labial adhesions are not a sign of abuse in themselves.
- **D:** Surgical separation is rarely needed and adhesions often recur.
- **E:** Steroids are not injected; a short course of topical oestrogen is used if treatment is needed.

Key point: Labial adhesions without symptoms: leave alone.

Reference: Gynaecology by Ten Teachers — Paediatric gynaecology

MCQ 75 · Paediatric Gynaecology · **Moderate** · C3

A 6-year-old girl has had a foul-smelling, blood-stained vaginal discharge for 3 weeks despite a course of oral antibiotics. Examination of the vulva shows mild redness only. She is otherwise well.

What is the most likely cause?

A. Candida infection
B. Foreign body in the vagina
C. Lichen sclerosus
D. Sarcoma botryoides
E. Threadworm infestation

Answer: B. Foreign body in the vagina

A persistent, offensive, blood-stained discharge in a young girl suggests a vaginal foreign body, often toilet paper. Examination, sometimes under anaesthesia with vaginoscopy, and saline irrigation remove it.

Why not the others

- **A:** Candida is uncommon before puberty unless the child is diabetic or in nappies.
- **C:** Lichen sclerosus causes itching and white skin, not foul discharge.
- **D:** Sarcoma botryoides is a rare tumour presenting as grape-like masses, usually under age 5.
- **E:** Threadworms cause perianal itching at night.

Key point: Offensive bloody discharge in a child: think foreign body; examine carefully and consider abuse.

Reference: Gynaecology by Ten Teachers — Paediatric gynaecology

MCQ 76 · Paediatric Gynaecology · **Easy** · C3

A 5-year-old girl has vulval soreness and a slight non-offensive discharge for 2 weeks. She wipes from back to front and uses bubble baths. Examination shows mild vulval redness with no lesions. Swab grows mixed skin flora only.

What is the most appropriate management?

A. Examination under anaesthesia
B. Hygiene advice and avoiding irritants
C. Oral antibiotics
D. Topical antifungal cream
E. Topical oestrogen cream

Answer: B. Hygiene advice and avoiding irritants

Non-specific vulvovaginitis is the commonest gynaecological problem in young girls. The thin, unoestrogenised skin is easily irritated. Front-to-back wiping, cotton underwear and avoiding bubble baths and soaps are usually enough.

Why not the others

- **A:** EUA is only for persistent bloody discharge or suspected foreign body.
- **C:** The swab grew skin flora only; antibiotics are not needed.
- **D:** Candida is unlikely at this age.
- **E:** Oestrogen cream is for labial adhesions.

Key point: Prepubertal vulvovaginitis: hygiene first.

Reference: Gynaecology by Ten Teachers — Paediatric gynaecology

MCQ 77 · Menstrual Physiology · **Moderate** · C2

A 29-year-old woman with regular 28-day cycles is trying to conceive. She asks when she is most likely to ovulate. She is using urinary LH kits, which turn positive on day 13.

When does ovulation usually occur in relation to the start of the LH surge?

A. About 12 hours before the surge
B. About 24–36 hours after the onset of the surge
C. About 72 hours after the surge
D. About one week after the surge
E. At the same time as the onset of the surge

Answer: B. About 24–36 hours after the onset of the surge

Ovulation occurs about 24–36 hours after the onset of the LH surge (around 10–12 hours after its peak). Intercourse on the day of the positive test and the day after gives the best chance of conception.

Why not the others

- **A:** Ovulation follows, not precedes, the surge.
- **C:** By 72 hours the egg is no longer fertilisable.
- **D:** Seven days after the surge is the mid-luteal phase, when progesterone peaks.
- **E:** The follicle needs time to rupture after the surge begins.

Key point: The egg survives about 12–24 hours; sperm survive up to 5 days.

Reference: Gynaecology by Ten Teachers — The normal menstrual cycle

MCQ 78 · Androgen Insensitivity · **Hard** · C3

A 17-year-old girl is diagnosed with complete androgen insensitivity syndrome (46,XY). Her breasts developed normally at puberty. Testes are present in both inguinal canals. She and her parents ask about removing them.

What is the most appropriate advice about gonadectomy?

A. Gonadectomy at birth is mandatory
B. Gonadectomy is never needed
C. Gonadectomy should be done only if she wants pregnancy
D. Gonadectomy usually after puberty, with lifelong oestrogen replacement afterwards
E. Gonadectomy with testosterone replacement afterwards

Answer: D. Gonadectomy usually after puberty, with lifelong oestrogen replacement afterwards

In complete androgen insensitivity the testes convert testosterone to oestrogen, allowing natural breast development at puberty. The malignancy risk before adulthood is low, so gonadectomy is usually done after puberty (or deferred after informed discussion), followed by oestrogen replacement to protect bone.

Why not the others

- **A:** Early removal stops natural puberty and the cancer risk in childhood is very low.
- **B:** There is a small long-term risk of germ cell tumour, so removal is usually advised or close surveillance is needed.
- **C:** She has no uterus; pregnancy is not possible.
- **E:** Testosterone has no effect because androgen receptors do not work.

Key point: Complete AIS: female identity, no uterus, short vagina. Treat the vagina with dilators if needed.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Disorders of sex development

MCQ 79 · Hypothalamic Amenorrhoea · **Moderate** · C3

A 21-year-old dancer has had amenorrhoea for 18 months due to functional hypothalamic amenorrhoea. Her BMI is 18 kg/m². She has had a stress fracture of the metatarsal.

Which investigation is most important to assess the long-term effect of her amenorrhoea?

A. Bone densitometry (DEXA scan)
B. Endometrial biopsy
C. Pelvic MRI
D. Serum AMH
E. Thyroid ultrasound

Answer: A. Bone densitometry (DEXA scan)

Low oestrogen for more than 6 months causes bone loss, and peak bone mass is still being built at her age. A DEXA scan assesses this. Treatment is nutritional restoration, reduced training and, if needed, transdermal oestrogen.

Why not the others

- **B:** Low oestrogen does not cause endometrial hyperplasia.
- **C:** Pelvic MRI does not assess the complications.
- **D:** AMH is often normal and does not guide treatment.
- **E:** Thyroid ultrasound is not relevant.

Key point: Amenorrhoea for more than 6 months with low oestrogen → check bone density.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 80 · Delayed Puberty · **Hard** · C2

A 13-year-old girl has had headaches for 6 months and bumps into objects on both sides. She has no breast development and has fallen from the 50th to the 9th centile for height. Visual field testing shows bitemporal hemianopia. CT shows a calcified suprasellar cystic mass.

What is the most likely diagnosis?

A. Constitutional delay
B. Craniopharyngioma
C. Kallmann syndrome
D. Pituitary microadenoma
E. Turner syndrome

Answer: B. Craniopharyngioma

Craniopharyngioma is the commonest tumour causing hypopituitarism in children. It arises from Rathke's pouch remnants and is typically cystic and calcified above the sella. It compresses the optic chiasm and causes growth failure and delayed puberty.

Why not the others

- **A:** Constitutional delay does not cause headaches or visual loss.
- **C:** Kallmann syndrome does not cause headaches, visual loss or a mass.
- **D:** A microadenoma is under 10 mm and does not compress the chiasm.
- **E:** Turner syndrome has no intracranial mass.

Key point: Delayed puberty + headaches or visual symptoms → urgent brain imaging.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 81 · Dysmenorrhoea · **Easy** · C3

A 17-year-old girl has crampy lower abdominal pain starting on the first day of each period and lasting 2 days, causing her to miss school. Periods are regular. She is not sexually active. Abdominal examination is normal.

What is the most appropriate first-line treatment?

A. Diagnostic laparoscopy
B. GnRH analogue injections
C. Levonorgestrel intrauterine system
D. Mefenamic acid starting at the onset of pain
E. Paracetamol with codeine

Answer: D. Mefenamic acid starting at the onset of pain

This is primary dysmenorrhoea, caused by prostaglandin release from the endometrium. NSAIDs such as mefenamic acid or ibuprofen inhibit prostaglandin synthesis and are first line. The combined pill is an alternative.

Why not the others

- **A:** Laparoscopy is for pain not responding to treatment or with features of endometriosis.
- **B:** GnRH analogues are for severe endometriosis, not primary dysmenorrhoea.
- **C:** The LNG-IUS is not first line in a young girl who is not sexually active.
- **E:** Codeine is less effective and causes constipation and dependence.

Key point: Primary dysmenorrhoea starts within a few years of menarche, with pain only during menses.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 82 · Dysmenorrhoea · **Easy** · C2

A 16-year-old girl has severe cramping pain on the first two days of her periods, with nausea and diarrhoea. Examination and ultrasound are normal. Her doctor explains the cause before prescribing treatment.

What is the main cause of her pain?

A. Adenomyosis
B. Cervical stenosis
C. Endometriosis
D. Pelvic congestion
E. Prostaglandin release from the endometrium

Answer: E. Prostaglandin release from the endometrium

Prostaglandins (PGF2-alpha) released as the endometrium breaks down cause strong uterine contractions and ischaemia. They also act on the gut, explaining the nausea and diarrhoea.

Why not the others

- **A:** Adenomyosis causes secondary dysmenorrhoea in older parous women.
- **B:** Cervical stenosis is rare and usually follows surgery.
- **C:** Endometriosis causes secondary dysmenorrhoea with other features.
- **D:** Pelvic congestion causes a dull ache worse on standing.

Key point: Prostaglandins explain why NSAIDs work so well in primary dysmenorrhoea.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 83 · Premenstrual Syndrome · **Moderate** · C3

A 30-year-old woman has severe irritability, low mood, bloating and breast tenderness for 7 days before each period, which settle within 2 days of bleeding starting. A symptom diary over 3 cycles confirms the pattern. Symptoms are affecting her work. Lifestyle changes have not helped.

What is the most appropriate next treatment?

A. Danazol
B. Evening primrose oil
C. Oral progesterone in the luteal phase
D. Selective serotonin reuptake inhibitor
E. Total hysterectomy and oophorectomy

Answer: D. Selective serotonin reuptake inhibitor

For moderate to severe premenstrual syndrome, SSRIs (continuously or in the luteal phase) are effective first-line drugs. A combined pill with a drospirenone component is another option.

Why not the others

- **A:** Danazol has androgenic side effects and is no longer used for PMS.
- **B:** Evening primrose oil has no proven benefit.
- **C:** Progesterone has not been shown to work and may worsen symptoms.
- **E:** Surgery is a last resort for severe resistant cases.

Key point: PMS diagnosis needs a prospective symptom diary over 2–3 cycles.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 84 · Menstrual Physiology · **Moderate** · C3

A 30-year-old woman with regular 35-day cycles is being investigated for subfertility. The doctor wants to confirm ovulation with a serum progesterone level.

On which day of her cycle should progesterone be measured?

A. Day 2
B. Day 14
C. Day 21
D. Day 28
E. Day 35

Answer: D. Day 28

Progesterone should be measured in the mid-luteal phase, 7 days before the next expected period. The luteal phase is fairly constant at 14 days, so in a 35-day cycle the test is on day 28.

Why not the others

- **A:** Day 2 is the early follicular phase, used for FSH and LH.
- **B:** Day 14 is too early; she will not yet have ovulated.
- **C:** Day 21 is correct only for a 28-day cycle.
- **E:** Day 35 is the start of the next period, when progesterone has fallen.

Key point: Mid-luteal progesterone = 7 days before the next period. Over 30 nmol/L confirms ovulation.

Reference: Gynaecology by Ten Teachers — The normal menstrual cycle; Subfertility

MCQ 85 · Menstrual Physiology · **Moderate** · C2

A 32-year-old woman has an endometrial biopsy on day 22 of a 28-day cycle. The pathologist reports tortuous glands with subnuclear vacuoles and secretions in the gland lumens.

Which hormone is responsible for these changes?

A. Follicle-stimulating hormone
B. Luteinising hormone
C. Oestradiol
D. Progesterone
E. Prolactin

Answer: D. Progesterone

After ovulation, progesterone from the corpus luteum converts the proliferative endometrium to secretory endometrium, with coiled glands, glycogen-rich vacuoles and secretions, preparing it for implantation.

Why not the others

- **A:** FSH acts on the ovary, not the endometrium.
- **B:** LH triggers ovulation but does not act directly on the endometrium.
- **C:** Oestradiol causes proliferation of glands and stroma in the first half of the cycle.
- **E:** Prolactin does not cause secretory change.

Key point: Proliferative phase = oestrogen. Secretory phase = progesterone.

Reference: Gynaecology by Ten Teachers — The normal menstrual cycle

MCQ 86 · Menstrual Physiology · **Hard** · C2

In a 26-year-old woman being monitored on ultrasound, several antral follicles grow in the early follicular phase. By day 8 one follicle becomes dominant while the others undergo atresia.

What mainly causes the non-dominant follicles to undergo atresia?

A. A fall in FSH caused by rising oestradiol and inhibin B
B. A rise in LH causing luteinisation
C. A rise in prolactin
D. Increased progesterone from the corpus luteum
E. Increased testosterone from theca cells

Answer: A. A fall in FSH caused by rising oestradiol and inhibin B

Rising oestradiol and inhibin B from the growing follicles suppress FSH. The dominant follicle has the most FSH receptors and aromatase activity, so it survives the fall in FSH, while the others become atretic.

Why not the others

- **B:** The LH surge comes later, at mid-cycle.
- **C:** Prolactin does not select the dominant follicle.
- **D:** There is no corpus luteum in the follicular phase.
- **E:** Local androgen excess contributes to atresia in PCOS but is not the normal mechanism.

Key point: The FSH "window" explains why exogenous FSH in IVF produces many follicles.

Reference: Gynaecology by Ten Teachers — The normal menstrual cycle

MCQ 87 · Menstrual Physiology · **Moderate** · C2

A 27-year-old woman has a positive pregnancy test 2 weeks after a missed period. Her doctor explains that the corpus luteum must keep producing progesterone to sustain the early pregnancy until the placenta takes over.

Which hormone maintains the corpus luteum in early pregnancy?

A. Follicle-stimulating hormone
B. Human chorionic gonadotrophin
C. Human placental lactogen
D. Oxytocin
E. Prolactin

Answer: B. Human chorionic gonadotrophin

hCG from the trophoblast acts on LH receptors to rescue and maintain the corpus luteum. The corpus luteum produces progesterone until about 8–10 weeks, when the placenta takes over (the luteo-placental shift).

Why not the others

- **A:** FSH is suppressed in pregnancy.
- **C:** Human placental lactogen affects maternal metabolism later in pregnancy.
- **D:** Oxytocin is involved in labour and lactation.
- **E:** Prolactin prepares the breasts for lactation.

Key point: Removal of the corpus luteum before about 8 weeks needs progesterone support.

Reference: Gynaecology by Ten Teachers — The normal menstrual cycle; Early pregnancy

MCQ 88 · Hyperprolactinaemia · **Hard** · C3

A 30-year-old woman had blood tests for tiredness. Prolactin is 1,600 mIU/L. She has regular periods, no galactorrhoea, no headaches and takes no medication. TSH and pregnancy test are normal.

What is the most appropriate next step?

A. Cabergoline treatment
B. Pituitary MRI
C. Reassurance without further testing
D. Test for macroprolactin
E. Visual field testing

Answer: D. Test for macroprolactin

Macroprolactin is a large complex of prolactin and antibody that is detected by assays but is biologically inactive. It explains raised prolactin in women without symptoms. Checking for macroprolactin avoids unnecessary MRI and treatment.

Why not the others

- **A:** Treatment is not needed until true hyperprolactinaemia is confirmed.
- **B:** MRI is done after macroprolactin is excluded.
- **C:** Raised prolactin needs explanation before reassurance.
- **E:** Visual fields are needed for a macroadenoma, which is unlikely here.

Key point: Raised prolactin with no symptoms → check for macroprolactin.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 89 · Hyperprolactinaemia · **Hard** · C3

A 29-year-old woman with a 6 mm microprolactinoma has been taking cabergoline. Her periods returned and she now has a positive pregnancy test at 5 weeks. She has no headaches or visual problems.

What is the most appropriate management of her cabergoline?

A. Continue cabergoline throughout pregnancy
B. Double the dose of cabergoline
C. Stop cabergoline and monitor clinically
D. Switch to bromocriptine
E. Terminate the pregnancy

Answer: C. Stop cabergoline and monitor clinically

For a microprolactinoma the risk of significant growth in pregnancy is low (about 2–3%). Cabergoline is usually stopped once pregnancy is confirmed, with clinical review for headaches or visual change. Prolactin levels are not useful in pregnancy because they rise normally.

Why not the others

- **A:** Continuing is not needed for a microadenoma; it may be needed for a macroadenoma.
- **B:** There is no indication to increase the dose.
- **D:** Switching is not needed; she can stop.
- **E:** There is no reason to terminate.

Key point: Macroprolactinomas grow more in pregnancy; they need visual field checks each trimester.

Reference: Gynaecology by Ten Teachers — Amenorrhoea; Endocrine disorders in pregnancy

MCQ 90 · Asherman Syndrome · **Moderate** · C3

A 30-year-old woman has had very light periods since a repeat surgical evacuation for retained products 1 year ago. She wants to conceive. Hormone tests are normal and hysteroscopy shows dense adhesions across the uterine cavity.

What is the most appropriate treatment?

A. Abdominal hysterectomy
B. Clomiphene citrate
C. Diagnostic laparoscopy
D. Hysteroscopic adhesiolysis
E. Repeat dilatation and curettage

Answer: D. Hysteroscopic adhesiolysis

Hysteroscopic division of adhesions under direct vision is the treatment of choice. Postoperative oestrogen, an intrauterine balloon or a gel may reduce re-formation. Pregnancy rates improve but later pregnancies carry a risk of placenta accreta.

Why not the others

- **A:** Hysterectomy ends fertility and is not needed.
- **B:** She ovulates normally; clomiphene will not help.
- **C:** Laparoscopy does not treat intrauterine adhesions.
- **E:** Blind curettage can worsen adhesions.

Key point: Avoid vigorous curettage, especially in the postpartum or infected uterus.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 91 · Cervical Stenosis · **Moderate** · C2

A 38-year-old woman had a deep cone biopsy for CIN 3 six months ago. She has had no periods since, but has severe lower abdominal pain each month. Pregnancy test is negative. Ultrasound shows a fluid-filled uterine cavity.

What is the most likely diagnosis?

A. Asherman syndrome
B. Cervical stenosis with haematometra
C. Ectopic pregnancy
D. Premature ovarian insufficiency
E. Recurrent CIN

Answer: B. Cervical stenosis with haematometra

Deep cone biopsy can scar the cervical canal and block it. Menstrual blood collects in the uterus (haematometra), causing cyclical pain without bleeding. Dilatation of the cervix drains the blood.

Why not the others

- **A:** Asherman syndrome causes amenorrhoea without a distended cavity or cyclical pain.
- **C:** The pregnancy test is negative.
- **D:** POI does not cause cyclical pain or fluid in the uterus.
- **E:** Recurrent CIN does not cause amenorrhoea.

Key point: Cyclical pain without bleeding after cervical surgery → think cervical stenosis.

Reference: Gynaecology by Ten Teachers — Amenorrhoea; Premalignant disease of the cervix

MCQ 92 · Contraception and Amenorrhoea · **Easy** · C3

A 27-year-old woman stopped depot medroxyprogesterone acetate injections 7 months ago after using them for 3 years. She has not had a period since and wants to conceive. Pregnancy test is negative. Examination is normal.

What is the most appropriate management?

A. Clomiphene citrate
B. Endometrial biopsy
C. Hysteroscopy
D. Pituitary MRI
E. Reassurance and review if no periods by 12 months

Answer: E. Reassurance and review if no periods by 12 months

Return of ovulation after stopping the depot injection can take up to a year (median about 9 months from the last injection). Reassurance is appropriate; investigate if periods have not returned by about a year.

Why not the others

- **A:** Ovulation induction is premature.
- **B:** An endometrial biopsy is not needed.
- **C:** There is no reason to suspect a cavity problem.
- **D:** MRI is not needed without other signs.

Key point: Women planning pregnancy soon should be told about the delayed return of fertility with the depot injection.

Reference: Gynaecology by Ten Teachers — Contraception; Amenorrhoea

MCQ 93 · Premature Ovarian Insufficiency · **Moderate** · C3

A 24-year-old unmarried woman has just been diagnosed with Hodgkin lymphoma and needs alkylating chemotherapy. She asks about her future fertility. There is time for treatment before chemotherapy starts.

What is the most appropriate fertility advice?

A. Fertility is never affected by chemotherapy
B. GnRH agonist alone guarantees fertility
C. Hysterectomy before chemotherapy
D. Oocyte cryopreservation before chemotherapy
E. Wait until after chemotherapy and test AMH

Answer: D. Oocyte cryopreservation before chemotherapy

Alkylating agents can destroy the ovarian follicle pool and cause POI. Egg (or embryo) freezing after ovarian stimulation, or ovarian tissue freezing, should be offered before treatment starts.

Why not the others

- **A:** Alkylating agents carry a high risk of ovarian failure.
- **B:** GnRH agonists may reduce the risk but do not guarantee fertility.
- **C:** Hysterectomy is irrelevant and harmful.
- **E:** Waiting may lose the chance to preserve eggs.

Key point: Discuss fertility preservation with every young woman before gonadotoxic treatment.

Reference: Gynaecology by Ten Teachers — Amenorrhoea; Subfertility

MCQ 94 · Virilisation · **Hard** · C3

A 32-year-old woman has had amenorrhoea for 6 months with rapidly worsening hirsutism, frontal balding, deepening voice and clitoromegaly. Serum testosterone is 7.5 nmol/L (normal under 2) and DHEAS is markedly raised. Pelvic ultrasound shows normal ovaries.

What is the most appropriate next investigation?

A. CT scan of the adrenal glands
B. Dexamethasone suppression test only
C. Laparoscopic ovarian biopsy
D. Pelvic ultrasound repeat in 3 months
E. Serum 17-hydroxyprogesterone only

Answer: A. CT scan of the adrenal glands

Rapid virilisation with very high testosterone suggests an androgen-secreting tumour. A markedly raised DHEAS points to the adrenal gland, so adrenal CT (or MRI) is needed.

Why not the others

- **B:** Dexamethasone testing does not localise a tumour.
- **C:** The ovaries appear normal and biopsy is not the next step.
- **D:** Delay is unsafe with a possible malignant tumour.
- **E:** 17-OHP is for late-onset CAH, which does not cause rapid virilisation.

Key point: Rapid virilisation = tumour until proved otherwise. High DHEAS → adrenal; high testosterone with normal DHEAS → ovary.

Reference: Gynaecology by Ten Teachers — Amenorrhoea; Hirsutism and virilism

MCQ 95 · Turner Syndrome · **Moderate** · C3

A 12-year-old girl with Turner syndrome has completed growth hormone treatment and has no breast development. FSH is high. The endocrinologist plans to induce puberty.

What is the most appropriate method of pubertal induction?

A. Combined oral contraceptive pill at full dose
B. Gonadotrophin injections
C. High-dose oestrogen to speed up breast growth
D. Low-dose oestrogen increased gradually, with a progestogen added later
E. Progestogen alone

Answer: D. Low-dose oestrogen increased gradually, with a progestogen added later

Puberty is induced with low-dose oestrogen (usually transdermal) increased slowly over about 2 years. This mimics natural puberty, gives better breast shape and allows final height. A progestogen is added after breakthrough bleeding or about 2 years, to protect the endometrium.

Why not the others

- **A:** Starting a full-dose pill gives poor breast development and may limit height.
- **B:** Gonadotrophins do not work because the ovaries have failed.
- **C:** High-dose oestrogen causes poor breast shape and early epiphyseal fusion.
- **E:** Progestogen alone does not cause breast development.

Key point: Start low, go slow with oestrogen in pubertal induction.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 96 · Normal Puberty · **Easy** · C2

A 13-year-old girl is examined in the adolescent clinic. Her breasts show enlargement of the breast and areola with no separation of their contours. She has darker, coarse curly pubic hair spreading over the mons pubis.

What is her Tanner stage?

A. Stage 1
B. Stage 2
C. Stage 3
D. Stage 4
E. Stage 5

Answer: C. Stage 3

Tanner stage 3: the breast and areola enlarge further with no separation of contours, and pubic hair becomes darker, coarser and curlier over the mons.

Why not the others

- **A:** Stage 1 is prepubertal.
- **B:** Stage 2 is breast budding with sparse fine hair on the labia.
- **D:** Stage 4 has the areola forming a secondary mound and adult-type hair not reaching the thighs.
- **E:** Stage 5 is the adult pattern, with hair spreading onto the thighs.

Key point: Tanner staging tracks the progress of puberty and helps detect delay or precocity.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders

MCQ 97 · Hypothalamic Amenorrhoea · **Moderate** · C3

A 18-year-old student has lost 12 kg over 8 months through severe food restriction. Her BMI is now 15 kg/m² and she has had no periods for 6 months. Pulse is 48/min. FSH, LH and oestradiol are all low.

What is the most important step in managing her amenorrhoea?

A. Clomiphene citrate

B. Combined oral contraceptive pill alone

C. Multidisciplinary care with nutritional restoration

D. Pituitary MRI

E. Pulsatile GnRH

Answer: C. Multidisciplinary care with nutritional restoration

Low weight suppresses the hypothalamus. Restoring weight through multidisciplinary care (psychiatry, dietitian, medical team) is the key treatment, and periods usually return when weight recovers. Her low pulse also needs medical assessment.

Why not the others

- **A:** Ovulation induction is inappropriate while she is underweight and unwell.
- **B:** The pill causes bleeds that mask the problem and does not protect bone well.
- **D:** MRI is not needed when weight loss explains the picture.
- **E:** Pulsatile GnRH is for fertility once well, not first-line care.

Key point: Bradycardia and very low BMI may need urgent medical admission.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 98 · Disorders of Sex Development · **Hard** · C3

A 15-year-old girl of short stature has primary amenorrhoea and no breast development. She has some features of Turner syndrome. Karyotype shows 45,X/46,XY mosaicism. Ultrasound shows a small uterus and no visible ovaries.

What is the most important management step?

A. Bilateral gonadectomy

B. Clomiphene to induce ovulation

C. Growth hormone alone

D. Observation

E. Vaginoplasty

Answer: A. Bilateral gonadectomy

Any Y chromosome material in a patient with dysgenetic gonads carries a significant risk of gonadoblastoma and dysgerminoma. Prophylactic gonadectomy is recommended, followed by oestrogen for pubertal induction.

Why not the others

- **B:** The gonads do not contain functional follicles.
- **C:** Growth hormone may be used for height, but does not deal with the cancer risk.
- **D:** Observation leaves the tumour risk.
- **E:** There is no indication for vaginoplasty.

Key point: Turner syndrome with Y material → gonadectomy.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Disorders of sex development

MCQ 99 · Secondary Amenorrhoea · **Moderate** · C3

A 26-year-old woman has had no periods for 6 months. Pregnancy test is negative. FSH, LH, prolactin and TSH are normal. She does not bleed after a progestogen challenge, but bleeds after taking combined oestrogen and progestogen for 21 days.

What does this result indicate?

A. Absent endometrium
B. Adequate oestrogen with anovulation
C. Low oestrogen with a normal endometrium and outflow tract
D. Outflow tract obstruction
E. Pregnancy

Answer: C. Low oestrogen with a normal endometrium and outflow tract

No bleed with progestogen alone means there is not enough oestrogen to build the endometrium. A bleed after oestrogen plus progestogen shows the endometrium and outflow tract work. The problem is central (hypothalamic or pituitary) or ovarian.

Why not the others

- **A:** An absent endometrium would not bleed even with oestrogen.
- **B:** Adequate oestrogen would give a progestogen withdrawal bleed.
- **D:** Outflow obstruction would not bleed after either.
- **E:** Pregnancy has been excluded.

Key point: With low oestrogen, FSH tells you where the problem is: high → ovary, low or normal → hypothalamus or pituitary.

Reference: Gynaecology by Ten Teachers — Amenorrhoea

MCQ 100 · Turner Syndrome · **Easy** · C3

A 27-year-old married woman with 45,X Turner syndrome is on hormone replacement and wants to have a baby. She has a normal uterus on ultrasound. FSH is very high and AMH is undetectable. Her cardiac assessment is normal.

What is the most realistic option for her to achieve pregnancy?

A. Clomiphene citrate
B. Gonadotrophin ovulation induction
C. Intrauterine insemination
D. IVF with donor eggs
E. IVF with her own eggs

Answer: D. IVF with donor eggs

Her ovaries have failed, so her own eggs cannot be used. With a normal uterus, IVF using donor eggs and hormone preparation of the endometrium gives a good chance of pregnancy. Pregnancy is high risk because of aortic dissection, so cardiology input continues throughout.

Why not the others

- **A:** Clomiphene needs working ovaries.
- **B:** Gonadotrophins cannot stimulate failed ovaries.
- **C:** Insemination does not help without ovulation.
- **E:** She has no eggs of her own left.

Key point: Turner syndrome pregnancy needs pre-pregnancy cardiac imaging and specialist care.

Reference: Gynaecology by Ten Teachers — Puberty and its disorders; Subfertility

CHAPTER 3

Heavy Menstrual Bleeding and Fibroids

MCQ 101 · Fibroids · **Easy** · C2

A 38-year-old woman (para 3) has had heavy, prolonged periods for 2 years. Her haemoglobin is 8.9 g/dL. Abdominal examination shows a firm, irregular, non-tender mass arising from the pelvis, equal in size to a 16-week pregnancy. The mass moves when the cervix is moved.

What is the most likely diagnosis?

A. Adenomyosis
B. Endometrial hyperplasia
C. Endometrial polyp
D. Ovarian fibroma
E. Uterine leiomyoma

Answer: E. Uterine leiomyoma

A firm, irregular, enlarged uterus with heavy menstrual bleeding is classic for fibroids. A mass that moves with the cervix is uterine in origin.

Why not the others

- **A:** Adenomyosis gives a uniformly enlarged, soft and tender ("boggy") uterus, usually no bigger than 12–14 weeks, with painful periods.
- **B:** Endometrial hyperplasia causes abnormal bleeding but not a large irregular mass.
- **C:** An endometrial polyp causes intermenstrual bleeding with a normal-sized uterus.
- **D:** An ovarian fibroma is adnexal and moves separately from the cervix; it may cause Meigs' syndrome.

Key point: Mass moves with the cervix → uterine. Moves separately from the cervix → adnexal.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 102 · Heavy Menstrual Bleeding · **Moderate** · C3

A 34-year-old woman (para 2) has regular but heavy periods with clots, needing double sanitary protection, for one year. She would like contraception as her family is complete. Pelvic examination is normal. Transvaginal ultrasound shows a normal-sized uterus with no fibroids or polyps. Haemoglobin is 11.2 g/dL.

What is the most appropriate first-line treatment?

A. Combined oral contraceptive pill
B. Endometrial ablation
C. Levonorgestrel-releasing intrauterine system
D. Oral norethisterone from day 5 to day 26
E. Tranexamic acid during menses

Answer: C. Levonorgestrel-releasing intrauterine system

For heavy menstrual bleeding without significant structural pathology, the LNG-IUS is the first-line treatment. It reduces blood loss by over 90% at one year and gives highly effective contraception, which she wants.

Why not the others

- **A:** The combined pill is a second-line option and adds thrombotic risk.
- **B:** Endometrial ablation is for women who have completed their family and in whom medical treatment has failed; it is not first line.
- **D:** Long-cycle norethisterone is effective but is a second-line option with more side effects.
- **E:** Tranexamic acid reduces blood loss by about 50% but gives no contraception; it suits women who want to conceive.

Key point: HMB with a normal uterus: LNG-IUS first; then tranexamic acid, NSAIDs or the combined pill; then surgery.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; NICE NG88

MCQ 103 · Heavy Menstrual Bleeding · **Easy** · C2

A 36-year-old teacher has regular periods but changes pads every hour on the first two days, passes large clots and has had to leave class because of flooding. Her haemoglobin is 10.8 g/dL.

How is heavy menstrual bleeding defined in current clinical practice?

A. Any bleeding with clots
B. Bleeding lasting longer than 3 days
C. Blood loss measured above 20 mL per cycle
D. Cycle length shorter than 28 days
E. Excessive menstrual loss that interferes with a woman's quality of life

Answer: E. Excessive menstrual loss that interferes with a woman's quality of life

Heavy menstrual bleeding is now defined clinically as excessive menstrual blood loss that interferes with a woman's physical, social, emotional or material quality of life. The research definition is loss over 80 mL per cycle, but measurement is impractical.

Why not the others

- **A:** Small clots can be normal; their presence alone does not define HMB.
- **B:** Normal periods last up to 7–8 days.
- **C:** Normal loss is up to about 80 mL; 20 mL is light.
- **D:** Cycle length does not define HMB; normal cycles are 24–38 days.

Key point: Focus on the woman's experience; check a full blood count in all women with HMB.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; NICE NG88

MCQ 104 · Heavy Menstrual Bleeding · **Moderate** · C2

A 40-year-old woman with heavy periods is assessed using the FIGO PALM-COEIN system. Ultrasound shows a 2 cm submucous fibroid, and she also takes rivaroxaban for a previous pulmonary embolism.

Which categories of the PALM-COEIN classification apply to her?

A. A and E
B. C and I
C. L and C
D. M and O
E. P and N

Answer: C. L and C

PALM-COEIN groups causes into structural (Polyp, Adenomyosis, Leiomyoma, Malignancy/hyperplasia) and non-structural (Coagulopathy, Ovulatory dysfunction, Endometrial, Iatrogenic, Not yet classified). She has a leiomyoma (L) and a coagulopathy (C). Anticoagulants are classified under C in the current FIGO system.

Why not the others

- **A:** There is no adenomyosis or endometrial disorder.
- **B:** Iatrogenic (I) covers hormonal treatments and IUDs; anticoagulation is now placed under coagulopathy.
- **D:** There is no malignancy or ovulatory problem.
- **E:** There is no polyp or unclassified cause.

Key point: PALM = structural causes seen on imaging or histology. COEIN = non-structural causes.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 105 · Heavy Menstrual Bleeding · **Moderate** · C3

A 33-year-old woman has heavy regular periods. She has no intermenstrual or postcoital bleeding, no pelvic pain, and pelvic examination is normal. Haemoglobin is 11.0 g/dL. She would like treatment.

Which investigation is needed before starting treatment?

A. Endometrial biopsy
B. Full blood count only
C. Hysteroscopy
D. Pelvic MRI
E. Transvaginal ultrasound

Answer: B. Full blood count only

For heavy periods with no other symptoms and a normal examination, a full blood count is enough and treatment such as the LNG-IUS can start. Imaging is needed if the uterus is enlarged or structural pathology is suspected.

Why not the others

- **A:** Endometrial biopsy is for women aged 45 or more, or with risk factors or persistent IMB.
- **C:** Hysteroscopy is for suspected submucous fibroids or polyps.
- **D:** MRI is not routine.
- **E:** Ultrasound is for a palpable uterus, pelvic mass or treatment failure.

Key point: Do not delay treatment for unnecessary tests in women with uncomplicated HMB.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; NICE NG88

MCQ 106 · Heavy Menstrual Bleeding · **Moderate** · C3

A 47-year-old woman has had heavy periods with intermenstrual bleeding for 6 months. She is obese (BMI 38 kg/m²) and has PCOS. Ultrasound shows a 13 mm endometrium with no fibroids.

What is the most appropriate next step?

A. Combined oral contraceptive pill
B. Endometrial ablation
C. Hysteroscopy and endometrial biopsy
D. Levonorgestrel intrauterine system without biopsy
E. Tranexamic acid

Answer: C. Hysteroscopy and endometrial biopsy

Age over 45, intermenstrual bleeding, obesity and PCOS (unopposed oestrogen) all raise the risk of endometrial hyperplasia and cancer. Hysteroscopy with biopsy is needed before treatment.

Why not the others

- **A:** Starting hormones without histology could miss cancer.
- **B:** Ablation without histology is unsafe and would hide later disease.
- **D:** The LNG-IUS may be suitable after histology but not before.
- **E:** Tranexamic acid treats bleeding but leaves the risk unassessed.

Key point: Biopsy the endometrium in HMB if age ≥45, IMB, treatment failure or risk factors for cancer.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; Malignant disease of the uterus

MCQ 107 · Heavy Menstrual Bleeding · **Easy** · C2

A 30-year-old woman who wants to conceive soon has heavy periods. Investigations are normal. She is prescribed tranexamic acid 1 g three times a day for up to 4 days during her periods.

How does tranexamic acid reduce menstrual blood loss?

A. Antifibrinolytic action by blocking plasminogen activation
B. Inhibition of prostaglandin synthesis
C. Suppression of ovulation
D. Thinning of the endometrium
E. Vasoconstriction of spiral arterioles

Answer: A. Antifibrinolytic action by blocking plasminogen activation

Tranexamic acid is an antifibrinolytic. It blocks the conversion of plasminogen to plasmin, stabilising clots in the endometrium and reducing blood loss by about 50%. It does not affect fertility.

Why not the others

- **B:** NSAIDs such as mefenamic acid inhibit prostaglandins.
- **C:** The combined pill suppresses ovulation.
- **D:** Progestogens thin the endometrium.
- **E:** Vasopressin causes vasoconstriction; tranexamic acid does not.

Key point: Tranexamic acid and NSAIDs are suitable when a woman wants to conceive.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 108 · Heavy Menstrual Bleeding · **Moderate** · C3

A 38-year-old woman has heavy periods with no structural cause. She had a deep vein thrombosis 2 years ago and is no longer anticoagulated. She has a migraine with aura. She does not want an intrauterine device.

Which treatment is most appropriate?

A. Combined oral contraceptive pill
B. Desmopressin
C. Long-cycle oral norethisterone
D. Mefenamic acid
E. Tranexamic acid

Answer: D. Mefenamic acid

NSAIDs such as mefenamic acid reduce blood loss by about 25–30% and also help pain. They have no thrombotic risk and suit her history.

Why not the others

- **A:** The combined pill is contraindicated with previous DVT and migraine with aura.
- **B:** Desmopressin is for some bleeding disorders, not routine HMB.
- **C:** High-dose norethisterone carries some thrombotic risk and is second line.
- **E:** Tranexamic acid is relatively contraindicated with previous venous thromboembolism.

Key point: Check VTE history before prescribing tranexamic acid or combined hormones.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 109 · Acute Uterine Bleeding · **Moderate** · C3

A 42-year-old woman presents with very heavy bleeding for 5 days. She is soaking a pad every 30 minutes. Pulse is 98/min and BP 118/74 mmHg. Haemoglobin is 9.2 g/dL. Pregnancy test is negative and ultrasound shows a normal uterus with a 9 mm endometrium.

What is the most appropriate treatment to stop the bleeding?

A. Emergency hysterectomy
B. Endometrial ablation
C. GnRH agonist injection
D. Oral norethisterone 5 mg three times a day
E. Uterine artery embolisation

Answer: D. Oral norethisterone 5 mg three times a day

High-dose oral progestogen (norethisterone 5 mg three times a day) stabilises the endometrium and usually stops acute heavy bleeding within days. Tranexamic acid can be added. Endometrial sampling should be planned given her age.

Why not the others

- **A:** Hysterectomy is a last resort for uncontrollable bleeding.
- **B:** Ablation is not done without histology and is not an emergency treatment.
- **C:** GnRH agonists cause an initial flare and take weeks to work.
- **E:** Embolisation is for bleeding not controlled by medical treatment.

Key point: Acute HMB in a stable woman: high-dose progestogen ± tranexamic acid; resuscitate if unstable.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 110 · Endometrial Ablation · **Moderate** · C3

A 44-year-old woman (para 3) has heavy periods not controlled by the LNG-IUS or tranexamic acid. Her family is complete. Biopsy shows normal endometrium. Ultrasound shows a normal-sized uterus with no fibroids. She wants to avoid a major operation.

What is the most appropriate treatment?

A. Endometrial ablation
B. Myomectomy
C. Subtotal hysterectomy
D. Total abdominal hysterectomy
E. Uterine artery embolisation

Answer: A. Endometrial ablation

Second-generation endometrial ablation is suitable for women with HMB, a normal-sized uterus, normal histology and no wish for future pregnancy. It is a day-case procedure, with about 80–90% satisfaction.

Why not the others

- **B:** Myomectomy is for fibroids.
- **C:** Hysterectomy is more invasive; ablation should be offered first.
- **D:** Hysterectomy is more invasive; ablation should be offered first.
- **E:** Embolisation is for fibroids.

Key point: After ablation women still need contraception; pregnancy is dangerous.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; NICE NG88

MCQ 111 · Endometrial Ablation · **Hard** · C3

A 46-year-old woman had a second-generation endometrial ablation 2 years ago with good results. She now has cyclical lower abdominal pain each month but very little bleeding. Ultrasound shows fluid collecting in the upper uterine cavity behind a scarred lower segment.

What is the most likely diagnosis?

A. Adenomyosis
B. Ectopic pregnancy
C. Endometrial cancer
D. Haematometra
E. Pelvic inflammatory disease

Answer: D. Haematometra

After ablation, scarring in the lower cavity or cervix can trap blood from remaining endometrium in the fundus. This causes haematometra with cyclical pain. Hysteroscopic drainage or hysterectomy may be needed.

Why not the others

- **A:** Adenomyosis can cause pain after ablation, but does not cause fluid trapped in the cavity.
- **B:** Ectopic pregnancy would give a positive pregnancy test.
- **C:** Endometrial cancer usually causes bleeding, not cyclical pain with trapped fluid.
- **E:** PID causes fever and discharge, not cyclical pain with haematometra.

Key point: Late complications of ablation include haematometra and difficulty sampling the endometrium later.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; Gynaecological surgery

MCQ 112 · Hysterectomy · **Moderate** · C3

A 45-year-old woman with heavy periods and fibroids asks to keep her cervix at hysterectomy because she thinks it will be quicker. Her cervical screening has always been normal.

What is the most important advice after a subtotal hysterectomy?

A. Cervical screening must continue
B. She can stop cervical screening
C. She will need lifelong HRT
D. She will never have any vaginal bleeding
E. She will no longer need contraception only if her ovaries are removed

Answer: A. Cervical screening must continue

In a subtotal hysterectomy the cervix remains, so she can still develop cervical cancer and must continue routine screening. Some women have light cyclical bleeding from residual endometrium in the cervical canal.

Why not the others

- **B:** Screening stops only after total hysterectomy with no history of CIN.
- **C:** HRT is not needed if the ovaries are kept.
- **D:** Light cyclical bleeding from the cervical stump can occur.
- **E:** She cannot become pregnant without a uterus, whether or not the ovaries are kept.

Key point: Subtotal hysterectomy keeps the cervix, so the risk of cervical cancer remains.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery

MCQ 113 · Iron Deficiency · **Easy** · C3

A 35-year-old woman with heavy periods is started on an LNG-IUS. Her haemoglobin is 9.6 g/dL, MCV 71 fL and ferritin 6 µg/L. She is not breathless and is haemodynamically stable.

What is the most appropriate treatment for her anaemia?

A. Blood transfusion
B. Erythropoietin
C. Intramuscular vitamin B12
D. Oral folic acid alone
E. Oral iron supplements

Answer: E. Oral iron supplements

She has iron deficiency anaemia from menstrual loss. Oral iron (for example ferrous sulfate once daily or on alternate days) is first line, with a check of response in 2–4 weeks. IV iron is for intolerance or poor response.

Why not the others

- **A:** Transfusion is for symptomatic or severe anaemia.
- **B:** Erythropoietin is used in renal anaemia.
- **C:** B12 deficiency gives a high MCV.
- **D:** Folic acid does not correct iron deficiency.

Key point: Treat the anaemia and the cause of bleeding at the same time.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 114 · Intrauterine Device · **Easy** · C3

A 29-year-old woman had a copper intrauterine device fitted 4 months ago. Her periods have become heavier and more painful. The threads are visible and ultrasound shows the device correctly placed. She is otherwise well.

What is the most appropriate management if she wants to keep using intrauterine contraception?

A. Add the combined pill to the copper IUD
B. Change to the levonorgestrel intrauterine system
C. Leave the IUD and start long-term antibiotics
D. Remove the IUD and offer no further contraception
E. Replace with a new copper IUD

Answer: B. Change to the levonorgestrel intrauterine system

Heavier, more painful periods are a common side effect of the copper IUD. The levonorgestrel IUS gives equally effective intrauterine contraception and greatly reduces menstrual blood loss.

Why not the others

- **A:** Using two methods is unnecessary.
- **C:** There is no infection to treat.
- **D:** She wants contraception.
- **E:** A new copper IUD will cause the same problem.

Key point: Copper IUD → heavier periods. LNG-IUS → lighter periods.

Reference: Gynaecology by Ten Teachers — Contraception; Disorders of the menstrual cycle

MCQ 115 · Fibroids · **Easy** · C2

A 34-year-old woman has heavy periods. Ultrasound shows a 3 cm fibroid that bulges into the uterine cavity, with more than half of it inside the cavity.

Which type of fibroid is most likely to cause heavy menstrual bleeding and subfertility?

A. Cervical
B. Intramural
C. Pedunculated subserosal
D. Submucous
E. Subserosal

Answer: D. Submucous

Submucous fibroids distort the endometrial cavity, increasing the bleeding surface and interfering with implantation. Even small ones can cause heavy bleeding and subfertility, and they are removed by hysteroscopic resection.

Why not the others

- **A:** Cervical fibroids cause pressure symptoms and surgical difficulty.
- **B:** Intramural fibroids cause bleeding mainly when large or distorting the cavity.
- **C:** Pedunculated subserosal fibroids may twist but do not cause bleeding.
- **E:** Subserosal fibroids cause pressure symptoms, not bleeding.

Key point: Submucous fibroids: small size, big symptoms.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 116 · Fibroids · **Moderate** · C3

A 31-year-old woman has primary subfertility for 2 years and heavy periods. Hysteroscopy shows a 2.5 cm type 0 submucous fibroid (entirely within the cavity, on a stalk). Her tubes and her husband's semen analysis are normal.

What is the most appropriate treatment?

A. GnRH agonist for 6 months
B. Hysteroscopic resection of the fibroid
C. Laparoscopic myomectomy
D. Total abdominal hysterectomy
E. Uterine artery embolisation

Answer: B. Hysteroscopic resection of the fibroid

Type 0 and type 1 submucous fibroids are best removed hysteroscopically. This treats the bleeding and improves fertility without a uterine scar.

Why not the others

- **A:** GnRH agonists shrink fibroids temporarily and prevent conception during use.
- **C:** Laparoscopic myomectomy is for intramural or subserosal fibroids.
- **D:** Hysterectomy ends fertility.
- **E:** Embolisation is not advised in women wanting pregnancy.

Key point: FIGO type 0: entirely in the cavity. Type 1: more than 50% in the cavity. Type 2: less than 50% in the cavity.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 117 · Fibroids · **Moderate** · C3

A 33-year-old woman has a 9 cm intramural fibroid causing heavy periods and pressure symptoms. She wants to keep her fertility. Haemoglobin is 9.0 g/dL. Myomectomy is planned in 3 months.

What is the purpose of giving a GnRH analogue before surgery?

A. To cure the fibroid permanently
B. To make the fibroid easier to enucleate by softening its capsule
C. To prevent recurrence after surgery
D. To reduce fibroid size and allow haemoglobin to recover
E. To test for sarcoma

Answer: D. To reduce fibroid size and allow haemoglobin to recover

Three months of a GnRH analogue before surgery shrinks the fibroid (by about 30–50%) and stops periods so the haemoglobin can rise. This reduces blood loss and the need for transfusion, and may allow a smaller incision.

Why not the others

- **A:** Fibroids regrow when treatment stops.
- **B:** GnRH analogues can make the cleavage plane harder to find, not easier.
- **C:** They do not prevent recurrence.
- **E:** They do not diagnose sarcoma; failure to shrink may raise suspicion but is not a test.

Key point: Limit GnRH analogues to about 6 months, or add back HRT, because of bone loss.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 118 · Fibroids in Pregnancy · **Moderate** · C3

A 28-year-old woman at 18 weeks of pregnancy has severe localised abdominal pain and a low-grade fever for 2 days. She has a known 7 cm intramural fibroid that is now tender on palpation. There is no bleeding and the fetus is well. White count is mildly raised.

What is the most appropriate management?

A. Emergency myomectomy
B. Hysterectomy
C. Laparoscopy
D. Rest, analgesia and observation
E. Termination of pregnancy

Answer: D. Rest, analgesia and observation

This is red degeneration of a fibroid, caused by haemorrhagic infarction as the fibroid outgrows its blood supply in pregnancy. It is managed conservatively with rest and analgesia (paracetamol, opioids; avoid NSAIDs after 20 weeks). It settles in about 1–2 weeks.

Why not the others

- **A:** Myomectomy in pregnancy risks severe bleeding and miscarriage.
- **B:** Hysterectomy has no place here.
- **C:** Laparoscopy is not needed when the diagnosis is clear.
- **E:** The pregnancy is not threatened.

Key point: Red degeneration: pain, tenderness over a fibroid, low-grade fever, mid-pregnancy.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus; Medical disorders in pregnancy

MCQ 119 · Fibroids · **Moderate** · C2

A 52-year-old woman has a 12-week-size fibroid uterus that has not grown for 5 years. She is now 2 years past her last period and asks what will happen to her fibroids.

What usually happens to fibroids after menopause?

A. They become malignant
B. They calcify and shrink
C. They grow faster
D. They need routine removal
E. They turn into adenomyosis

Answer: B. They calcify and shrink

Fibroids depend on oestrogen and progesterone. After menopause they usually shrink and may calcify. A fibroid that grows after menopause, without HRT, is a warning sign for sarcoma.

Why not the others

- **A:** Malignant change is rare (under 0.5%).
- **C:** Growth after menopause is unusual and needs investigation.
- **D:** Asymptomatic fibroids need no treatment.
- **E:** Fibroids and adenomyosis are separate conditions.

Key point: Growing fibroid after menopause = investigate for leiomyosarcoma.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 120 · Leiomyosarcoma · **Hard** · C3

A 58-year-old woman, 7 years after menopause and not on HRT, has a pelvic mass that has grown from 8 cm to 13 cm in 6 months. She has vague pelvic pain and some vaginal bleeding. MRI shows an irregular, heterogeneous uterine mass with areas of necrosis.

What is the most appropriate management?

A. GnRH analogue to shrink the mass
B. Laparoscopic myomectomy with power morcellation
C. Total abdominal hysterectomy and bilateral salpingo-oophorectomy without morcellation
D. Ulipristal acetate
E. Uterine artery embolisation

Answer: C. Total abdominal hysterectomy and bilateral salpingo-oophorectomy without morcellation

Rapid growth after menopause, necrosis on MRI and bleeding suggest leiomyosarcoma. The uterus should be removed intact by total hysterectomy with BSO, avoiding morcellation, which could spread tumour.

Why not the others

- **A:** GnRH analogues delay treatment of a possible cancer.
- **B:** Morcellation can disseminate sarcoma and worsen survival.
- **D:** Ulipristal is for symptomatic fibroids and is restricted because of liver injury.
- **E:** Embolisation is for benign fibroids and delays diagnosis.

Key point: Avoid uncontained morcellation when sarcoma is suspected.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus; Malignant disease of the uterus

MCQ 121 · Uterine Artery Embolisation · **Moderate** · C3

A 42-year-old woman with a 14-week fibroid uterus causing heavy periods wants to avoid surgery and does not want more children. She had uterine artery embolisation yesterday. Today she has pelvic pain, nausea, fever of 38.0°C and malaise.

What is the most likely cause of her symptoms?

A. Bowel perforation
B. Fibroid expulsion
C. Ovarian failure
D. Post-embolisation syndrome
E. Uterine rupture

Answer: D. Post-embolisation syndrome

Post-embolisation syndrome is common in the first days after UAE, caused by ischaemia of the fibroids. It causes pain, low-grade fever, nausea and malaise, and is managed with analgesia and anti-emetics. Infection must be excluded if symptoms persist.

Why not the others

- **A:** Perforation is not a recognised complication of UAE.
- **B:** Fibroid expulsion occurs later, with vaginal discharge and cramping.
- **C:** Ovarian failure is a later risk, especially in older women.
- **E:** Uterine rupture is not a complication of UAE.

Key point: UAE preserves the uterus but its effect on future fertility is uncertain, so myomectomy is preferred for women wanting pregnancy.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 122 · Fibroids · **Hard** · C2

A 45-year-old woman has a 20-week fibroid uterus. Routine blood tests show haemoglobin 18.5 g/dL with a raised haematocrit. She is not a smoker, has normal oxygen saturation and no splenomegaly.

What is the most likely explanation for her raised haemoglobin?

A. Chronic hypoxia
B. Dehydration
C. Erythropoietin secretion by the fibroid
D. Iron overload
E. Polycythaemia vera

Answer: C. Erythropoietin secretion by the fibroid

Rarely, fibroids secrete erythropoietin, causing myomatous erythrocytosis syndrome. The haemoglobin returns to normal after the fibroid is removed.

Why not the others

- **A:** Oxygen saturation is normal.
- **B:** Dehydration would not raise haemoglobin this much on its own and she is well.
- **D:** Iron overload does not raise haemoglobin.
- **E:** Polycythaemia vera usually has splenomegaly and raised white cells and platelets.

Key point: Most fibroids cause anaemia, but rarely they cause polycythaemia.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 123 · Fibroids · **Moderate** · C2

A 39-year-old woman has a 16-week fibroid uterus. She has urinary frequency and nocturia. CT shows a large fibroid in the broad ligament with right-sided hydronephrosis.

How is the hydronephrosis caused?

A. Fibroid compression of the ureter
B. Fibroid invasion of the bladder
C. Retrograde infection from the bladder
D. Secondary amyloidosis
E. Ureteric calculus

Answer: A. Fibroid compression of the ureter

Large fibroids, especially in the broad ligament or cervix, can compress the ureter at the pelvic brim or in the base of the broad ligament, causing hydronephrosis. This is an indication for treatment.

Why not the others

- **B:** Fibroids are benign and do not invade.
- **C:** Infection does not explain unilateral obstruction with a large mass.
- **D:** Amyloidosis is not linked.
- **E:** There is no evidence of a stone.

Key point: Hydronephrosis from a fibroid is an indication for surgery even if bleeding is mild.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 124 · Fibroids · **Easy** · C2

A 35-year-old woman asks about her risk of fibroids after her older sister had a myomectomy. She is nulliparous, obese and has early menarche.

Which factor reduces the risk of fibroids?

A. African ancestry
B. Early menarche
C. Increasing parity
D. Nulliparity
E. Obesity

Answer: C. Increasing parity

Fibroids depend on oestrogen and progesterone. Pregnancy and increasing parity reduce the risk, while nulliparity, early menarche, obesity, family history and African ancestry increase it.

Why not the others

- **A:** African ancestry increases the risk several-fold.
- **B:** Early menarche increases lifetime exposure to oestrogen.
- **D:** Nulliparity increases risk.
- **E:** Obesity increases risk through higher oestrogen.

Key point: Fibroids are the commonest tumours in women, present in up to 70% by age 50.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 125 · Fibroids · **Hard** · C3

A 41-year-old woman has a mass protruding from her cervix with heavy bleeding and an offensive discharge for 2 weeks. Examination shows a 4 cm smooth fleshy mass in the vagina attached by a stalk that passes through the dilated cervix into the uterus.

What is the most appropriate management?

A. Abdominal hysterectomy
B. Cervical cone biopsy
C. GnRH analogue for 3 months
D. Uterine artery embolisation
E. Vaginal removal by twisting and ligating the stalk

Answer: E. Vaginal removal by twisting and ligating the stalk

This is a prolapsed pedunculated submucous fibroid (fibroid polyp). It is removed vaginally by twisting, or by ligating and dividing the stalk, often with hysteroscopy to check the cavity. Antibiotics are given if it is infected.

Why not the others

- **A:** Hysterectomy is unnecessary for a removable fibroid polyp.
- **B:** Cone biopsy is for cervical intraepithelial neoplasia.
- **C:** A GnRH analogue delays treatment and the fibroid is already infected.
- **D:** Embolisation of a necrotic prolapsed fibroid risks sepsis.

Key point: Offensive discharge with a prolapsed fibroid suggests infection or necrosis; give antibiotics.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 126 · Endometrial Polyps · **Easy** · C3

A 39-year-old woman has had intermenstrual spotting for 4 months. Her periods are regular. Cervical screening is up to date and normal. Transvaginal ultrasound shows a 12 mm echogenic lesion in the uterine cavity with a feeding vessel on Doppler.

What is the most appropriate management?

A. Blind dilatation and curettage
B. Combined oral contraceptive pill
C. Endometrial ablation
D. Hysteroscopic polypectomy
E. Repeat scan in 1 year

Answer: D. Hysteroscopic polypectomy

This is an endometrial polyp causing intermenstrual bleeding. Hysteroscopic removal under direct vision treats the symptoms and gives histology.

Why not the others

- **A:** Blind curettage often misses polyps.
- **B:** The pill does not remove a polyp.
- **C:** Ablation without histology is not appropriate.
- **E:** A symptomatic polyp needs removal.

Key point: A feeding vessel on Doppler ("pedicle artery sign") is typical of a polyp.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 127 · Endometrial Polyps · **Moderate** · C2

A 50-year-old woman has been taking tamoxifen for 3 years after surgery for oestrogen receptor-positive breast cancer. She has had two episodes of vaginal spotting. Ultrasound shows a thickened, cystic-looking endometrium.

Which endometrial change is most commonly caused by tamoxifen?

A. Adenomyosis
B. Asherman syndrome
C. Atrophic endometrium
D. Endometrial polyps
E. Leiomyosarcoma

Answer: D. Endometrial polyps

Tamoxifen blocks oestrogen in the breast but acts as a weak oestrogen on the endometrium. It commonly causes endometrial polyps and also increases the risk of hyperplasia and endometrial cancer. Abnormal bleeding needs hysteroscopy and biopsy.

Why not the others

- **A:** Adenomyosis may worsen but is not the common finding.
- **B:** Asherman syndrome follows uterine trauma, not tamoxifen.
- **C:** Atrophy is typical of aromatase inhibitors, not tamoxifen.
- **E:** Uterine sarcoma risk rises slightly but it is rare.

Key point: Bleeding on tamoxifen always needs investigation; ultrasound thickness is unreliable on tamoxifen.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus; Malignant disease of the uterus

MCQ 128 · Myomectomy · **Moderate** · C3

A 32-year-old woman had an open myomectomy 18 months ago for a 10 cm intramural fibroid. The operation note says the uterine cavity was opened. She is now 34 weeks pregnant and asks about her delivery.

What is the most appropriate plan for delivery?

A. Induction of labour at 37 weeks
B. Planned caesarean section
C. Spontaneous labour with continuous monitoring
D. Vacuum delivery to shorten the second stage
E. Vaginal birth with epidural

Answer: B. Planned caesarean section

When the cavity was opened or a deep myomectomy performed, the risk of uterine rupture in labour is significant. A planned caesarean section before labour, usually at about 37–38 weeks, is recommended.

Why not the others

- **A:** Induction adds to the risk of rupture.
- **C:** Labour carries a risk of rupture after cavity entry.
- **D:** An assisted delivery does not prevent rupture during the first stage.
- **E:** An epidural does not prevent rupture.

Key point: Always read the myomectomy operation note to plan the next delivery.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 129 · Myomectomy · **Hard** · C2

During an open myomectomy for a 12 cm fibroid, the surgeon wants to reduce blood loss. The anaesthetist is told before a drug is injected into the myometrium around the fibroid.

Which drug is injected into the myometrium to reduce bleeding at myomectomy?

A. Adrenaline 1 in 1,000
B. Dilute vasopressin
C. Ergometrine
D. Oxytocin
E. Tranexamic acid

Answer: B. Dilute vasopressin

Dilute vasopressin injected into the myometrium causes vasoconstriction and reduces bleeding. The anaesthetist is warned because it can cause hypertension, bradycardia and arrhythmia if it enters the circulation.

Why not the others

- **A:** Undiluted adrenaline is dangerous and not used this way.
- **C:** Ergometrine contracts the pregnant uterus and is used in postpartum haemorrhage.
- **D:** Oxytocin works mainly on the pregnant uterus and has little effect here.
- **E:** Tranexamic acid is given intravenously, not injected into the myometrium.

Key point: Other methods: a tourniquet around the lower uterus, and preoperative GnRH analogue.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus; Gynaecological surgery

MCQ 130 · Fibroids in Pregnancy · **Moderate** · C3

A 30-year-old primigravida at 37 weeks has a known 8 cm fibroid in the lower uterine segment, below the presenting part. The fetal head is high and not engaged.

What is the most appropriate mode of delivery?

A. Caesarean section
B. External cephalic version
C. Induction of labour
D. Myomectomy at the time of vaginal birth
E. Vaginal birth with forceps

Answer: A. Caesarean section

A large lower segment or cervical fibroid can obstruct labour by lying in front of the presenting part. Caesarean section is planned. The fibroid is usually left alone at caesarean, because myomectomy then can cause heavy bleeding.

Why not the others

- **B:** The baby is not breech; ECV is not relevant.
- **C:** Labour may obstruct.
- **D:** Myomectomy at delivery causes major bleeding.
- **E:** Forceps cannot be applied if the head cannot descend.

Key point: Leave fibroids alone at caesarean section unless they block access or are pedunculated.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus; Medical disorders in pregnancy

MCQ 131 · Fibroids · **Hard** · C2

A 40-year-old woman with a known subserosal fibroid on a long stalk presents with sudden severe lower abdominal pain and vomiting for 6 hours. She is tender with guarding over a mobile pelvic mass. Pregnancy test is negative. Doppler shows no flow in the mass.

What is the most likely diagnosis?

A. Hyaline degeneration
B. Ovarian torsion
C. Red degeneration
D. Sarcomatous change
E. Torsion of a pedunculated fibroid

Answer: E. Torsion of a pedunculated fibroid

A pedunculated subserosal fibroid can twist on its stalk, causing ischaemia, sudden pain and peritonism. It needs urgent laparoscopy or laparotomy and removal of the fibroid.

Why not the others

- **A:** Hyaline degeneration is the commonest degeneration and is painless.
- **B:** Ovarian torsion is possible, but the mass is a known pedunculated fibroid.
- **C:** Red degeneration occurs in pregnancy.
- **D:** Sarcomatous change is rare and does not cause sudden pain.

Key point: Torsion of a pedunculated fibroid mimics ovarian torsion; both need surgery.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 132 · Fibroids · **Easy** · C2

A 47-year-old woman had a hysterectomy for fibroids. The pathologist reports that most of the fibroid shows homogeneous, glassy, pink acellular areas without necrosis.

What is the commonest type of degeneration in fibroids?

A. Calcific degeneration
B. Cystic degeneration
C. Hyaline degeneration
D. Red degeneration
E. Sarcomatous change

Answer: C. Hyaline degeneration

Hyaline degeneration is the commonest change in fibroids. The smooth muscle is replaced by acellular hyaline tissue as the fibroid outgrows its blood supply. It is usually painless.

Why not the others

- **A:** Calcification is seen mainly after menopause.
- **B:** Cystic degeneration follows hyaline change and is less common.
- **D:** Red degeneration occurs mainly in pregnancy.
- **E:** Sarcomatous change is very rare.

Key point: Degeneration types: hyaline (commonest), cystic, red (pregnancy), calcific (postmenopausal), sarcomatous (rare).

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 133 · Fibroids · **Moderate** · C3

A 36-year-old woman has symptomatic fibroids with heavy bleeding. She asks about a tablet that shrinks fibroids. Her doctor explains that ulipristal acetate, a selective progesterone receptor modulator, is now restricted.

Why is the use of ulipristal acetate for fibroids now restricted?

A. It causes osteoporosis
B. It causes rare but serious liver injury
C. It increases fibroid size
D. It is teratogenic
E. It raises the risk of venous thromboembolism

Answer: B. It causes rare but serious liver injury

Rare cases of severe liver injury, some needing transplantation, led to restriction of ulipristal acetate for fibroids. It can be used only in limited situations with regular liver function monitoring.

Why not the others

- **A:** Bone loss is a problem of GnRH analogues, not ulipristal.
- **C:** It shrinks fibroids.
- **D:** Teratogenicity is not the reason for restriction.
- **E:** It does not significantly raise VTE risk.

Key point: Ulipristal 30 mg as a single dose for emergency contraception is not affected by this restriction.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 134 · Fibroids and Fertility · **Hard** · C3

A 34-year-old woman is about to start IVF for tubal factor subfertility. Ultrasound shows a 3 cm intramural fibroid that does not distort the uterine cavity on hysteroscopy. She has no symptoms.

What is the most appropriate management of the fibroid?

A. GnRH analogue for 6 months before IVF
B. Hysteroscopic resection
C. Open myomectomy
D. Proceed with IVF without treating the fibroid
E. Uterine artery embolisation

Answer: D. Proceed with IVF without treating the fibroid

Small intramural fibroids that do not distort the cavity have little or no effect on IVF outcome. Surgery would delay treatment and add risk without clear benefit, so IVF can proceed.

Why not the others

- **A:** Six months of GnRH analogue delays IVF without proven benefit.
- **B:** It is not submucous, so it cannot be resected hysteroscopically.
- **C:** Myomectomy is considered for larger fibroids or those distorting the cavity.
- **E:** Embolisation is not advised in women seeking pregnancy.

Key point: Treat submucous fibroids before IVF; leave small intramural ones alone.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus; Subfertility

MCQ 135 · Fibroids · **Moderate** · C2

A 43-year-old woman has a 14-week fibroid uterus and has been on a GnRH analogue for 5 months before surgery. Surgery has been delayed by another 6 months. She has hot flushes and her doctor is concerned about her bones.

What is the most appropriate way to continue GnRH analogue treatment?

A. Add low-dose oestrogen and progestogen (add-back therapy)
B. Add tamoxifen
C. Double the GnRH analogue dose
D. Stop and restart after 6 months
E. Switch to oral progestogen alone

Answer: A. Add low-dose oestrogen and progestogen (add-back therapy)

GnRH analogues cause a menopause-like state with bone loss and vasomotor symptoms. Add-back therapy with low-dose HRT or tibolone protects bone and controls symptoms while keeping most of the benefit.

Why not the others

- **B:** Tamoxifen does not protect against bone loss in premenopausal women and stimulates the endometrium.
- **C:** A higher dose worsens bone loss.
- **D:** Stopping allows the fibroid to regrow quickly.
- **E:** Progestogen alone does not keep the fibroid suppressed as well.

Key point: Without add-back, limit GnRH analogues to about 6 months.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 136 · Hysterectomy · **Easy** · C3

A 46-year-old woman (para 3) needs a hysterectomy for heavy bleeding. The uterus is normal-sized and mobile, with good descent. She has no other pelvic pathology.

What is the preferred surgical route?

A. Abdominal hysterectomy through a midline incision
B. Abdominal hysterectomy through a Pfannenstiel incision
C. Robotic hysterectomy
D. Subtotal abdominal hysterectomy
E. Vaginal hysterectomy

Answer: E. Vaginal hysterectomy

When feasible, vaginal hysterectomy is preferred. It avoids an abdominal wound, causes less pain, allows quicker recovery and shorter stay. Laparoscopic hysterectomy is the next choice when vaginal access is limited.

Why not the others

- **A:** A midline incision is for large uteri or suspected cancer.
- **B:** Abdominal hysterectomy has a longer recovery.
- **C:** Robotic surgery adds cost without benefit over vaginal surgery here.
- **D:** Subtotal hysterectomy is done abdominally and does not offer advantages here.

Key point: Route preference for benign hysterectomy: vaginal, then laparoscopic, then abdominal.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery

MCQ 137 · Hysterectomy · **Moderate** · C3

A 43-year-old woman with normal ovaries on ultrasound is having a hysterectomy for fibroids. She has no family history of ovarian or breast cancer and asks whether her ovaries should also be removed.

What is the most appropriate advice?

A. Keep the ovaries, and consider removing the tubes
B. Remove both ovaries because HRT is safer than natural hormones
C. Remove both ovaries to prevent ovarian cancer
D. Remove one ovary only
E. Removing the ovaries has no long-term effect

Answer: A. Keep the ovaries, and consider removing the tubes

In a premenopausal woman without high genetic risk, keeping the ovaries avoids surgical menopause and its risks to bone and heart. Removing the fallopian tubes (opportunistic salpingectomy) reduces the risk of high-grade serous ovarian cancer without affecting hormones.

Why not the others

- **B:** HRT is not better than her own ovarian function.
- **C:** Routine oophorectomy increases cardiovascular disease and overall mortality in younger women.
- **D:** Removing one ovary has no clear benefit.
- **E:** Early oophorectomy has long-term effects on bone, heart and mood.

Key point: Many high-grade serous "ovarian" cancers start in the fallopian tube.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Malignant disease of the ovary

MCQ 138 · Hysterectomy · **Moderate** · C2

A 48-year-old woman is 6 days after a total laparoscopic hysterectomy. She has worsening pelvic pain, fever of 38.4°C and a brown vaginal discharge. Ultrasound shows a 6 cm collection above the vaginal vault.

What is the most likely diagnosis?

A. Bladder injury
B. Infected vault haematoma
C. Pulmonary embolism
D. Ureteric injury
E. Vault dehiscence

Answer: B. Infected vault haematoma

Blood collecting above the vaginal vault can become infected, causing fever, pain and discharge around the first week. Treatment is antibiotics with drainage through the vault or by radiology.

Why not the others

- **A:** A bladder injury causes urinary leakage or haematuria.
- **C:** PE causes breathlessness and chest pain.
- **D:** A ureteric injury causes loin pain and fluid leakage.
- **E:** Vault dehiscence is a later problem, often after intercourse, with bowel prolapse.

Key point: Fever after hysterectomy: check the wound, chest, urine, vault and legs.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 139 · Fibroids · **Hard** · C2

A 38-year-old woman has a 16-week fibroid uterus with a large posterior fibroid. She suddenly cannot pass urine. A catheter drains 1,200 mL. Examination shows the cervix pushed up behind the pubic symphysis.

What is the mechanism of her urinary retention?

A. Bladder neck obstruction by the fibroid pushing the cervix forward
B. Bladder outflow obstruction from urethral stricture
C. Detrusor failure from diabetes
D. Neurological damage from the fibroid
E. Ureteric obstruction

Answer: A. Bladder neck obstruction by the fibroid pushing the cervix forward

A large posterior or cervical fibroid fills the pouch of Douglas and pushes the cervix forward against the bladder neck and urethra, causing retention. Treatment is catheterisation and removal of the fibroid.

Why not the others

- **B:** There is no history of urethral stricture.
- **C:** There is no diabetes and the cause is mechanical.
- **D:** Fibroids do not damage nerves.
- **E:** Ureteric obstruction causes hydronephrosis, not retention.

Key point: Retention with a pelvic mass can also be caused by a retroverted gravid uterus at 12–14 weeks.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 140 · Heavy Menstrual Bleeding · **Moderate** · C3

A 46-year-old woman has irregular, heavy, unpredictable bleeding for 8 months. Hysteroscopy and biopsy show endometrial hyperplasia without atypia. She wants to avoid surgery.

What is the most appropriate first-line treatment?

A. Combined oral contraceptive pill
B. Endometrial ablation
C. Levonorgestrel intrauterine system
D. Observation without treatment
E. Total hysterectomy

Answer: C. Levonorgestrel intrauterine system

Endometrial hyperplasia without atypia is usually caused by unopposed oestrogen from anovulation. The LNG-IUS gives high local progestogen, achieves higher regression rates than oral progestogens and controls bleeding. Biopsy is repeated at 6 months.

Why not the others

- **A:** The pill is less effective than the LNG-IUS for hyperplasia.
- **B:** Ablation is not used for hyperplasia because it hides later disease.
- **D:** Observation is less effective than progestogen treatment.
- **E:** Hysterectomy is for failure of medical treatment or atypical hyperplasia.

Key point: Hyperplasia without atypia → LNG-IUS. Atypical hyperplasia → hysterectomy.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; Malignant disease of the uterus

MCQ 141 · Heavy Menstrual Bleeding · **Moderate** · C2

A 35-year-old woman has had heavy periods since starting a direct oral anticoagulant for atrial fibrillation 6 months ago. Haemoglobin has fallen from 12.8 to 10.1 g/dL. Ultrasound is normal.

What is the most appropriate treatment for her heavy bleeding?

A. Combined oral contraceptive pill
B. Endometrial ablation
C. Levonorgestrel intrauterine system
D. Stop the anticoagulant
E. Tranexamic acid

Answer: C. Levonorgestrel intrauterine system

The LNG-IUS is the most effective medical treatment for heavy bleeding in women on anticoagulants and is safe with them. Stopping anticoagulation would expose her to stroke risk.

Why not the others

- **A:** Combined hormones raise thrombotic risk and are generally avoided.
- **B:** Ablation is not first line and she may want children.
- **D:** Stopping anticoagulation risks stroke.
- **E:** Tranexamic acid is relatively contraindicated with a thrombotic history and is less effective.

Key point: Anticoagulant-related HMB: LNG-IUS or progestogen-only methods first.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 142 · Heavy Menstrual Bleeding · **Easy** · C2

A 37-year-old woman has heavy periods. She also complains of tiredness, weight gain, constipation and dry skin. Ultrasound of the pelvis is normal.

Which blood test is most likely to identify the cause of her heavy periods?

A. Coagulation screen
B. Serum ferritin
C. Serum FSH
D. Serum prolactin
E. Thyroid function tests

Answer: E. Thyroid function tests

Hypothyroidism can cause heavy menstrual bleeding. Her symptoms suggest it, so thyroid function should be tested. Thyroid tests are not routine in HMB without such symptoms.

Why not the others

- **A:** A coagulation screen is for HMB since menarche or a bleeding history.
- **B:** Ferritin assesses iron stores, not the cause.
- **C:** FSH is not useful in assessing HMB.
- **D:** Prolactin causes amenorrhoea rather than HMB.

Key point: Test thyroid function in HMB only when there are signs or symptoms of thyroid disease.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 143 · Heavy Menstrual Bleeding · **Hard** · C3

A 29-year-old woman has had heavy periods since menarche, needed a transfusion after a dental extraction, and bruises easily. Her platelet count is normal, APTT is slightly prolonged, and von Willebrand factor activity is low.

Which treatment can be used to reduce her menstrual blood loss by raising her von Willebrand factor level?

A. Desmopressin
B. Heparin
C. Mefenamic acid
D. Vitamin K
E. Warfarin

Answer: A. Desmopressin

Desmopressin (DDAVP) releases stored von Willebrand factor and factor VIII from endothelial cells. It can be used for heavy periods in type 1 von Willebrand disease, often with tranexamic acid, under haematology guidance.

Why not the others

- **B:** Heparin is an anticoagulant and would worsen bleeding.
- **C:** NSAIDs impair platelet function and should be avoided in bleeding disorders.
- **D:** Vitamin K treats deficiency of clotting factors II, VII, IX and X, not von Willebrand disease.
- **E:** Warfarin worsens bleeding.

Key point: Avoid NSAIDs in women with bleeding disorders.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle

MCQ 144 · Fibroids · **Easy** · C2

A 38-year-old woman has heavy periods. Abdominal examination shows a firm, irregular pelvic mass reaching halfway between the pubic symphysis and the umbilicus.

What size is this uterus, expressed in weeks of pregnancy?

A. 8 weeks
B. 12 weeks
C. 16 weeks
D. 20 weeks
E. 28 weeks

Answer: C. 16 weeks

Uterine size is described in weeks of pregnancy. At 12 weeks the uterus is just palpable above the symphysis, at 16 weeks it is halfway to the umbilicus, and at 20 weeks it reaches the umbilicus.

Why not the others

- **A:** An 8-week uterus is not palpable abdominally.
- **B:** A 12-week uterus is just palpable above the symphysis.
- **D:** A 20-week uterus reaches the umbilicus.
- **E:** A 28-week uterus is above the umbilicus.

Key point: Fibroid uterus size: 12 weeks = just palpable, 16 = halfway, 20 = umbilicus.

Reference: Gynaecology by Ten Teachers — Gynaecological history and examination; Benign conditions of the uterus

MCQ 145 · Fibroids · **Hard** · C3

A 40-year-old woman with symptomatic fibroids wants to keep her uterus and avoid surgery. MRI shows three intramural fibroids of 4–6 cm, well perfused, with no features of sarcoma. She has completed her family.

Which treatment is most appropriate?

A. Endometrial ablation
B. Hysteroscopic resection
C. Long-term ulipristal acetate
D. Observation
E. Uterine artery embolisation

Answer: E. Uterine artery embolisation

Uterine artery embolisation is a minimally invasive option for women with symptomatic fibroids who want to keep the uterus and have completed their family. It shrinks fibroids by about 40–60% and improves symptoms in most women.

Why not the others

- **A:** Ablation does not work well with large intramural fibroids.
- **B:** Hysteroscopic resection is only for submucous fibroids.
- **C:** Ulipristal is restricted because of liver injury.
- **D:** She has symptoms that need treatment.

Key point: Well-perfused fibroids on MRI respond best to embolisation.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 146 · Fibroids · **Moderate** · C2

A 36-year-old woman with a 15-week fibroid uterus has an MRI before planned treatment. The radiologist is asked to distinguish fibroids from adenomyosis.

Which MRI feature favours a fibroid over adenomyosis?

A. A well-defined mass with a clear margin
B. Diffuse thickening of the junctional zone over 12 mm
C. Ill-defined borders blending with the myometrium
D. Small high-signal cystic foci within the myometrium
E. Uniform globular enlargement of the uterus

Answer: A. A well-defined mass with a clear margin

Fibroids are well-defined masses with a pseudocapsule and clear margin. Adenomyosis shows a thickened, ill-defined junctional zone with small cystic foci and a uniformly enlarged uterus.

Why not the others

- **B:** A junctional zone over 12 mm suggests adenomyosis.
- **C:** Ill-defined borders suggest adenomyosis.
- **D:** Cystic foci are typical of adenomyosis.
- **E:** Uniform enlargement suggests adenomyosis.

Key point: Fibroids can be enucleated; adenomyosis has no clear plane, so it cannot be shelled out.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus; Endometriosis and adenomyosis

MCQ 147 · Intermenstrual Bleeding · **Moderate** · C3

A 32-year-old woman has had bleeding after intercourse and between periods for 3 months. She is using condoms. Her last cervical screening, 2 years ago, was normal.

What is the most important first step?

A. Pelvic ultrasound
B. Prescribe the combined pill
C. Repeat cervical screening only
D. Speculum examination of the cervix with STI swabs
E. Tranexamic acid

Answer: D. Speculum examination of the cervix with STI swabs

Postcoital and intermenstrual bleeding need a speculum examination to look at the cervix, with swabs for chlamydia and gonorrhoea. A suspicious cervix needs urgent colposcopy, regardless of previous screening.

Why not the others

- **A:** Ultrasound may follow but does not show the cervix well.
- **B:** Starting the pill without examination could miss cancer or infection.
- **C:** Screening is not a diagnostic test for symptoms.
- **E:** Tranexamic acid does not address the cause.

Key point: Screening tests are for women without symptoms; symptomatic women need examination.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; Premalignant disease of the cervix

MCQ 148 · Fibroids · **Easy** · C2

A 30-year-old woman is found to have a 2 cm subserosal fibroid on a scan done for another reason. She has normal periods and no pain or pressure symptoms.

What is the most appropriate management?

A. GnRH analogue
B. Laparoscopic myomectomy
C. Reassurance with no treatment
D. Ulipristal acetate
E. Uterine artery embolisation

Answer: C. Reassurance with no treatment

Most fibroids cause no symptoms and need no treatment. A small asymptomatic subserosal fibroid can be left alone.

Why not the others

- **A:** Hormone treatment is not needed without symptoms.
- **B:** Surgery carries risk with no benefit here.
- **D:** Ulipristal is for symptomatic fibroids and is restricted.
- **E:** Embolisation is for symptomatic fibroids.

Key point: Treat symptoms, not scan findings.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus

MCQ 149 · Fibroids · **Hard** · C3

A 33-year-old woman with recurrent second-trimester miscarriages has a 5 cm intramural fibroid that indents the uterine cavity by about 40% on hysteroscopy (FIGO type 2). Other causes of miscarriage have been excluded.

What is the most appropriate treatment?

A. Cervical cerclage
B. GnRH analogue alone
C. Hysterectomy
D. Myomectomy
E. Uterine artery embolisation

Answer: D. Myomectomy

A fibroid that distorts the cavity can contribute to miscarriage. A type 2 fibroid of 5 cm is difficult to remove completely by hysteroscopy, so myomectomy (laparoscopic or open, or staged hysteroscopic resection by an expert) is the appropriate treatment.

Why not the others

- **A:** Cerclage treats cervical weakness, which is not the problem.
- **B:** A GnRH analogue gives only temporary shrinkage.
- **C:** Hysterectomy ends fertility.
- **E:** Embolisation is not advised when pregnancy is wanted.

Key point: Treat cavity-distorting fibroids before trying to conceive.

Reference: Gynaecology by Ten Teachers — Benign conditions of the uterus; Recurrent miscarriage

MCQ 150 · Investigation of Bleeding · **Moderate** · C2

A 35-year-old woman has intermenstrual bleeding. Transvaginal ultrasound shows a 14 mm endometrium with a possible focal lesion, but the radiologist cannot tell whether it is a polyp, a small submucous fibroid or just thick endometrium.

Which imaging test best outlines the uterine cavity to clarify the finding?

A. CT scan of the pelvis
B. Hysterosalpingography
C. Pelvic MRI
D. Repeat transabdominal ultrasound
E. Saline infusion sonohysterography

Answer: E. Saline infusion sonohysterography

Instilling saline into the uterine cavity during transvaginal ultrasound distends it and clearly shows polyps and submucous fibroids against the fluid. Outpatient hysteroscopy is an alternative that also allows treatment and biopsy.

Why not the others

- **A:** CT shows soft tissue poorly in the uterine cavity.
- **B:** HSG mainly assesses tubal patency and shows the cavity less well.
- **C:** MRI is useful for fibroid mapping but is expensive and not first line for cavity lesions.
- **D:** Transabdominal scanning gives less detail than transvaginal.

Key point: Focal cavity lesion on scan → saline sonography or hysteroscopy.

Reference: Gynaecology by Ten Teachers — Disorders of the menstrual cycle; Benign conditions of the uterus

CHAPTER 4

PCOS and Hyperandrogenism

MCQ 151 · PCOS · **Easy** · C2

A 24-year-old unmarried woman has had irregular periods every 2–3 months since menarche and excess hair on her chin and upper lip. Her BMI is 31 kg/m² with acanthosis nigricans on the neck. Transvaginal scan shows more than 20 small follicles in each ovary. Serum testosterone is mildly raised and 17-hydroxyprogesterone is normal.

What is the most likely diagnosis?

A. Androgen-secreting ovarian tumour
B. Cushing syndrome
C. Hypothyroidism
D. Non-classic congenital adrenal hyperplasia
E. Polycystic ovary syndrome

Answer: E. Polycystic ovary syndrome

She meets all three Rotterdam criteria: oligo-ovulation, clinical and biochemical hyperandrogenism, and polycystic ovarian morphology (20 or more follicles per ovary). Obesity and acanthosis nigricans point to insulin resistance, typical of PCOS.

Why not the others

- **A:** A virilising tumour causes rapid-onset virilisation (clitoromegaly, deep voice) with markedly raised testosterone.
- **B:** Cushing syndrome shows purple striae, proximal myopathy and hypertension.
- **C:** Hypothyroidism may upset periods but does not cause hirsutism or polycystic ovaries.
- **D:** Non-classic CAH mimics PCOS but the normal 17-hydroxyprogesterone excludes it.

Key point: PCOS needs 2 of 3 Rotterdam criteria after excluding other causes of hyperandrogenism.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 152 · PCOS Diagnosis · **Easy** · C2

A 26-year-old woman has periods every 45–60 days since menarche. She has no hirsutism or acne and her testosterone is normal. Ultrasound shows 24 follicles in each ovary. TSH, prolactin and 17-hydroxyprogesterone are normal.

Does she meet the Rotterdam criteria for polycystic ovary syndrome?

A. No, because hyperandrogenism is essential
B. No, because she needs raised LH
C. No, because ultrasound alone is diagnostic
D. Yes, because she has oligo-ovulation and polycystic ovarian morphology
E. Yes, only if she is also obese

Answer: D. Yes, because she has oligo-ovulation and polycystic ovarian morphology

The Rotterdam criteria need 2 of 3: oligo- or anovulation, clinical or biochemical hyperandrogenism, and polycystic ovarian morphology, after excluding other causes. She has two, so PCOS is diagnosed.

Why not the others

- **A:** Hyperandrogenism is required in the Androgen Excess Society criteria, but not in Rotterdam.
- **B:** Raised LH is common but is not a diagnostic criterion.
- **C:** Polycystic ovaries alone are found in many normal women and are not diagnostic.
- **E:** Obesity is common but not required.

Key point: Rotterdam = any 2 of 3, after excluding thyroid, prolactin, CAH and androgen-secreting tumours.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 153 · PCOS Diagnosis · **Moderate** · C2

A 30-year-old woman with oligomenorrhoea has a transvaginal scan as part of her assessment for PCOS. The sonographer measures the follicles and the ovarian volume.

Which ultrasound finding meets the current criteria for polycystic ovarian morphology in adults?

A. 20 or more follicles of 2–9 mm in at least one ovary
B. 5 or more follicles per ovary
C. A dominant follicle of 18 mm
D. A single 4 cm simple cyst
E. Ovarian volume of 5 mL

Answer: A. 20 or more follicles of 2–9 mm in at least one ovary

The international PCOS guideline (2018/2023) uses a follicle count of 20 or more per ovary (2–9 mm) on a high-frequency transvaginal probe, or an ovarian volume of 10 mL or more, in at least one ovary.

Why not the others

- **B:** Five follicles is normal.
- **C:** A dominant follicle is normal ovulation.
- **D:** A single simple cyst is a functional cyst, not PCO.
- **E:** Normal ovaries are about 5 mL; 10 mL or more is the PCO threshold.

Key point: Do not use ultrasound to diagnose PCOS within 8 years of menarche; multifollicular ovaries are normal in adolescents.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 154 · PCOS Diagnosis · **Moderate** · C3

A 15-year-old girl, 2 years after menarche, has irregular periods every 2–3 months and mild acne. Her mother wants a scan to check for polycystic ovaries.

What is the most appropriate approach?

A. Diagnose PCOS on symptoms alone and start metformin

B. Laparoscopy to inspect the ovaries

C. Perform transvaginal ultrasound now

D. Reassess over time; ultrasound is not used to diagnose PCOS in the first 8 years after menarche

E. Start clomiphene

Answer: D. Reassess over time; ultrasound is not used to diagnose PCOS in the first 8 years after menarche

Irregular cycles and acne are common in the first years after menarche. Multifollicular ovaries are normal in adolescents, so ultrasound is not used. PCOS in adolescents needs both irregular cycles (beyond the expected time) and hyperandrogenism. She may be labelled "at risk" and reassessed.

Why not the others

- **A:** A diagnosis cannot be made yet and metformin is not indicated.
- **B:** Laparoscopy is not used to diagnose PCOS.
- **C:** Transvaginal scanning is inappropriate and unhelpful here.
- **E:** She does not want pregnancy.

Key point: Avoid overdiagnosis of PCOS in adolescents.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Puberty and its disorders

MCQ 155 · PCOS Pathophysiology · **Moderate** · C2

A 27-year-old woman with PCOS has a BMI of 34 kg/m² and acanthosis nigricans. Her fasting insulin is high. Her doctor explains how insulin worsens her hyperandrogenism.

How does hyperinsulinaemia increase free androgens in PCOS?

A. It increases aromatase activity in granulosa cells

B. It increases SHBG production by the liver

C. It lowers LH secretion

D. It stimulates ovarian theca cell androgen production and lowers SHBG

E. It suppresses adrenal androgens

Answer: D. It stimulates ovarian theca cell androgen production and lowers SHBG

Insulin acts with LH to stimulate theca cells to make androgens. It also reduces SHBG production in the liver, so more testosterone circulates in the free, active form. This worsens hirsutism and anovulation.

Why not the others

- **A:** Insulin does not increase conversion of androgens to oestrogens enough to lower androgens.
- **B:** Insulin lowers, not raises, SHBG.
- **C:** LH is often raised in PCOS.
- **E:** Insulin does not suppress adrenal androgens.

Key point: Weight loss lowers insulin, raises SHBG and can restore ovulation.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 156 · PCOS Investigations · **Easy** · C2

A 24-year-old woman has oligomenorrhoea and hirsutism. The doctor wants to confirm biochemical hyperandrogenism.

Which test is most useful for confirming biochemical hyperandrogenism in PCOS?

A. Free androgen index (testosterone and SHBG)
B. LH to FSH ratio
C. Serum cortisol
D. Serum oestradiol
E. Serum progesterone

Answer: A. Free androgen index (testosterone and SHBG)

Total testosterone with SHBG, giving a free androgen index (or calculated free testosterone), best reflects active androgen. It is often raised in PCOS even when total testosterone is normal.

Why not the others

- **B:** The LH:FSH ratio is often raised but is not a diagnostic criterion.
- **C:** Cortisol is for suspected Cushing's syndrome.
- **D:** Oestradiol is not useful for hyperandrogenism.
- **E:** Progesterone confirms ovulation.

Key point: Very high testosterone (over about 5 nmol/L) suggests a tumour rather than PCOS.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 157 · PCOS Investigations · **Moderate** · C3

A 29-year-old woman with newly diagnosed PCOS has a BMI of 33 kg/m² and a family history of type 2 diabetes. She is not pregnant.

Which test is recommended to screen for glucose intolerance?

A. Fasting insulin
B. HOMA-IR score
C. Oral glucose tolerance test
D. Random glucose
E. Urine dipstick for glucose

Answer: C. Oral glucose tolerance test

Women with PCOS have a high risk of impaired glucose tolerance and type 2 diabetes. An oral glucose tolerance test is the most sensitive test, especially when there are risk factors such as obesity or family history. HbA1c is an acceptable alternative.

Why not the others

- **A:** Fasting insulin varies widely and is not recommended for screening.
- **B:** HOMA-IR is a research tool.
- **D:** Random glucose is not sensitive.
- **E:** Urine glucose is insensitive.

Key point: Screen glucose status at diagnosis of PCOS and every 1–3 years thereafter.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 158 · PCOS Management · **Easy** · C3

A 25-year-old married woman with PCOS has a BMI of 32 kg/m², irregular periods and wants to conceive in the next year. She is otherwise healthy.

What is the most appropriate first step in management?

A. Bariatric surgery
B. Gonadotrophin injections
C. Laparoscopic ovarian drilling
D. Lifestyle change aiming for 5–10% weight loss
E. Start IVF

Answer: D. Lifestyle change aiming for 5–10% weight loss

Losing 5–10% of body weight improves insulin resistance, lowers androgens and often restores ovulation and periods. It also lowers the risks of pregnancy complications. It is the first step for overweight women with PCOS.

Why not the others

- **A:** Bariatric surgery is for severe obesity when other measures fail.
- **B:** Gonadotrophins are second-line ovulation induction.
- **C:** Drilling is second line.
- **E:** IVF is for failure of simpler treatments or other factors.

Key point: Even modest weight loss can restore ovulation in PCOS.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 159 · Ovulation Induction · **Moderate** · C3

A 28-year-old woman with PCOS and a BMI of 27 kg/m² has been trying to conceive for 18 months. She has irregular periods. Her tubes are patent and her husband's semen analysis is normal.

What is the first-line drug for ovulation induction?

A. Bromocriptine
B. Clomiphene citrate
C. Gonadotrophins
D. Letrozole
E. Metformin alone

Answer: D. Letrozole

The aromatase inhibitor letrozole is now first-line for ovulation induction in PCOS. It gives higher ovulation and live birth rates than clomiphene, with a lower multiple pregnancy rate and less adverse effect on the endometrium.

Why not the others

- **A:** Bromocriptine is for hyperprolactinaemia.
- **B:** Clomiphene is an alternative but is less effective than letrozole.
- **C:** Gonadotrophins are second line.
- **E:** Metformin alone is less effective for live birth.

Key point: Letrozole use for ovulation induction is off-label in some countries; consent the patient.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Subfertility

MCQ 160 · Ovulation Induction · **Moderate** · C2

A 30-year-old woman with PCOS is starting clomiphene citrate for ovulation induction. She asks how the tablet works.

What is the mechanism of action of clomiphene citrate?

A. Blocks oestrogen receptors in the hypothalamus, increasing FSH release
B. Directly stimulates the ovary like FSH
C. Inhibits aromatase, lowering oestrogen
D. Lowers insulin resistance
E. Suppresses LH secretion

Answer: A. Blocks oestrogen receptors in the hypothalamus, increasing FSH release

Clomiphene is a selective oestrogen receptor modulator. By blocking oestrogen receptors in the hypothalamus, it removes negative feedback, so GnRH and FSH rise and stimulate follicle growth.

Why not the others

- **B:** Gonadotrophins act directly on the ovary.
- **C:** Letrozole inhibits aromatase.
- **D:** Metformin lowers insulin resistance.
- **E:** Clomiphene does not suppress LH.

Key point: Clomiphene's anti-oestrogen effect on the cervix and endometrium may reduce pregnancy rates despite ovulation.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Subfertility

MCQ 161 · Ovulation Induction · **Moderate** · C3

A 27-year-old woman with PCOS is about to start her first cycle of clomiphene citrate 50 mg on days 2–6.

What monitoring is recommended during the first cycle?

A. Daily serum oestradiol
B. Hysterosalpingography during treatment
C. No monitoring is needed
D. Serum AMH every cycle
E. Ultrasound follicle tracking

Answer: E. Ultrasound follicle tracking

Ultrasound follicle tracking in at least the first cycle checks the response, guides dose adjustment and reduces the risk of multiple pregnancy if many follicles develop.

Why not the others

- **A:** Daily oestradiol is not needed for oral ovulation induction.
- **B:** HSG is done before treatment, not during it.
- **C:** Monitoring is recommended because of the risk of multiple pregnancy.
- **D:** AMH does not change cycle to cycle and is not a monitoring tool.

Key point: Limit clomiphene to about 6 ovulatory cycles (no more than 12 months in total).

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 162 · Ovulation Induction · **Hard** · C3

A 29-year-old woman with PCOS has taken clomiphene for 6 months. Scans confirmed ovulation in each cycle, but she has not conceived. Her tubes are patent and her husband's semen is normal. BMI is 24 kg/m².

What is the most appropriate next step?

A. Continue clomiphene for another 12 months
B. Gonadotrophin ovulation induction or laparoscopic ovarian drilling
C. Hysterectomy
D. Increase clomiphene to 250 mg
E. Metformin alone

Answer: B. Gonadotrophin ovulation induction or laparoscopic ovarian drilling

Women who ovulate on clomiphene but do not conceive after about 6 cycles should move to second-line treatment: low-dose gonadotrophins (with monitoring) or laparoscopic ovarian drilling. IVF is the next step after these.

Why not the others

- **A:** Prolonged clomiphene use has falling success and possible ovarian cancer concerns.
- **C:** Hysterectomy is irrelevant.
- **D:** She already ovulates; higher doses add side effects without benefit.
- **E:** Metformin alone will not help a woman who already ovulates.

Key point: Clomiphene resistance = no ovulation at 150 mg; clomiphene failure = ovulation without pregnancy.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 163 · Ovulation Induction · **Hard** · C2

A 26-year-old woman with PCOS and clomiphene resistance chooses laparoscopic ovarian drilling instead of gonadotrophin injections.

What is the main advantage of ovarian drilling over gonadotrophins?

A. It cures PCOS permanently
B. It does not need surgery
C. It has a lower risk of multiple pregnancy and OHSS
D. It increases ovarian reserve
E. It reliably improves hirsutism

Answer: C. It has a lower risk of multiple pregnancy and OHSS

Drilling destroys some androgen-producing ovarian tissue and can restore ovulation for months to years. It produces unifollicular ovulation, so multiple pregnancy and OHSS are rare, and it needs no intensive monitoring.

Why not the others

- **A:** Its effect is temporary in many women.
- **B:** It needs laparoscopy under general anaesthesia.
- **D:** It may reduce ovarian reserve if overdone.
- **E:** Effect on hirsutism is small.

Key point: Risks of drilling: adhesions and reduced ovarian reserve.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Subfertility

MCQ 164 · Ovarian Hyperstimulation Syndrome · **Moderate** · C3

A 31-year-old woman with PCOS had an IVF egg collection 5 days ago with 26 eggs retrieved. She now has abdominal distension, nausea and reduced urine output. Ultrasound shows enlarged ovaries and ascites. Haematocrit is 46%.

What is the most likely diagnosis?

A. Appendicitis
B. Ectopic pregnancy
C. Ovarian hyperstimulation syndrome
D. Ovarian torsion
E. Pelvic infection after egg collection

Answer: C. Ovarian hyperstimulation syndrome

OHSS is caused by vascular leak driven by VEGF from stimulated ovaries, made worse by hCG. Fluid shifts into the abdomen, causing ascites, haemoconcentration and reduced urine output. PCOS and many eggs are major risk factors.

Why not the others

- **A:** Appendicitis does not cause ascites and haemoconcentration.
- **B:** It is too early for ectopic pregnancy.
- **D:** Torsion causes sudden severe one-sided pain.
- **E:** Infection causes fever and pelvic tenderness, not ascites with haemoconcentration.

Key point: OHSS management: fluid balance, thromboprophylaxis, analgesia and paracentesis if tense ascites.

Reference: Gynaecology by Ten Teachers — Subfertility; Assisted conception

MCQ 165 · Ovarian Hyperstimulation Syndrome · **Hard** · C3

A 28-year-old woman with PCOS is having IVF. On the day of trigger she has 30 follicles and an oestradiol level that is very high. The team wants to reduce her risk of OHSS.

Which strategy most reduces her risk of severe OHSS?

A. Give an extra dose of hCG for luteal support
B. Give an hCG trigger and transfer a fresh embryo
C. GnRH agonist trigger with freezing of all embryos
D. Start metformin after egg collection
E. Transfer two embryos to improve success

Answer: C. GnRH agonist trigger with freezing of all embryos

With a GnRH antagonist protocol, a GnRH agonist trigger instead of hCG and freezing all embryos (no fresh transfer) almost eliminates severe OHSS, because there is no prolonged hCG exposure and no early pregnancy hCG.

Why not the others

- **A:** Extra hCG worsens OHSS.
- **B:** hCG trigger with fresh transfer gives the highest risk.
- **D:** Metformin is given during stimulation, not after collection, and has a modest effect.
- **E:** Twin pregnancy raises hCG and worsens late OHSS.

Key point: Pregnancy, especially twins, makes OHSS worse and longer.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 166 · Endometrial Protection · **Moderate** · C3

A 34-year-old woman with PCOS has only 2–3 periods a year. She does not want pregnancy now and declines the combined pill. Ultrasound shows a 9 mm endometrium.

What is the most appropriate way to protect her endometrium?

A. Cyclical progestogen to induce a withdrawal bleed at least every 3–4 months
B. Endometrial ablation
C. Metformin alone
D. No treatment needed
E. Oestrogen-only HRT

Answer: A. Cyclical progestogen to induce a withdrawal bleed at least every 3–4 months

Chronic anovulation exposes the endometrium to unopposed oestrogen, increasing the risk of hyperplasia and cancer. A progestogen course (for example 12–14 days) at least every 3–4 months, or an LNG-IUS, protects the endometrium.

Why not the others

- **B:** Ablation is not appropriate in a young woman.
- **C:** Metformin alone may not give regular bleeds.
- **D:** Leaving her untreated increases cancer risk.
- **E:** Oestrogen alone would increase the risk.

Key point: Fewer than 4 periods a year in PCOS → regular progestogen protection.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Malignant disease of the uterus

MCQ 167 · Long-term Risks · **Easy** · C2

A 32-year-old woman with PCOS asks about her long-term health risks. She has a BMI of 35 kg/m² and irregular periods.

Which cancer is she at increased risk of?

A. Breast cancer
B. Cervical cancer
C. Colorectal cancer
D. Endometrial cancer
E. Vulval cancer

Answer: D. Endometrial cancer

Women with PCOS have about a 2–3 times higher risk of endometrial cancer because of anovulation (unopposed oestrogen), obesity and insulin resistance.

Why not the others

- **A:** Breast cancer risk is not clearly increased.
- **B:** Cervical cancer is related to HPV.
- **C:** Colorectal cancer is not clearly linked.
- **E:** Vulval cancer is linked to HPV and lichen sclerosus.

Key point: Other long-term risks: type 2 diabetes, gestational diabetes, sleep apnoea, depression and anxiety.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 168 · Hirsutism · **Easy** · C2

A 23-year-old woman is concerned about coarse dark hair on her upper lip, chin, chest and lower abdomen. The doctor uses a standard visual scoring system across nine body areas.

Which scoring system is used to assess hirsutism?

A. Apgar score
B. Bishop score
C. Ferriman–Gallwey score
D. Gleason score
E. Tanner staging

Answer: C. Ferriman–Gallwey score

The modified Ferriman–Gallwey score rates terminal hair growth in nine androgen-sensitive areas from 0 to 4. A score of 4–6 or more (varying by ethnicity) defines hirsutism.

Why not the others

- **A:** Apgar assesses newborns.
- **B:** Bishop assesses the cervix before induction of labour.
- **D:** Gleason grades prostate cancer.
- **E:** Tanner staging assesses puberty.

Key point: Women of South Asian origin may have lower thresholds for hirsutism.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Hirsutism

MCQ 169 · Hirsutism · **Moderate** · C3

A 22-year-old unmarried woman with PCOS is troubled by facial hirsutism and acne. She has regular sexual partners and no wish for pregnancy. BMI is 24 kg/m² and she has no contraindications to oestrogen.

What is the first-line drug treatment for her hirsutism?

A. Combined oral contraceptive pill
B. Finasteride alone
C. Metformin
D. Spironolactone alone
E. Topical steroid

Answer: A. Combined oral contraceptive pill

The combined pill suppresses ovarian androgen production and raises SHBG, lowering free testosterone. It also regulates cycles, protects the endometrium and gives contraception. Effects on hair take 6 months or more.

Why not the others

- **B:** Finasteride is teratogenic and needs reliable contraception; it is not first line.
- **C:** Metformin has little effect on hirsutism.
- **D:** Spironolactone is added if the pill alone is insufficient, with contraception.
- **E:** Steroids do not treat hirsutism.

Key point: Cosmetic methods (laser, threading) help while drug treatment takes effect.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Hirsutism

MCQ 170 · Hirsutism · **Hard** · C3

A 27-year-old woman with PCOS has had persistent hirsutism despite 9 months of the combined pill. Her doctor plans to add an anti-androgen.

What important advice must be given before starting an anti-androgen such as spironolactone?

A. It cures PCOS
B. It improves fertility
C. It must be stopped if periods become regular
D. It should be taken only during periods
E. Reliable contraception is essential because it can feminise a male fetus

Answer: E. Reliable contraception is essential because it can feminise a male fetus

Anti-androgens block androgen action and can cause feminisation of a male fetus. Effective contraception is essential throughout treatment.

Why not the others

- **A:** It treats symptoms only.
- **B:** It does not improve fertility.
- **C:** Regular periods are not a reason to stop.
- **D:** It is taken daily.

Key point: Anti-androgens: spironolactone, cyproterone acetate, finasteride — all need contraception.

Reference: Gynaecology by Ten Teachers — Hirsutism

MCQ 171 · Hirsutism · **Moderate** · C2

A 33-year-old woman wants treatment for facial hair only. She does not want tablets. Her androgen levels are normal and she has regular periods.

Which topical treatment slows facial hair growth?

A. Benzoyl peroxide
B. Clobetasol
C. Eflornithine cream
D. Hydroquinone
E. Minoxidil

Answer: C. Eflornithine cream

Eflornithine cream inhibits ornithine decarboxylase in hair follicles, slowing facial hair growth. It is used with hair removal methods and needs about 8 weeks to show effect.

Why not the others

- **A:** Benzoyl peroxide treats acne.
- **B:** Clobetasol is a strong steroid for skin disease.
- **D:** Hydroquinone lightens pigmentation.
- **E:** Minoxidil promotes hair growth.

Key point: Normal androgens with regular periods and hirsutism = idiopathic hirsutism.

Reference: Gynaecology by Ten Teachers — Hirsutism

MCQ 172 · Hirsutism · **Moderate** · C3

A 30-year-old woman has PCOS with hirsutism and heavy acne. Her doctor considers co-cyprindiol (ethinylestradiol with cyproterone acetate). She has a BMI of 29 kg/m².

What is the main safety concern with co-cyprindiol compared with other combined pills?

A. Higher risk of venous thromboembolism
B. Liver failure
C. Osteoporosis
D. Ovarian cancer
E. Weight loss

Answer: A. Higher risk of venous thromboembolism

Co-cyprindiol has a higher risk of venous thromboembolism than levonorgestrel-containing pills. It should be used for moderate to severe acne or hirsutism, and stopped about 3 months after symptoms are controlled.

Why not the others

- **B:** Liver injury is linked to high-dose cyproterone, not this low dose.
- **C:** It does not cause osteoporosis.
- **D:** Combined pills reduce ovarian cancer risk.
- **E:** It does not cause weight loss.

Key point: Check BMI and VTE risk before starting co-cyprindiol.

Reference: Gynaecology by Ten Teachers — Hirsutism; Contraception

MCQ 173 · Hyperandrogenism · **Hard** · C2

A 25-year-old woman has hirsutism and irregular periods. Her early-morning follicular phase 17-hydroxyprogesterone is 9 nmol/L (raised). An ACTH stimulation test produces a marked rise in 17-hydroxyprogesterone.

What is the most likely diagnosis?

A. Androgen-secreting adrenal tumour
B. Cushing syndrome
C. Non-classic congenital adrenal hyperplasia
D. Ovarian hyperthecosis
E. Polycystic ovary syndrome

Answer: C. Non-classic congenital adrenal hyperplasia

Non-classic (late-onset) CAH, usually partial 21-hydroxylase deficiency, mimics PCOS with hirsutism and irregular periods. A raised basal 17-OHP with an exaggerated rise after ACTH confirms it.

Why not the others

- **A:** An adrenal tumour gives high DHEAS and rapid virilisation.
- **B:** Cushing syndrome has other features and normal 17-OHP.
- **D:** Hyperthecosis usually occurs after menopause with high testosterone.
- **E:** PCOS has normal 17-OHP.

Key point: Check 17-OHP in hyperandrogenic women, especially in high-risk ethnic groups.

Reference: Gynaecology by Ten Teachers — Hirsutism; Polycystic ovary syndrome

MCQ 174 · Hyperandrogenism · **Hard** · C2

A 62-year-old woman, 10 years past menopause, has had slowly progressive hirsutism, scalp hair thinning and clitoromegaly over 3 years. Testosterone is 4.2 nmol/L. DHEAS is normal. Ultrasound shows bilaterally enlarged solid ovaries without a discrete mass.

What is the most likely diagnosis?

A. Adrenal carcinoma
B. Cushing syndrome
C. Granulosa cell tumour
D. Ovarian hyperthecosis
E. Polycystic ovary syndrome

Answer: D. Ovarian hyperthecosis

Ovarian hyperthecosis is the presence of nests of luteinised theca cells in the ovarian stroma, producing androgens. It causes gradual virilisation, often after menopause, with bilateral solid ovarian enlargement and normal DHEAS. Bilateral oophorectomy is curative.

Why not the others

- **A:** Adrenal carcinoma gives high DHEAS and rapid onset.
- **B:** Cushing syndrome has other clinical features.
- **C:** Granulosa cell tumours produce oestrogen, not androgens.
- **E:** PCOS starts at puberty, not after menopause.

Key point: Gradual onset suggests hyperthecosis; rapid onset suggests a tumour.

Reference: Gynaecology by Ten Teachers — Hirsutism; Benign conditions of the ovary

MCQ 175 · Hyperandrogenism · **Hard** · C2

A 28-year-old woman has developed hirsutism, deepening voice and amenorrhoea over 5 months. Testosterone is 8 nmol/L and DHEAS is normal. Ultrasound shows a 5 cm solid unilateral ovarian mass.

What is the most likely diagnosis?

A. Dermoid cyst
B. Granulosa cell tumour
C. Mucinous cystadenoma
D. Polycystic ovary syndrome
E. Sertoli–Leydig cell tumour

Answer: E. Sertoli–Leydig cell tumour

Sertoli–Leydig cell tumours are rare sex cord-stromal tumours of young women. They secrete androgens, causing rapid virilisation. Normal DHEAS and a solid ovarian mass point to the ovary. Treatment is surgical.

Why not the others

- **A:** Dermoids rarely secrete hormones.
- **B:** Granulosa cell tumours secrete oestrogen.
- **C:** Mucinous tumours are cystic and usually non-functioning.
- **D:** PCOS does not cause rapid virilisation or a solid mass.

Key point: Rapid virilisation + solid ovarian mass + normal DHEAS = Sertoli–Leydig cell tumour.

Reference: Gynaecology by Ten Teachers — Hirsutism; Malignant disease of the ovary

MCQ 176 · PCOS Diagnosis · **Easy** · C2

A 24-year-old woman has a pelvic scan for right iliac fossa pain, which settles. The report mentions 22 small follicles in each ovary. She has regular 28-day periods, no hirsutism or acne, and normal androgens.

What is the correct interpretation?

A. She has non-classic CAH
B. She has PCOS and needs metformin
C. She has polycystic ovarian morphology but does not have PCOS
D. She needs a laparoscopy
E. She will be infertile

Answer: C. She has polycystic ovarian morphology but does not have PCOS

Polycystic ovarian morphology is found in about 20–30% of women and is not a disease on its own. With regular cycles and no hyperandrogenism she meets only one Rotterdam criterion, so she does not have PCOS.

Why not the others

- **A:** There is nothing to suggest CAH.
- **B:** She does not meet the criteria and needs no treatment.
- **D:** Laparoscopy is not indicated.
- **E:** She ovulates regularly; fertility is not affected.

Key point: PCO on a scan is a finding, not a diagnosis.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 177 · PCOS Diagnosis · **Easy** · C2

A 27-year-old woman reports that her periods come every 40 to 90 days and she has about 6 periods a year. She asks whether this counts as irregular.

Which definition of oligomenorrhoea is used for PCOS?

A. Cycles longer than 21 days
B. Cycles longer than 35 days or fewer than 8 periods a year
C. Cycles shorter than 28 days
D. No periods for 6 months
E. Periods lasting more than 7 days

Answer: B. Cycles longer than 35 days or fewer than 8 periods a year

Oligomenorrhoea in adults is defined as cycles longer than 35 days or fewer than 8 periods a year, and is a marker of oligo-ovulation. Amenorrhoea is no periods for 3–6 months or more.

Why not the others

- **A:** A 21-day cycle is at the short end of normal.
- **C:** Short cycles are not oligomenorrhoea.
- **D:** Six months without a period is amenorrhoea.
- **E:** Duration of bleeding does not define oligomenorrhoea.

Key point: Regular cycles can still be anovulatory; check mid-luteal progesterone if infertile.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 178 · PCOS Investigations · **Moderate** · C2

A 28-year-old woman with PCOS has blood tests. Her doctor notes several typical hormonal changes.

Which result is typical of PCOS?

A. High AMH
B. High SHBG
C. Low LH
D. Low testosterone
E. Raised FSH above 25 IU/L

Answer: A. High AMH

Women with PCOS have many small antral follicles, which produce anti-Müllerian hormone, so AMH is often high. LH is often raised, SHBG low and testosterone normal or high, while FSH is normal.

Why not the others

- **B:** SHBG is usually low because of insulin resistance and obesity.
- **C:** LH is often high.
- **D:** Testosterone is normal or raised.
- **E:** A high FSH suggests ovarian insufficiency, not PCOS.

Key point: High AMH in PCOS predicts a strong response to ovarian stimulation, so OHSS risk is higher.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 179 · PCOS Management · **Moderate** · C3

A 30-year-old woman with PCOS and a BMI of 36 kg/m² has impaired glucose tolerance on an OGTT. She is making lifestyle changes. She is not trying to conceive at present.

Which additional drug is most appropriate for her metabolic risk?

A. Clomiphene citrate
B. Combined pill containing cyproterone
C. Metformin
D. Spironolactone
E. Tamoxifen

Answer: C. Metformin

Metformin improves insulin sensitivity and reduces progression to type 2 diabetes in women with impaired glucose tolerance. In PCOS it is added to lifestyle change for metabolic benefit and modest weight and cycle improvement.

Why not the others

- **A:** Clomiphene is for ovulation induction.
- **B:** Cyproterone pills raise VTE risk, especially with a BMI of 36.
- **D:** Spironolactone treats hirsutism, not glucose intolerance.
- **E:** Tamoxifen is not used in PCOS.

Key point: Common metformin side effects are gastrointestinal; start low and increase slowly.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 180 · PCOS in Pregnancy · **Moderate** · C3

A 29-year-old woman with PCOS and a BMI of 31 kg/m² is 10 weeks pregnant after letrozole treatment. She asks which pregnancy complication she is particularly at risk of.

Which complication should she be screened for during this pregnancy?

A. Gestational diabetes
B. Obstetric cholestasis
C. Placenta praevia
D. Polyhydramnios
E. Rhesus isoimmunisation

Answer: A. Gestational diabetes

PCOS, especially with obesity, increases the risk of gestational diabetes, pre-eclampsia and preterm birth. She should have an oral glucose tolerance test, usually at 24–28 weeks or earlier if risk is high.

Why not the others

- **B:** Obstetric cholestasis is not linked to PCOS.
- **C:** Placenta praevia is linked to previous caesarean and IVF, not PCOS.
- **D:** Polyhydramnios may follow diabetes but is not the screening target.
- **E:** Rhesus disease depends on blood group.

Key point: Women with PCOS should have glucose status checked before and during pregnancy.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Medical disorders in pregnancy

MCQ 181 · Long-term Risks · **Moderate** · C2

A 35-year-old woman with PCOS and a BMI of 40 kg/m² complains of daytime sleepiness, morning headaches and loud snoring. Her husband says she stops breathing at night.

Which condition should be investigated?

A. Hypothyroidism
B. Narcolepsy
C. Obstructive sleep apnoea
D. Restless legs syndrome
E. Temporal lobe epilepsy

Answer: C. Obstructive sleep apnoea

Obstructive sleep apnoea is more common in women with PCOS, related to obesity and androgens. It should be screened for when symptoms are present, because it worsens insulin resistance and cardiovascular risk.

Why not the others

- **A:** Hypothyroidism causes tiredness but not witnessed apnoeas.
- **B:** Narcolepsy causes sudden sleep attacks, not snoring and apnoea.
- **D:** Restless legs cause an urge to move the legs at night.
- **E:** Epilepsy does not explain snoring and apnoea.

Key point: Screen women with PCOS for depression, anxiety and sleep apnoea.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 182 · Hirsutism · **Easy** · C2

A 40-year-old woman has developed fine, non-pigmented hair growth all over her face, arms and back over 6 months. Her periods are regular and androgens are normal. She started a new tablet for hypertension a year ago.

What is the most likely cause?

A. Androgen-secreting tumour
B. Drug-induced hypertrichosis
C. Idiopathic hirsutism
D. Non-classic CAH
E. Polycystic ovary syndrome

Answer: B. Drug-induced hypertrichosis

Hypertrichosis is diffuse growth of fine hair not in an androgen pattern. It is caused by drugs such as minoxidil, ciclosporin and phenytoin, not by androgens. Hirsutism is coarse terminal hair in a male pattern.

Why not the others

- **A:** A tumour causes male-pattern coarse hair and high androgens.
- **C:** Idiopathic hirsutism is male-pattern coarse hair.
- **D:** CAH causes male-pattern hirsutism.
- **E:** PCOS causes male-pattern hirsutism with irregular periods.

Key point: Hirsutism = androgen-dependent coarse hair. Hypertrichosis = diffuse fine hair, often drug-related.

Reference: Gynaecology by Ten Teachers — Hirsutism

MCQ 183 · Hirsutism · **Moderate** · C2

A 26-year-old bodybuilder has developed acne, hirsutism, deepening of the voice, clitoromegaly and amenorrhoea over a year. Her LH and FSH are suppressed. Ovarian and adrenal imaging is normal.

What is the most likely cause?

A. Adrenal carcinoma
B. Anabolic steroid use
C. Cushing syndrome
D. Ovarian hyperthecosis
E. Sertoli–Leydig cell tumour

Answer: B. Anabolic steroid use

Exogenous anabolic androgens cause virilisation and suppress the hypothalamic–pituitary axis, giving low LH and FSH. Imaging is normal because there is no tumour. A careful history is the key.

Why not the others

- **A:** Adrenal imaging is normal.
- **C:** Cushing syndrome would show other features and high cortisol.
- **D:** Hyperthecosis is usually seen after menopause with enlarged ovaries.
- **E:** Ovarian imaging is normal.

Key point: Always ask about anabolic steroids, danazol and testosterone gels in virilised women.

Reference: Gynaecology by Ten Teachers — Hirsutism

MCQ 184 · Hyperandrogenism · **Hard** · C3

A 34-year-old woman has irregular periods and hirsutism. She has also gained weight centrally, bruises easily, has proximal muscle weakness and wide purple striae on her abdomen. BP is 158/96 mmHg.

What is the most appropriate first investigation?

A. 17-hydroxyprogesterone
B. Overnight dexamethasone suppression test
C. Pelvic ultrasound
D. Serum DHEAS
E. Serum testosterone

Answer: B. Overnight dexamethasone suppression test

These features suggest Cushing syndrome, which can mimic PCOS. The overnight 1 mg dexamethasone suppression test (or 24-hour urinary free cortisol or late-night salivary cortisol) screens for cortisol excess.

Why not the others

- **A:** 17-OHP screens for non-classic CAH.
- **C:** Pelvic ultrasound will not show the cause.
- **D:** DHEAS helps with adrenal tumours but does not screen for cortisol excess.
- **E:** Testosterone may be raised but does not diagnose Cushing syndrome.

Key point: Purple striae, proximal myopathy, easy bruising and hypertension point to Cushing syndrome.

Reference: Gynaecology by Ten Teachers — Hirsutism; Polycystic ovary syndrome

MCQ 185 · Hyperandrogenism · **Hard** · C2

A 32-year-old woman has severe acanthosis nigricans, marked hirsutism, acne and amenorrhoea. Her fasting insulin is extremely high, and testosterone is raised. She is obese.

Which syndrome is this?

A. Cushing syndrome
B. HAIR-AN syndrome
C. Kallmann syndrome
D. Meigs' syndrome
E. Sheehan syndrome

Answer: B. HAIR-AN syndrome

HAIR-AN syndrome is HyperAndrogenism, Insulin Resistance and Acanthosis Nigricans. It is a severe form of insulin resistance in which very high insulin drives ovarian androgen production.

Why not the others

- **A:** Cushing syndrome is cortisol excess.
- **C:** Kallmann syndrome is hypogonadotrophic hypogonadism with anosmia.
- **D:** Meigs' syndrome is ovarian fibroma with ascites and pleural effusion.
- **E:** Sheehan syndrome is postpartum pituitary failure.

Key point: Acanthosis nigricans is a visible marker of insulin resistance.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Hirsutism

MCQ 186 · Hyperandrogenism · **Hard** · C2

A 30-year-old woman develops hirsutism and deepening of the voice in the third trimester of pregnancy. Ultrasound shows bilateral solid ovarian enlargement. Testosterone is very high. Her female baby shows some clitoromegaly at birth.

What is the most likely diagnosis?

A. Granulosa cell tumour
B. Luteoma of pregnancy
C. Mature cystic teratoma
D. Polycystic ovary syndrome
E. Theca-lutein cysts

Answer: B. Luteoma of pregnancy

Luteoma of pregnancy is a benign, hCG-driven solid enlargement of the ovaries that can secrete androgens and virilise the mother and a female fetus. It regresses spontaneously after delivery and needs no surgery.

Why not the others

- **A:** Granulosa tumours secrete oestrogen.
- **C:** Dermoids are cystic and usually non-functioning.
- **D:** PCOS does not cause rapid virilisation in pregnancy.
- **E:** Theca-lutein cysts are cystic and seen with molar pregnancy or multiples.

Key point: Avoid unnecessary surgery: luteomas regress after delivery.

Reference: Gynaecology by Ten Teachers — Hirsutism; Benign conditions of the ovary

MCQ 187 · Ovulation Induction · **Moderate** · C3

A 31-year-old woman with PCOS is taking clomiphene citrate. She complains of blurred vision and flashing lights during her cycle.

What is the most appropriate action?

A. Add metformin
B. Continue and review after 3 cycles
C. Increase the dose
D. Reduce the dose by half
E. Stop clomiphene permanently

Answer: E. Stop clomiphene permanently

Visual disturbance is an uncommon but important side effect of clomiphene. It is an indication to stop the drug permanently and use another method of ovulation induction.

Why not the others

- **A:** Metformin will not prevent visual side effects.
- **B:** Continuing risks persistent visual problems.
- **C:** Increasing the dose increases side effects.
- **D:** Dose reduction is not recommended; the drug should be stopped.

Key point: Common clomiphene side effects: hot flushes, mood change and multiple pregnancy.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 188 · Ovulation Induction · **Easy** · C2

A 27-year-old woman starting ovulation induction with clomiphene asks about the chance of twins.

What is the approximate risk of multiple pregnancy with clomiphene?

A. 1%
B. 10%
C. 25%
D. 40%
E. 60%

Answer: B. 10%

Clomiphene can cause more than one follicle to ovulate. The risk of multiple pregnancy is about 10%, mostly twins. Ultrasound monitoring reduces this risk.

Why not the others

- **A:** 1% is close to the natural twin rate.
- **C:** 25% is too high for clomiphene.
- **D:** 40% is far too high.
- **E:** 60% is far too high.

Key point: Letrozole has a lower multiple pregnancy rate than clomiphene.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 189 · Ovulation Induction · **Hard** · C3

A 30-year-old woman with PCOS has not ovulated on letrozole at the maximum dose. She chooses gonadotrophin ovulation induction.

Which gonadotrophin regimen is safest for her?

A. Fixed high-dose FSH from day 2
B. hCG alone
C. Long agonist protocol as for IVF
D. Low-dose step-up FSH with ultrasound monitoring
E. Simultaneous clomiphene and high-dose FSH

Answer: D. Low-dose step-up FSH with ultrasound monitoring

Women with PCOS are very sensitive to FSH. A low-dose step-up protocol, starting low and increasing slowly with close ultrasound monitoring, aims for a single dominant follicle, reducing OHSS and multiple pregnancy. Cycles with too many follicles are cancelled.

Why not the others

- **A:** High fixed doses cause many follicles and OHSS.
- **B:** hCG alone does not stimulate follicle growth.
- **C:** IVF protocols aim for many follicles, not single ovulation.
- **E:** Combining with high-dose FSH increases the risk of overresponse.

Key point: Cancel the cycle if more than 2–3 follicles over 14 mm develop.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 190 · Ovarian Hyperstimulation Syndrome · **Hard** · C3

A 29-year-old woman with severe OHSS after IVF is admitted with tense ascites, abdominal pain and breathlessness. Haematocrit is 49%, sodium 129 mmol/L and urine output low.

Which complication is she at particular risk of and must be prevented?

A. Endometrial hyperplasia
B. Hypercalcaemia
C. Hypoglycaemia
D. Ovarian cancer
E. Venous thromboembolism

Answer: E. Venous thromboembolism

Severe OHSS causes haemoconcentration and high oestrogen, greatly raising the risk of venous and arterial thrombosis, sometimes in unusual sites such as the neck. Low molecular weight heparin is given, with careful fluid balance and paracentesis if needed.

Why not the others

- **A:** Hyperplasia is not an acute risk.
- **B:** Calcium is not typically affected.
- **C:** Hypoglycaemia is not a feature.
- **D:** OHSS does not cause ovarian cancer.

Key point: Severe OHSS: daily weight, girth, fluid balance, haematocrit and thromboprophylaxis.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 191 · PCOS Management · **Moderate** · C3

A 33-year-old woman with PCOS had sleeve gastrectomy 4 months ago and has lost 25 kg. Her periods have returned and she wants to try for a baby now.

What is the most appropriate advice about timing of conception?

A. Conceive immediately while ovulating
B. Delay conception for about 12–18 months after surgery
C. Pregnancy is contraindicated after bariatric surgery
D. Start IVF now
E. Use clomiphene to conceive faster

Answer: B. Delay conception for about 12–18 months after surgery

Pregnancy is advised to be delayed for about 12–18 months after bariatric surgery, during the phase of rapid weight loss, to avoid nutritional deficiency and poor fetal growth. Effective contraception is needed meanwhile (oral methods may be less reliable after some procedures).

Why not the others

- **A:** Rapid weight loss and nutritional deficiency are risks for the fetus.
- **C:** Pregnancy is not contraindicated after the advised delay.
- **D:** IVF is not needed; she is ovulating.
- **E:** Ovulation induction is not needed and the timing is too early.

Key point: Fertility often returns quickly after bariatric surgery; contraception is important.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 192 · Contraception in PCOS · **Moderate** · C3

A 36-year-old woman with PCOS has a BMI of 38 kg/m², is a smoker and has hypertension. She wants contraception that will also protect her endometrium and regulate bleeding.

Which method is most appropriate?

A. Combined oral contraceptive pill
B. Combined vaginal ring
C. Copper intrauterine device
D. Levonorgestrel intrauterine system
E. Natural family planning

Answer: D. Levonorgestrel intrauterine system

Her age over 35 with smoking, obesity and hypertension makes combined hormonal methods unsafe. The LNG-IUS gives highly effective contraception, protects the endometrium and lightens bleeding, without thrombotic risk.

Why not the others

- **A:** Combined pills are contraindicated by smoking over 35 and multiple cardiovascular risks.
- **B:** The ring has the same risks as other combined methods.
- **C:** A copper IUD gives no endometrial protection and may increase bleeding.
- **E:** Natural family planning is unreliable with irregular cycles.

Key point: Multiple cardiovascular risk factors → avoid combined hormonal contraception.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Contraception

MCQ 193 · Endometrial Protection · **Hard** · C3

A 38-year-old woman with PCOS has had no periods for 14 months. She has a BMI of 41 kg/m². Pregnancy test is negative. Transvaginal ultrasound shows an endometrial thickness of 15 mm.

What is the most appropriate next step?

A. Cyclical progestogen and repeat scan in 1 year
B. Endometrial biopsy
C. Metformin and review in 6 months
D. Reassurance
E. Start the combined pill

Answer: B. Endometrial biopsy

Prolonged amenorrhoea with obesity and a thick endometrium (over 7–10 mm in an amenorrhoeic woman with PCOS) raises the risk of hyperplasia or cancer. Endometrial sampling is needed before starting treatment.

Why not the others

- **A:** Treatment without histology could miss cancer.
- **C:** Metformin does not assess the endometrium.
- **D:** Reassurance is unsafe.
- **E:** Starting the pill without biopsy could mask a problem, and her BMI makes it unsuitable.

Key point: PCOS with long amenorrhoea and thick endometrium → biopsy.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Malignant disease of the uterus

MCQ 194 · Hyperandrogenism · **Easy** · C2

A 22-year-old woman with PCOS is distressed by thinning hair over the crown with a preserved frontal hairline. Her doctor explains the cause.

What is this pattern of hair loss called?

A. Alopecia areata
B. Female pattern (androgenic) hair loss
C. Telogen effluvium
D. Traction alopecia
E. Trichotillomania

Answer: B. Female pattern (androgenic) hair loss

Androgens shrink scalp follicles in a genetically susceptible pattern, causing diffuse thinning over the crown with the frontal hairline kept (Ludwig pattern). It is a feature of hyperandrogenism in PCOS.

Why not the others

- **A:** Alopecia areata causes round bald patches.
- **C:** Telogen effluvium is diffuse shedding after stress or illness.
- **D:** Traction alopecia is caused by tight hairstyles at the hairline.
- **E:** Trichotillomania is self-pulling of hair, with broken hairs.

Key point: Topical minoxidil helps female pattern hair loss.

Reference: Gynaecology by Ten Teachers — Hirsutism; Polycystic ovary syndrome

MCQ 195 · Hyperandrogenism · **Moderate** · C2

A 25-year-old woman has mild hirsutism with regular ovulatory cycles. Testosterone, SHBG, 17-hydroxyprogesterone, prolactin and TSH are all normal. Ultrasound shows normal ovaries.

What is the most likely diagnosis?

A. Cushing syndrome
B. Idiopathic hirsutism
C. Non-classic CAH
D. Ovarian hyperthecosis
E. Polycystic ovary syndrome

Answer: B. Idiopathic hirsutism

Idiopathic hirsutism is hirsutism with regular ovulation, normal androgens and normal ovaries. It is thought to be due to increased sensitivity of the hair follicles to normal androgen levels.

Why not the others

- **A:** Cushing syndrome has other features.
- **C:** 17-OHP is normal.
- **D:** Hyperthecosis gives high testosterone.
- **E:** She meets only one criterion for PCOS (hirsutism).

Key point: Treatment is the same as other hirsutism: cosmetic measures, the pill or anti-androgens.

Reference: Gynaecology by Ten Teachers — Hirsutism

MCQ 196 · PCOS Pathophysiology · **Hard** · C2

A 26-year-old woman with PCOS asks why she does not ovulate even though she has many follicles on her scan.

What is the main reason follicles fail to reach ovulation in PCOS?

A. Absence of FSH receptors
B. Arrest of follicle development caused by high androgens and insulin with relatively low FSH
C. Excess progesterone
D. High prolactin
E. Ovarian failure

Answer: B. Arrest of follicle development caused by high androgens and insulin with relatively low FSH

In PCOS, high intra-ovarian androgens, raised LH and insulin, and relatively low FSH cause follicles to stop growing at 2–9 mm. No dominant follicle is selected, so there is no LH surge and no ovulation.

Why not the others

- **A:** FSH receptors are present.
- **C:** Progesterone is low because there is no ovulation.
- **D:** Prolactin is usually normal.
- **E:** The ovaries have plenty of follicles.

Key point: Ovulation induction works by raising FSH (letrozole, clomiphene, gonadotrophins).

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 197 · Ovulation Induction · **Moderate** · C2

A 29-year-old woman with PCOS is taking letrozole 2.5 mg on days 3–7. She asks how letrozole causes ovulation.

What is the mechanism of action of letrozole?

A. Blocks oestrogen receptors in the endometrium
B. Directly stimulates LH receptors
C. Increases SHBG
D. Inhibits aromatase, lowering oestrogen and increasing FSH release
E. Lowers prolactin

Answer: D. Inhibits aromatase, lowering oestrogen and increasing FSH release

Letrozole inhibits aromatase, reducing oestrogen production. The low oestrogen removes negative feedback on the hypothalamus and pituitary, so FSH rises and drives follicle growth. Its short half-life spares the endometrium.

Why not the others

- **A:** Clomiphene, not letrozole, blocks oestrogen receptors.
- **B:** hCG stimulates LH receptors.
- **C:** Letrozole does not increase SHBG.
- **E:** Dopamine agonists lower prolactin.

Key point: Letrozole tends to produce a single dominant follicle.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 198 · PCOS Management · **Easy** · C3

A 23-year-old unmarried woman with PCOS has irregular periods and mild acne. She is not sexually active and wants regular periods. BMI is 23 kg/m² and she has no contraindications to oestrogen.

What is the most appropriate treatment to regulate her cycles?

A. Clomiphene citrate
B. Combined oral contraceptive pill
C. GnRH analogue
D. Laparoscopic ovarian drilling
E. Letrozole

Answer: B. Combined oral contraceptive pill

The combined pill gives regular withdrawal bleeds, protects the endometrium and improves acne and hirsutism. It is first line for cycle control in women with PCOS who are not trying to conceive.

Why not the others

- **A:** Clomiphene is for women trying to conceive.
- **C:** GnRH analogues cause menopause-like effects and are not used.
- **D:** Drilling is for ovulation induction.
- **E:** Letrozole is for ovulation induction.

Key point: Pills with lower thrombotic risk are preferred when choosing a pill for PCOS.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 199 · Long-term Risks · **Moderate** · C2

A 30-year-old woman with PCOS is reviewed annually. She has had low mood and poor self-esteem related to her weight and hirsutism.

What does international guidance advise about mental health in PCOS?

A. Antidepressants should be started in all women
B. Mental health problems are not linked to PCOS
C. Screen for depression and anxiety at diagnosis and during follow-up
D. Screen only if she asks
E. Treat only the hirsutism and mood will improve

Answer: C. Screen for depression and anxiety at diagnosis and during follow-up

Depression, anxiety, poor body image and eating problems are more common in PCOS. Guidelines recommend screening at diagnosis and during follow-up, with treatment or referral as needed.

Why not the others

- **A:** Not all women need antidepressants.
- **B:** There is a clear association.
- **D:** Screening should be routine, not only on request.
- **E:** Treating symptoms helps but does not replace screening.

Key point: PCOS care is holistic: metabolic, reproductive and psychological.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome

MCQ 200 · Ovulation Induction · **Moderate** · C3

A 32-year-old woman with PCOS and a BMI of 33 kg/m² has not ovulated on clomiphene 150 mg for 3 cycles. Letrozole is not available locally. She has lost 4 kg and is continuing lifestyle change. She declines injections and surgery for now.

Which addition is most likely to help her ovulate?

A. Bromocriptine
B. Danazol
C. Dexamethasone
D. Hydrocortisone
E. Metformin added to clomiphene

Answer: E. Metformin added to clomiphene

In obese women with clomiphene-resistant PCOS, adding metformin to clomiphene improves ovulation and pregnancy rates compared with clomiphene alone by reducing insulin and androgen levels.

Why not the others

- **A:** Bromocriptine is for hyperprolactinaemia.
- **B:** Danazol is an androgenic drug and worsens PCOS.
- **C:** Dexamethasone has been tried but has little evidence and causes side effects.
- **D:** Hydrocortisone is used in classical CAH, not PCOS.

Key point: Clomiphene resistance: add metformin, switch to letrozole, or use gonadotrophins or drilling.

Reference: Gynaecology by Ten Teachers — Polycystic ovary syndrome; Subfertility

CHAPTER 5

Endometriosis and Adenomyosis

MCQ 201 · Endometriosis · **Moderate** · C3

A 28-year-old woman has progressively worsening painful periods, deep dyspareunia and 3 years of primary subfertility. On bimanual examination the uterus is fixed and retroverted, with tender nodules along the uterosacral ligaments. Her transvaginal ultrasound is normal.

What is the investigation of choice to confirm the diagnosis?

A. CA-125 level
B. Diagnostic hysteroscopy
C. Diagnostic laparoscopy with biopsy
D. MRI pelvis
E. Repeat transvaginal ultrasound in 3 months

Answer: C. Diagnostic laparoscopy with biopsy

Laparoscopy with histological confirmation is the gold standard for endometriosis. It also allows staging and treatment at the same time, which matters in a subfertile woman.

Why not the others

- **A:** CA-125 may rise in endometriosis but is neither sensitive nor specific.
- **B:** Hysteroscopy shows only the uterine cavity, not peritoneal disease.
- **D:** MRI maps deep disease before surgery, but a normal MRI does not exclude superficial peritoneal disease.
- **E:** Repeating the scan delays diagnosis; a normal scan does not exclude endometriosis.

Key point: A normal scan does not exclude endometriosis. Laparoscopy remains the gold standard.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 202 · Endometriosis Basics · **Easy** · C2

A 26-year-old woman is diagnosed with endometriosis at laparoscopy. She asks what the condition is.

What is the definition of endometriosis?

A. Endometrial glands and stroma within the myometrium
B. Endometrial-like tissue outside the uterus
C. Fibrous adhesions after pelvic infection
D. Overgrowth of the endometrium inside the uterus
E. Smooth muscle tumours of the uterus

Answer: B. Endometrial-like tissue outside the uterus

Endometriosis is the presence of endometrial-like tissue (glands and stroma) outside the uterus, causing a chronic inflammatory reaction. It affects about 10% of women of reproductive age.

Why not the others

- **A:** Endometrial tissue within the myometrium is adenomyosis.
- **C:** Adhesions after infection are a feature of PID.
- **D:** Overgrowth inside the uterus is hyperplasia.
- **E:** Smooth muscle tumours are fibroids.

Key point: Endometriosis is oestrogen-dependent and usually improves after menopause.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 203 · Endometriosis Basics · **Moderate** · C2

A 29-year-old woman with endometriosis asks how it developed. Her doctor explains the most widely accepted theory, supported by the finding that most lesions lie in the dependent parts of the pelvis.

Which theory best explains most pelvic endometriosis?

A. Coelomic metaplasia
B. Genetic mutation in the ovary
C. Haematogenous spread
D. Lymphatic spread
E. Retrograde menstruation

Answer: E. Retrograde menstruation

Sampson's theory of retrograde menstruation proposes that endometrial cells flow back through the tubes during menstruation and implant on the pelvic peritoneum. It explains why lesions are commonest on the ovaries, uterosacral ligaments and pouch of Douglas.

Why not the others

- **A:** Coelomic metaplasia may explain endometriosis in women without a uterus, but not most cases.
- **B:** No single ovarian mutation explains endometriosis.
- **C:** Haematogenous spread explains rare distant lesions such as in the lung.
- **D:** Lymphatic spread explains lymph node lesions.

Key point: Retrograde menstruation happens in most women, so immune and genetic factors also matter.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 204 · Endometriosis Basics · **Easy** · C2

At laparoscopy for chronic pelvic pain in a 30-year-old woman, the surgeon documents the sites of endometriosis.

Which is the commonest site of endometriosis?

A. Bladder
B. Lung
C. Ovary
D. Rectum
E. Umbilicus

Answer: C. Ovary

The ovary is the commonest site, followed by the uterosacral ligaments, pouch of Douglas and pelvic peritoneum. Ovarian disease can form endometriomas ("chocolate cysts").

Why not the others

- **A:** Bladder endometriosis is uncommon.
- **B:** Lung lesions are rare.
- **D:** Rectal disease occurs in deep endometriosis but is less common than ovarian disease.
- **E:** Umbilical endometriosis is rare.

Key point: Commonest sites: ovaries > uterosacral ligaments > pouch of Douglas.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 205 · Clinical Features · **Easy** · C2

A 28-year-old woman has painful periods getting worse over 3 years, deep pain during intercourse, and pain on opening her bowels during periods. She has been trying to conceive for 18 months.

What is the most likely diagnosis?

A. Endometriosis
B. Irritable bowel syndrome
C. Pelvic inflammatory disease
D. Primary dysmenorrhoea
E. Uterine fibroids

Answer: A. Endometriosis

Progressive secondary dysmenorrhoea, deep dyspareunia, dyschezia during menses and subfertility are the classic features of endometriosis, particularly with disease in the pouch of Douglas and uterosacral ligaments.

Why not the others

- **B:** IBS does not cause cyclical deep dyspareunia and subfertility.
- **C:** PID causes fever and discharge.
- **D:** Primary dysmenorrhoea does not worsen progressively or cause dyspareunia.
- **E:** Fibroids mainly cause heavy bleeding.

Key point: The average delay to diagnosis of endometriosis is several years; think of it early.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 206 · Clinical Features · **Hard** · C2

A 33-year-old woman has had three episodes of right-sided chest pain and breathlessness, each starting within 48 hours of the onset of her period. Chest X-ray during the latest episode shows a right pneumothorax.

What is the most likely cause?

A. Asthma
B. Catamenial pneumothorax due to thoracic endometriosis
C. Primary spontaneous pneumothorax unrelated to menses
D. Pulmonary embolism
E. Tuberculosis

Answer: B. Catamenial pneumothorax due to thoracic endometriosis

Thoracic endometriosis syndrome includes catamenial pneumothorax, usually right-sided and recurring around menstruation. It is managed with hormonal suppression and thoracic surgery.

Why not the others

- **A:** Asthma does not cause pneumothorax with menses.
- **C:** The repeated link to menses makes catamenial pneumothorax likely.
- **D:** PE does not cause pneumothorax.
- **E:** TB does not relate to the cycle.

Key point: Cyclical symptoms at distant sites (chest, umbilicus, scar) suggest endometriosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 207 · Clinical Features · **Moderate** · C2

A 32-year-old woman had a caesarean section 3 years ago. She now has a painful lump at the edge of her Pfannenstiel scar that becomes larger and more tender during each period.

What is the most likely diagnosis?

A. Desmoid tumour
B. Incisional hernia
C. Lipoma
D. Scar endometriosis
E. Stitch granuloma

Answer: D. Scar endometriosis

Endometrial cells can be implanted in the wound at caesarean section. They grow into a nodule that swells and hurts with each period. Treatment is wide excision.

Why not the others

- **A:** Desmoid tumours are firm and not cyclical.
- **B:** A hernia has a cough impulse and is not cyclical.
- **C:** A lipoma is soft and painless.
- **E:** A stitch granuloma is not cyclical and may discharge.

Key point: Cyclical pain in a scar nodule = scar endometriosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 208 · Clinical Features · **Hard** · C3

A 36-year-old woman with known deep endometriosis has mild left loin ache. Ultrasound shows moderate left hydronephrosis. Her creatinine is normal. She has no urinary symptoms.

What is the most likely cause of the hydronephrosis?

A. Bladder endometriosis
B. Kidney stone
C. Pyelonephritis
D. Retroperitoneal fibrosis from radiotherapy
E. Ureteric endometriosis

Answer: E. Ureteric endometriosis

Endometriosis on or around the ureter (often on the left, near the uterosacral ligament) can cause silent obstruction and loss of kidney function. It needs surgical treatment, often with a urologist, to save the kidney.

Why not the others

- **A:** Bladder endometriosis causes cyclical urinary symptoms, not hydronephrosis.
- **B:** Stones usually cause colic.
- **C:** Pyelonephritis causes fever.
- **D:** She has had no radiotherapy.

Key point: Image the kidneys in women with deep endometriosis; ureteric disease can be silent.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 209 · Examination · **Moderate** · C2

A 30-year-old woman has severe dysmenorrhoea and dyschezia. Bimanual examination is done during her period.

Which examination finding is most suggestive of deep endometriosis?

A. Bulky, soft, uniformly enlarged uterus
B. Cervical motion tenderness with purulent discharge
C. Mobile anteverted uterus
D. Normal-sized mobile uterus with a fluctuant adnexal mass
E. Tender nodules in the posterior fornix and uterosacral ligaments

Answer: E. Tender nodules in the posterior fornix and uterosacral ligaments

Tender nodularity in the posterior fornix and along the uterosacral ligaments, often with a fixed retroverted uterus, suggests deep infiltrating endometriosis. Examination during menstruation may increase sensitivity.

Why not the others

- **A:** A bulky soft uterus suggests adenomyosis.
- **B:** Cervical motion tenderness with pus suggests PID.
- **C:** A mobile anteverted uterus is normal.
- **D:** A fluctuant mass with a mobile uterus suggests a simple cyst.

Key point: A normal examination does not exclude endometriosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 210 · Investigation · **Moderate** · C3

A 27-year-old woman has symptoms suggestive of endometriosis. Abdominal and pelvic examination are normal. Her GP wants to start investigations.

According to current guidance, what is the first-line imaging test?

A. CT abdomen and pelvis
B. Diagnostic laparoscopy
C. Hysterosalpingography
D. PET scan
E. Transvaginal ultrasound

Answer: E. Transvaginal ultrasound

Transvaginal ultrasound is the first-line imaging test. It identifies endometriomas and, in expert hands, deep endometriosis. A normal scan does not exclude endometriosis, so treatment or referral should still be considered.

Why not the others

- **A:** CT is not useful for endometriosis.
- **B:** Laparoscopy is the definitive diagnostic test but not first-line imaging.
- **C:** HSG assesses tubal patency.
- **D:** PET has no role.

Key point: Do not use CA-125 to diagnose endometriosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; NICE NG73

MCQ 211 · Investigation · **Moderate** · C2

A 31-year-old woman has a 5 cm left adnexal cyst on transvaginal ultrasound. It is unilocular with uniform low-level internal echoes, no solid areas and no blood flow.

What is the most likely diagnosis?

A. Dermoid cyst
B. Endometrioma
C. Haemorrhagic corpus luteum cyst
D. Hydrosalpinx
E. Serous cystadenoma

Answer: B. Endometrioma

An endometrioma typically shows homogeneous low-level "ground-glass" echoes, caused by old blood. It is often persistent and may be bilateral.

Why not the others

- **A:** A dermoid shows echogenic nodules with shadowing and fat-fluid levels.
- **C:** A haemorrhagic cyst has a lace-like reticular pattern and resolves in 6–8 weeks.
- **D:** A hydrosalpinx is tubular with incomplete septa.
- **E:** A serous cystadenoma is anechoic.

Key point: Rescan a possible haemorrhagic cyst after 6–8 weeks; an endometrioma persists.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Benign conditions of the ovary

MCQ 212 · Investigation · **Moderate** · C2

At laparoscopy for pelvic pain, a 24-year-old woman is found to have lesions on the peritoneum of the pouch of Douglas. The surgeon describes them typically.

Which appearance is typical of endometriosis lesions?

A. Fine "violin-string" adhesions between liver and diaphragm
B. Multiple yellow nodules on the omentum
C. Powder-burn black or red flame-like lesions and white scarring
D. Small cysts on the fimbriae only
E. Thick purulent exudate

Answer: C. Powder-burn black or red flame-like lesions and white scarring

Endometriotic lesions vary from red flame-like and clear vesicles (active) to black "powder-burn" lesions and white fibrotic scars (older). Biopsy confirms the diagnosis.

Why not the others

- **A:** Violin-string adhesions are typical of Fitz-Hugh–Curtis syndrome after chlamydia.
- **B:** Yellow nodules on the omentum suggest tuberculosis or metastasis.
- **D:** Small fimbrial cysts are hydatids of Morgagni.
- **E:** Purulent exudate suggests PID.

Key point: Histological confirmation is recommended, especially for atypical lesions.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 213 · Investigation · **Hard** · C3

A 33-year-old woman has severe dyschezia and cyclical rectal bleeding. Transvaginal ultrasound suggests a nodule in the rectovaginal septum. Surgery is being considered.

Which investigation best maps the extent of deep disease before surgery?

A. Barium enema
B. CA-125
C. Colonoscopy alone
D. MRI of the pelvis
E. Repeat transabdominal ultrasound

Answer: D. MRI of the pelvis

Pelvic MRI maps deep infiltrating endometriosis, including rectovaginal, bowel and bladder involvement. This helps plan surgery with a multidisciplinary team, including colorectal surgeons.

Why not the others

- **A:** Barium enema is outdated and shows only bowel lumen changes.
- **B:** CA-125 does not map disease.
- **C:** Colonoscopy shows mucosa only; endometriosis usually involves the outer bowel wall.
- **E:** Transabdominal ultrasound has poor detail.

Key point: Deep endometriosis with bowel involvement should be treated in a specialist centre.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 214 · Investigation · **Moderate** · C2

A 29-year-old woman with pelvic pain has a CA-125 of 68 U/mL. Ultrasound shows a 4 cm endometrioma. She is worried about cancer.

What is the correct interpretation of the raised CA-125?

A. CA-125 is commonly raised in endometriosis and is not diagnostic
B. CA-125 is diagnostic of ovarian cancer
C. CA-125 is used to confirm endometriosis
D. CA-125 is used to stage endometriosis
E. CA-125 rules out endometriosis

Answer: A. CA-125 is commonly raised in endometriosis and is not diagnostic

CA-125 can be raised in many benign conditions, including endometriosis, fibroids, PID and pregnancy. It is not used to diagnose endometriosis, and a raised level in a premenopausal woman with an endometrioma is common.

Why not the others

- **B:** CA-125 is not diagnostic of cancer, especially before menopause.
- **C:** It is not sensitive or specific enough.
- **D:** Staging is surgical.
- **E:** A normal or raised CA-125 does not rule endometriosis in or out.

Key point: CA-125 is most useful in postmenopausal women with an adnexal mass.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Malignant disease of the ovary

MCQ 215 · Staging · **Hard** · C2

At laparoscopy, a 32-year-old woman has bilateral endometriomas over 3 cm, dense adhesions of both ovaries and complete obliteration of the pouch of Douglas.

What is her revised ASRM stage?

A. Stage I (minimal)
B. Stage II (mild)
C. Stage III (moderate)
D. Stage IV (severe)
E. It cannot be staged without MRI

Answer: D. Stage IV (severe)

The revised ASRM system scores the size of peritoneal and ovarian lesions, adhesions and pouch of Douglas obliteration. Bilateral endometriomas over 3 cm with dense adhesions and complete obliteration score over 40 points, which is stage IV (severe).

Why not the others

- **A:** Stage I is a few superficial lesions.
- **B:** Stage II is more superficial disease without large endometriomas.
- **C:** Stage III includes endometriomas or adhesions but less than this.
- **E:** ASRM staging is surgical, not radiological.

Key point: Stage does not correlate well with pain but does relate to fertility outcomes.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 216 · Medical Treatment · **Easy** · C3

A 23-year-old woman has painful periods and suspected endometriosis. Ultrasound is normal. She does not want to conceive now and has no contraindications to hormones.

What is the most appropriate first-line treatment?

A. Danazol
B. GnRH agonist
C. Laparoscopic excision
D. NSAIDs with a combined oral contraceptive or progestogen
E. Total hysterectomy

Answer: D. NSAIDs with a combined oral contraceptive or progestogen

Empirical treatment with analgesics (NSAIDs) and hormonal suppression (the combined pill, often taken continuously, or a progestogen) is appropriate first line, without needing laparoscopy first.

Why not the others

- **A:** Danazol has androgenic side effects and is no longer recommended.
- **B:** GnRH agonists are second line because of side effects.
- **C:** Surgery is for treatment failure, endometriomas or fertility problems.
- **E:** Hysterectomy is far too radical for a young woman.

Key point: Treatment can start without a laparoscopic diagnosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; NICE NG73

MCQ 217 · Medical Treatment · **Moderate** · C3

A 30-year-old woman with endometriosis has persistent pain on the combined pill. She has a history of migraine with aura. She asks for another hormonal option.

Which treatment is most appropriate?

A. Continuous combined pill at higher dose
B. Danazol
C. Dienogest (progestogen-only)
D. Ethinylestradiol alone
E. Tibolone

Answer: C. Dienogest (progestogen-only)

Progestogens such as dienogest, desogestrel, medroxyprogesterone or the LNG-IUS suppress endometriotic lesions and are safe with migraine with aura, which contraindicates oestrogen.

Why not the others

- **A:** Oestrogen-containing pills are contraindicated with migraine with aura.
- **B:** Danazol has poor tolerability.
- **D:** Oestrogen alone stimulates endometriosis.
- **E:** Tibolone is used for add-back or postmenopausal HRT.

Key point: Common progestogen side effect: irregular bleeding.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 218 · Medical Treatment · **Moderate** · C2

A 34-year-old woman with severe endometriosis is starting a GnRH agonist for 6 months. Her doctor also prescribes low-dose HRT to take at the same time.

What is the purpose of add-back HRT with a GnRH agonist?

A. To increase the effect of the GnRH agonist
B. To prevent bone loss and menopausal symptoms
C. To prevent ovulation
D. To shrink endometriomas
E. To stimulate the endometrium

Answer: B. To prevent bone loss and menopausal symptoms

GnRH agonists suppress oestrogen to menopausal levels, causing hot flushes and bone loss. Add-back HRT or tibolone reduces these side effects without reducing the benefit for endometriosis pain, allowing longer use.

Why not the others

- **A:** Add-back does not increase the effect.
- **C:** The GnRH agonist already suppresses ovulation.
- **D:** Add-back does not shrink endometriomas.
- **E:** Stimulating the endometrium is not the aim.

Key point: The initial flare with GnRH agonists can worsen symptoms in the first 2 weeks.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 219 · Medical Treatment · **Hard** · C2

A 32-year-old woman with endometriosis is offered an oral GnRH antagonist combined with low-dose oestradiol and norethisterone acetate (relugolix combination therapy).

What is an advantage of a GnRH antagonist over a GnRH agonist?

A. It causes a stronger initial flare
B. It does not cause any bone loss
C. It has an immediate effect without an initial flare
D. It improves fertility while being taken
E. It must be given by injection

Answer: C. It has an immediate effect without an initial flare

GnRH antagonists block the receptor directly, suppressing gonadotrophins within hours without the initial flare of agonists. Oral formulations with add-back allow long-term use.

Why not the others

- **A:** Antagonists cause no flare; agonists do.
- **B:** They can cause bone loss, which is why add-back is included.
- **D:** They suppress ovulation, so they do not help fertility during use.
- **E:** The relugolix combination is oral.

Key point: No hormonal treatment for endometriosis improves fertility.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 220 · Fertility · **Moderate** · C3

A 29-year-old woman with 2 years of subfertility has a laparoscopy that shows minimal to mild (stage I–II) peritoneal endometriosis. Her tubes are patent.

What is the most appropriate treatment of the endometriosis at the time of laparoscopy?

A. Continuous combined pill for 6 months, then try to conceive
B. Excision or ablation of the lesions and adhesiolysis
C. GnRH agonist for 6 months
D. Hysterectomy
E. No surgical treatment

Answer: B. Excision or ablation of the lesions and adhesiolysis

In minimal and mild endometriosis, excision or ablation of lesions with adhesiolysis at the diagnostic laparoscopy improves spontaneous pregnancy rates compared with diagnostic laparoscopy alone.

Why not the others

- **A:** Hormonal suppression prevents conception and does not improve fertility.
- **C:** GnRH agonists delay conception without benefit.
- **D:** Hysterectomy ends fertility.
- **E:** Treating the lesions improves the chance of pregnancy.

Key point: Hormonal treatment does not improve fertility in endometriosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Subfertility

MCQ 221 · Fertility · **Hard** · C3

A 36-year-old woman with stage IV endometriosis has been trying to conceive for 3 years. She has bilateral endometriomas of 3 cm, a low AMH and dense adhesions. Her husband's semen is normal.

What is the most appropriate fertility treatment?

A. Bilateral ovarian cystectomy before trying again naturally
B. Clomiphene citrate
C. GnRH agonist for 6 months, then natural conception
D. In vitro fertilisation
E. Intrauterine insemination

Answer: D. In vitro fertilisation

With severe endometriosis, older age and reduced ovarian reserve, IVF gives the best chance of pregnancy. Removing small endometriomas before IVF may reduce ovarian reserve further and is not routinely needed.

Why not the others

- **A:** Cystectomy further reduces ovarian reserve and delays treatment.
- **B:** Clomiphene does not overcome tubal and pelvic damage.
- **C:** Prolonged GnRH treatment delays treatment without improving natural fertility.
- **E:** IUI is unlikely to succeed with dense adhesions.

Key point: Discuss AMH and ovarian reserve before ovarian surgery in women wanting fertility.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Subfertility

MCQ 222 · Surgical Treatment · **Moderate** · C3

A 28-year-old woman has a 5 cm endometrioma causing pain. She wants to conceive in the future. Laparoscopy is planned.

Which surgical approach is recommended?

A. Aspiration of the cyst only
B. Bilateral oophorectomy
C. Drainage and ablation of the cyst wall
D. Laparoscopic ovarian cystectomy (excision of the cyst wall)
E. Laparotomy and oophorectomy

Answer: D. Laparoscopic ovarian cystectomy (excision of the cyst wall)

Excision of the cyst wall (cystectomy) reduces recurrence and pain and improves spontaneous pregnancy rates compared with drainage and ablation. It should be done carefully to preserve healthy ovarian tissue.

Why not the others

- **A:** Aspiration alone has a very high recurrence rate.
- **B:** Removing both ovaries ends fertility.
- **C:** Drainage and ablation have higher recurrence.
- **E:** Laparotomy and oophorectomy are unnecessary.

Key point: Cystectomy reduces AMH; balance benefits against ovarian reserve.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 223 · Surgical Treatment · **Hard** · C3

A 44-year-old woman with severe endometriosis has completed her family. Medical treatment has failed. She has a total hysterectomy with bilateral salpingo-oophorectomy and excision of all visible disease.

What type of HRT is recommended after surgery?

A. Continuous combined oestrogen and progestogen (or tibolone)
B. No HRT is allowed
C. Oestrogen-only HRT
D. Testosterone alone
E. Vaginal oestrogen only

Answer: A. Continuous combined oestrogen and progestogen (or tibolone)

After hysterectomy and BSO for endometriosis, HRT is advised to protect bone and heart. Combined HRT or tibolone is usually preferred over oestrogen alone because unopposed oestrogen may reactivate residual endometriosis and, rarely, cause malignant change.

Why not the others

- **B:** HRT is safe and beneficial in most women after surgical menopause.
- **C:** Oestrogen alone may reactivate residual disease.
- **D:** Testosterone does not replace oestrogen.
- **E:** Vaginal oestrogen does not treat systemic symptoms or protect bone.

Key point: Surgical menopause at 44 without HRT increases cardiovascular and bone risks.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; The menopause

MCQ 224 · Malignancy · **Hard** · C2

A 48-year-old woman with a long history of endometriosis has a 9 cm complex left ovarian cyst with a solid enhancing area on MRI. She has surgery.

Which ovarian cancer types are associated with endometriosis?

A. Clear cell and endometrioid carcinoma
B. Dysgerminoma and yolk sac tumour
C. Granulosa cell tumour
D. High-grade serous carcinoma only
E. Mucinous carcinoma

Answer: A. Clear cell and endometrioid carcinoma

Endometriosis is linked with a small increase in risk of clear cell and endometrioid ovarian cancers. Solid enhancing areas in an endometrioma in an older woman need investigation for malignancy.

Why not the others

- **B:** Germ cell tumours occur in young women and are not linked to endometriosis.
- **C:** Granulosa tumours are sex cord-stromal tumours, not linked.
- **D:** High-grade serous cancer is mainly linked to tubal origin and BRCA.
- **E:** Mucinous tumours are not linked.

Key point: The absolute risk is small; reassure most women.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Malignant disease of the ovary

MCQ 225 · Risk Factors · **Easy** · C2

A 25-year-old woman whose mother and sister both have endometriosis asks about her own risk factors. She had menarche at 10, has short 24-day cycles and has never been pregnant.

Which factor is associated with a lower risk of endometriosis?

A. Early menarche
B. Family history in a first-degree relative
C. Nulliparity
D. Previous pregnancy
E. Short menstrual cycles

Answer: D. Previous pregnancy

Pregnancy and breastfeeding reduce exposure to menstruation and are associated with a lower risk. Early menarche, short cycles, heavy periods, nulliparity and a family history increase the risk.

Why not the others

- **A:** Early menarche increases the number of menstrual cycles.
- **B:** A first-degree relative increases the risk about 7-fold.
- **C:** Nulliparity increases risk.
- **E:** Short cycles increase retrograde menstruation exposure.

Key point: Risk factors reflect more menstruation over a lifetime.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 226 · Clinical Features · **Moderate** · C2

A 35-year-old woman has frequency, urgency and painful voiding with visible blood in her urine only during her periods. Urine cultures are always negative.

What is the most likely diagnosis?

A. Bladder endometriosis
B. Bladder transitional cell carcinoma
C. Interstitial cystitis
D. Recurrent urinary tract infection
E. Urethral diverticulum

Answer: A. Bladder endometriosis

Endometriosis of the bladder wall causes cyclical urinary symptoms and haematuria during menstruation. Cystoscopy during menses may show a bluish nodule. Treatment is hormonal suppression or partial cystectomy.

Why not the others

- **B:** Bladder cancer gives painless haematuria not linked to the cycle.
- **C:** Interstitial cystitis is not cyclical with menses.
- **D:** Cultures are negative.
- **E:** A urethral diverticulum gives dribbling and dyspareunia, not cyclical haematuria.

Key point: Cyclical haematuria = bladder endometriosis until proved otherwise.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 227 · Clinical Features · **Moderate** · C2

A 34-year-old woman with endometriosis has cyclical rectal bleeding, pain on defecation and bloating during her periods. Colonoscopy is normal. MRI shows a 2.5 cm nodule infiltrating the anterior rectal wall muscle.

Why was the colonoscopy normal?

A. Bowel endometriosis is always on the right colon

B. Bowel endometriosis usually infiltrates from the serosa and rarely breaches the mucosa

C. Colonoscopy was done too late

D. The nodule is in the rectovaginal septum only

E. The patient has irritable bowel syndrome

Answer: B. Bowel endometriosis usually infiltrates from the serosa and rarely breaches the mucosa

Bowel endometriosis grows from the outside (serosa) into the muscle and usually spares the mucosa, so colonoscopy is often normal. MRI or specialist ultrasound shows the nodule.

Why not the others

- **A:** The rectosigmoid is the commonest bowel site.
- **C:** Timing is not the reason; the mucosa is usually not involved.
- **D:** MRI shows rectal wall involvement.
- **E:** MRI shows a structural cause.

Key point: Deep bowel endometriosis needs a specialist team with colorectal surgeons.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 228 · Clinical Features · **Hard** · C2

A 30-year-old woman has a small bluish-brown nodule in her umbilicus that becomes painful and bleeds during her periods. She has never had abdominal surgery.

What is the most likely diagnosis?

A. Metastatic Sister Mary Joseph nodule

B. Primary umbilical endometriosis

C. Pyogenic granuloma

D. Umbilical hernia

E. Urachal cyst

Answer: B. Primary umbilical endometriosis

Primary umbilical endometriosis (Villar's nodule) presents as a bluish nodule with cyclical pain and bleeding. Excision is diagnostic and curative.

Why not the others

- **A:** A Sister Mary Joseph nodule is metastatic cancer and is not cyclical.
- **C:** A pyogenic granuloma bleeds easily but not cyclically.
- **D:** A hernia has a cough impulse.
- **E:** A urachal cyst discharges urine or pus, not cyclical blood.

Key point: Cyclical bleeding at an unusual site = endometriosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 229 · Clinical Features · **Moderate** · C3

A 17-year-old girl has severe dysmenorrhoea that does not respond to NSAIDs or 6 months of the combined pill. She misses school every month. Ultrasound is normal.

What is the most appropriate next step?

A. Continue the same treatment for another year
B. GnRH agonist without add-back for 2 years
C. Hysterectomy
D. Laparoscopy by an experienced gynaecologist
E. Reassure that pain will settle after marriage

Answer: D. Laparoscopy by an experienced gynaecologist

Endometriosis is common in adolescents with dysmenorrhoea that does not respond to NSAIDs and the pill. Laparoscopy can diagnose and treat it. Delay in diagnosis can mean years of avoidable pain.

Why not the others

- **A:** Continuing failed treatment delays diagnosis.
- **B:** Long-term GnRH without add-back causes bone loss at a critical age.
- **C:** Hysterectomy is never appropriate here.
- **E:** Dismissing pain delays care and is not evidence-based.

Key point: Take adolescent period pain seriously.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Puberty and its disorders

MCQ 230 · Endometrioma · **Hard** · C3

A 26-year-old woman with a known 6 cm left endometrioma has sudden severe lower abdominal pain and fever of 37.9°C. She has generalised tenderness and guarding. Pregnancy test is negative. Ultrasound shows free fluid with echoes and a smaller, collapsed cyst.

What is the most likely diagnosis?

A. Acute appendicitis
B. Ectopic pregnancy
C. Ovarian torsion
D. Ruptured endometrioma
E. Tubo-ovarian abscess

Answer: D. Ruptured endometrioma

Rupture of an endometrioma releases thick old blood into the peritoneum, causing chemical peritonitis with severe pain, mild fever and free fluid. The cyst becomes smaller. Laparoscopy with washout and cystectomy is needed.

Why not the others

- **A:** Appendicitis does not cause a collapsed ovarian cyst.
- **B:** The pregnancy test is negative.
- **C:** Torsion gives an enlarged, not collapsed, ovary.
- **E:** A tubo-ovarian abscess has a complex mass and higher fever with discharge.

Key point: Endometrioma rupture can mimic an acute abdomen.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Acute gynaecology

MCQ 231 · Endometrioma · **Hard** · C3

A 31-year-old woman with a known endometrioma is 20 weeks pregnant. Routine scan shows the cyst now has solid-looking papillary projections with blood flow. She has no symptoms.

What is the most likely explanation?

A. Borderline ovarian tumour
B. Clear cell carcinoma
C. Decidualised endometrioma
D. Dermoid cyst
E. Ovarian torsion

Answer: C. Decidualised endometrioma

In pregnancy, progesterone causes decidualisation of the endometriotic tissue, producing vascular papillary projections that can mimic malignancy. Recognising this avoids unnecessary surgery; MRI can help, and the change regresses after delivery.

Why not the others

- **A:** Borderline tumours are possible but much less likely in a known endometrioma in pregnancy.
- **B:** Malignancy is rare.
- **D:** The cyst was known to be an endometrioma.
- **E:** Torsion causes pain.

Key point: Avoid surgery in pregnancy unless there is a real concern; image with MRI.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 232 · Medical Treatment · **Easy** · C3

A 33-year-old woman with endometriosis has heavy painful periods. She does not want pregnancy for at least 5 years and prefers a long-acting method.

Which treatment is most suitable?

A. Copper intrauterine device
B. Danazol
C. Levonorgestrel intrauterine system
D. Natural family planning
E. Oestrogen-only HRT

Answer: C. Levonorgestrel intrauterine system

The LNG-IUS reduces endometriosis-related pain and heavy bleeding, and provides long-acting contraception. It is also effective for adenomyosis.

Why not the others

- **A:** A copper IUD worsens heavy and painful periods.
- **B:** Danazol has androgenic side effects and is not long-acting.
- **D:** Natural methods do not treat endometriosis.
- **E:** Oestrogen alone stimulates endometriosis.

Key point: LNG-IUS helps both endometriosis and adenomyosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 233 · Medical Treatment · **Moderate** · C2

A 30-year-old woman was treated for endometriosis with danazol in the past. She developed side effects that have not fully gone.

Which side effect of danazol may be irreversible?

A. Acne
B. Deepening of the voice
C. Hot flushes
D. Oily skin
E. Weight gain

Answer: B. Deepening of the voice

Danazol is a synthetic androgen. Its androgenic effects include acne, weight gain, oily skin and hirsutism, which reverse on stopping, but deepening of the voice may be permanent. This is why it is rarely used now.

Why not the others

- **A:** Acne resolves after stopping.
- **C:** Hot flushes resolve.
- **D:** Oily skin resolves.
- **E:** Weight gain usually reverses.

Key point: Danazol has largely been replaced by better-tolerated treatments.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 234 · Recurrence · **Moderate** · C3

A 32-year-old woman had laparoscopic excision of endometriosis 6 months ago with excellent pain relief. She does not want pregnancy for 3 years and asks how to reduce recurrence.

What is the most appropriate advice?

A. Endometriosis cannot recur after excision
B. Hormonal suppression (such as the pill or LNG-IUS) after surgery reduces recurrence
C. Repeat laparoscopy every 6 months
D. Start IVF now
E. Stop all hormonal treatment

Answer: B. Hormonal suppression (such as the pill or LNG-IUS) after surgery reduces recurrence

Endometriosis recurs in up to half of women within 5 years of surgery. Postoperative hormonal suppression with the combined pill, a progestogen or the LNG-IUS reduces recurrence of pain and endometriomas in women not trying to conceive.

Why not the others

- **A:** Recurrence is common.
- **C:** Repeated surgery causes adhesions and reduced ovarian reserve.
- **D:** She does not want pregnancy now.
- **E:** Stopping hormones increases recurrence.

Key point: Long-term management of endometriosis is a chronic disease approach.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 235 · Surgical Treatment · **Hard** · C3

A 38-year-old woman with severe endometriosis has a hysterectomy but keeps both ovaries. Two years later her pain returns.

What is the most likely reason?

A. Endometriosis cannot recur after hysterectomy
B. Ovarian hormones continue to stimulate residual endometriosis
C. She has developed adenomyosis
D. She has developed fibroids
E. The cervix was left

Answer: B. Ovarian hormones continue to stimulate residual endometriosis

Endometriosis lies outside the uterus and depends on oestrogen. If the ovaries are kept, residual disease can be stimulated and pain may recur. Conserving ovaries is still often appropriate in younger women, with counselling about this risk.

Why not the others

- **A:** Recurrence is possible when the ovaries are preserved.
- **C:** Adenomyosis is in the uterus, which has been removed.
- **D:** Fibroids are in the uterus.
- **E:** The cervix is not the source of endometriosis pain.

Key point: Excise all visible disease at hysterectomy to lower recurrence.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 236 · Surgical Treatment · **Hard** · C2

A 47-year-old woman had a bilateral salpingo-oophorectomy for endometriosis 3 years ago. She is not on HRT, yet her cyclical pelvic pain has returned. Her FSH is in the premenopausal range and oestradiol is detectable.

What is the most likely diagnosis?

A. Adenomyosis
B. Interstitial cystitis
C. Irritable bowel syndrome
D. Ovarian remnant syndrome
E. Primary ovarian cancer

Answer: D. Ovarian remnant syndrome

In ovarian remnant syndrome, a small piece of ovarian tissue left behind after difficult oophorectomy continues to function. Premenopausal FSH and detectable oestradiol after BSO confirm it. It is common after surgery for severe endometriosis with adhesions.

Why not the others

- **A:** Adenomyosis does not explain hormone levels.
- **B:** Interstitial cystitis does not produce oestrogen.
- **C:** IBS does not produce oestrogen.
- **E:** Primary ovarian cancer is unlikely after BSO.

Key point: After BSO, FSH should be in the postmenopausal range.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Gynaecological surgery

MCQ 237 · Fertility · **Moderate** · C3

A 33-year-old woman with a 3 cm endometrioma and low-normal AMH is about to start IVF. The endometrioma causes no pain. She asks if it should be removed first.

What is the most appropriate advice?

A. Aspirate and inject alcohol before every cycle

B. Delay IVF for 6 months of GnRH agonist

C. Hysterectomy

D. Proceed with IVF without removing the endometrioma

E. Remove the endometrioma before IVF to improve pregnancy rates

Answer: D. Proceed with IVF without removing the endometrioma

Removing an endometrioma before IVF does not improve live birth rates and can reduce ovarian reserve. Surgery before IVF is considered only for pain, large size, suspicion of malignancy or access problems for egg collection.

Why not the others

- **A:** Repeated aspiration is not routine.
- **B:** Delay reduces success with low reserve.
- **C:** Hysterectomy ends fertility.
- **E:** Surgery does not improve IVF outcome and harms reserve.

Key point: Protect ovarian reserve in women planning IVF.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Subfertility

MCQ 238 · Chronic Pelvic Pain · **Easy** · C2

A 34-year-old woman has had lower abdominal pain for 9 months that is not only during her periods or intercourse. She is referred to the pelvic pain clinic.

How is chronic pelvic pain defined?

A. Any pelvic pain lasting 1 week

B. Intermittent or constant pelvic pain for at least 6 months, not only with menses or intercourse, and not from pregnancy

C. Pain only during intercourse

D. Pain only during menstruation

E. Pelvic pain for at least 2 weeks after surgery

Answer: B. Intermittent or constant pelvic pain for at least 6 months, not only with menses or intercourse, and not from pregnancy

Chronic pelvic pain is intermittent or constant pain in the lower abdomen or pelvis lasting at least 6 months, not occurring only with menstruation or intercourse and not caused by pregnancy.

Why not the others

- **A:** One week is acute pain.
- **C:** Pain only with intercourse is dyspareunia.
- **D:** Pain only with menses is dysmenorrhoea.
- **E:** Two weeks after surgery is acute postoperative pain.

Key point: Common causes: endometriosis, adhesions, IBS, interstitial cystitis, pelvic congestion and musculoskeletal pain.

Reference: Gynaecology by Ten Teachers — Chronic pelvic pain

MCQ 239 · Chronic Pelvic Pain · **Moderate** · C2

A 31-year-old woman has chronic lower abdominal pain with bloating and alternating constipation and diarrhoea. The pain is relieved by defecation and is worse with stress. Laparoscopy is normal.

What is the most likely diagnosis?

A. Adhesions
B. Endometriosis
C. Interstitial cystitis
D. Irritable bowel syndrome
E. Pelvic congestion syndrome

Answer: D. Irritable bowel syndrome

Irritable bowel syndrome is a common cause of chronic pelvic pain. Pain related to defecation, bloating and change in stool form or frequency fit the Rome criteria. A normal laparoscopy supports it.

Why not the others

- **A:** Adhesions would be seen at laparoscopy.
- **B:** Endometriosis would usually be seen at laparoscopy.
- **C:** Interstitial cystitis gives bladder pain and urgency.
- **E:** Pelvic congestion gives a dull ache worse on standing.

Key point: Ask about bowel and bladder symptoms in every woman with pelvic pain.

Reference: Gynaecology by Ten Teachers — Chronic pelvic pain

MCQ 240 · Chronic Pelvic Pain · **Hard** · C2

A 40-year-old woman has bladder pain that gets worse as the bladder fills and is relieved by voiding. She has frequency of 18 times a day and nocturia. Urine cultures are repeatedly negative. Cystoscopy shows small haemorrhages (glomerulations) after hydrodistension.

What is the most likely diagnosis?

A. Bladder endometriosis
B. Bladder pain syndrome (interstitial cystitis)
C. Detrusor overactivity
D. Recurrent urinary tract infection
E. Urethral diverticulum

Answer: B. Bladder pain syndrome (interstitial cystitis)

Bladder pain syndrome causes pain related to bladder filling, frequency and urgency with sterile urine. Glomerulations or Hunner's lesions on cystoscopy support the diagnosis.

Why not the others

- **A:** Bladder endometriosis is cyclical.
- **C:** Detrusor overactivity causes urgency without much pain.
- **D:** Cultures are negative.
- **E:** A diverticulum causes dribbling and an anterior vaginal mass.

Key point: Bladder pain syndrome often coexists with endometriosis and IBS.

Reference: Gynaecology by Ten Teachers — Chronic pelvic pain; Urogynaecology

MCQ 241 · Adenomyosis · **Easy** · C2

A 43-year-old woman (para 4) has heavy, increasingly painful periods for 2 years. On examination the uterus is uniformly enlarged to 12-week size, soft and tender, especially during menstruation.

What is the most likely diagnosis?

A. Adenomyosis
B. Endometrial cancer
C. Endometriosis of the ovary
D. Pelvic inflammatory disease
E. Subserosal fibroid

Answer: A. Adenomyosis

Adenomyosis is the presence of endometrial glands and stroma within the myometrium. It causes heavy painful periods and a bulky, globular, tender uterus, typically in parous women in their 40s.

Why not the others

- **B:** Endometrial cancer usually causes postmenopausal bleeding.
- **C:** Ovarian endometriosis gives an adnexal mass.
- **D:** PID causes fever and discharge.
- **E:** A subserosal fibroid causes an irregular, non-tender mass.

Key point: Bulky, boggy, tender uterus = adenomyosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 242 · Adenomyosis · **Moderate** · C2

A 41-year-old woman with heavy painful periods has an MRI of the pelvis to investigate a uniformly enlarged uterus.

Which MRI finding is most typical of adenomyosis?

A. A well-circumscribed mass with a pseudocapsule
B. An enlarged ovary with a fluid level
C. Junctional zone thickness of 12 mm or more
D. Normal junctional zone with a polyp
E. Thin endometrium under 4 mm

Answer: C. Junctional zone thickness of 12 mm or more

On T2-weighted MRI, a thickened junctional zone (12 mm or more), often with small high-signal foci, is characteristic of adenomyosis.

Why not the others

- **A:** A well-defined mass with a pseudocapsule is a fibroid.
- **B:** An ovarian fluid level suggests an endometrioma or dermoid.
- **D:** A normal junctional zone argues against adenomyosis.
- **E:** Endometrial thickness does not define adenomyosis.

Key point: Transvaginal ultrasound features: asymmetric myometrial thickening, cysts, fan-shaped shadowing.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 243 · Adenomyosis · **Moderate** · C3

A 40-year-old woman with adenomyosis has heavy periods and dysmenorrhoea. She has completed her family but wants to avoid surgery.

What is the most appropriate first-line treatment?

A. Endometrial ablation
B. Levonorgestrel intrauterine system
C. Myomectomy
D. Total hysterectomy
E. Uterine artery embolisation

Answer: B. Levonorgestrel intrauterine system

The LNG-IUS reduces bleeding and pain in adenomyosis and is the first-line treatment for women who want to avoid surgery.

Why not the others

- **A:** Ablation is less effective in adenomyosis because the tissue is deep in the myometrium.
- **C:** Adenomyosis cannot be shelled out like a fibroid.
- **D:** Hysterectomy is definitive but she wants to avoid surgery.
- **E:** Embolisation is less effective for adenomyosis than for fibroids.

Key point: Hysterectomy is the only definitive cure for adenomyosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 244 · Adenomyosis · **Hard** · C3

A 45-year-old woman with adenomyosis has had heavy painful periods despite the LNG-IUS and tranexamic acid for a year. She has completed her family and her haemoglobin is 9.4 g/dL.

What is the definitive treatment?

A. Endometrial ablation
B. GnRH analogue for 6 months
C. Hysterectomy
D. Myomectomy
E. Uterine artery embolisation

Answer: C. Hysterectomy

Hysterectomy is the only definitive treatment for adenomyosis. It is appropriate when medical treatment has failed and the woman has completed her family.

Why not the others

- **A:** Ablation fails often in adenomyosis.
- **B:** GnRH analogues give only temporary relief.
- **D:** There is no fibroid to remove.
- **E:** Embolisation has lower long-term success in adenomyosis.

Key point: Diagnosis of adenomyosis is often made only on the hysterectomy specimen.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 245 · Adenomyosis · **Hard** · C3

A 37-year-old woman with diffuse adenomyosis has had two failed IVF embryo transfers with good-quality embryos.

Which strategy may improve the chance of implantation in the next frozen embryo transfer?

A. GnRH agonist pretreatment for 2–3 months before transfer
B. Hysterectomy
C. Immediate fresh transfer with high-dose hCG
D. Myomectomy
E. Stop all hormones

Answer: A. GnRH agonist pretreatment for 2–3 months before transfer

Adenomyosis is linked with lower implantation and higher miscarriage rates. Down-regulation with a GnRH agonist for 2–3 months before frozen embryo transfer may improve outcomes in women with adenomyosis.

Why not the others

- **B:** Hysterectomy ends fertility.
- **C:** High-dose hCG does not help and raises OHSS risk.
- **D:** Diffuse adenomyosis cannot be removed like a fibroid.
- **E:** Stopping hormones does not help.

Key point: Adenomyosis may affect fertility; consider it in repeated implantation failure.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Subfertility

MCQ 246 · Adenomyosis · **Moderate** · C2

A 39-year-old woman has a 4 cm ill-defined area within the posterior myometrium on MRI, with small cystic spaces and no clear capsule. It is mistaken for a fibroid on ultrasound.

What is this lesion?

A. Adenomyoma
B. Endometrial polyp
C. Leiomyoma
D. Leiomyosarcoma
E. Ovarian fibroma

Answer: A. Adenomyoma

An adenomyoma is a focal area of adenomyosis forming a mass. Unlike a fibroid it has no capsule and blends into the myometrium, so it cannot be enucleated easily.

Why not the others

- **B:** A polyp lies in the cavity.
- **C:** A leiomyoma has a well-defined capsule.
- **D:** Sarcoma usually shows necrosis and rapid growth.
- **E:** An ovarian fibroma is in the ovary.

Key point: Surgery for an adenomyoma risks a weak uterine wall.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 247 · Surgical Treatment · **Hard** · C2

A 34-year-old woman had laparoscopic excision of a rectovaginal endometriosis nodule with shaving of the rectum. On day 7 she has a feculent vaginal discharge.

What complication has most likely occurred?

A. Bladder injury
B. Pelvic abscess
C. Rectovaginal fistula
D. Ureteric injury
E. Vault haematoma

Answer: C. Rectovaginal fistula

Deep rectovaginal surgery risks bowel injury. Delayed thermal injury or leakage can lead to a rectovaginal fistula, presenting as faecal or feculent discharge from the vagina about a week after surgery.

Why not the others

- **A:** Bladder injury causes urine leakage.
- **B:** An abscess causes fever and pain, not faecal discharge.
- **D:** Ureteric injury causes urine leakage or loin pain.
- **E:** A vault haematoma causes brown discharge and fever.

Key point: Deep endometriosis surgery should be done in specialist centres for this reason.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Complications of surgery

MCQ 248 · Medical Treatment · **Hard** · C3

A 49-year-old woman has severe recurrent endometriosis after hysterectomy and BSO. She is on tibolone. Pain persists and MRI shows residual active deep disease. She declines further surgery.

Which additional drug may help refractory postmenopausal endometriosis?

A. Aromatase inhibitor
B. Clomiphene
C. Higher-dose oestrogen
D. Letrozole stopped after 5 days
E. Testosterone

Answer: A. Aromatase inhibitor

Endometriotic tissue can make its own oestrogen via aromatase. Continuous aromatase inhibitors (such as anastrozole or letrozole) can reduce pain in refractory and postmenopausal endometriosis, with bone protection.

Why not the others

- **B:** Clomiphene is for ovulation induction.
- **C:** More oestrogen worsens endometriosis.
- **D:** A 5-day course is for ovulation induction, not suppression.
- **E:** Testosterone does not treat endometriosis.

Key point: Aromatase inhibitors cause bone loss; monitor and protect bones.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

MCQ 249 · Fertility · **Moderate** · C2

A 30-year-old woman with endometriosis asks why her condition affects fertility even though her tubes are open.

Which mechanism contributes to subfertility in endometriosis with patent tubes?

A. Absence of the uterus
B. Antisperm antibodies in all cases
C. High progesterone levels
D. Inflammatory peritoneal fluid impairing egg, sperm and embryo
E. Low prolactin

Answer: D. Inflammatory peritoneal fluid impairing egg, sperm and embryo

Endometriosis creates an inflammatory peritoneal environment with cytokines and macrophages that can impair egg quality, sperm function, fertilisation and implantation, even when the tubes are open. Distorted anatomy and reduced ovarian reserve also contribute.

Why not the others

- **A:** The uterus is present.
- **B:** Antisperm antibodies are not a general feature.
- **C:** Progesterone is not high.
- **E:** Prolactin is not low.

Key point: About 30–50% of women with endometriosis have subfertility.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis; Subfertility

MCQ 250 · Endometriosis Basics · **Easy** · C2

A 52-year-old woman who had severe endometriosis in her 30s has had no pelvic pain since her periods stopped 2 years ago. She is not on HRT. She asks why her symptoms disappeared.

On which hormone does endometriosis mainly depend for its growth?

A. Androgen
B. Cortisol
C. Oestrogen
D. Prolactin
E. Thyroxine

Answer: C. Oestrogen

Endometriosis is an oestrogen-dependent condition. After natural menopause oestrogen falls and lesions usually become inactive, so symptoms settle. This is also why treatments aim to suppress oestrogen or ovulation.

Why not the others

- **A:** Androgens do not stimulate endometriosis; danazol (an androgen) was used to suppress it.
- **B:** Cortisol does not drive endometriosis.
- **D:** Prolactin is not the main driver.
- **E:** Thyroxine does not affect endometriotic growth directly.

Key point: HRT after menopause can occasionally reactivate endometriosis.

Reference: Gynaecology by Ten Teachers — Endometriosis and adenomyosis

CHAPTER 6

Early Pregnancy Problems

MCQ 251 · Ectopic Pregnancy · **Hard** · C3

A 26-year-old woman (G2 P1) presents at 7 weeks of amenorrhoea with mild left iliac fossa pain. She is haemodynamically stable. Serum β-hCG is 2,800 IU/L. Transvaginal scan shows an empty uterus and a 40 mm left adnexal mass with no fetal heartbeat and minimal free fluid. The right tube appears normal.

What is the most appropriate management?

A. Expectant management
B. Laparoscopic salpingectomy
C. Laparoscopic salpingotomy
D. Laparotomy and salpingectomy
E. Systemic methotrexate

Answer: B. Laparoscopic salpingectomy

A mass of 35 mm or more excludes medical treatment, so she needs surgery. She is stable, so laparoscopy is preferred. With a healthy contralateral tube, salpingectomy is preferred over salpingotomy: fertility outcomes are similar and there is no risk of persistent trophoblast.

Why not the others

- **A:** Expectant management is only for pain-free women with hCG ≤1,500 IU/L and a small mass.
- **C:** Salpingotomy is for women whose other tube is damaged or absent, and needs hCG follow-up.
- **D:** Laparotomy is for haemodynamically unstable patients or when laparoscopy is not feasible.
- **E:** Methotrexate needs a mass under 35 mm, no significant pain and a low hCG (ideally under 1,500 IU/L).

Key point: Methotrexate rule of thumb: mass under 35 mm, hCG under 1,500 IU/L, no significant pain, no fetal heartbeat.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; NICE NG126

MCQ 252 · Gestational Trophoblastic Disease · **Moderate** · C2

A 22-year-old primigravida at 11 weeks presents with vaginal bleeding and severe vomiting. Her uterus is the size of a 16-week pregnancy. BP is 150/95 mmHg. Serum β-hCG is 250,000 IU/L. Ultrasound shows a uterus filled with multiple small cystic spaces ("snowstorm") and no fetal parts. Both ovaries contain large multiloculated cysts.

What is the most likely diagnosis?

A. Choriocarcinoma
B. Complete hydatidiform mole
C. Missed miscarriage
D. Partial hydatidiform mole
E. Twin pregnancy

Answer: B. Complete hydatidiform mole

Very high hCG, a uterus large for dates, hyperemesis, early pre-eclampsia, theca-lutein cysts and a snowstorm pattern with no fetal tissue are the classic features of a complete mole. It is diploid (usually 46,XX) and entirely paternal in origin. Treatment is suction evacuation followed by hCG surveillance.

Why not the others

- **A:** Choriocarcinoma usually follows a pregnancy (often a mole) and presents with persistent bleeding or metastases, not a first-trimester snowstorm uterus.
- **C:** Missed miscarriage gives a small-for-dates uterus with low hCG.
- **D:** A partial mole is triploid with fetal parts present and a less marked rise in hCG.
- **E:** Twins raise hCG and uterine size but show two gestational sacs with fetal parts.

Key point: Complete mole: no fetus, 46,XX paternal. Partial mole: fetal parts, triploid 69,XXY.

Reference: Gynaecology by Ten Teachers — Gestational trophoblastic disease

MCQ 253 · Miscarriage · **Easy** · C2

A 26-year-old woman at 8 weeks has light vaginal bleeding and mild cramps. Speculum examination shows a closed cervical os. Transvaginal ultrasound shows a live intrauterine pregnancy with a heartbeat, consistent with dates.

What is the diagnosis?

A. Complete miscarriage
B. Incomplete miscarriage
C. Inevitable miscarriage
D. Missed miscarriage
E. Threatened miscarriage

Answer: E. Threatened miscarriage

Bleeding in early pregnancy with a closed os and a viable intrauterine pregnancy is a threatened miscarriage. Most continue normally, especially once a heartbeat is seen.

Why not the others

- **A:** Complete miscarriage has an empty uterus after passing tissue.
- **B:** Incomplete miscarriage has retained tissue and usually an open os.
- **C:** Inevitable miscarriage has an open os with heavy bleeding.
- **D:** Missed miscarriage has a non-viable pregnancy.

Key point: Threatened miscarriage: closed os, viable pregnancy.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 254 · Miscarriage · **Easy** · C2

A 30-year-old woman at 10 weeks has heavy bleeding with clots and strong cramps. Speculum examination shows an open cervical os with blood coming through it, but no tissue in the canal. Ultrasound shows a gestational sac low in the uterus.

What is the diagnosis?

A. Complete miscarriage
B. Ectopic pregnancy
C. Inevitable miscarriage
D. Missed miscarriage
E. Threatened miscarriage

Answer: C. Inevitable miscarriage

An open internal os with bleeding and the pregnancy still in the uterus means miscarriage is inevitable. It will usually progress to an incomplete or complete miscarriage.

Why not the others

- **A:** The sac is still present.
- **B:** The pregnancy is intrauterine.
- **D:** Missed miscarriage usually has a closed os and few symptoms.
- **E:** Threatened miscarriage has a closed os.

Key point: Open os = inevitable or incomplete; closed os = threatened, missed or complete.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 255 · Miscarriage · **Moderate** · C2

A 33-year-old woman at 9 weeks by dates has had brown spotting and loss of breast tenderness. She has no pain. Ultrasound shows an intrauterine pregnancy with a crown–rump length of 8 mm and no fetal heartbeat. The os is closed.

What is the diagnosis?

A. Anembryonic pregnancy
B. Ectopic pregnancy
C. Incomplete miscarriage
D. Missed miscarriage
E. Threatened miscarriage

Answer: D. Missed miscarriage

A crown–rump length of 7 mm or more with no heartbeat on transvaginal scan confirms a missed (delayed) miscarriage. A second opinion or repeat scan after 7 days is often advised before management.

Why not the others

- **A:** Anembryonic means there is a sac but no embryo.
- **B:** The pregnancy is intrauterine.
- **C:** Incomplete miscarriage follows passage of some tissue, usually with an open os.
- **E:** There is no heartbeat, so the pregnancy is not viable.

Key point: Miscarriage criteria: CRL ≥7 mm with no heartbeat, or mean sac diameter ≥25 mm with no embryo.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; NICE NG126

MCQ 256 · Miscarriage · **Moderate** · C3

A 28-year-old woman at 7 weeks has a transvaginal scan. It shows an intrauterine gestational sac with a mean diameter of 18 mm, with no yolk sac and no embryo. She has no pain or bleeding.

What is the most appropriate next step?

A. Arrange manual vacuum aspiration
B. Diagnose miscarriage and give misoprostol
C. Methotrexate injection
D. Repeat transvaginal scan in at least 7 days
E. Serum progesterone and discharge

Answer: D. Repeat transvaginal scan in at least 7 days

With a mean sac diameter under 25 mm and no embryo, miscarriage cannot be diagnosed yet; it may be an early viable pregnancy. A repeat scan at least 7 days later is needed before making a diagnosis.

Why not the others

- **A:** Surgery before confirming non-viability could end a viable pregnancy.
- **B:** Miscarriage is not yet confirmed.
- **C:** The pregnancy is intrauterine; methotrexate is for ectopic pregnancy.
- **E:** A single progesterone does not confirm viability.

Key point: Never diagnose miscarriage on a single uncertain scan.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; NICE NG126

MCQ 257 · Miscarriage · **Moderate** · C3

A 31-year-old woman has a confirmed missed miscarriage at 9 weeks. She is well, not bleeding heavily and has no signs of infection. She wants to avoid surgery but does not want to wait.

What is the recommended medical management?

A. Methotrexate 50 mg/m² intramuscularly
B. Mifepristone 200 mg orally, then misoprostol 800 micrograms 48 hours later
C. Oral norethisterone
D. Oxytocin infusion
E. Ulipristal acetate

Answer: B. Mifepristone 200 mg orally, then misoprostol 800 micrograms 48 hours later

For missed miscarriage, mifepristone followed 48 hours later by misoprostol 800 micrograms (vaginal, oral or sublingual) is more effective than misoprostol alone.

Why not the others

- **A:** Methotrexate treats ectopic pregnancy.
- **C:** Norethisterone does not empty the uterus.
- **D:** Oxytocin is ineffective in early pregnancy because the uterus has few receptors.
- **E:** Ulipristal is used for emergency contraception and fibroids.

Key point: Offer a pregnancy test 3 weeks after medical management.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; NICE NG126

MCQ 258 · Miscarriage · **Easy** · C3

A 25-year-old woman with a confirmed missed miscarriage at 8 weeks is clinically well and wants the most natural approach. She has no heavy bleeding or infection.

What is the first-line management recommended by NICE?

A. Expectant management for 7–14 days
B. Immediate surgical evacuation under general anaesthesia
C. Methotrexate
D. Misoprostol only after 6 weeks of waiting
E. Total hysterectomy

Answer: A. Expectant management for 7–14 days

Expectant management for 7–14 days is first-line for most women with a confirmed miscarriage. Medical or surgical management is offered if she prefers, if expectant management fails, or if there is heavy bleeding, infection or other risk.

Why not the others

- **B:** Surgery is an option but not first line for most women.
- **C:** Methotrexate is not used for intrauterine miscarriage.
- **D:** Waiting 6 weeks is not recommended.
- **E:** Hysterectomy is never appropriate.

Key point: Respect the woman's choice; all three options are safe in suitable women.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; NICE NG126

MCQ 259 · Miscarriage · **Hard** · C3

A 24-year-old woman at 9 weeks is brought in pale and sweaty with heavy bleeding. Pulse is 48/min and BP 82/50 mmHg. Speculum examination shows products of conception distending the cervical os.

What is the most appropriate immediate action?

A. Arrange an ultrasound scan
B. Give intramuscular methotrexate
C. Remove the products from the os with sponge forceps
D. Start an oxytocin infusion
E. Transfer to theatre for laparotomy

Answer: C. Remove the products from the os with sponge forceps

Products of conception stretching the cervical os cause vagal stimulation ("cervical shock"), with bradycardia and hypotension out of proportion to blood loss. Removing them with sponge forceps relieves this quickly, along with resuscitation.

Why not the others

- **A:** Scanning delays a simple life-saving step.
- **B:** Methotrexate is for ectopic pregnancy.
- **D:** Oxytocin does little in early pregnancy.
- **E:** Laparotomy is not needed; the pregnancy is intrauterine.

Key point: Bradycardia with hypotension in miscarriage → look for products in the os.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 260 · Miscarriage · **Moderate** · C3

A 32-year-old woman (Rh-negative) has a surgical evacuation for a missed miscarriage at 11 weeks.

What is the advice about anti-D immunoglobulin?

A. Anti-D is given only if she bleeds again
B. Anti-D is not needed in the first trimester under any circumstances
C. Give anti-D because she had surgical management
D. Give anti-D only in the next pregnancy
E. Give anti-D only to Rh-positive women

Answer: C. Give anti-D because she had surgical management

Anti-D is recommended for Rh-negative women having surgical management of miscarriage or ectopic pregnancy. It is not needed for threatened miscarriage, complete miscarriage or medical management under 12 weeks (per NICE).

Why not the others

- **A:** Sensitisation may have already happened at surgery.
- **B:** Surgical management is an indication.
- **D:** It must be given within 72 hours of the event.
- **E:** Rh-positive women do not need anti-D.

Key point: Anti-D within 72 hours: surgical management of miscarriage or ectopic, and any bleeding after 12 weeks.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 261 · Septic Miscarriage · **Hard** · C3

A 22-year-old woman presents 4 days after an unsafe abortion by an unqualified provider. She has fever of 39.2°C, pulse 128/min, BP 88/54 mmHg, offensive vaginal discharge and a tender uterus. Ultrasound shows retained products.

What is the most appropriate management?

A. Antibiotics and review in 48 hours
B. Expectant management
C. IV fluids and broad-spectrum antibiotics, then urgent evacuation of retained products
D. Methotrexate
E. Misoprostol at home

Answer: C. IV fluids and broad-spectrum antibiotics, then urgent evacuation of retained products

This is septic miscarriage with sepsis. She needs the Sepsis Six: fluids, cultures and broad-spectrum IV antibiotics, followed by urgent evacuation of the infected tissue once antibiotics are started. Delay can lead to septic shock and death.

Why not the others

- **A:** Waiting allows sepsis to worsen.
- **B:** Infected retained products must be removed.
- **D:** Methotrexate is irrelevant.
- **E:** Outpatient misoprostol is unsafe in sepsis.

Key point: Unsafe abortion remains a major cause of maternal death worldwide.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 262 · Recurrent Miscarriage · **Moderate** · C2

A 33-year-old woman has had three consecutive miscarriages at 7–9 weeks. She has no living children. She is referred to the recurrent miscarriage clinic.

Which investigation is recommended for all couples in this clinic?

A. Antiphospholipid antibodies (lupus anticoagulant and anticardiolipin)
B. Inherited thrombophilia screen for factor V Leiden only
C. Natural killer cell testing
D. Prolactin in all women
E. TORCH screen

Answer: A. Antiphospholipid antibodies (lupus anticoagulant and anticardiolipin)

Antiphospholipid syndrome is the most important treatable cause of recurrent miscarriage. Lupus anticoagulant and anticardiolipin antibodies (and anti-β2 glycoprotein I) are checked twice, at least 12 weeks apart.

Why not the others

- **B:** Inherited thrombophilia testing is not routine for first-trimester losses.
- **C:** NK cell testing is not recommended.
- **D:** Prolactin is tested only if indicated.
- **E:** TORCH infections do not cause recurrent miscarriage.

Key point: Also karyotype the pregnancy tissue from the third or later miscarriage, and arrange a pelvic ultrasound.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; Recurrent miscarriage

MCQ 263 · Recurrent Miscarriage · **Moderate** · C3

A 34-year-old woman with four first-trimester miscarriages has lupus anticoagulant positive on two tests 12 weeks apart. She is now 5 weeks pregnant.

What is the most appropriate treatment in this pregnancy?

A. Low-dose aspirin and prophylactic low molecular weight heparin
B. No treatment
C. Oral prednisolone
D. Progesterone alone
E. Warfarin from 6 weeks

Answer: A. Low-dose aspirin and prophylactic low molecular weight heparin

In antiphospholipid syndrome with recurrent miscarriage, low-dose aspirin plus prophylactic low molecular weight heparin improves the live birth rate.

Why not the others

- **B:** Without treatment the live birth rate is low.
- **C:** Steroids do not improve outcome and cause harm.
- **D:** Progesterone alone does not treat APS.
- **E:** Warfarin is teratogenic in the first trimester.

Key point: APS also increases the risk of pre-eclampsia and growth restriction later in pregnancy.

Reference: Gynaecology by Ten Teachers — Recurrent miscarriage

MCQ 264 · Recurrent Miscarriage · **Hard** · C3

A 30-year-old woman with two previous miscarriages has vaginal bleeding at 7 weeks. Ultrasound shows a live intrauterine pregnancy.

Which treatment is recommended to improve the chance of a live birth?

A. Human chorionic gonadotrophin injections
B. Low molecular weight heparin
C. Oral dydrogesterone only after 12 weeks
D. Strict bed rest
E. Vaginal micronised progesterone 400 mg twice daily until 16 weeks

Answer: E. Vaginal micronised progesterone 400 mg twice daily until 16 weeks

In women with early pregnancy bleeding and at least one previous miscarriage, vaginal micronised progesterone 400 mg twice daily until 16 weeks increases live birth rates (PRISM trial; recommended by NICE).

Why not the others

- **A:** hCG has no proven benefit.
- **B:** Heparin is for antiphospholipid syndrome.
- **C:** Starting after 12 weeks misses the window of benefit.
- **D:** Bed rest does not prevent miscarriage.

Key point: The benefit is greatest in women with three or more previous miscarriages.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; NICE NG126

MCQ 265 · Cervical Weakness · **Moderate** · C3

A 29-year-old woman has had two second-trimester losses at 18 and 20 weeks. Each time she had painless cervical dilatation followed by rapid delivery. She had a large cone biopsy in the past.

What is the most appropriate management in her next pregnancy?

A. Bed rest from 12 weeks
B. Cervical cerclage at about 12–14 weeks
C. Low-dose aspirin
D. Progesterone only after 24 weeks
E. Termination at 12 weeks

Answer: B. Cervical cerclage at about 12–14 weeks

Painless second-trimester loss with cervical dilatation suggests cervical weakness. A history-indicated cerclage at 12–14 weeks is recommended after three or more such losses or preterm births, and is commonly offered after two with a typical history; serial cervical length scanning is an alternative.

Why not the others

- **A:** Bed rest has no proven benefit.
- **C:** Aspirin is for pre-eclampsia risk.
- **D:** Progesterone after 24 weeks is too late.
- **E:** There is no reason to end the pregnancy.

Key point: Previous large cone biopsy is a risk factor for cervical weakness.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; Recurrent miscarriage

MCQ 266 · Pregnancy of Unknown Location · **Moderate** · C3

A 27-year-old woman with a positive pregnancy test has mild lower abdominal pain. Transvaginal scan shows no intrauterine or adnexal pregnancy. Serum hCG is 900 IU/L. Repeat hCG after 48 hours is 1,550 IU/L. She is stable.

What is the most likely outcome?

A. Complete miscarriage
B. Developing intrauterine pregnancy
C. Ectopic pregnancy needing methotrexate now
D. Failing pregnancy
E. Molar pregnancy

Answer: B. Developing intrauterine pregnancy

A rise in hCG of more than 63% over 48 hours suggests a developing intrauterine pregnancy (though ectopic is not excluded). A repeat scan is arranged when hCG is likely to be above the discriminatory level, or in 7–14 days.

Why not the others

- **A:** hCG would fall by more than 50% in a complete miscarriage.
- **C:** A normal rise does not indicate ectopic and no mass is seen.
- **D:** A failing pregnancy shows falling hCG.
- **E:** Molar pregnancy gives very high hCG with typical scan appearances.

Key point: hCG change over 48 h: rise >63% → likely intrauterine; fall >50% → likely failing; in between → ectopic risk.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; NICE NG126

MCQ 267 · Pregnancy of Unknown Location · **Hard** · C3

A 30-year-old woman with a pregnancy of unknown location has hCG of 1,200 IU/L. After 48 hours it is 1,350 IU/L. She has mild pain and is stable. Repeat scan shows no pregnancy in or outside the uterus.

What is the most appropriate interpretation?

A. Complete miscarriage
B. Ectopic pregnancy cannot be excluded and she needs senior review and close follow-up
C. Normal intrauterine pregnancy
D. Reassure and discharge
E. Successful pregnancy with twins

Answer: B. Ectopic pregnancy cannot be excluded and she needs senior review and close follow-up

An hCG change between a 50% fall and a 63% rise is abnormal and carries a significant risk of ectopic pregnancy. She needs senior review within 24 hours and close follow-up with repeat hCG and scanning.

Why not the others

- **A:** A complete miscarriage shows a fall of more than 50%.
- **C:** A rise of only about 12% is suboptimal for an intrauterine pregnancy.
- **D:** Discharge is unsafe.
- **E:** Twins give a higher rise.

Key point: Suboptimal hCG rise = ectopic until proved otherwise.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 268 · Ectopic Pregnancy · **Easy** · C2

A 29-year-old woman with 6 weeks of amenorrhoea has a positive pregnancy test and left iliac fossa pain. She had chlamydial pelvic inflammatory disease 3 years ago and smokes 15 cigarettes a day.

Which factor most increases her risk of ectopic pregnancy?

A. Age 29
B. Combined pill use in the past
C. Previous normal vaginal delivery
D. Previous pelvic inflammatory disease
E. Regular cycles

Answer: D. Previous pelvic inflammatory disease

Tubal damage from PID (especially chlamydia) is a major risk factor for ectopic pregnancy. Others include previous ectopic, tubal surgery, IVF, IUD in place at conception and smoking.

Why not the others

- **A:** Risk increases with age, but 29 is not high-risk.
- **B:** Past combined pill use does not increase risk.
- **C:** Previous vaginal delivery is not a risk factor.
- **E:** Regular cycles are not a risk factor.

Key point: Up to half of women with ectopic pregnancy have no risk factors.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 269 · Ectopic Pregnancy · **Easy** · C3

A 25-year-old woman with 7 weeks of amenorrhoea collapses at home with severe abdominal pain. In hospital, pulse is 136/min and BP 74/40 mmHg. Abdomen is distended and very tender. Pregnancy test is positive. Bedside scan shows a large amount of free fluid.

What is the most appropriate management?

A. Expectant management
B. Immediate surgery (laparoscopy or laparotomy) with resuscitation
C. Methotrexate
D. Repeat hCG in 48 hours
E. Transvaginal ultrasound in the department first

Answer: B. Immediate surgery (laparoscopy or laparotomy) with resuscitation

This is a ruptured ectopic pregnancy with haemorrhagic shock. She needs resuscitation and immediate surgery to stop the bleeding. Laparotomy is often chosen when the patient is very unstable; laparoscopy if the surgeon is skilled and resuscitation is ongoing.

Why not the others

- **A:** Expectant management is for stable, pain-free women with low hCG.
- **C:** Methotrexate is for stable unruptured ectopics.
- **D:** Waiting would be fatal.
- **E:** Further imaging delays life-saving surgery.

Key point: Unstable + positive pregnancy test + free fluid = straight to theatre.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 270 · Ectopic Pregnancy · **Moderate** · C3

A 28-year-old woman has an unruptured right tubal ectopic of 25 mm with no heartbeat. She is stable, has minimal pain, and hCG is 1,100 IU/L. She can return for follow-up.

What is the first-line treatment?

A. Expectant management only if hCG is above 5,000
B. Laparoscopic salpingectomy
C. Laparotomy
D. Mifepristone and misoprostol
E. Systemic methotrexate

Answer: E. Systemic methotrexate

NICE advises methotrexate as first-line treatment for women who have no significant pain, an unruptured ectopic under 35 mm with no heartbeat, hCG under 1,500 IU/L, and no intrauterine pregnancy, and who can attend follow-up.

Why not the others

- **A:** Expectant management is for low hCG (≤1,000–1,500), not over 5,000.
- **B:** Surgery is an alternative but not first line here.
- **C:** Laparotomy is not needed.
- **D:** These drugs are for intrauterine miscarriage.

Key point: Expectant management is also an option when hCG is ≤1,000 IU/L and she is pain-free.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; NICE NG126

MCQ 271 · Ectopic Pregnancy · **Moderate** · C3

A 29-year-old woman received methotrexate for an ectopic pregnancy on day 1. hCG was 1,300 IU/L on day 1, 1,400 IU/L on day 4 and 1,050 IU/L on day 7. She is well.

What is the most appropriate next step?

A. Continue weekly hCG until negative
B. Give a second dose of methotrexate
C. Laparoscopic salpingectomy
D. Repeat full course with folinic acid
E. Stop follow-up now

Answer: A. Continue weekly hCG until negative

After methotrexate, hCG often rises by day 4. A fall of 15% or more between day 4 and day 7 shows a good response. Here it fell by 25%, so weekly hCG is checked until negative.

Why not the others

- **B:** A second dose is given if hCG falls less than 15% between days 4 and 7.
- **C:** Surgery is for rupture or failed medical treatment.
- **D:** Multi-dose regimens with folinic acid are not needed here.
- **E:** Follow-up must continue until hCG is negative.

Key point: Advise avoiding pregnancy for 3 months after methotrexate.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 272 · Ectopic Pregnancy · **Moderate** · C2

A 26-year-old woman is being treated with methotrexate for an ectopic pregnancy. She asks what she should avoid during treatment.

Which advice is correct?

A. Avoid folic acid supplements, alcohol and NSAIDs
B. Bed rest for 2 weeks
C. Start trying to conceive next month
D. Take a high-dose folic acid tablet every day
E. Take ibuprofen for pain

Answer: A. Avoid folic acid supplements, alcohol and NSAIDs

Methotrexate is a folate antagonist. Folic acid reduces its effect; alcohol increases liver toxicity; NSAIDs reduce its clearance and increase toxicity. Paracetamol is used for pain. Pregnancy should be avoided for 3 months.

Why not the others

- **B:** Bed rest is not needed.
- **C:** Pregnancy should be delayed for 3 months.
- **D:** Folic acid reduces its effect during treatment.
- **E:** NSAIDs increase methotrexate toxicity.

Key point: Pain increasing after methotrexate may mean rupture; she must return urgently.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 273 · Ectopic Pregnancy · **Hard** · C3

A 33-year-old woman with two previous caesarean sections is 7 weeks pregnant. Transvaginal scan shows an empty uterine cavity and empty cervical canal, with a gestational sac embedded in the anterior lower segment at the scar, with thin myometrium between the sac and bladder.

What is the diagnosis?

A. Caesarean scar ectopic pregnancy
B. Cervical ectopic pregnancy
C. Incomplete miscarriage
D. Interstitial pregnancy
E. Normal low-lying intrauterine pregnancy

Answer: A. Caesarean scar ectopic pregnancy

A caesarean scar ectopic implants in the scar niche. It risks uterine rupture and severe haemorrhage, and if it continues, placenta accreta spectrum. Management is individualised (surgical removal, suction under guidance or methotrexate) in a specialist unit.

Why not the others

- **B:** A cervical ectopic lies in the cervical canal below the internal os.
- **C:** Incomplete miscarriage has tissue in the cavity or canal, not embedded in the scar.
- **D:** Interstitial pregnancy is in the cornual part of the tube.
- **E:** A normal pregnancy is in the cavity, not embedded in the scar.

Key point: Rising caesarean rates make scar ectopics more common.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 274 · Ectopic Pregnancy · **Hard** · C2

A 31-year-old woman conceived by IVF with transfer of two embryos. At 7 weeks she has right iliac fossa pain and free fluid in the pelvis. Ultrasound shows a live intrauterine pregnancy and a separate right adnexal mass with a yolk sac.

What is the most likely diagnosis?

A. Corpus luteum cyst rupture only
B. Heterotopic pregnancy
C. Ovarian hyperstimulation syndrome
D. Twin intrauterine pregnancy
E. Vanishing twin

Answer: B. Heterotopic pregnancy

Heterotopic pregnancy is an intrauterine and an ectopic pregnancy at the same time. It is rare naturally but more common after IVF (up to 1 in 100). Treatment is laparoscopic salpingectomy, preserving the intrauterine pregnancy; methotrexate is contraindicated.

Why not the others

- **A:** A corpus luteum cyst does not contain a yolk sac.
- **C:** OHSS gives enlarged ovaries and ascites, not an adnexal sac.
- **D:** Twins would both be in the uterus.
- **E:** A vanishing twin is inside the uterus.

Key point: An intrauterine pregnancy does not completely exclude ectopic after IVF.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; Assisted conception

MCQ 275 · Ectopic Pregnancy · **Moderate** · C2

A 30-year-old woman has a positive pregnancy test with a copper intrauterine device in place. She has mild lower abdominal pain.

What is the correct statement about IUDs and ectopic pregnancy?

A. An IUD causes ectopic pregnancy in most users
B. An IUD has no link with ectopic pregnancy
C. An IUD lowers the overall risk of ectopic, but if pregnancy occurs it is more likely to be ectopic
D. IUD users cannot become pregnant
E. The IUD should be left in and no scan is needed

Answer: C. An IUD lowers the overall risk of ectopic, but if pregnancy occurs it is more likely to be ectopic

IUDs are very effective, so the absolute risk of ectopic pregnancy is lower than in women using no contraception. But if pregnancy occurs with an IUD in place, a higher proportion are ectopic, so urgent scanning is needed.

Why not the others

- **A:** Most IUD users never become pregnant.
- **B:** Failure is associated with a higher proportion of ectopic.
- **D:** IUDs can fail, although rarely.
- **E:** An ectopic must be excluded by scan.

Key point: Pregnancy with an IUD: scan urgently to locate it.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; Contraception

MCQ 276 · Ectopic Pregnancy · **Hard** · C2

A 32-year-old woman at 6 weeks has painless heavy vaginal bleeding. Ultrasound shows an empty uterus with an hourglass shape, and a gestational sac below the internal os within a ballooned cervical canal. Doppler shows blood flow around the sac. The internal os is closed.

What is the diagnosis?

A. Caesarean scar ectopic pregnancy
B. Cervical ectopic pregnancy
C. Incomplete miscarriage passing through the cervix
D. Interstitial pregnancy
E. Ovarian pregnancy

Answer: B. Cervical ectopic pregnancy

In a cervical ectopic, the sac is implanted in the cervical canal with blood flow around it, the internal os is closed and the uterus has an hourglass shape. A miscarriage passing through the cervix has no blood flow and the os is open.

Why not the others

- **A:** A scar ectopic is in the anterior lower segment scar, above the cervix.
- **C:** Miscarriage passing through has an open os and no peritrophoblastic flow.
- **D:** Interstitial pregnancy is in the cornual region.
- **E:** Ovarian pregnancy lies in the ovary.

Key point: Cervical ectopic can bleed massively; avoid blind evacuation.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 277 · Miscarriage · **Easy** · C2

A 38-year-old woman has her first miscarriage at 8 weeks. She asks why it happened and whether she did something wrong.

What is the commonest cause of sporadic first-trimester miscarriage?

A. Antiphospholipid syndrome
B. Cervical weakness
C. Fetal chromosomal abnormality
D. Heavy lifting
E. Maternal stress

Answer: C. Fetal chromosomal abnormality

About half of first-trimester miscarriages are caused by chromosomal abnormalities in the embryo, most commonly autosomal trisomies (especially trisomy 16). The risk rises with maternal age. She should be reassured it was not caused by her activities.

Why not the others

- **A:** APS is a cause of recurrent, not most sporadic, miscarriage.
- **B:** Cervical weakness causes second-trimester loss.
- **D:** Normal activity and lifting do not cause miscarriage.
- **E:** Everyday stress does not cause miscarriage.

Key point: Miscarriage occurs in about 1 in 5 recognised pregnancies; risk rises sharply after age 40.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 278 · Miscarriage · **Moderate** · C3

A 27-year-old woman at 9 weeks had heavy bleeding and passed tissue at home yesterday. Bleeding has now settled. A scan done 2 weeks ago showed an intrauterine pregnancy. Today's transvaginal scan shows an empty uterus with endometrial thickness of 8 mm.

What is the most appropriate management?

A. Laparoscopy
B. Methotrexate
C. Misoprostol
D. Surgical evacuation
E. Urine pregnancy test after 3 weeks

Answer: E. Urine pregnancy test after 3 weeks

With a previously confirmed intrauterine pregnancy and now an empty uterus, this is a complete miscarriage. No treatment is needed. A urine pregnancy test after 3 weeks confirms resolution.

Why not the others

- **A:** Laparoscopy is not needed because the pregnancy was previously seen in the uterus.
- **B:** Methotrexate is for ectopic pregnancy.
- **C:** Misoprostol is not needed for an empty uterus.
- **D:** Surgery is not needed.

Key point: Without a previous scan showing an intrauterine pregnancy, an empty uterus is a pregnancy of unknown location, not a complete miscarriage.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 279 · Miscarriage · **Moderate** · C3

A 30-year-old woman has a confirmed incomplete miscarriage at 10 weeks with 30 mm of retained tissue. She is stable, not bleeding heavily, and wants surgical management but would prefer to avoid a general anaesthetic.

Which procedure is most appropriate?

A. Dilatation and sharp curettage under general anaesthesia
B. Hysterectomy
C. Hysteroscopic resection
D. Laparoscopy
E. Manual vacuum aspiration under local anaesthetic

Answer: E. Manual vacuum aspiration under local anaesthetic

Manual vacuum aspiration under local anaesthetic is safe, effective and acceptable for women choosing surgical management of miscarriage in the first trimester, avoiding a general anaesthetic.

Why not the others

- **A:** Sharp curettage is no longer recommended; suction is preferred.
- **B:** Hysterectomy is never indicated.
- **C:** Hysteroscopy is used for persistent retained tissue, not routinely.
- **D:** Laparoscopy does not remove intrauterine tissue.

Key point: Suction evacuation is safer than sharp curettage, with less risk of Asherman syndrome.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 280 · Miscarriage · **Hard** · C2

A 26-year-old woman at 8 weeks has painless spotting. Ultrasound shows a live intrauterine pregnancy with a crescent-shaped hypoechoic collection between the chorion and the uterine wall, about one-fifth of the size of the sac.

What is this finding?

A. Anembryonic pregnancy
B. Ectopic pregnancy
C. Hydatidiform mole
D. Subchorionic haematoma
E. Twin pregnancy

Answer: D. Subchorionic haematoma

A subchorionic haematoma is a collection of blood between the chorion and uterine wall. Small haematomas are common and usually resolve. Large ones slightly increase the risk of miscarriage.

Why not the others

- **A:** There is a live embryo.
- **B:** The pregnancy is intrauterine.
- **C:** A mole has a snowstorm appearance.
- **E:** A second sac would contain a yolk sac or embryo.

Key point: Reassure: most small subchorionic haematomas do not affect outcome.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 281 · Recurrent Miscarriage · **Hard** · C3

A 32-year-old woman has had four miscarriages. Karyotyping of the products from the last miscarriage shows an unbalanced translocation.

What is the most appropriate next investigation?

A. Endometrial biopsy
B. Hysterosalpingography
C. Natural killer cell assay
D. Parental peripheral blood karyotyping
E. Repeat antiphospholipid antibodies

Answer: D. Parental peripheral blood karyotyping

An unbalanced structural chromosome abnormality in pregnancy tissue suggests one parent may carry a balanced translocation. Both parents should be karyotyped, and carriers referred for genetic counselling.

Why not the others

- **A:** Endometrial biopsy does not assess chromosomes.
- **B:** HSG assesses the tubes, not chromosomes.
- **C:** NK cell testing is not recommended.
- **E:** Antiphospholipid testing is part of the work-up but does not explain a translocation.

Key point: Carriers of balanced translocations have a good chance of a healthy pregnancy with or without preimplantation genetic testing.

Reference: Gynaecology by Ten Teachers — Recurrent miscarriage

MCQ 282 · Hyperemesis Gravidarum · **Easy** · C2

A 24-year-old primigravida at 9 weeks has vomited more than 10 times a day for a week and cannot keep down fluids. She has lost 6% of her pre-pregnancy weight. Urine shows 3+ ketones.

What is the most likely diagnosis?

A. Gastroenteritis
B. Hyperemesis gravidarum
C. Migraine
D. Peptic ulcer
E. Urinary tract infection

Answer: B. Hyperemesis gravidarum

Hyperemesis gravidarum is severe nausea and vomiting in pregnancy with weight loss over 5%, dehydration and electrolyte imbalance. It usually starts before 16 weeks.

Why not the others

- **A:** Gastroenteritis usually has diarrhoea and a short course.
- **C:** Migraine causes headache with vomiting.
- **D:** Peptic ulcer causes epigastric pain.
- **E:** UTI can cause vomiting but needs urinary symptoms; it should be excluded.

Key point: Exclude UTI, molar and multiple pregnancy in hyperemesis.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 283 · Hyperemesis Gravidarum · **Moderate** · C3

A 28-year-old woman at 10 weeks with hyperemesis gravidarum is admitted for IV fluids. She has been vomiting for 3 weeks. The team plans to give dextrose-containing fluids.

What must be given before or with dextrose to prevent a serious complication?

A. Folic acid
B. Iron
C. Potassium-free fluids only
D. Thiamine
E. Vitamin K

Answer: D. Thiamine

Prolonged vomiting depletes thiamine. Giving dextrose without thiamine can precipitate Wernicke's encephalopathy (confusion, ataxia, eye signs). Thiamine is given to all women with prolonged vomiting, and normal saline with potassium is preferred for rehydration.

Why not the others

- **A:** Folic acid is important but does not prevent Wernicke's.
- **B:** Iron does not prevent Wernicke's.
- **C:** Potassium is often needed, not avoided.
- **E:** Vitamin K is not relevant.

Key point: Use normal saline with potassium; avoid dextrose-only fluids.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 284 · Hyperemesis Gravidarum · **Moderate** · C3

A 26-year-old woman at 8 weeks has severe nausea and vomiting. She is mildly dehydrated. She has not responded to dietary advice.

Which first-line antiemetic is appropriate?

A. Cyclizine
B. Domperidone for 6 months
C. High-dose corticosteroids
D. Isotretinoin
E. Sodium valproate

Answer: A. Cyclizine

First-line antiemetics in pregnancy include cyclizine, promethazine, prochlorperazine and the doxylamine-pyridoxine combination. Ondansetron and metoclopramide are second line. Steroids are reserved for severe resistant cases.

Why not the others

- **B:** Domperidone is not first line and long courses are avoided.
- **C:** Steroids are a last resort for resistant cases.
- **D:** Isotretinoin is highly teratogenic.
- **E:** Valproate is teratogenic and not an antiemetic.

Key point: Give thromboprophylaxis to women admitted with hyperemesis.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 285 · Hyperemesis Gravidarum · **Hard** · C2

A 25-year-old woman at 10 weeks with severe hyperemesis has a TSH below 0.01 mU/L and a mildly raised free T4. She has no goitre, no eye signs and no history of thyroid disease. Thyroid antibodies are negative.

What is the most likely explanation?

A. Gestational transient thyrotoxicosis
B. Graves' disease
C. Hashimoto's thyroiditis
D. Thyroid storm
E. Toxic multinodular goitre

Answer: A. Gestational transient thyrotoxicosis

hCG is structurally similar to TSH and stimulates the thyroid. In hyperemesis (and molar or twin pregnancy) high hCG causes transient biochemical thyrotoxicosis. It settles as hCG falls and usually needs no antithyroid drugs.

Why not the others

- **B:** Graves' disease has antibodies, goitre or eye signs.
- **C:** Hashimoto's usually causes hypothyroidism.
- **D:** Thyroid storm is life-threatening with fever and tachycardia.
- **E:** There is no goitre.

Key point: Do not start antithyroid drugs for gestational transient thyrotoxicosis.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 286 · Gestational Trophoblastic Disease · **Moderate** · C2

A 30-year-old woman has suction evacuation for a suspected molar pregnancy. Histology shows a partial hydatidiform mole with some fetal tissue.

What is the usual karyotype of a partial mole?

A. 45,X
B. 46,XX of paternal origin
C. 46,XY of maternal origin
D. 69,XXY (triploid)
E. 92,XXXX

Answer: D. 69,XXY (triploid)

A partial mole is usually triploid (69,XXY or 69,XXX), with one maternal and two paternal sets of chromosomes, from fertilisation of one egg by two sperm. Fetal parts may be present.

Why not the others

- **A:** 45,X is Turner syndrome.
- **B:** 46,XX paternal is a complete mole.
- **C:** A mole is not of maternal origin only.
- **E:** Tetraploidy is not typical.

Key point: Partial moles have a lower risk of persistent disease (0.5–1%) than complete moles (about 15%).

Reference: Gynaecology by Ten Teachers — Gestational trophoblastic disease

MCQ 287 · Gestational Trophoblastic Disease · **Moderate** · C3

A 23-year-old woman has a suction evacuation for a complete hydatidiform mole. Histology confirms the diagnosis.

What is the most important follow-up?

A. CT chest every 3 months
B. Hysterectomy
C. Registration with a trophoblastic centre and serial hCG monitoring
D. Repeat evacuation after 2 weeks
E. Routine follow-up is not needed

Answer: C. Registration with a trophoblastic centre and serial hCG monitoring

All women with molar pregnancy should be registered with a specialist centre for serial hCG monitoring in blood or urine until normal and for a period after, to detect persistent gestational trophoblastic neoplasia early.

Why not the others

- **A:** CT is not routine.
- **B:** Hysterectomy is not needed after evacuation in a young woman.
- **D:** Repeat evacuation is not routine.
- **E:** Follow-up is essential.

Key point: Persistent or rising hCG after a mole = gestational trophoblastic neoplasia.

Reference: Gynaecology by Ten Teachers — Gestational trophoblastic disease

MCQ 288 · Gestational Trophoblastic Disease · **Hard** · C3

A 25-year-old woman had a complete mole evacuated 8 weeks ago. Her hCG has plateaued over three weekly samples at about 2,500 IU/L. Chest X-ray is normal and she is well. Her FIGO risk score is low.

What is the most appropriate treatment?

A. Combination chemotherapy (EMA-CO)
B. Hysterectomy
C. Radiotherapy
D. Repeat suction evacuation every week
E. Single-agent methotrexate

Answer: E. Single-agent methotrexate

A plateau or rise in hCG after a mole indicates gestational trophoblastic neoplasia. Low-risk disease (FIGO score 0–6) is treated with single-agent methotrexate (with folinic acid), with cure rates close to 100%.

Why not the others

- **A:** EMA-CO is for high-risk disease.
- **B:** Hysterectomy is not first line in a young woman.
- **C:** Radiotherapy is not used.
- **D:** Repeated evacuation does not treat persistent disease.

Key point: GTN is one of the most curable cancers.

Reference: Gynaecology by Ten Teachers — Gestational trophoblastic disease

MCQ 289 · Gestational Trophoblastic Disease · **Hard** · C2

A 32-year-old woman delivered a healthy baby 4 months ago. She now has haemoptysis and irregular vaginal bleeding. Serum hCG is 85,000 IU/L. Chest X-ray shows multiple rounded opacities.

What is the most likely diagnosis?

A. Choriocarcinoma
B. Complete mole
C. Placental site trophoblastic tumour
D. Retained placenta
E. Tuberculosis

Answer: A. Choriocarcinoma

Choriocarcinoma can follow any pregnancy, including a normal term delivery. It spreads early by blood, commonly to the lungs, causing haemoptysis. Very high hCG confirms trophoblastic disease. It is highly chemosensitive.

Why not the others

- **B:** A complete mole occurs in early pregnancy, not after a term birth.
- **C:** PSTT has low hCG and spreads less often to the lungs.
- **D:** Retained placenta does not cause lung lesions or such high hCG.
- **E:** TB does not raise hCG.

Key point: Check hCG in any woman of reproductive age with unexplained lung lesions or bleeding.

Reference: Gynaecology by Ten Teachers — Gestational trophoblastic disease

MCQ 290 · Gestational Trophoblastic Disease · **Moderate** · C3

A 26-year-old woman had a complete mole 3 months ago. Her hCG became normal within 6 weeks. She asks about contraception and when she can try to conceive again.

What is the most appropriate advice?

A. A copper IUD should be inserted immediately after evacuation while hCG is raised

B. Combined pill can be used once hCG is normal; wait until follow-up is complete before conceiving

C. She can conceive immediately

D. She can never have another pregnancy

E. Use no contraception and repeat hCG only if pregnant

Answer: B. Combined pill can be used once hCG is normal; wait until follow-up is complete before conceiving

Hormonal contraception including the combined pill is safe once hCG is normal. She should avoid pregnancy until hCG follow-up is complete (usually 6 months after normalisation for complete mole, or as advised by the centre), so that a rise can be interpreted.

Why not the others

- **A:** IUDs should not be inserted until hCG is normal because of the risk of perforation if there is persistent disease.
- **C:** A new pregnancy would make hCG monitoring impossible.
- **D:** Future pregnancy is possible and usually normal.
- **E:** Contraception is advised during follow-up.

Key point: Recurrence risk of molar pregnancy is about 1 in 80; scan early in the next pregnancy.

Reference: Gynaecology by Ten Teachers — Gestational trophoblastic disease

MCQ 291 · Gestational Trophoblastic Disease · **Moderate** · C2

A 19-year-old woman at 12 weeks has a complete hydatidiform mole. She has tremor, tachycardia and heat intolerance. Free T4 is raised.

What causes her thyrotoxic symptoms?

A. Autoimmune antibodies

B. hCG stimulating TSH receptors

C. Iodine deficiency

D. Pituitary tumour

E. Thyroid nodule

Answer: B. hCG stimulating TSH receptors

The very high hCG in molar pregnancy stimulates TSH receptors because of the shared alpha subunit and similar structure, causing thyrotoxicosis. It resolves after evacuation; beta-blockers may be needed meanwhile.

Why not the others

- **A:** There are no antibodies.
- **C:** Iodine deficiency causes hypothyroidism.
- **D:** A pituitary tumour is unlikely.
- **E:** A nodule is unlikely to explain this.

Key point: Control thyrotoxicosis before anaesthesia for evacuation.

Reference: Gynaecology by Ten Teachers — Gestational trophoblastic disease

MCQ 292 · Ectopic Pregnancy · **Moderate** · C3

A 29-year-old woman has a laparoscopic salpingotomy (tube conserved) for an ectopic pregnancy because her other tube was removed for a previous ectopic.

What follow-up is required after salpingotomy?

A. CT scan at 6 weeks
B. Hysterosalpingography in 1 week
C. No follow-up
D. Repeat laparoscopy in 6 weeks
E. Serial serum hCG until negative

Answer: E. Serial serum hCG until negative

After salpingotomy some trophoblast may remain in the tube (persistent trophoblast in about 4–8%). Serial hCG is measured until negative; methotrexate or salpingectomy is needed if it persists.

Why not the others

- **A:** CT has no role.
- **B:** HSG soon after surgery is not indicated.
- **C:** Follow-up is needed.
- **D:** Repeat laparoscopy is not routine.

Key point: Salpingectomy does not need hCG follow-up beyond a urine test at 3 weeks.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 293 · Ectopic Pregnancy · **Moderate** · C3

A 27-year-old woman has a small tubal ectopic of 15 mm with no heartbeat. She is pain-free and stable. hCG is 650 IU/L and falling on repeat. She can attend follow-up.

What is the most appropriate management?

A. Expectant management with hCG monitoring
B. Immediate laparotomy
C. Laparoscopic salpingectomy
D. Methotrexate in two doses
E. Mifepristone

Answer: A. Expectant management with hCG monitoring

Women who are clinically stable and pain-free with a small tubal ectopic, no heartbeat and hCG of 1,000 IU/L or less (or falling) can be offered expectant management, with hCG checked until negative. Most resolve.

Why not the others

- **B:** Laparotomy is unnecessary.
- **C:** Surgery is not needed for a resolving ectopic.
- **D:** Methotrexate adds side effects unnecessarily.
- **E:** Mifepristone is not used for ectopic.

Key point: She must return immediately if pain develops.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; NICE NG126

MCQ 294 · Ectopic Pregnancy · **Hard** · C3

A 30-year-old woman with an unruptured tubal ectopic is offered methotrexate. Her blood tests show ALT 340 U/L and creatinine 210 µmol/L. She is stable.

What is the most appropriate management?

A. Expectant management regardless of hCG
B. Give methotrexate at half dose
C. Give methotrexate with folinic acid
D. Laparoscopic salpingectomy
E. Mifepristone and misoprostol

Answer: D. Laparoscopic salpingectomy

Methotrexate is contraindicated with significant liver or kidney impairment, because it is cleared by the kidney and is toxic to the liver. Surgery is the appropriate treatment.

Why not the others

- **A:** Expectant management depends on hCG and symptoms, not a replacement for treatment.
- **B:** Reducing the dose is not safe practice here.
- **C:** Folinic acid does not make it safe with renal failure.
- **E:** These drugs do not treat ectopic pregnancy.

Key point: Check FBC, liver and kidney function before methotrexate.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 295 · Ectopic Pregnancy · **Hard** · C2

At laparoscopy for suspected ectopic pregnancy in a 32-year-old woman, both tubes are normal. A haemorrhagic mass is found within the right ovary. Histology confirms trophoblastic tissue within the ovarian cortex.

What type of ectopic pregnancy is this?

A. Abdominal pregnancy
B. Cervical pregnancy
C. Interstitial pregnancy
D. Ovarian pregnancy
E. Tubal ampullary pregnancy

Answer: D. Ovarian pregnancy

An ovarian pregnancy implants in the ovary. Spiegelberg's criteria require an intact tube on that side, the sac in the position of the ovary, connection to the uterus by the ovarian ligament and ovarian tissue in the sac wall.

Why not the others

- **A:** An abdominal pregnancy implants on the peritoneum or bowel.
- **B:** A cervical pregnancy is in the cervix.
- **C:** Interstitial pregnancy is in the cornual part of the tube.
- **E:** The tubes are normal.

Key point: Ovarian pregnancies are rare (about 1–3% of ectopics) and often mistaken for a haemorrhagic cyst.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 296 · Ectopic Pregnancy · **Easy** · C2

A 31-year-old woman with a positive pregnancy test has mild left iliac fossa pain. She is stable. Serum hCG is 2,400 IU/L. The early pregnancy unit plans a transvaginal scan.

Above what serum hCG level should an intrauterine pregnancy usually be seen on transvaginal scan?

A. 100 IU/L
B. 1,500–2,000 IU/L
C. 10,000 IU/L
D. 25,000 IU/L
E. 50,000 IU/L

Answer: B. 1,500–2,000 IU/L

The discriminatory zone for transvaginal ultrasound is about 1,500–2,000 IU/L (some units use up to 3,500). Above this, an empty uterus raises strong suspicion of ectopic pregnancy, although twins and early miscarriage can confuse it.

Why not the others

- **A:** At 100 IU/L nothing would be seen.
- **C:** 10,000 IU/L is far above the discriminatory zone.
- **D:** 25,000 IU/L is far above it.
- **E:** 50,000 IU/L is far above it.

Key point: Do not rely on hCG alone; use the scan and clinical picture.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 297 · Miscarriage · **Easy** · C2

A 41-year-old woman who has just become pregnant asks about her chance of miscarriage compared with a younger woman.

How does maternal age affect the risk of miscarriage?

A. Risk falls with age
B. Risk is highest under 20 and does not change after
C. Risk is not related to age
D. Risk rises only after 50
E. Risk rises with age, to about 40% or more at age 40–44

Answer: E. Risk rises with age, to about 40% or more at age 40–44

Miscarriage risk rises with maternal age, mainly because of more chromosomal abnormalities in eggs. It is about 10–15% in women in their 20s and about 40% or more at 40–44.

Why not the others

- **A:** Risk does not fall with age.
- **B:** Teenagers have only a slightly raised risk.
- **C:** Age is a strong risk factor.
- **D:** Risk is already high well before 50.

Key point: Paternal age over 45 also slightly increases miscarriage risk.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

MCQ 298 · Miscarriage · **Hard** · C3

A 34-year-old woman with type 1 diabetes and poor glucose control (HbA1c 9.8%) asks how to reduce her risk of miscarriage in her next pregnancy.

What is the most important advice?

A. Avoid all exercise
B. Bed rest in the first trimester
C. Improve glucose control before conception with high-dose folic acid
D. Start progesterone before conception
E. Stop insulin while trying to conceive

Answer: C. Improve glucose control before conception with high-dose folic acid

Poor glucose control around conception increases the risk of miscarriage and congenital anomalies. Pre-pregnancy care aims for HbA1c under 48 mmol/mol (6.5%) and 5 mg folic acid daily.

Why not the others

- **A:** Exercise is beneficial.
- **B:** Bed rest has no benefit.
- **D:** Progesterone has no benefit here.
- **E:** Stopping insulin would be dangerous.

Key point: Good pre-pregnancy control in diabetes reduces both miscarriage and anomalies.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems; Medical disorders in pregnancy

MCQ 299 · Gestational Trophoblastic Disease · **Easy** · C2

A 45-year-old woman (para 5) has vaginal bleeding at 10 weeks of pregnancy. hCG is very high and ultrasound suggests a molar pregnancy.

Which factor most increases the risk of a molar pregnancy?

A. Maternal age over 40
B. Previous caesarean section
C. Previous normal pregnancy
D. Smoking
E. Use of the combined pill

Answer: A. Maternal age over 40

Extremes of maternal age (under 20 and especially over 40) and a previous molar pregnancy are the main risk factors. Asian ethnicity is also associated with a higher incidence.

Why not the others

- **B:** Caesarean section is not linked.
- **C:** A previous normal pregnancy is not a risk factor.
- **D:** Smoking is not a clear risk factor.
- **E:** The pill is not a recognised risk factor.

Key point: Women over 40 with a mole sometimes choose hysterectomy because of the higher risk of persistent disease.

Reference: Gynaecology by Ten Teachers — Gestational trophoblastic disease

MCQ 300 · Ectopic Pregnancy · **Moderate** · C2

A 26-year-old woman is diagnosed with a tubal ectopic pregnancy. Before methotrexate is given, the doctor checks the scan carefully.

Which finding is an absolute contraindication to methotrexate?

A. A coexisting viable intrauterine pregnancy

B. Ectopic mass of 20 mm

C. hCG of 900 IU/L

D. Mild pain

E. Previous caesarean section

Answer: A. A coexisting viable intrauterine pregnancy

Methotrexate would harm a coexisting intrauterine pregnancy (heterotopic pregnancy). Other contraindications include haemodynamic instability, breastfeeding, significant liver or kidney disease and inability to attend follow-up.

Why not the others

- **B:** A 20 mm mass is suitable for methotrexate.
- **C:** An hCG of 900 is suitable.
- **D:** Mild pain does not exclude methotrexate; significant pain does.
- **E:** A previous caesarean is not a contraindication.

Key point: Always exclude an intrauterine pregnancy before giving methotrexate.

Reference: Gynaecology by Ten Teachers — Early pregnancy problems

CHAPTER 7

Subfertility

MCQ 301 · Tubal Factor · **Hard** · C3

A 29-year-old woman and her husband have been trying to conceive for 2 years. She has regular 28-day cycles and her day-21 progesterone is 38 nmol/L. Her husband's semen analysis is normal. Three years ago she was admitted with pelvic inflammatory disease and a tubo-ovarian abscess was drained.

What is the most appropriate investigation of tubal patency?

A. Hysterosalpingo-contrast sonography (HyCoSy)
B. Hysterosalpingography
C. Laparoscopy and dye test
D. MRI of the pelvis
E. Serum anti-Müllerian hormone

Answer: C. Laparoscopy and dye test

She ovulates and her husband's semen is normal, so the tubes are next. Women with known comorbidities such as previous PID, ectopic pregnancy or endometriosis should be offered laparoscopy and dye, because it also assesses pelvic adhesions and allows treatment at the same time.

Why not the others

- **A:** HyCoSy is a screening test for women with no known comorbidity.
- **B:** HSG is the screening test for women without known comorbidity; she has a history of tubo-ovarian abscess.
- **D:** MRI does not assess tubal patency.
- **E:** AMH measures ovarian reserve, not the tubes.

Key point: No comorbidity → HSG or HyCoSy. Known PID, endometriosis or previous ectopic → laparoscopy and dye.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 302 · Definition and Causes · **Easy** · C2

A couple, both aged 28, have been having regular unprotected intercourse for 8 months without pregnancy. They are both healthy and anxious.

When is subfertility usually defined and investigated in a woman of this age?

A. After 3 months
B. After 6 months
C. After 12 months of regular unprotected intercourse
D. After 3 years
E. Only after age 35

Answer: C. After 12 months of regular unprotected intercourse

Subfertility is failure to conceive after 1 year of regular unprotected intercourse (every 2–3 days). About 84% of couples conceive within a year and 92% within 2 years.

Why not the others

- **A:** Three months is too early; many normal couples have not yet conceived.
- **B:** Six months is the threshold for women aged 36 or over, not at 28.
- **D:** Three years is too long to wait.
- **E:** Age 35 is not the threshold for investigation.

Key point: Refer earlier if the woman is 36 or older or there is a known cause.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 303 · Definition and Causes · **Easy** · C2

A fertility clinic reviews the causes found in couples attending over a year.

What is the approximate contribution of male factor to subfertility?

A. 5%
B. 10%
C. About 30% (sole cause), contributing in up to half
D. 70%
E. 90%

Answer: C. About 30% (sole cause), contributing in up to half

Male factor is the only cause in about 30% of couples and contributes in up to half. Ovulatory disorders account for about 25%, tubal disease 20% and unexplained subfertility about 25%.

Why not the others

- **A:** Five percent is far too low.
- **B:** Ten percent underestimates male factor.
- **D:** Seventy percent is too high.
- **E:** Ninety percent is far too high.

Key point: Always investigate both partners from the start.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 304 · General Advice · **Easy** · C3

A 30-year-old woman and her husband are trying to conceive. She has been timing intercourse with ovulation kits each month and finds it stressful.

What is the recommended advice about intercourse?

A. Avoid intercourse until the LH kit is positive

B. Daily temperature charting

C. Have intercourse only on day 14

D. Intercourse once a month at ovulation

E. Regular intercourse every 2–3 days throughout the cycle

Answer: E. Regular intercourse every 2–3 days throughout the cycle

Intercourse every 2–3 days maximises the chance of pregnancy without the stress of timing. Ovulation kits and temperature charts are not recommended because they add stress without improving outcomes.

Why not the others

- **A:** Abstaining can reduce chances.
- **B:** Temperature charts are unreliable for predicting ovulation.
- **C:** Ovulation day varies between cycles.
- **D:** Once a month is too infrequent.

Key point: Also advise folic acid 400 micrograms daily, healthy BMI, stopping smoking and limiting alcohol.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 305 · General Advice · **Moderate** · C3

A 32-year-old woman is planning pregnancy. Her BMI is 33 kg/m², she smokes, and she drinks alcohol socially. She has no medical problems and her cycles are regular.

Which pre-conception advice is most appropriate?

A. Continue smoking but reduce alcohol

B. Folic acid is needed only after a positive test

C. Lose weight, stop smoking, avoid alcohol and take folic acid 400 micrograms daily

D. Start clomiphene now

E. Weight loss is only needed if BMI is over 45

Answer: C. Lose weight, stop smoking, avoid alcohol and take folic acid 400 micrograms daily

A BMI over 30, smoking and alcohol reduce fertility and increase pregnancy risks. Folic acid 400 micrograms daily before conception and for the first 12 weeks reduces neural tube defects (5 mg if BMI ≥30 in some guidance).

Why not the others

- **A:** Smoking reduces fertility and harms pregnancy.
- **B:** Folic acid must start before conception.
- **D:** She ovulates regularly and has not tried for a year.
- **E:** Weight loss helps at a BMI over 30.

Key point: Check rubella immunity and cervical screening status before conception.

Reference: Gynaecology by Ten Teachers — Subfertility; Pre-pregnancy care

MCQ 306 · Semen Analysis · **Moderate** · C2

A 33-year-old man has a semen analysis after 2 years of subfertility. Volume is 2.5 mL, concentration 25 million/mL, progressive motility 35% and normal forms 6%.

How should this result be interpreted?

A. Asthenozoospermia
B. Azoospermia
C. Normal semen analysis
D. Oligozoospermia
E. Teratozoospermia

Answer: C. Normal semen analysis

WHO lower reference limits are approximately: volume 1.4 mL, concentration 16 million/mL, progressive motility 30% and normal forms 4%. All his values are above these limits, so the analysis is normal.

Why not the others

- **A:** Asthenozoospermia means low motility; his motility is normal.
- **B:** Azoospermia means no sperm.
- **D:** Oligozoospermia means low concentration.
- **E:** Teratozoospermia means low normal forms.

Key point: Repeat an abnormal semen analysis after about 3 months (one spermatogenic cycle).

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 307 · Semen Analysis · **Moderate** · C3

A 35-year-old man's first semen analysis shows a concentration of 9 million/mL with low motility. He has no symptoms. He had a fever 6 weeks ago.

What is the most appropriate next step?

A. Immediate ICSI
B. Karyotype
C. Refer for testicular biopsy
D. Repeat semen analysis in about 3 months
E. Start testosterone

Answer: D. Repeat semen analysis in about 3 months

Sperm production takes about 74 days, so illness or fever can lower counts for up to 3 months. An abnormal result should be repeated after 3 months before further action, or sooner if azoospermic or severely abnormal.

Why not the others

- **A:** Treatment decisions should not be based on a single abnormal sample.
- **B:** Karyotype is for severe oligozoospermia or azoospermia.
- **C:** Biopsy is for azoospermia.
- **E:** Testosterone suppresses sperm production.

Key point: Never give testosterone to a man trying to father a child.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 308 · Male Factor · **Hard** · C2

A 30-year-old man has azoospermia on two semen samples. He is tall with small firm testes (4 mL each) and gynaecomastia. FSH and LH are high and testosterone is low.

What is the most likely diagnosis?

A. Congenital bilateral absence of the vas deferens
B. Kallmann syndrome
C. Klinefelter syndrome
D. Retrograde ejaculation
E. Varicocele

Answer: C. Klinefelter syndrome

Klinefelter syndrome (47,XXY) is the commonest chromosomal cause of azoospermia. Small firm testes, tall stature, gynaecomastia and high gonadotrophins with low testosterone are typical. Sperm can sometimes be retrieved surgically (micro-TESE) for ICSI.

Why not the others

- **A:** CBAVD has normal testes, normal FSH and low semen volume.
- **B:** Kallmann syndrome has low FSH and LH.
- **D:** Retrograde ejaculation has sperm in post-ejaculatory urine.
- **E:** A varicocele does not cause small firm testes and high FSH.

Key point: Azoospermia with high FSH = testicular failure; normal FSH = consider obstruction.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 309 · Male Factor · **Hard** · C3

A 29-year-old man has azoospermia with low semen volume (0.6 mL) and acidic pH. Testes are normal in size and FSH is normal. On examination neither vas deferens can be felt.

Which test is most important before treatment?

A. Brain MRI
B. Cystic fibrosis (CFTR) gene testing for both partners
C. Repeat semen analysis in 1 year
D. Serum prolactin
E. Testicular ultrasound only

Answer: B. Cystic fibrosis (CFTR) gene testing for both partners

Congenital bilateral absence of the vas deferens is strongly linked with CFTR mutations. Sperm can be retrieved surgically for ICSI, but both partners should be tested and counselled because the child could inherit cystic fibrosis.

Why not the others

- **A:** MRI is for low gonadotrophins.
- **C:** Repeating in a year is pointless; the problem is structural.
- **D:** Prolactin does not explain the findings.
- **E:** Ultrasound may help but does not address the genetic risk.

Key point: Absent vas on examination → test CFTR.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 310 · Male Factor · **Moderate** · C2

A 45-year-old man with type 1 diabetes for 25 years has a very low semen volume with almost no sperm. He reports orgasm with little fluid. Examination is normal.

Which test will confirm the most likely cause?

A. Karyotype
B. Post-ejaculatory urine for sperm
C. Scrotal ultrasound
D. Serum FSH
E. Testicular biopsy

Answer: B. Post-ejaculatory urine for sperm

Diabetic autonomic neuropathy (or prostate surgery or alpha-blockers) can cause retrograde ejaculation, where semen passes into the bladder. Finding sperm in post-ejaculatory urine confirms it. Sperm can be recovered from alkalinised urine for assisted conception.

Why not the others

- **A:** Karyotype is for testicular failure.
- **C:** Scrotal ultrasound does not show retrograde ejaculation.
- **D:** FSH does not confirm the diagnosis.
- **E:** Biopsy is not needed.

Key point: Low volume + diabetes or alpha-blocker → think retrograde ejaculation.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 311 · Male Factor · **Moderate** · C3

A 27-year-old bodybuilder has azoospermia. He has been injecting testosterone and anabolic steroids for 2 years. FSH and LH are very low. Testes are small.

What is the most appropriate first step?

A. Bilateral orchidectomy
B. Immediate ICSI with donor sperm
C. Start clomiphene at once
D. Stop anabolic steroids and repeat semen analysis after several months
E. Varicocele repair

Answer: D. Stop anabolic steroids and repeat semen analysis after several months

Exogenous androgens suppress LH and FSH, stopping sperm production. Stopping them usually allows recovery, although this can take 6–12 months or longer. Specialist treatment can help recovery if needed.

Why not the others

- **A:** Orchidectomy is never indicated.
- **B:** Donor sperm is premature; recovery is likely.
- **C:** Drugs may be used later by a specialist, but stopping steroids comes first.
- **E:** There is no varicocele.

Key point: Ask every subfertile man about testosterone and anabolic steroid use.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 312 · Male Factor · **Hard** · C2

A 31-year-old man has had azoospermia since mumps orchitis affecting both testes at age 16. FSH is high and testes are small.

Which treatment gives the best chance of a pregnancy with his own sperm?

A. Clomiphene
B. Intrauterine insemination
C. Microsurgical testicular sperm extraction with ICSI
D. Testosterone injections
E. Varicocele repair

Answer: C. Microsurgical testicular sperm extraction with ICSI

Even with testicular failure, small foci of sperm production may exist. Micro-TESE can retrieve sperm in some men, which are then used for ICSI. If none are found, donor sperm is an option.

Why not the others

- **A:** Clomiphene does not help established testicular failure.
- **B:** IUI needs sperm in the ejaculate.
- **D:** Testosterone further suppresses sperm production.
- **E:** There is no varicocele.

Key point: Mumps orchitis after puberty can cause testicular atrophy and subfertility.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 313 · Male Factor · **Moderate** · C2

A 24-year-old unmarried man is about to start chemotherapy for testicular cancer. He wants children in the future.

What is the most appropriate fertility preservation?

A. Gonadotrophin injections during chemotherapy
B. No action is needed
C. Sperm cryopreservation before chemotherapy
D. Testicular biopsy after chemotherapy
E. Testosterone during chemotherapy

Answer: C. Sperm cryopreservation before chemotherapy

Chemotherapy and radiotherapy can permanently damage sperm production. Freezing semen samples before treatment is simple and effective and should be offered to all men before gonadotoxic therapy.

Why not the others

- **A:** Gonadotrophins do not protect against chemotherapy damage.
- **B:** Action is needed before damage occurs.
- **D:** Biopsy afterwards may find no sperm.
- **E:** Testosterone does not protect fertility.

Key point: Sperm banking should be discussed before any gonadotoxic treatment.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 314 · Ovarian Reserve · **Moderate** · C2

A 38-year-old woman has been trying to conceive for 8 months. She wants to know how many eggs she has left before deciding on IVF.

Which test best predicts ovarian response to IVF stimulation?

A. Day 21 progesterone
B. Endometrial thickness
C. Prolactin
D. Serum anti-Müllerian hormone or antral follicle count
E. Thyroid function

Answer: D. Serum anti-Müllerian hormone or antral follicle count

AMH and the antral follicle count on ultrasound are the best predictors of how many eggs will be collected in IVF. They reflect ovarian reserve but do not predict natural conception well.

Why not the others

- **A:** Day 21 progesterone confirms ovulation, not reserve.
- **B:** Endometrial thickness does not reflect reserve.
- **C:** Prolactin does not measure reserve.
- **E:** Thyroid function does not measure reserve.

Key point: Low AMH does not mean she cannot conceive naturally; it predicts IVF response.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 315 · Female Age · **Easy** · C2

A 42-year-old woman is about to start IVF with her own eggs. She asks what affects her chance of success most.

Which factor has the greatest effect on IVF success?

A. Cause of subfertility
B. Day of the week of egg collection
C. Female age
D. Male partner's height
E. Number of previous normal periods

Answer: C. Female age

Female age is the most important factor affecting IVF success, because egg quality and number fall with age. Live birth rates fall sharply after 40.

Why not the others

- **A:** The cause matters less than age.
- **B:** The day of collection is irrelevant.
- **D:** Male height has no effect.
- **E:** The number of previous periods is not a recognised factor.

Key point: Egg donation removes much of the age effect.

Reference: Gynaecology by Ten Teachers — Subfertility; Assisted conception

MCQ 316 · Tubal Factor · **Easy** · C3

A 30-year-old woman with no history of pelvic infection, endometriosis or surgery has been trying to conceive for 18 months. She ovulates and her husband's semen is normal.

What is the most appropriate test of tubal patency?

A. CT scan
B. Diagnostic laparoscopy and dye
C. Hysterosalpingography
D. MRI pelvis
E. Serum chlamydia antibodies alone

Answer: C. Hysterosalpingography

Women without known comorbidities should be offered hysterosalpingography (or HyCoSy) to screen for tubal occlusion. It is less invasive than laparoscopy.

Why not the others

- **A:** CT does not show tubal patency.
- **B:** Laparoscopy is for women with known comorbidities.
- **D:** MRI does not assess patency well.
- **E:** Chlamydia serology can suggest risk but does not show patency.

Key point: Screen for chlamydia before uterine instrumentation, or give prophylactic antibiotics.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 317 · Tubal Factor · **Moderate** · C3

A 33-year-old woman with a history of PID is about to start IVF. Ultrasound shows a 4 cm fluid-filled, sausage-shaped right adnexal structure consistent with a hydrosalpinx.

What is the most appropriate management before IVF?

A. Aspiration at egg collection only
B. Laparoscopic salpingectomy
C. Leave it alone
D. Long-term antibiotics
E. Salpingostomy to restore natural fertility

Answer: B. Laparoscopic salpingectomy

Hydrosalpinx fluid is toxic to embryos and can flow into the uterus, halving IVF success. Laparoscopic salpingectomy (or proximal tubal occlusion) before IVF improves pregnancy rates.

Why not the others

- **A:** Simple aspiration has a high recurrence and is less effective.
- **C:** Leaving it reduces IVF success.
- **D:** Antibiotics do not drain the tube.
- **E:** Salpingostomy has poor success with damaged tubes and delays IVF.

Key point: Hydrosalpinx visible on ultrasound halves the IVF live birth rate.

Reference: Gynaecology by Ten Teachers — Subfertility; Assisted conception

MCQ 318 · Tubal Factor · **Hard** · C2

A 28-year-old woman from a rural area has primary subfertility. She had night sweats and weight loss 3 years ago. HSG shows rigid, beaded tubes with multiple constrictions and a small, irregular uterine cavity.

What is the most likely cause?

A. Endometriosis
B. Genital tuberculosis
C. Gonorrhoea
D. Salpingitis isthmica nodosa alone
E. Septate uterus

Answer: B. Genital tuberculosis

Genital tuberculosis is a common cause of subfertility in countries such as Pakistan. It spreads by blood to the tubes and endometrium, giving beaded "lead-pipe" tubes and intrauterine adhesions. Diagnosis is by endometrial biopsy for culture, histology or PCR.

Why not the others

- **A:** Endometriosis does not cause beaded rigid tubes and cavity adhesions.
- **C:** Gonorrhoea usually causes distal blockage and hydrosalpinx.
- **D:** SIN causes nodular thickening of the isthmus, not adhesions in the cavity.
- **E:** A septate uterus has a septum, not adhesions.

Key point: Genital TB needs full antituberculous therapy; IVF is often needed afterwards.

Reference: Gynaecology by Ten Teachers — Subfertility; Pelvic infection

MCQ 319 · Tubal Factor · **Moderate** · C3

A 36-year-old woman had a laparoscopic tubal sterilisation (Filshie clips) 5 years ago. She has remarried and wants another child. Her AMH is normal and her husband's semen is normal.

What are her options?

A. Clomiphene alone
B. IUI
C. Nothing can be done
D. Removal of the uterus
E. Reversal of sterilisation or IVF

Answer: E. Reversal of sterilisation or IVF

Clip sterilisation causes limited tubal damage and can often be reversed with good results in younger women. IVF bypasses the tubes and is an alternative, particularly with increasing age or if reversal is not suitable.

Why not the others

- **A:** Clomiphene does not overcome blocked tubes.
- **B:** IUI needs open tubes.
- **C:** Pregnancy is possible.
- **D:** Removing the uterus is not a fertility treatment.

Key point: Reversal success depends on age, method of sterilisation and remaining tube length.

Reference: Gynaecology by Ten Teachers — Subfertility; Contraception

MCQ 320 · Unexplained Subfertility · **Moderate** · C3

A 34-year-old woman and her husband have been trying to conceive for 2 years. She ovulates, her tubes are patent and his semen analysis is normal. There is no endometriosis.

What is the recommended treatment?

A. Clomiphene citrate
B. Continue trying for another 5 years
C. In vitro fertilisation
D. Intrauterine insemination
E. Ovarian drilling

Answer: C. In vitro fertilisation

For unexplained subfertility after 2 years of trying (including up to 1 year before investigation), NICE recommends IVF. Clomiphene alone does not improve pregnancy rates in women who already ovulate, and IUI is not routinely recommended.

Why not the others

- **A:** Clomiphene does not help women who ovulate.
- **B:** Waiting further reduces success with age.
- **D:** IUI is not routinely recommended for unexplained subfertility.
- **E:** Drilling is for PCOS.

Key point: Unexplained subfertility affects about a quarter of couples.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 321 · Assisted Conception · **Moderate** · C2

A woman in a same-sex relationship wants to conceive using donor sperm. She ovulates regularly and her tubes are patent.

Which treatment is most appropriate first?

A. Clomiphene alone
B. Intracytoplasmic sperm injection
C. Intrauterine insemination with donor sperm
D. IVF with donor eggs
E. Ovarian drilling

Answer: C. Intrauterine insemination with donor sperm

IUI with donor sperm is appropriate for women with normal tubes and ovulation who need donor sperm. If several cycles fail, IVF is offered.

Why not the others

- **A:** Clomiphene does not provide sperm.
- **B:** ICSI is for severe male factor.
- **D:** She has her own eggs.
- **E:** Drilling is for PCOS.

Key point: Other IUI indications: sexual dysfunction, HIV-positive man (sperm washing).

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 322 · Assisted Conception · **Moderate** · C2

A couple are having IVF. The husband's sperm concentration is 0.5 million/mL with very poor motility.

Which laboratory technique is required?

A. Assisted hatching only
B. Conventional IVF insemination
C. Intracytoplasmic sperm injection (ICSI)
D. Intrauterine insemination
E. Preimplantation genetic testing only

Answer: C. Intracytoplasmic sperm injection (ICSI)

With severe male factor, ICSI injects a single sperm directly into each egg, overcoming poor count, motility and morphology.

Why not the others

- **A:** Assisted hatching helps implantation, not fertilisation.
- **B:** Conventional IVF needs many motile sperm.
- **D:** IUI will not work with such low counts.
- **E:** PGT checks embryos but does not achieve fertilisation.

Key point: ICSI is also used when surgically retrieved sperm are used.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 323 · Assisted Conception · **Easy** · C3

A 33-year-old woman is having her first IVF cycle. She has three good-quality blastocysts. She asks how many embryos to transfer.

What is the recommended approach?

A. Elective single embryo transfer
B. Transfer all three
C. Transfer none and freeze all always
D. Transfer three to improve success
E. Transfer two always

Answer: A. Elective single embryo transfer

Elective single embryo transfer of a good-quality embryo reduces multiple pregnancy, which carries risks of preterm birth and complications, with little reduction in cumulative live birth rate when the remaining embryos are frozen.

Why not the others

- **B:** Transferring three risks triplets.
- **C:** Freeze-all is used in specific situations such as OHSS risk.
- **D:** Three increases multiple pregnancy risk without much benefit.
- **E:** Double transfer is not routine for a young woman with good embryos.

Key point: Multiple pregnancy is the biggest health risk of IVF to children.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 324 · Assisted Conception · **Hard** · C3

A couple both carry a mutation for beta-thalassaemia major and have one affected child. They want a healthy child and are willing to have IVF.

Which technique allows them to avoid passing on the condition?

A. Egg donation only
B. ICSI alone
C. Intrauterine insemination
D. Preimplantation genetic testing for monogenic disease (PGT-M)
E. Prenatal diagnosis is never possible

Answer: D. Preimplantation genetic testing for monogenic disease (PGT-M)

PGT-M tests embryos created by IVF for the specific mutation, so that only unaffected embryos are transferred. Alternatively, natural conception with prenatal diagnosis (CVS) is possible.

Why not the others

- **A:** Egg donation would still risk carrier status and does not test embryos.
- **B:** ICSI does not test embryos.
- **C:** IUI does not test embryos.
- **E:** Prenatal diagnosis by CVS is possible.

Key point: Thalassaemia carrier screening is important in Pakistan.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 325 · Assisted Conception · **Moderate** · C2

A 45-year-old woman with very low AMH has had three failed IVF cycles with her own eggs, producing only one poor-quality embryo each time. Her uterus is normal.

Which option gives her the highest chance of pregnancy?

A. Another IVF cycle with her own eggs
B. Clomiphene
C. IUI
D. IVF with donor eggs
E. Ovarian drilling

Answer: D. IVF with donor eggs

Donor eggs from a younger woman give live birth rates related to the donor's age, much higher than with her own eggs at 45.

Why not the others

- **A:** Further cycles with her own eggs have a very low success rate.
- **B:** Clomiphene will not help.
- **C:** IUI will not help.
- **E:** Drilling is for PCOS.

Key point: Egg donation raises ethical and legal issues that vary between countries.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 326 · Ovulatory Disorders · **Moderate** · C2

A 26-year-old woman has amenorrhoea and subfertility. FSH and LH are low, oestradiol is low and prolactin is normal. Her BMI is 17 kg/m² after excessive dieting.

Which WHO group of ovulatory disorder is this?

A. WHO Group I (hypothalamic–pituitary failure)

B. WHO Group II (hypothalamic–pituitary dysfunction, such as PCOS)

C. WHO Group III (ovarian failure)

D. WHO Group IV (hyperprolactinaemia)

E. Not an ovulatory disorder

Answer: A. WHO Group I (hypothalamic–pituitary failure)

WHO Group I is hypogonadotrophic hypogonadism with low FSH, LH and oestrogen, as in low weight, excessive exercise and Kallmann syndrome. Treatment is weight gain, then pulsatile GnRH or gonadotrophins with LH activity.

Why not the others

- **B:** Group II has normal gonadotrophins and oestrogen, mainly PCOS.
- **C:** Group III has high FSH.
- **D:** Hyperprolactinaemia is classified separately and prolactin is normal.
- **E:** She is anovulatory.

Key point: Clomiphene does not work in Group I because the hypothalamus cannot respond.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 327 · Ovulatory Disorders · **Hard** · C3

A 29-year-old woman with Kallmann syndrome wants to conceive. She has been on HRT. FSH and LH are low. Her husband's semen is normal and her tubes are patent.

Which treatment will induce ovulation?

A. Clomiphene citrate

B. Letrozole

C. Metformin

D. Ovarian drilling

E. Pulsatile GnRH or gonadotrophins containing LH

Answer: E. Pulsatile GnRH or gonadotrophins containing LH

In hypogonadotrophic hypogonadism the pituitary is not stimulated. Pulsatile GnRH by pump, or gonadotrophins containing both FSH and LH activity, induce ovulation with good success.

Why not the others

- **A:** Clomiphene needs a functioning hypothalamic–pituitary axis.
- **B:** Letrozole also needs an intact axis.
- **C:** Metformin is for insulin resistance.
- **D:** Drilling is for PCOS.

Key point: Pure FSH alone is less effective in Group I because some LH is needed for oestrogen production.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 328 · Ovulatory Disorders · **Moderate** · C3

A 37-year-old woman has had irregular then absent periods for 10 months with hot flushes. FSH is 55 IU/L on two occasions and AMH is undetectable. She wants a baby.

Which option gives her the best chance of pregnancy?

A. Clomiphene citrate
B. IVF with donor eggs
C. IVF with her own eggs
D. Letrozole
E. Pulsatile GnRH

Answer: B. IVF with donor eggs

This is premature ovarian insufficiency (WHO Group III). Ovulation induction does not work because the ovaries have very few follicles left. Egg donation gives the best chance; a small chance of spontaneous pregnancy remains.

Why not the others

- **A:** Clomiphene cannot stimulate failed ovaries.
- **C:** Very few or no eggs would be collected.
- **D:** Letrozole also needs responsive ovaries.
- **E:** GnRH is for hypothalamic failure.

Key point: Women with POI need HRT for long-term health whether or not they pursue fertility treatment.

Reference: Gynaecology by Ten Teachers — Subfertility; Amenorrhoea

MCQ 329 · Investigations · **Moderate** · C2

A 35-year-old woman has a day 2 FSH of 14 IU/L and an AMH of 3 pmol/L (low). She has regular cycles and asks what this means.

What is the correct interpretation?

A. She has hyperprolactinaemia
B. She has PCOS
C. She has reduced ovarian reserve and may respond poorly to IVF stimulation
D. She is in menopause and cannot conceive
E. She is not ovulating

Answer: C. She has reduced ovarian reserve and may respond poorly to IVF stimulation

A raised early follicular FSH and low AMH suggest reduced ovarian reserve. She is still ovulating with regular cycles and may conceive naturally, but she would produce fewer eggs in IVF and should not delay treatment if needed.

Why not the others

- **A:** Prolactin was not measured and does not explain this.
- **B:** PCOS gives high AMH.
- **D:** She still has regular cycles and can conceive.
- **E:** Regular cycles suggest ovulation.

Key point: Ovarian reserve tests predict IVF response, not natural fertility.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 330 · Investigations · **Moderate** · C3

A 30-year-old woman is booked for a hysterosalpingogram to check her tubes. She asks when in her cycle it should be done.

When should HSG be performed?

A. Any time in the luteal phase
B. During menstruation
C. In the follicular phase after bleeding stops and before ovulation
D. On the day of ovulation
E. Only after a positive pregnancy test

Answer: C. In the follicular phase after bleeding stops and before ovulation

HSG is done in the early follicular phase after bleeding stops (days 6–10), to avoid irradiating an early pregnancy and to reduce the risk of spreading menstrual debris. Chlamydia screening or prophylactic antibiotics are given.

Why not the others

- **A:** An early pregnancy could be present.
- **B:** Menstrual blood obscures the image and increases infection risk.
- **D:** An egg may be fertilised that cycle.
- **E:** HSG is contraindicated in pregnancy.

Key point: HSG can occasionally be therapeutic; pregnancy rates may rise slightly after an oil-based HSG.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 331 · Investigations · **Easy** · C2

A couple are being investigated for 2 years of subfertility. The woman asks whether a test of sperm in her cervical mucus after intercourse would help.

What is the current recommendation about the postcoital test?

A. It is essential in all couples
B. It is not recommended because it does not predict pregnancy
C. It is used to decide on ICSI
D. It replaces semen analysis
E. It should be done on day 2 of the cycle

Answer: B. It is not recommended because it does not predict pregnancy

The postcoital test has poor predictive value and does not change management, so it is not recommended in routine investigation of subfertility.

Why not the others

- **A:** It is not recommended.
- **C:** ICSI decisions are based on semen analysis.
- **D:** Semen analysis remains essential.
- **E:** The test was timed around ovulation, not day 2.

Key point: Basic tests: semen analysis, ovulation check, tubal patency and ovarian reserve if IVF is considered.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 332 · Uterine Factors · **Moderate** · C3

A 32-year-old woman with 2 years of unexplained subfertility has a saline sonohysterogram showing a 12 mm endometrial polyp. Everything else is normal.

What is the most appropriate management?

A. Endometrial ablation
B. GnRH agonist
C. Hysterectomy
D. Hysteroscopic polypectomy
E. Leave it and start IVF

Answer: D. Hysteroscopic polypectomy

Endometrial polyps can impair implantation. Hysteroscopic polypectomy improves spontaneous and IUI pregnancy rates in subfertile women and is a simple procedure.

Why not the others

- **A:** Ablation destroys the endometrium.
- **B:** GnRH agonists do not remove polyps.
- **C:** Hysterectomy ends fertility.
- **E:** Removing the polyp first is recommended.

Key point: Remove cavity lesions (polyps, submucous fibroids, septum) before fertility treatment.

Reference: Gynaecology by Ten Teachers — Subfertility; Benign conditions of the uterus

MCQ 333 · Uterine Factors · **Hard** · C3

A 30-year-old woman with MRKH syndrome has normal ovaries and wants a genetic child of her own with her husband. Surrogacy is legal in her country.

Which treatment makes this possible?

A. Clomiphene and timed intercourse
B. Egg donation to her
C. IUI
D. IVF with her own eggs and her husband's sperm, with transfer to a gestational surrogate
E. Ovarian drilling

Answer: D. IVF with her own eggs and her husband's sperm, with transfer to a gestational surrogate

Women with MRKH have functioning ovaries but no uterus. IVF using her eggs and her husband's sperm, with embryos transferred to a gestational surrogate, can produce a genetically related child. Uterine transplantation is an emerging research option.

Why not the others

- **A:** Without a uterus she cannot carry a pregnancy.
- **B:** She has her own eggs.
- **C:** IUI needs a uterus.
- **E:** Drilling is for PCOS.

Key point: Laws on surrogacy differ widely between countries; counsel accordingly.

Reference: Gynaecology by Ten Teachers — Subfertility; Assisted conception

MCQ 334 · Assisted Conception · **Moderate** · C2

A 31-year-old woman is having IVF. Her follicles have reached 18–20 mm and an hCG trigger injection is given at 10 pm.

When should egg collection be scheduled?

A. 12 hours later
B. 20 hours later
C. About 34–36 hours later
D. 72 hours later
E. One week later

Answer: C. About 34–36 hours later

hCG mimics the LH surge. Egg collection is timed about 34–36 hours after the trigger, just before the follicles would rupture, so mature eggs can be retrieved.

Why not the others

- **A:** At 12 hours the eggs are not yet mature.
- **B:** At 20 hours the eggs are not fully mature.
- **D:** At 72 hours the eggs would have been released.
- **E:** One week later is far too late.

Key point: Late collection risks ovulation before retrieval.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 335 · Assisted Conception · **Moderate** · C2

A 33-year-old woman has a fresh IVF embryo transfer after a GnRH agonist protocol. Her doctor prescribes vaginal progesterone from the day of egg collection.

Why is progesterone given after IVF?

A. To prevent OHSS
B. To prevent ovulation
C. To stimulate more follicles
D. To support the luteal phase, which is deficient after IVF stimulation
E. To treat endometriosis

Answer: D. To support the luteal phase, which is deficient after IVF stimulation

Pituitary down-regulation and aspiration of granulosa cells during egg collection lead to a deficient luteal phase. Progesterone support improves implantation and pregnancy rates.

Why not the others

- **A:** Progesterone does not prevent OHSS.
- **B:** Ovulation has already been triggered and eggs collected.
- **C:** Progesterone does not stimulate follicles.
- **E:** It is not given to treat endometriosis here.

Key point: Luteal support is usually continued until the pregnancy test or up to 8–12 weeks.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 336 · Assisted Conception · **Hard** · C2

A 34-year-old woman has egg collection under sedation. Six hours later she has abdominal pain, dizziness and a pulse of 118/min with BP 92/60 mmHg. Haemoglobin has fallen by 3 g/dL. Ultrasound shows free fluid.

What is the most likely complication?

A. Bowel perforation

B. Early OHSS

C. Intra-abdominal bleeding from ovarian puncture

D. Ovarian torsion

E. Pelvic infection

Answer: C. Intra-abdominal bleeding from ovarian puncture

Transvaginal needle puncture of the ovary can cause intra-abdominal bleeding. A fall in haemoglobin with tachycardia, hypotension and free fluid within hours of collection suggests haemorrhage; she needs resuscitation and may need laparoscopy.

Why not the others

- **A:** Perforation is rare and causes peritonitis later.
- **B:** OHSS develops over days and causes haemoconcentration, not a falling haemoglobin.
- **D:** Torsion causes severe one-sided pain, not a falling haemoglobin.
- **E:** Infection develops over days with fever.

Key point: Serious complications of egg collection are rare (under 1%).

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 337 · Lifestyle Factors · **Easy** · C3

A 32-year-old man has a semen analysis showing mildly reduced count. He smokes 20 cigarettes a day, drinks heavily, has a BMI of 33 kg/m² and works long hours in a hot bakery.

What is the most appropriate first advice?

A. Have a vasectomy reversal

B. Start testosterone

C. Stop smoking, reduce alcohol, lose weight and avoid testicular heat

D. Take antibiotics for 3 months

E. Undergo varicocele surgery

Answer: C. Stop smoking, reduce alcohol, lose weight and avoid testicular heat

Smoking, alcohol, obesity and heat exposure can all reduce sperm quality. Lifestyle change may improve semen parameters over 3 months.

Why not the others

- **A:** He has not had a vasectomy.
- **B:** Testosterone suppresses sperm production.
- **D:** There is no infection.
- **E:** There is no varicocele.

Key point: Loose underwear and avoiding hot baths and laptops on the lap may help.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 338 · Male Factor · **Hard** · C3

A 30-year-old man with mild oligozoospermia has a left varicocele found on examination. His wife is 29 with normal tests. They have been trying for 18 months.

What does current evidence say about varicocele repair for subfertility?

A. It guarantees pregnancy
B. It is not routinely recommended for subfertility because it does not clearly improve pregnancy rates
C. It is the only treatment for male factor
D. It should always be done before any other treatment
E. It worsens sperm counts

Answer: B. It is not routinely recommended for subfertility because it does not clearly improve pregnancy rates

NICE does not recommend surgery for varicocele as a form of fertility treatment because it does not clearly improve pregnancy rates. Selected cases with clinical varicocele and abnormal semen may be considered by andrologists.

Why not the others

- **A:** No treatment guarantees pregnancy.
- **C:** IUI, IVF and ICSI are also options.
- **D:** It is not first-line treatment.
- **E:** Repair does not worsen counts.

Key point: Varicoceles are common (about 15% of men) and many are fertile.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 339 · Male Factor · **Moderate** · C3

A 33-year-old man has azoospermia. Testes are 20 mL each, FSH and testosterone are normal, and semen volume is normal. He had bilateral inguinal hernia repairs as a child.

What is the most likely type of azoospermia?

A. Hypogonadotrophic hypogonadism
B. Klinefelter syndrome
C. Obstructive azoospermia
D. Primary testicular failure
E. Retrograde ejaculation

Answer: C. Obstructive azoospermia

Normal testis size and normal FSH suggest normal sperm production with blockage. Previous bilateral inguinal surgery can damage the vas deferens. Sperm can usually be retrieved surgically for ICSI, or the blockage repaired.

Why not the others

- **A:** Hypogonadotrophic hypogonadism has low FSH and small testes.
- **B:** Klinefelter syndrome has small testes and high FSH.
- **D:** Testicular failure has high FSH and small testes.
- **E:** Retrograde ejaculation has low volume.

Key point: Obstructive azoospermia: normal testes, normal FSH. Non-obstructive: small testes, high FSH.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 340 · Sexual Problems · **Moderate** · C3

A 24-year-old woman has been married for 2 years but intercourse has never been completed because of intense fear and involuntary tightening of the vaginal muscles. Examination under gentle conditions is otherwise normal. The couple wants a child soon.

What is the most appropriate approach?

A. Clomiphene
B. Hymenectomy
C. IVF immediately
D. Psychosexual therapy with vaginal trainers, with self-insemination or IUI as an option if they want to conceive meanwhile
E. Vaginoplasty

Answer: D. Psychosexual therapy with vaginal trainers, with self-insemination or IUI as an option if they want to conceive meanwhile

Vaginismus is treated by psychosexual therapy and graded vaginal trainers, with good success. If pregnancy is wanted before intercourse is possible, home self-insemination or IUI can be used.

Why not the others

- **A:** There is no ovulatory problem.
- **B:** The hymen is not the cause.
- **C:** IVF is not needed when tubes and semen are normal.
- **E:** The anatomy is normal.

Key point: Non-consummation is an important and often hidden cause of subfertility in conservative societies.

Reference: Gynaecology by Ten Teachers — Subfertility; Psychosexual medicine

MCQ 341 · Assisted Conception · **Moderate** · C2

A 35-year-old woman is having IVF in a publicly funded programme. She asks why she was asked to lose weight first. Her BMI is 34 kg/m².

Why is a BMI under about 30 advised before IVF?

A. High BMI has no effect on IVF
B. Higher BMI improves egg quality
C. IVF drugs cannot be absorbed in obesity
D. Obesity lowers live birth rates and increases risks of anaesthesia and pregnancy complications
E. Obesity prevents embryo freezing

Answer: D. Obesity lowers live birth rates and increases risks of anaesthesia and pregnancy complications

Obesity reduces IVF success, increases miscarriage, and raises the risks of egg collection under sedation and of pregnancy complications such as gestational diabetes and pre-eclampsia. Many programmes require a BMI between 19 and 30.

Why not the others

- **A:** BMI does affect outcomes.
- **B:** Higher BMI does not improve egg quality.
- **C:** Drugs are absorbed, but higher doses may be needed.
- **E:** Freezing is not affected.

Key point: Weight loss before treatment can also restore natural ovulation.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 342 · Tubal Factor · **Hard** · C3

A 31-year-old woman has bilateral proximal tubal blockage on HSG. A repeat test shows the same. Her distal tubes look normal at laparoscopy.

Which procedure may restore tubal patency?

A. Bilateral salpingectomy
B. Hysterectomy
C. Laparoscopic fimbrioplasty
D. Ovarian drilling
E. Selective salpingography and tubal cannulation

Answer: E. Selective salpingography and tubal cannulation

Proximal tubal blockage may be caused by mucus plugs or debris. Selective salpingography with tubal cannulation (under radiological or hysteroscopic guidance) can clear the blockage. IVF remains an alternative.

Why not the others

- **A:** Salpingectomy removes the tubes.
- **B:** Hysterectomy ends fertility.
- **C:** Fimbrioplasty treats distal disease.
- **D:** Drilling treats PCOS.

Key point: Proximal blockage on HSG is sometimes due to tubal spasm; repeat or confirm before treatment.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 343 · Investigations · **Easy** · C3

A 33-year-old woman is starting fertility investigations. She has had all her childhood vaccinations but is unsure about rubella.

Which test should be offered before she tries to conceive?

A. Hepatitis E antibodies
B. Rubella immunity
C. Serum ferritin
D. Toxoplasma antibodies
E. Varicella PCR

Answer: B. Rubella immunity

Women trying to conceive should be offered rubella immunity testing, and vaccination if not immune, with advice to avoid pregnancy for one month after the MMR vaccine.

Why not the others

- **A:** Hepatitis E is not routinely tested.
- **C:** Ferritin is not a pre-conception screen.
- **D:** Toxoplasma screening is not recommended.
- **E:** Varicella PCR is for active infection.

Key point: Also check cervical screening is up to date.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 344 · Assisted Conception · **Moderate** · C2

A 30-year-old woman asks whether children born after IVF are at higher risk of problems.

What is the most accurate statement?

A. IVF children are at no increased risk of anything
B. IVF children are very likely to have a major disability
C. IVF only increases the risk of twins
D. IVF reduces the risk of birth defects
E. There is a small increase in congenital anomalies and perinatal complications, partly due to multiple pregnancy and parental factors

Answer: E. There is a small increase in congenital anomalies and perinatal complications, partly due to multiple pregnancy and parental factors

Assisted conception is associated with a small increase in congenital anomalies, preterm birth and low birthweight. Much of this is due to multiple pregnancy and the underlying causes of subfertility. Single embryo transfer reduces risk.

Why not the others

- **A:** There is a small increase in risk.
- **B:** Most children are healthy.
- **C:** Other risks also exist.
- **D:** IVF does not reduce birth defects.

Key point: Overall, most children born after IVF are healthy.

Reference: Gynaecology by Ten Teachers — Assisted conception

MCQ 345 · Investigations · **Hard** · C3

A 32-year-old woman has primary subfertility. HSG shows a normal cavity but bilateral hydrosalpinges. She had a positive chlamydia test 4 years ago, treated.

What is the most appropriate fertility treatment?

A. Clomiphene with timed intercourse
B. IUI
C. Laparoscopic salpingectomy followed by IVF
D. Salpingostomy and wait 5 years
E. Tubal cannulation

Answer: C. Laparoscopic salpingectomy followed by IVF

Bilateral hydrosalpinges mean the tubes are badly damaged. IVF is the treatment of choice, and removing (or blocking) the hydrosalpinges first doubles the IVF success rate.

Why not the others

- **A:** Damaged tubes prevent natural conception.
- **B:** IUI needs healthy tubes.
- **D:** Salpingostomy has poor results with significant damage.
- **E:** Cannulation treats proximal blockage, not hydrosalpinx.

Key point: Chlamydia is a leading cause of tubal subfertility.

Reference: Gynaecology by Ten Teachers — Subfertility; Pelvic infection

MCQ 346 · Definition and Causes · **Easy** · C2

A couple have one child aged 4, conceived easily. They have now been trying for another for 14 months without success.

What is this type of subfertility called?

A. Absolute sterility
B. Primary subfertility
C. Recurrent miscarriage
D. Secondary subfertility
E. Unexplained infertility by definition

Answer: D. Secondary subfertility

Secondary subfertility is difficulty conceiving after a previous pregnancy (regardless of outcome). Primary subfertility is when there has never been a pregnancy. Both are investigated in the same way.

Why not the others

- **A:** Sterility means no possibility of conception.
- **B:** Primary means no previous pregnancy.
- **C:** They have not had miscarriages.
- **E:** The cause has not yet been investigated.

Key point: Secondary subfertility may follow pelvic infection after childbirth or miscarriage.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 347 · Male Factor · **Moderate** · C2

A 34-year-old man has azoospermia with small testes, low FSH, low LH and low testosterone. He has a normal sense of smell. MRI of the pituitary shows a 6 mm adenoma and prolactin is 3,200 mIU/L.

What is the most appropriate treatment to restore fertility?

A. Cabergoline
B. Clomiphene
C. Donor sperm
D. Testosterone
E. Varicocele repair

Answer: A. Cabergoline

Hyperprolactinaemia suppresses GnRH, causing low gonadotrophins and absent sperm production. A dopamine agonist such as cabergoline lowers prolactin and restores the axis and sperm production.

Why not the others

- **B:** Clomiphene will not help while prolactin is high.
- **C:** Donor sperm is premature; this is treatable.
- **D:** Testosterone suppresses sperm production.
- **E:** There is no varicocele.

Key point: Check prolactin in men with low testosterone and low gonadotrophins.

Reference: Gynaecology by Ten Teachers — Subfertility

MCQ 348 · Female Age · **Moderate** · C3

A 39-year-old woman has been trying to conceive for 6 months. Her periods are regular and she has no symptoms.

What is the most appropriate advice?

A. Investigate now because of her age
B. She is too old for any treatment
C. Start clomiphene now without tests
D. Try for 2 more years first
E. Wait until 12 months before any assessment

Answer: A. Investigate now because of her age

Female fertility falls with age, and IVF success falls sharply after 40. Women aged 36 or over should be referred after 6 months of trying, so that investigations and any treatment are not delayed.

Why not the others

- **B:** Treatment is still possible at 39.
- **C:** Clomiphene without investigations is not appropriate.
- **D:** Waiting 2 years reduces success.
- **E:** Twelve months is the threshold for younger women.

Key point: Each year of delay after 35 reduces the chance of success.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

MCQ 349 · Assisted Conception · **Hard** · C2

A 30-year-old man has severe oligozoospermia and needs ICSI. Before treatment, the clinic offers him genetic testing.

Which genetic tests are recommended in men with severe oligozoospermia or non-obstructive azoospermia?

A. BRCA testing
B. Factor V Leiden
C. Fragile X testing only
D. Karyotype and Y chromosome microdeletion testing
E. Thalassaemia testing only

Answer: D. Karyotype and Y chromosome microdeletion testing

Severe male factor is associated with chromosomal abnormalities (such as Klinefelter syndrome or translocations) and Y chromosome microdeletions (AZF regions). These may be passed to sons through ICSI, so testing and counselling are important.

Why not the others

- **A:** BRCA is for breast and ovarian cancer risk.
- **B:** Factor V Leiden is a thrombophilia.
- **C:** Fragile X is relevant to female POI, not male oligozoospermia.
- **E:** Thalassaemia testing is a separate carrier screen.

Key point: Y microdeletions are inherited by sons born after ICSI.

Reference: Gynaecology by Ten Teachers — Subfertility; Assisted conception

MCQ 350 · Investigations · **Easy** · C2

A 29-year-old woman with regular cycles is starting fertility investigations. Her GP wants to check whether she ovulates.

Which is the simplest reliable test of ovulation?

A. Basal body temperature chart
B. Cervical mucus examination
C. Endometrial biopsy
D. Mid-luteal serum progesterone
E. Urinary LH kit for one cycle

Answer: D. Mid-luteal serum progesterone

A mid-luteal progesterone level (7 days before the expected period) over about 30 nmol/L confirms ovulation. It is simple and reliable. Women with regular cycles are very likely to be ovulating.

Why not the others

- **A:** Temperature charts are unreliable and not recommended.
- **B:** Mucus examination is subjective.
- **C:** Endometrial biopsy is invasive and no longer used for this.
- **E:** An LH surge does not confirm the egg was released.

Key point: Women with irregular cycles need serial progesterone tests.

Reference: Gynaecology by Ten Teachers — Subfertility; NICE CG156

CHAPTER 8

Contraception

MCQ 351 · Emergency Contraception · **Easy** · C3

A 25-year-old married woman attends 4 days (96 hours) after unprotected intercourse. Her periods are regular and her last period started 13 days ago. She does not want a pregnancy now and has no contraindications to any method.

What is the most effective emergency contraception for her?

A. Combined oral contraceptive pill (Yuzpe method)
B. Copper intrauterine device
C. Levonorgestrel 1.5 mg orally
D. Progestogen-only implant
E. Ulipristal acetate 30 mg orally

Answer: B. Copper intrauterine device

The copper IUD is the most effective emergency contraceptive (failure rate under 0.1%). It can be fitted up to 5 days after unprotected intercourse or up to 5 days after the earliest expected ovulation. It also gives ongoing contraception.

Why not the others

- **A:** The Yuzpe method is less effective and causes more nausea; it is largely obsolete.
- **C:** Levonorgestrel is licensed only up to 72 hours and works poorly close to ovulation.
- **D:** An implant gives ongoing contraception but is not an emergency contraceptive.
- **E:** Ulipristal works up to 120 hours but is less effective than the copper IUD, especially near ovulation.

Key point: Emergency contraception: copper IUD (5 days) > ulipristal (120 h) > levonorgestrel (72 h).

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 352 · Effectiveness · **Easy** · C2

A 25-year-old married woman wants the most effective reversible contraception available. She does not want to remember to take anything daily.

Which method has the lowest failure rate with typical use?

A. Combined oral contraceptive pill
B. Male condom
C. Progestogen-only implant
D. Progestogen-only pill
E. Withdrawal method

Answer: C. Progestogen-only implant

The etonogestrel implant has a typical-use failure rate of about 0.05% per year, the lowest of any method. Because it does not depend on the user, typical and perfect use are almost the same.

Why not the others

- **A:** Typical-use failure of the pill is about 7–9% per year.
- **B:** Condoms fail in about 13–18% per year with typical use.
- **D:** The POP fails in about 7–9% per year with typical use.
- **E:** Withdrawal fails in about 20% per year.

Key point: Long-acting reversible contraception (LARC): implant, IUS, copper IUD and injection.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 353 · Eligibility Criteria · **Easy** · C2

A doctor uses the UK Medical Eligibility Criteria (UKMEC) to decide whether a method is safe for a woman with a medical condition.

What does UKMEC category 4 mean?

A. A condition where the advantages generally outweigh the risks
B. A condition with no restriction on use
C. A condition which represents an unacceptable health risk if the method is used
D. A condition where the risks generally outweigh the advantages
E. Use only with specialist advice

Answer: C. A condition which represents an unacceptable health risk if the method is used

UKMEC 1 = no restriction; 2 = advantages generally outweigh risks; 3 = risks generally outweigh advantages (use only with expert judgement); 4 = unacceptable health risk — the method should not be used.

Why not the others

- **A:** That is category 2.
- **B:** That is category 1.
- **D:** That is category 3.
- **E:** Expert judgement applies to category 3.

Key point: The WHO Medical Eligibility Criteria use the same 1–4 categories.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 354 · Combined Hormonal Contraception · **Easy** · C2

A 22-year-old woman starting the combined pill asks how it prevents pregnancy.

What is the main mechanism of action of the combined oral contraceptive pill?

A. Damaging the sperm
B. Inhibition of ovulation
C. Making the uterus contract
D. Preventing implantation only
E. Thickening the vaginal wall

Answer: B. Inhibition of ovulation

Oestrogen and progestogen suppress FSH and LH, preventing follicle development and ovulation. The progestogen also thickens cervical mucus and thins the endometrium.

Why not the others

- **A:** The pill does not damage sperm.
- **C:** The pill does not cause uterine contractions.
- **D:** Effects on the endometrium are secondary.
- **E:** The pill does not thicken the vaginal wall.

Key point: The pill-free interval is the most risky time for loss of ovulation suppression.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 355 · Combined Hormonal Contraception · **Moderate** · C3

A 26-year-old woman has migraine with visual aura before her headaches. She wants to start the combined pill.

What is the most appropriate advice?

A. Combined pill is contraindicated (UKMEC 4); offer a progestogen-only or non-hormonal method
B. Combined pill is safe with migraine with aura
C. Use the combined patch instead
D. Use the combined pill only in a lower dose
E. Use the combined vaginal ring instead

Answer: A. Combined pill is contraindicated (UKMEC 4); offer a progestogen-only or non-hormonal method

Migraine with aura increases the risk of ischaemic stroke, and oestrogen increases it further. All combined hormonal methods are UKMEC 4. Progestogen-only methods and the copper IUD are safe.

Why not the others

- **B:** It is not safe.
- **C:** The patch contains oestrogen.
- **D:** Even low-dose oestrogen is contraindicated.
- **E:** The ring contains oestrogen.

Key point: Migraine without aura is UKMEC 2 for starting the combined pill.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 356 · Combined Hormonal Contraception · **Moderate** · C3

A 37-year-old woman who smokes 20 cigarettes a day asks to start the combined pill. Her BMI is 27 kg/m² and BP is normal.

What is the correct advice?

A. Combined pill is acceptable if she reduces to 10 a day
B. Combined pill is acceptable with no restriction
C. Combined pill is contraindicated; offer a progestogen-only method, IUS or copper IUD
D. Combined pill only if she uses condoms too
E. Combined pill only with aspirin

Answer: C. Combined pill is contraindicated; offer a progestogen-only method, IUS or copper IUD

Smoking 15 or more cigarettes a day at age 35 or over is UKMEC 4 for combined hormonal contraception because of the high risk of myocardial infarction and stroke.

Why not the others

- **A:** Smoking under 15 a day at 35 or over is still UKMEC 3.
- **B:** It is not unrestricted.
- **D:** Condoms do not reduce the cardiovascular risk.
- **E:** Aspirin does not make it safe.

Key point: Stopping smoking for over a year removes this restriction.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 357 · Combined Hormonal Contraception · **Hard** · C3

A 29-year-old woman on the combined pill (21 active pills, 7-day break) forgot to take two pills on days 3 and 4 of her pack (week 1). She had unprotected intercourse during the pill-free interval 2 days before starting the pack.

What is the most appropriate advice?

A. Discard the pack and start a new one after 7 days

B. No action needed

C. Stop the pill

D. Take the most recent missed pill now, continue the pack, use condoms for 7 days and consider emergency contraception

E. Take two pills a day for the rest of the pack

Answer: D. Take the most recent missed pill now, continue the pack, use condoms for 7 days and consider emergency contraception

Missing 2 or more pills in week 1 extends the pill-free interval, so ovulation may occur. She should take the last missed pill, continue the pack, use condoms for 7 days and consider emergency contraception because of intercourse in the pill-free week.

Why not the others

- **A:** A new 7-day break would make it worse.
- **B:** Action is needed.
- **C:** Stopping increases pregnancy risk.
- **E:** Doubling up is not the advice.

Key point: Missed pills in week 3: finish the active pills and omit the pill-free interval.

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 358 · Combined Hormonal Contraception · **Moderate** · C2

A 24-year-old woman on the combined pill missed one pill yesterday (24 hours late). It is day 10 of her pack.

What is the correct advice?

A. Emergency contraception is required

B. Restart a new pack

C. Stop the pill for 7 days

D. Take the missed pill now and continue as normal; no extra precautions are needed

E. Use condoms for 14 days

Answer: D. Take the missed pill now and continue as normal; no extra precautions are needed

Missing one pill (up to 48 hours since the last pill should have been taken) does not reduce protection. She should take it as soon as she remembers, even if that means two pills in one day, and continue normally.

Why not the others

- **A:** Emergency contraception is not needed for one missed pill.
- **B:** Restarting a pack is unnecessary.
- **C:** Stopping would increase the risk.
- **E:** Extra precautions are not needed.

Key point: One missed pill: take it, carry on.

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 359 · Combined Hormonal Contraception · **Moderate** · C3

A 28-year-old woman on the combined pill is started on rifampicin for 6 months for tuberculosis.

What is the most appropriate contraceptive advice?

A. Continue the usual combined pill without change
B. Progestogen-only implant
C. Progestogen-only pill
D. Switch to a copper IUD, LNG-IUS or depot injection during treatment and for 28 days after
E. Take the combined pill continuously at the same dose

Answer: D. Switch to a copper IUD, LNG-IUS or depot injection during treatment and for 28 days after

Rifampicin is a potent liver enzyme inducer that reduces the effectiveness of the pill, POP and implant. The copper IUD, LNG-IUS and DMPA injection are not affected and should be used during treatment and for 28 days after stopping.

Why not the others

- **A:** The pill will be less effective.
- **B:** The implant is also affected.
- **C:** The POP is also affected.
- **E:** Continuous use does not overcome enzyme induction reliably.

Key point: Enzyme inducers include rifampicin, carbamazepine, phenytoin and St John's wort.

Reference: Gynaecology by Ten Teachers — Contraception; Drug interactions

MCQ 360 · Combined Hormonal Contraception · **Hard** · C3

A 32-year-old woman with epilepsy controlled on lamotrigine wants to start the combined pill.

What is the important interaction to consider?

A. Lamotrigine makes the pill ineffective
B. Lamotrigine raises oestrogen levels
C. No interaction exists
D. Oestrogen lowers lamotrigine levels and may cause seizures
E. The pill causes lamotrigine toxicity

Answer: D. Oestrogen lowers lamotrigine levels and may cause seizures

Oestrogen increases the metabolism of lamotrigine, lowering its level and risking seizures, with levels rising again in the pill-free week. Lamotrigine itself does not reduce pill effectiveness. A progestogen-only or intrauterine method is often preferred.

Why not the others

- **A:** Lamotrigine is not an enzyme inducer and does not make the pill fail.
- **B:** Lamotrigine does not raise oestrogen.
- **C:** There is an important interaction.
- **E:** Levels fall, not rise, on the pill.

Key point: Women on valproate need highly effective contraception because valproate is teratogenic.

Reference: Gynaecology by Ten Teachers — Contraception; Drug interactions

MCQ 361 · Combined Hormonal Contraception · **Moderate** · C2

A 30-year-old woman asks about the long-term risks and benefits of taking the combined pill for 10 years.

Which cancer is reduced by long-term combined pill use?

A. Breast cancer
B. Cervical cancer
C. Liver cancer
D. Ovarian cancer
E. Skin cancer

Answer: D. Ovarian cancer

Combined pill use reduces the risk of ovarian and endometrial cancer by up to half, and the protection lasts for many years after stopping. It also reduces colorectal cancer risk.

Why not the others

- **A:** Breast cancer risk is slightly increased during use and returns to normal 10 years after stopping.
- **B:** Cervical cancer risk is slightly increased with long use.
- **C:** Liver cancer is very rare and slightly increased.
- **E:** Skin cancer is not affected.

Key point: The pill also reduces benign breast disease, ovarian cysts and painful periods.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 362 · Combined Hormonal Contraception · **Moderate** · C3

A 34-year-old woman on the combined pill is booked for a total knee replacement in 6 weeks, after which she will have reduced mobility.

What is the most appropriate advice?

A. Continue the pill with aspirin
B. Continue the pill without change
C. Double the pill dose before surgery
D. Stop the pill 4 weeks before surgery and use another method
E. Switch to the combined patch

Answer: D. Stop the pill 4 weeks before surgery and use another method

Major surgery with prolonged immobilisation increases venous thromboembolism risk, which the combined pill adds to (UKMEC 4). The pill should be stopped at least 4 weeks before and restarted 2 weeks after full mobility. A progestogen-only method can be used meanwhile.

Why not the others

- **A:** Aspirin does not prevent venous thrombosis adequately.
- **B:** Continuing raises VTE risk.
- **C:** A higher dose increases risk.
- **E:** The patch also contains oestrogen.

Key point: Progestogen-only methods can usually be continued through surgery.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 363 · Combined Hormonal Contraception · **Easy** · C2

A 23-year-old woman on the combined pill has diarrhoea and vomiting. She vomited 1 hour after taking today's pill.

What is the correct advice?

A. Emergency contraception is needed
B. No action needed
C. Stop the pill for the rest of the pack
D. Take another pill as soon as possible
E. Use condoms for one month

Answer: D. Take another pill as soon as possible

If vomiting occurs within 3 hours of taking the pill, it may not have been absorbed and another pill should be taken. If vomiting continues, follow the missed pill rules.

Why not the others

- **A:** EC is not needed for a single episode.
- **B:** The pill may not have been absorbed.
- **C:** Stopping increases risk.
- **E:** Condoms for a month is excessive.

Key point: Severe persistent diarrhoea counts as missed pills.

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 364 · Progestogen-only Pill · **Moderate** · C2

A 33-year-old breastfeeding woman wants a pill. She asks how long she can be late taking a desogestrel progestogen-only pill.

What is the window for a late desogestrel pill before extra precautions are needed?

A. 1 hour
B. 3 hours
C. 12 hours
D. 24 hours
E. 48 hours

Answer: C. 12 hours

Desogestrel 75 microgram POP inhibits ovulation in most cycles and has a 12-hour window. Traditional POPs (such as levonorgestrel) have only a 3-hour window. If late beyond the window, take it and use condoms for 2 days.

Why not the others

- **A:** One hour is too short.
- **B:** Three hours applies to traditional POPs.
- **D:** 24 hours is too long for a POP.
- **E:** 48 hours applies to the combined pill.

Key point: Drospirenone-only pill has a 24-hour window.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 365 · Progestogen-only Pill · **Hard** · C2

A 40-year-old woman with a history of deep vein thrombosis asks why the progestogen-only pill is safe for her when the combined pill is not.

What is the main reason?

A. Progestogen-only methods do not significantly increase the risk of venous thromboembolism
B. Progestogen-only pills are not absorbed
C. Progestogen-only pills contain lower oestrogen
D. Progestogen-only pills thin the blood
E. She is too old for oestrogen

Answer: A. Progestogen-only methods do not significantly increase the risk of venous thromboembolism

The thrombotic risk of combined methods comes mainly from oestrogen, which increases clotting factors. Progestogen-only methods do not significantly increase VTE risk and are UKMEC 2 after previous VTE.

Why not the others

- **B:** POPs are absorbed.
- **C:** POPs contain no oestrogen.
- **D:** POPs are not anticoagulants.
- **E:** Age alone is not the reason.

Key point: Copper IUD is UKMEC 1 after previous VTE.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 366 · Implant · **Easy** · C2

A 19-year-old woman had an etonogestrel implant inserted. She asks how long it lasts and what the commonest side effect is.

What is correct about the contraceptive implant?

A. It lasts 1 year and causes weight loss
B. It lasts 3 years; irregular bleeding is the commonest reason for removal
C. It lasts 5 years and stops periods in all women
D. It lasts 10 years and causes no side effects
E. It must be replaced every 3 months

Answer: B. It lasts 3 years; irregular bleeding is the commonest reason for removal

The etonogestrel implant is licensed for 3 years. Unpredictable bleeding is the commonest side effect and reason for removal; about a fifth of women have no bleeding.

Why not the others

- **A:** It lasts 3 years and does not cause weight loss.
- **C:** It does not stop periods in all women.
- **D:** The copper IUD lasts 10 years; implants cause side effects.
- **E:** Three-monthly replacement is the injection.

Key point: Fertility returns quickly after implant removal.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 367 · Implant · **Moderate** · C3

A 21-year-old woman with an implant for 8 months has troublesome frequent spotting. Pregnancy test and STI screen are negative, and cervical screening is up to date. She wants to keep the implant.

What is the most appropriate treatment?

A. Add a 3-month course of the combined pill if no contraindications
B. High-dose oestrogen
C. Insert a second implant
D. Remove and replace the implant
E. Tranexamic acid for 1 year

Answer: A. Add a 3-month course of the combined pill if no contraindications

A short course (up to 3 months) of the combined pill can control troublesome bleeding with an implant, if there are no contraindications. Alternatives include mefenamic acid or a progestogen-only pill.

Why not the others

- **B:** High-dose oestrogen is not used.
- **C:** A second implant does not help.
- **D:** Replacing it does not change the bleeding pattern.
- **E:** Long-term tranexamic acid is not the approach.

Key point: Exclude STI, pregnancy and cervical disease before treating bleeding.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 368 · Injectable · **Moderate** · C2

A 27-year-old woman uses depot medroxyprogesterone acetate. She attends 14 weeks after her last injection and has not had sex since 12 weeks.

What is the correct advice?

A. She is too late and needs a pregnancy test in 3 weeks before any injection
B. She must wait for her next period
C. She needs emergency contraception
D. The injection can be given now without extra precautions because she is within the 14-week window
E. The injection is given every 6 months

Answer: D. The injection can be given now without extra precautions because she is within the 14-week window

DMPA is given every 13 weeks, but can be given up to 14 weeks without extra precautions. Beyond 14 weeks, pregnancy must be excluded and condoms used for 7 days.

Why not the others

- **A:** She is within 14 weeks.
- **B:** Waiting for a period exposes her to pregnancy.
- **C:** She has not had unprotected sex since the window.
- **E:** DMPA is every 13 weeks.

Key point: Subcutaneous DMPA can be self-injected.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 369 · Injectable · **Moderate** · C3

A 17-year-old girl wants contraception. She is considering the depot injection.

What specific concern must be discussed about depot medroxyprogesterone acetate in adolescents?

A. Increased breast cancer risk
B. Increased risk of ovarian cysts
C. Increased thrombosis risk
D. Reduction in bone mineral density
E. Weight loss

Answer: D. Reduction in bone mineral density

DMPA suppresses ovarian oestrogen and causes a small reversible loss of bone density. This matters in adolescents who have not yet reached peak bone mass. It can be used after other methods are considered, with review every 2 years.

Why not the others

- **A:** Breast cancer risk is not significantly increased.
- **B:** Ovarian cysts are not a concern.
- **C:** VTE risk is not significantly increased.
- **E:** DMPA is associated with weight gain in some women.

Key point: DMPA is also associated with delayed return of fertility of up to a year.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 370 · Intrauterine Contraception · **Easy** · C2

A 30-year-old woman wants non-hormonal long-acting contraception. She chooses a copper IUD (380 mm² copper).

For how long is a copper IUD with 380 mm² of copper effective?

A. 1 year
B. 3 years
C. 5 years
D. 10 years
E. 20 years

Answer: D. 10 years

Copper IUDs with 380 mm² of copper are licensed for 10 years. Inserted at age 40 or over, they can stay until menopause.

Why not the others

- **A:** One year is far too short.
- **B:** Three years is the implant.
- **C:** Five years applies to some smaller copper IUDs.
- **E:** Twenty years is beyond licence.

Key point: Copper is toxic to sperm and eggs and prevents fertilisation.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 371 · Intrauterine Contraception · **Moderate** · C2

A 28-year-old woman is counselled before IUD insertion.

What is the approximate risk of uterine perforation at IUD insertion?

A. Up to 2 in 1,000
B. 1 in 10
C. 1 in 20
D. 1 in 50
E. 1 in 100,000

Answer: A. Up to 2 in 1,000

Uterine perforation occurs in up to 2 per 1,000 insertions, more commonly in breastfeeding women and soon after childbirth. Expulsion occurs in about 1 in 20, mostly in the first year.

Why not the others

- **B:** 1 in 10 is far too high.
- **C:** 1 in 20 is the expulsion rate.
- **D:** 1 in 50 is too high.
- **E:** 1 in 100,000 is too low.

Key point: Infection risk is highest in the first 20 days after insertion.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 372 · Intrauterine Contraception · **Moderate** · C3

A 32-year-old woman with a copper IUD cannot feel her threads and the threads are not seen on speculum examination. Pregnancy test is negative. She has had unprotected sex in the last 5 days.

What is the most appropriate next step?

A. Abdominal X-ray first
B. Assume the IUD is in place and reassure
C. Hysterectomy
D. Insert a new IUD
E. Pelvic ultrasound and advise condoms (with emergency contraception if needed) until location is confirmed

Answer: E. Pelvic ultrasound and advise condoms (with emergency contraception if needed) until location is confirmed

Missing threads may mean expulsion, perforation or threads drawn up into the canal. Ultrasound locates the device. Until it is confirmed in the uterus she needs alternative contraception, and emergency contraception if there was recent unprotected sex.

Why not the others

- **A:** X-ray is done only if ultrasound cannot find the device.
- **B:** She may not be protected.
- **C:** Hysterectomy is never indicated.
- **D:** A new IUD should not be inserted until the first is located.

Key point: If not seen in the uterus on scan, an abdominal X-ray checks for perforation.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 373 · Intrauterine Contraception · **Hard** · C3

A 29-year-old woman with a copper IUD has a positive pregnancy test. Ultrasound shows a live intrauterine pregnancy of 7 weeks and the IUD threads are visible. She wants to continue the pregnancy.

What is the most appropriate management?

A. Leave the IUD in place throughout pregnancy without discussion
B. Methotrexate
C. Remove the IUD by gently pulling the threads
D. Terminate the pregnancy
E. Wait until 20 weeks to remove it

Answer: C. Remove the IUD by gently pulling the threads

If the threads are visible and pregnancy is under 12 weeks, removing the IUD reduces the risks of miscarriage, infection and preterm birth, although removal itself carries a small risk of miscarriage.

Why not the others

- **A:** Leaving it increases risks of second-trimester loss and infection.
- **B:** Methotrexate is for ectopic pregnancy.
- **D:** Termination is not needed.
- **E:** Waiting removes the benefit.

Key point: Always exclude ectopic when an IUD user is pregnant.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 374 · Intrauterine Contraception · **Moderate** · C3

A 45-year-old woman has an LNG-IUS (52 mg) for contraception and heavy periods. She asks how long it is effective for contraception.

What is the current licensed duration of a 52 mg LNG-IUS for contraception?

A. 1 year
B. 3 years
C. 5 years
D. 8 years
E. 15 years

Answer: D. 8 years

The 52 mg LNG-IUS (such as Mirena) is now licensed for 8 years for contraception. It remains effective for heavy menstrual bleeding for 5 years, and as endometrial protection in HRT for 5 years.

Why not the others

- **A:** One year is far too short.
- **B:** Three years is the smaller 13.5 mg device.
- **C:** Five years is for HMB and endometrial protection.
- **E:** Fifteen years is beyond licence.

Key point: If inserted at 45 or over for contraception, it can stay until age 55.

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 375 · Emergency Contraception · **Moderate** · C3

A 24-year-old woman took ulipristal acetate emergency contraception this morning. She wants to start the combined pill straight away.

What is the correct advice?

A. Start the pill 5 days after ulipristal and use condoms for 7 days after starting

B. Start the pill immediately with no extra precautions

C. Take levonorgestrel too

D. Wait for 3 months

E. Wait for her next period before using any contraception

Answer: A. Start the pill 5 days after ulipristal and use condoms for 7 days after starting

Progestogens can reduce the effect of ulipristal. Hormonal contraception should be started 5 days after ulipristal, with condoms until it becomes effective (7 days for the combined pill). Levonorgestrel and ulipristal should not be used together.

Why not the others

- **B:** Starting immediately may reduce ulipristal's effect.
- **C:** Levonorgestrel interferes with ulipristal.
- **D:** Three months is unnecessary.
- **E:** She is at risk without contraception.

Key point: After levonorgestrel EC, hormonal contraception can start immediately.

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 376 · Emergency Contraception · **Hard** · C3

A 26-year-old woman weighing 92 kg (BMI 33 kg/m²) had unprotected intercourse 30 hours ago. She declines an IUD and ulipristal is not available.

What is the recommended levonorgestrel dose for her?

A. 0.75 mg

B. 1.5 mg

C. 3 mg

D. 6 mg

E. Levonorgestrel cannot be used

Answer: C. 3 mg

Levonorgestrel may be less effective in women with a BMI over 26 or weight over 70 kg. FSRH guidance suggests a double dose (3 mg). The copper IUD remains the most effective option and is not affected by weight.

Why not the others

- **A:** 0.75 mg is half the standard dose.
- **B:** 1.5 mg is the standard dose, possibly less effective at her weight.
- **D:** 6 mg is not recommended.
- **E:** It can be used at a higher dose.

Key point: A double dose is also used with enzyme-inducing drugs.

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 377 · Postpartum Contraception · **Easy** · C2

A 26-year-old woman delivered 8 weeks ago. She is fully breastfeeding day and night, has had no periods, and asks if breastfeeding alone will protect her from pregnancy.

When is the lactational amenorrhoea method about 98% effective?

A. At any time while breastfeeding
B. If she is less than 6 months postpartum, fully breastfeeding and amenorrhoeic
C. Only for the first 2 weeks
D. Only if she also takes iron
E. When she gives formula at night

Answer: B. If she is less than 6 months postpartum, fully breastfeeding and amenorrhoeic

The lactational amenorrhoea method is over 98% effective if all three conditions are met: less than 6 months after birth, fully or nearly fully breastfeeding, and no periods. Once any condition stops, another method is needed.

Why not the others

- **A:** Effectiveness falls after 6 months or with reduced feeding.
- **C:** It works for up to 6 months.
- **D:** Iron is irrelevant.
- **E:** Formula feeds reduce suckling and effectiveness.

Key point: Contraception is needed from day 21 postpartum if LAM criteria are not met.

Reference: Gynaecology by Ten Teachers — Contraception; Postnatal care

MCQ 378 · Postpartum Contraception · **Moderate** · C3

A 30-year-old woman is breastfeeding her 3-week-old baby. She wants the combined pill.

What is the correct advice?

A. Combined pill can be started at any time after delivery
B. Combined pill improves milk supply
C. Combined pill is UKMEC 4 under 6 weeks postpartum while breastfeeding; use a progestogen-only method
D. Combined pill should be started on day 1 after delivery
E. No contraception is needed until 6 months

Answer: C. Combined pill is UKMEC 4 under 6 weeks postpartum while breastfeeding; use a progestogen-only method

Under 6 weeks postpartum, breastfeeding women should not use combined methods (UKMEC 4) because of high VTE risk and possible effects on milk. Progestogen-only methods can be started at any time.

Why not the others

- **A:** Timing matters after delivery.
- **B:** Oestrogen may reduce milk supply.
- **D:** VTE risk is highest in the first weeks after delivery.
- **E:** Ovulation can return before the first period.

Key point: Non-breastfeeding women can start the combined pill from day 21 if no other VTE risk.

Reference: Gynaecology by Ten Teachers — Contraception; Postnatal care

MCQ 379 · Postpartum Contraception · **Moderate** · C3

A 28-year-old woman had a vaginal delivery 2 days ago and wants a copper IUD inserted before going home.

When can an IUD be inserted after vaginal delivery?

A. Any time between 48 hours and 4 weeks
B. Not until 6 months
C. Only after the first period
D. Within 48 hours of delivery, or from 4 weeks after delivery
E. Within 7 days only

Answer: D. Within 48 hours of delivery, or from 4 weeks after delivery

An IUD can be inserted within 48 hours of delivery (including at caesarean) or from 4 weeks postpartum. Between 48 hours and 4 weeks the risk of perforation and expulsion is higher.

Why not the others

- **A:** This period has a higher risk of perforation and expulsion.
- **B:** Waiting 6 months is unnecessary.
- **C:** Waiting for a period risks pregnancy.
- **E:** Within 7 days includes the higher-risk window.

Key point: Postpartum IUD insertion has a higher expulsion rate than interval insertion.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 380 · Female Sterilisation · **Moderate** · C2

A 36-year-old woman (para 4) asks for laparoscopic tubal occlusion with Filshie clips.

What is the lifetime failure rate of laparoscopic clip sterilisation?

A. About 1 in 20
B. About 1 in 50
C. About 1 in 200
D. About 1 in 2,000
E. About 1 in 20,000

Answer: C. About 1 in 200

Laparoscopic Filshie clip sterilisation has a lifetime failure rate of about 1 in 200. If it fails, there is a higher chance that the pregnancy is ectopic. Long-acting methods such as the implant and IUS are as effective and reversible.

Why not the others

- **A:** 1 in 20 is far too high.
- **B:** 1 in 50 is too high.
- **D:** 1 in 2,000 is the vasectomy failure rate after clearance.
- **E:** 1 in 20,000 is too low.

Key point: Counsel that sterilisation is intended to be permanent.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 381 · Female Sterilisation · **Moderate** · C3

A 24-year-old woman with two children asks for sterilisation because she is sure she wants no more children. Her husband agrees.

What is the most important counselling point?

A. Regret is more common in women sterilised under 30, and LARC methods are as effective
B. Sterilisation increases ovarian cancer risk
C. Sterilisation is easily reversed
D. Sterilisation makes periods heavier
E. Sterilisation must be done at caesarean only

Answer: A. Regret is more common in women sterilised under 30, and LARC methods are as effective

Women sterilised under 30, or soon after a pregnancy or relationship change, are more likely to regret it. LARC methods are at least as effective, reversible and avoid surgery. Sterilisation can still be offered after full counselling.

Why not the others

- **B:** Tubal occlusion slightly reduces ovarian cancer risk.
- **C:** Reversal is surgery with uncertain success.
- **D:** Sterilisation does not cause heavier periods; stopping the pill may.
- **E:** It can be done laparoscopically at any time.

Key point: Salpingectomy may further reduce ovarian cancer risk.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 382 · Vasectomy · **Moderate** · C3

A 40-year-old man has a vasectomy. He asks when he can stop using other contraception.

What is the correct advice?

A. Immediately after surgery
B. After 1 week
C. After 3 months only, without testing
D. After a semen test about 12 weeks later shows no sperm
E. Never; other contraception must always be used

Answer: D. After a semen test about 12 weeks later shows no sperm

Sperm remain in the vas beyond the cut for some time. Other contraception must be used until a post-vasectomy semen analysis at about 12 weeks shows azoospermia (or only rare non-motile sperm).

Why not the others

- **A:** Sperm are still present after surgery.
- **B:** One week is too soon.
- **C:** Testing is needed, not just time.
- **E:** After clearance, other contraception is not needed.

Key point: Vasectomy failure is about 1 in 2,000 after clearance.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 383 · Barrier Methods · **Easy** · C2

A 22-year-old unmarried woman has a new partner and uses the combined pill. She asks whether she needs anything else.

Which method also protects against sexually transmitted infections?

A. Combined pill
B. Copper IUD
C. Implant
D. Male condom
E. Progestogen-only injection

Answer: D. Male condom

Condoms are the only contraceptive method that reduces the risk of sexually transmitted infections, including HIV. Using condoms with another method ("double Dutch") gives protection against both pregnancy and STIs.

Why not the others

- **A:** The pill does not protect against STIs.
- **B:** The IUD does not protect against STIs.
- **C:** The implant does not protect against STIs.
- **E:** The injection does not protect against STIs.

Key point: Oil-based lubricants damage latex condoms.

Reference: Gynaecology by Ten Teachers — Contraception; Sexually transmitted infections

MCQ 384 · Contraception at Older Age · **Moderate** · C3

A 51-year-old woman using a copper IUD has had no periods for 8 months. She is not on HRT.

When can she stop contraception?

A. Immediately
B. After 12 months of amenorrhoea
C. After 2 years of amenorrhoea
D. At age 60
E. Only after measuring FSH twice

Answer: B. After 12 months of amenorrhoea

Contraception can be stopped after 12 months of amenorrhoea in women aged over 50 (2 years if under 50), or at age 55 regardless. FSH testing is not reliable while on hormonal methods.

Why not the others

- **A:** She has not yet had 12 months without periods.
- **C:** Two years applies to women under 50.
- **D:** Contraception can stop by 55.
- **E:** FSH is not needed at this age with a copper IUD.

Key point: All women can stop contraception at 55.

Reference: Gynaecology by Ten Teachers — Contraception; The menopause

MCQ 385 · Contraception at Older Age · **Moderate** · C3

A 48-year-old woman with no medical problems, a BMI of 24 kg/m² and normal BP has used the combined pill for years. She is a non-smoker.

Until what age can she continue the combined pill if she remains well?

A. 40
B. 45
C. 50
D. 55
E. 60

Answer: C. 50

Healthy women without risk factors can use the combined pill until age 50, then switch to a progestogen-only method or non-hormonal method until contraception is no longer needed.

Why not the others

- **A:** Age alone over 40 is UKMEC 2, not a reason to stop.
- **B:** She can continue beyond 45 if healthy.
- **D:** After 50 the risks outweigh benefits.
- **E:** Well beyond recommended use.

Key point: DMPA should usually be stopped at 50 because of bone density concerns.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 386 · Medical Conditions · **Moderate** · C3

A 38-year-old woman had breast cancer treated 3 years ago and is in remission. She wants reliable contraception.

Which method is most appropriate?

A. Combined pill
B. Copper IUD
C. Depot injection
D. Implant
E. LNG-IUS

Answer: B. Copper IUD

Current or past breast cancer is UKMEC 4 (current) or 3 (past) for all hormonal methods. The copper IUD is non-hormonal and is the method of choice.

Why not the others

- **A:** Combined methods are contraindicated.
- **C:** Hormonal methods are UKMEC 3 after breast cancer.
- **D:** Hormonal methods are UKMEC 3 after breast cancer.
- **E:** The LNG-IUS is hormonal and UKMEC 3.

Key point: Breast cancer is the main condition where all hormonal methods are restricted.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 387 · Medical Conditions · **Hard** · C2

A 25-year-old woman with Wilson's disease asks for long-acting contraception.

Which method should be avoided?

A. Copper intrauterine device
B. Etonogestrel implant
C. LNG-IUS
D. Male condoms
E. Progestogen-only pill

Answer: A. Copper intrauterine device

Wilson's disease is a disorder of copper metabolism. The copper IUD is traditionally avoided (UKMEC 2 in current guidance but often avoided in practice), and the LNG-IUS or implant are good alternatives.

Why not the others

- **B:** The implant is suitable.
- **C:** The LNG-IUS contains no copper.
- **D:** Condoms are safe.
- **E:** The POP is safe.

Key point: Copper allergy is another reason to avoid the copper IUD.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 388 · Medical Conditions · **Moderate** · C3

A 33-year-old woman with a BMI of 37 kg/m² and no other risk factors wants to start the combined pill.

What is the UKMEC category for the combined pill at this BMI?

A. UKMEC 1
B. UKMEC 2
C. UKMEC 3
D. UKMEC 4
E. Not covered by UKMEC

Answer: C. UKMEC 3

A BMI of 35 or more is UKMEC 3 for combined hormonal contraception because of increased VTE risk. Progestogen-only methods and IUDs are safer options.

Why not the others

- **A:** UKMEC 1 is no restriction.
- **B:** UKMEC 2 applies to a BMI of 30–34.
- **D:** UKMEC 4 applies only with additional major risk factors.
- **E:** Obesity is covered.

Key point: Multiple cardiovascular risk factors together can make combined methods UKMEC 3 or 4.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 389 · Medical Conditions · **Hard** · C3

A 35-year-old woman with type 1 diabetes for 25 years has retinopathy and nephropathy. She wants contraception.

Which method is most appropriate?

A. Combined patch
B. Combined pill
C. Combined vaginal ring
D. LNG-IUS
E. No method is safe

Answer: D. LNG-IUS

Diabetes with vascular complications or duration over 20 years is UKMEC 3 or 4 for combined methods. The LNG-IUS, implant, POP and copper IUD are suitable. Pregnancy should be planned with good glucose control.

Why not the others

- **A:** The patch contains oestrogen.
- **B:** Combined pills are contraindicated.
- **C:** The ring contains oestrogen.
- **E:** Several methods are safe.

Key point: Women with diabetes need effective contraception until pre-pregnancy optimisation.

Reference: Gynaecology by Ten Teachers — Contraception; Medical disorders in pregnancy

MCQ 390 · Medical Conditions · **Hard** · C3

A 26-year-old woman with epilepsy takes sodium valproate. She is sexually active and does not want pregnancy now.

What is the most appropriate contraceptive advice?

A. Condoms alone are sufficient
B. Contraception is not needed if she takes folic acid
C. Highly effective contraception such as an IUD or implant is required
D. She must stop valproate before starting any contraception
E. The combined pill is the only option

Answer: C. Highly effective contraception such as an IUD or implant is required

Valproate is highly teratogenic, causing major malformations and developmental delay. Women of childbearing potential on valproate must use highly effective contraception (user-independent methods such as an IUD or implant) as part of a pregnancy prevention programme.

Why not the others

- **A:** Condoms have a higher failure rate.
- **B:** Folic acid does not prevent valproate harm.
- **D:** Valproate should not be stopped abruptly.
- **E:** Other methods are better and user-independent.

Key point: Valproate is not an enzyme inducer, so it does not reduce hormonal contraception.

Reference: Gynaecology by Ten Teachers — Contraception; Drug interactions

MCQ 391 · Combined Hormonal Contraception · **Moderate** · C2

A 21-year-old woman on the combined pill is prescribed amoxicillin for a chest infection.

What is the correct advice?

A. Double the pill dose
B. No extra precautions are needed unless she has vomiting or diarrhoea
C. Stop the pill during antibiotics
D. Take emergency contraception
E. Use condoms for 7 days after the antibiotics

Answer: B. No extra precautions are needed unless she has vomiting or diarrhoea

Non-enzyme-inducing antibiotics such as amoxicillin do not reduce the effectiveness of the combined pill. Extra precautions are needed only if vomiting or diarrhoea affects absorption.

Why not the others

- **A:** Doubling the dose is unnecessary.
- **C:** Stopping the pill increases risk.
- **D:** EC is not needed.
- **E:** This was old advice and is no longer recommended.

Key point: Only enzyme-inducing antibiotics (rifampicin, rifabutin) reduce effectiveness.

Reference: Gynaecology by Ten Teachers — Contraception; Drug interactions

MCQ 392 · Combined Hormonal Contraception · **Easy** · C2

A 27-year-old woman on the combined pill asks whether she can take it continuously to avoid monthly bleeds.

What is the correct advice?

A. Continuous or tailored use is safe and may reduce symptoms
B. It is dangerous to skip the pill-free week
C. It reduces effectiveness
D. It requires a different pill
E. It will cause infertility

Answer: A. Continuous or tailored use is safe and may reduce symptoms

Tailored regimens (shortened or no pill-free interval, or extended use) are safe, may reduce headaches, heavy bleeding and period pain, and may even improve effectiveness by shortening the hormone-free interval.

Why not the others

- **B:** Skipping the break is safe.
- **C:** Effectiveness may be slightly better.
- **D:** Most monophasic pills can be used this way.
- **E:** It does not cause infertility.

Key point: Breakthrough bleeding is common with continuous use; a 4-day break can be taken if needed.

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 393 · Combined Hormonal Contraception · **Hard** · C2

A 30-year-old woman asks why some combined pills carry a higher risk of venous thrombosis than others.

Which progestogen in combined pills has the lowest VTE risk?

A. Cyproterone acetate
B. Desogestrel
C. Drospirenone
D. Gestodene
E. Levonorgestrel

Answer: E. Levonorgestrel

Combined pills with levonorgestrel or norethisterone have the lowest VTE risk (about 5–7 per 10,000 women per year). Those with desogestrel, gestodene, drospirenone or cyproterone acetate have about 9–12 per 10,000.

Why not the others

- **A:** Cyproterone pills have a higher risk.
- **B:** Desogestrel pills have a higher risk.
- **C:** Drospirenone pills have a higher risk.
- **D:** Gestodene pills have a higher risk.

Key point: VTE risk in pregnancy and postpartum is much higher than with any pill.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 394 · Starting Contraception · **Moderate** · C3

A 23-year-old woman attends on day 18 of her cycle wanting to start the combined pill today. Her last unprotected intercourse was 10 days ago. Pregnancy test is negative.

What is the recommended approach?

A. Insert an IUD instead
B. Quick start the pill today, use condoms for 7 days, and do a pregnancy test in 3 weeks
C. Refuse until a pregnancy test in 6 weeks
D. Start only on the first day of the next period
E. Take emergency contraception now

Answer: B. Quick start the pill today, use condoms for 7 days, and do a pregnancy test in 3 weeks

Quick starting allows contraception to begin immediately when pregnancy is reasonably excluded. Condoms are used for 7 days and a pregnancy test is done 3 weeks after the last unprotected sex.

Why not the others

- **A:** An IUD is not necessary.
- **C:** Delaying exposes her to pregnancy risk.
- **D:** Waiting for a period is unnecessary.
- **E:** Unprotected sex was 10 days ago; oral EC works only within 5 days.

Key point: Quick start applies to most hormonal methods.

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 395 · Progestogen-only Pill · **Moderate** · C2

A 35-year-old woman takes a traditional levonorgestrel progestogen-only pill. She asks how it works.

What is the main mechanism of action of traditional POPs?

A. Complete ovulation inhibition in every cycle
B. Destruction of sperm
C. Increase in uterine contractions
D. Prevention of embryo implantation only
E. Thickening of cervical mucus

Answer: E. Thickening of cervical mucus

Traditional POPs work mainly by thickening cervical mucus, which blocks sperm. They inhibit ovulation in only some cycles. Desogestrel POPs inhibit ovulation in almost all cycles.

Why not the others

- **A:** Traditional POPs do not inhibit ovulation reliably.
- **B:** POPs do not destroy sperm.
- **C:** POPs do not increase contractions.
- **D:** Effects on the endometrium are secondary.

Key point: The mucus effect wears off after about 27 hours, hence the strict 3-hour window.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 396 · Emergency Contraception · **Hard** · C3

A 30-year-old woman with regular 28-day cycles had unprotected intercourse on day 10 and again on day 17. She attends on day 18.

Can a copper IUD be inserted as emergency contraception now?

A. No, because she is past ovulation
B. No, because there were two episodes
C. Only after a negative pregnancy test in 3 weeks
D. Only within 72 hours of the first episode
E. Yes, up to 5 days after the earliest expected ovulation (day 19 in her cycle)

Answer: E. Yes, up to 5 days after the earliest expected ovulation (day 19 in her cycle)

A copper IUD can be inserted up to 5 days after the first unprotected intercourse, or up to 5 days after the earliest likely ovulation (day 14 in a 28-day cycle, so up to day 19), whichever is later. It works before implantation.

Why not the others

- **A:** It can be used up to 5 days after expected ovulation.
- **B:** Multiple episodes do not exclude an IUD within the time limit.
- **C:** Waiting would miss the window.
- **D:** The 72-hour limit applies to levonorgestrel.

Key point: The copper IUD is the most effective emergency contraception.

Reference: Gynaecology by Ten Teachers — Contraception; FSRH guidance

MCQ 397 · Natural Methods · **Easy** · C2

A 28-year-old married woman with regular cycles does not want hormonal or intrauterine methods for religious reasons. She asks about natural family planning.

What is correct about fertility awareness methods?

A. They are equally effective as the implant with typical use
B. They are reliable with irregular cycles
C. They need careful teaching, and typical-use failure is about 2–23% per year
D. They protect against STIs
E. They require no training

Answer: C. They need careful teaching, and typical-use failure is about 2–23% per year

Fertility awareness methods use cycle length, temperature and cervical mucus to identify fertile days. With good teaching and consistent use they can be effective, but typical use failure is much higher.

Why not the others

- **A:** They are much less effective than the implant.
- **B:** Irregular cycles make them unreliable.
- **D:** They do not protect against STIs.
- **E:** Training is essential.

Key point: Respect the woman's values while explaining effectiveness honestly.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 398 · Contraception after Abortion · **Easy** · C3

A 26-year-old woman has a surgical evacuation for a miscarriage at 9 weeks. She wants to start an implant.

When can the implant be inserted?

A. After 3 months
B. After 6 weeks
C. After her next period
D. Immediately, at the time of the procedure
E. Only after a negative pregnancy test in 3 weeks

Answer: D. Immediately, at the time of the procedure

All methods, including implants, injections and IUDs, can be started immediately after miscarriage or abortion. Ovulation can return within 2 weeks.

Why not the others

- **A:** Three months leaves her at risk.
- **B:** Six weeks is unnecessary.
- **C:** Ovulation can occur before the next period.
- **E:** Waiting is unnecessary.

Key point: Immediate contraception after abortion reduces repeat unintended pregnancy.

Reference: Gynaecology by Ten Teachers — Contraception

MCQ 399 · Intrauterine Contraception · **Moderate** · C3

A 26-year-old woman had a copper IUD inserted 2 weeks ago. She now has lower abdominal pain, fever and purulent discharge. Chlamydia swab is positive.

What is the most appropriate management?

A. Antibiotics for PID and leave the IUD in place, reviewing in 48–72 hours
B. Hysterectomy
C. Remove the IUD and insert a new one
D. Remove the IUD immediately without antibiotics
E. Stop all treatment and observe

Answer: A. Antibiotics for PID and leave the IUD in place, reviewing in 48–72 hours

PID in an IUD user is treated with antibiotics. The device can usually be left in place; removal is considered if there is no improvement after 48–72 hours. Removal requires emergency contraception if there was recent intercourse.

Why not the others

- **B:** Hysterectomy is not indicated.
- **C:** A new IUD is not inserted during active infection.
- **D:** Antibiotics are needed; removal alone does not treat infection.
- **E:** PID needs treatment.

Key point: Screen for STIs before IUD insertion in women at risk.

Reference: Gynaecology by Ten Teachers — Contraception; Pelvic infection

MCQ 400 · Contraception and HIV · **Hard** · C3

A 30-year-old woman living with HIV takes an efavirenz-based antiretroviral regimen. She wants contraception.

Which method is unaffected by efavirenz?

A. Combined oral pill
B. Etonogestrel implant
C. Levonorgestrel emergency contraception at standard dose
D. Levonorgestrel intrauterine system
E. Progestogen-only pill

Answer: D. Levonorgestrel intrauterine system

Efavirenz is an enzyme inducer that reduces levels of oral hormones and the implant. Intrauterine methods (LNG-IUS and copper IUD) and DMPA are not affected. Condoms are also recommended to prevent HIV transmission.

Why not the others

- **A:** Efavirenz reduces the pill's effectiveness.
- **B:** Efavirenz reduces implant effectiveness.
- **C:** A double dose is needed with enzyme inducers.
- **E:** The POP is affected.

Key point: Check drug interactions for all antiretrovirals.

Reference: Gynaecology by Ten Teachers — Contraception; Drug interactions

CHAPTER 9

Menopause and HRT

MCQ 401 · Hormone Replacement Therapy · **Easy** · C3

A 51-year-old woman has troublesome hot flushes and night sweats for 8 months that disturb her sleep. She had a total abdominal hysterectomy for fibroids 5 years ago. She has no history of breast cancer, thrombosis or liver disease and her BP is normal.

What is the most appropriate hormone replacement therapy?

A. Continuous combined HRT
B. Oestrogen-only HRT
C. Sequential combined HRT
D. Tibolone
E. Vaginal oestrogen alone

Answer: B. Oestrogen-only HRT

A woman without a uterus does not need a progestogen, because there is no endometrium to protect. Oestrogen-only HRT treats vasomotor symptoms and avoids the extra breast cancer risk of added progestogen.

Why not the others

- **A:** Continuous combined HRT is for women with a uterus who are more than 12 months past their last period.
- **C:** Sequential combined HRT is for women with a uterus who are perimenopausal.
- **D:** Tibolone is an alternative for women with a uterus; it has no advantage here.
- **E:** Vaginal oestrogen treats local urogenital atrophy but not hot flushes.

Key point: Uterus present → oestrogen plus progestogen. No uterus → oestrogen alone (transdermal if VTE risk).

Reference: Gynaecology by Ten Teachers — The menopause and HRT; NICE NG23

MCQ 402 · Definitions · **Easy** · C2

A 52-year-old woman's last menstrual period was 13 months ago. She has hot flushes and is not on any hormones.

How is menopause defined?

A. A raised FSH on a single test
B. Any woman over 50
C. The final menstrual period, confirmed after 12 months of amenorrhoea
D. The first missed period after age 45
E. The onset of hot flushes

Answer: C. The final menstrual period, confirmed after 12 months of amenorrhoea

Menopause is the permanent end of menstruation due to loss of ovarian follicular activity. It is diagnosed retrospectively after 12 consecutive months without periods. The average age in the UK is 51.

Why not the others

- **A:** A single FSH is unreliable around the menopause.
- **B:** Age alone does not define it.
- **D:** A missed period may be perimenopause.
- **E:** Flushes start in perimenopause.

Key point: Perimenopause is the time of irregular cycles and symptoms before the final period.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 403 · Diagnosis · **Moderate** · C3

A 47-year-old woman has irregular periods, hot flushes and night sweats for 6 months. She is otherwise well and not on hormonal contraception.

How should perimenopause be diagnosed in her?

A. AMH level
B. Clinically, based on age and symptoms, without blood tests
C. Pelvic ultrasound
D. Serial FSH every month
E. Serum oestradiol

Answer: B. Clinically, based on age and symptoms, without blood tests

In women over 45 with typical symptoms, perimenopause and menopause are diagnosed clinically. FSH is unreliable because it fluctuates in perimenopause. FSH testing is reserved for women under 45 or when the diagnosis is uncertain.

Why not the others

- **A:** AMH is not recommended to diagnose menopause.
- **C:** Ultrasound does not diagnose menopause.
- **D:** Serial FSH is unnecessary.
- **E:** Oestradiol fluctuates and is unreliable.

Key point: Under 40 with symptoms: test FSH twice to diagnose POI.

Reference: Gynaecology by Ten Teachers — The menopause; NICE NG23

MCQ 404 · Symptoms · **Easy** · C2

A 54-year-old woman has vaginal dryness, pain with intercourse, burning and recurrent urinary infections since her menopause 3 years ago. Examination shows pale, thin vaginal walls with loss of rugae.

What is this condition called?

A. Candidiasis
B. Genitourinary syndrome of menopause
C. Lichen planus
D. Lichen sclerosus
E. Vulval intraepithelial neoplasia

Answer: B. Genitourinary syndrome of menopause

Genitourinary syndrome of menopause (vulvovaginal atrophy) is caused by oestrogen deficiency. The vaginal epithelium becomes thin and dry, pH rises, lactobacilli fall, and urinary symptoms and infections increase.

Why not the others

- **A:** Candida causes itching and thick discharge, less common after menopause.
- **C:** Lichen planus causes erosive red areas.
- **D:** Lichen sclerosus causes white plaques on the vulva.
- **E:** VIN causes raised or pigmented lesions.

Key point: Unlike flushes, genitourinary symptoms often worsen over time without treatment.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 405 · Symptoms · **Hard** · C2

A 50-year-old woman asks why menopause causes hot flushes. Her doctor explains the role of a group of neurones in the hypothalamus.

What causes vasomotor symptoms?

A. Excess progesterone
B. High thyroxine
C. Loss of oestrogen feedback causing overactivity of KNDy neurones and a narrowed thermoneutral zone
D. Low cortisol
E. Raised prolactin

Answer: C. Loss of oestrogen feedback causing overactivity of KNDy neurones and a narrowed thermoneutral zone

Falling oestrogen removes inhibition of kisspeptin–neurokinin B–dynorphin (KNDy) neurones in the hypothalamus. Their overactivity narrows the thermoneutral zone, so small rises in core temperature trigger heat loss (flushing and sweating).

Why not the others

- **A:** Progesterone falls after menopause.
- **B:** Thyroxine is normal.
- **D:** Cortisol is not the cause.
- **E:** Prolactin is not raised.

Key point: Fezolinetant, a neurokinin 3 receptor antagonist, is a new non-hormonal treatment for flushes.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 406 · HRT Regimens · **Moderate** · C3

A 48-year-old woman with a uterus still has irregular periods and troublesome hot flushes. She wants HRT.

Which HRT regimen is most appropriate?

A. Continuous combined HRT
B. No HRT until periods stop
C. Oestrogen only
D. Sequential (cyclical) combined HRT
E. Tibolone

Answer: D. Sequential (cyclical) combined HRT

Perimenopausal women with a uterus should use sequential combined HRT: oestrogen daily with a progestogen for 10–14 days each month, giving a regular withdrawal bleed. Continuous combined HRT used too early causes irregular bleeding.

Why not the others

- **A:** Continuous combined is for women over 12 months after the last period.
- **B:** HRT can start in perimenopause.
- **C:** Oestrogen alone risks endometrial hyperplasia with a uterus.
- **E:** Tibolone is for postmenopausal women.

Key point: After 1 year on sequential HRT (or at 54), switch to continuous combined.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 407 · HRT Regimens · **Moderate** · C3

A 55-year-old woman, 4 years after her last period, has severe hot flushes. She has a uterus and no contraindications to HRT.

Which regimen is most appropriate?

A. Continuous combined oestrogen and progestogen
B. Oestrogen only
C. Progestogen only
D. Sequential combined HRT
E. Vaginal oestrogen only

Answer: A. Continuous combined oestrogen and progestogen

Postmenopausal women with a uterus who are more than 12 months after their last period should use continuous combined HRT. It usually leads to no bleeding after the first few months.

Why not the others

- **B:** Oestrogen alone increases endometrial cancer risk with a uterus.
- **C:** Progestogen alone is not effective HRT.
- **D:** Sequential HRT causes monthly bleeds unnecessarily.
- **E:** Vaginal oestrogen does not relieve flushes.

Key point: Irregular bleeding beyond 6 months on continuous combined HRT needs investigation.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 408 · HRT Routes · **Moderate** · C3

A 52-year-old woman with a BMI of 36 kg/m² and migraine wants HRT for severe flushes. She has a uterus and her last period was 2 years ago.

Which HRT is most appropriate?

A. Oral conjugated oestrogen alone
B. Oral continuous combined HRT
C. Oral oestrogen with no progestogen
D. Tibolone
E. Transdermal oestradiol with micronised progesterone or LNG-IUS

Answer: E. Transdermal oestradiol with micronised progesterone or LNG-IUS

Transdermal oestradiol avoids first-pass liver metabolism and does not increase VTE or stroke risk above baseline. It is preferred in women with obesity, migraine or VTE risk. A progestogen is needed to protect the endometrium.

Why not the others

- **A:** Oral oestrogen alone is unsafe with a uterus and raises VTE risk.
- **B:** Oral HRT increases VTE risk.
- **C:** No progestogen is unsafe with a uterus.
- **D:** Tibolone carries a small stroke risk, especially over 60.

Key point: Micronised progesterone has the least effect on breast cancer and VTE risk.

Reference: Gynaecology by Ten Teachers — The menopause; NICE NG23

MCQ 409 · HRT Risks · **Moderate** · C2

A 51-year-old woman with a uterus asks about the risk of breast cancer with HRT.

Which statement is correct?

A. All HRT doubles breast cancer risk immediately
B. Combined HRT slightly increases risk with duration, mostly reversing after stopping; oestrogen-only has little or no increase
C. HRT causes breast cancer in most women
D. HRT has no effect on breast cancer risk
E. Vaginal oestrogen greatly increases risk

Answer: B. Combined HRT slightly increases risk with duration, mostly reversing after stopping; oestrogen-only has little or no increase

Combined HRT is associated with a small increase in breast cancer risk related to duration of use, which falls after stopping. Oestrogen-only HRT is associated with little or no change. Being overweight or drinking alcohol carries a similar or larger risk.

Why not the others

- **A:** Risk does not double immediately.
- **C:** Most women on HRT do not develop breast cancer.
- **D:** Combined HRT does have a small effect.
- **E:** Low-dose vaginal oestrogen does not significantly increase risk.

Key point: Put risks in context: alcohol and obesity raise breast cancer risk too.

Reference: Gynaecology by Ten Teachers — The menopause; NICE NG23

MCQ 410 · HRT Risks · **Moderate** · C2

A 53-year-old woman asks about the risk of blood clots with HRT.

Which HRT does not increase VTE risk above baseline?

A. Oral combined HRT
B. Oral oestrogen only
C. Oral tibolone at high dose
D. Raloxifene
E. Transdermal oestradiol

Answer: E. Transdermal oestradiol

Oral oestrogen increases VTE risk by increasing hepatic production of clotting factors. Transdermal oestradiol at standard doses does not increase VTE risk above baseline.

Why not the others

- **A:** Oral combined HRT increases VTE risk.
- **B:** Oral oestrogen increases VTE risk.
- **C:** Tibolone at any dose is not the safest option for VTE.
- **D:** Raloxifene increases VTE risk.

Key point: Previous VTE: transdermal HRT after specialist advice.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 411 · HRT Contraindications · **Easy** · C2

A 55-year-old woman asks for HRT for hot flushes. She has had unexplained vaginal bleeding for 2 months.

What must happen before HRT is started?

A. Bone density scan
B. Mammogram only
C. Nothing; HRT will stop the bleeding
D. Start oestrogen-only HRT
E. The bleeding must be investigated to exclude endometrial cancer

Answer: E. The bleeding must be investigated to exclude endometrial cancer

Undiagnosed postmenopausal bleeding is a contraindication to HRT until endometrial cancer and other causes are excluded by ultrasound and, if indicated, biopsy or hysteroscopy.

Why not the others

- **A:** A DEXA scan does not investigate bleeding.
- **B:** A mammogram is not the priority.
- **C:** HRT could mask cancer.
- **D:** Oestrogen-only HRT could worsen an endometrial cancer.

Key point: Other contraindications: current breast cancer, active VTE, active liver disease.

Reference: Gynaecology by Ten Teachers — The menopause; Malignant disease of the uterus

MCQ 412 · HRT Contraindications · **Hard** · C3

A 49-year-old woman had oestrogen receptor-positive breast cancer 2 years ago and takes tamoxifen. She has severe hot flushes.

Which treatment should be avoided for her flushes?

A. Clonidine
B. Gabapentin
C. Lifestyle advice and cognitive behavioural therapy
D. Paroxetine
E. Venlafaxine

Answer: D. Paroxetine

Paroxetine and fluoxetine strongly inhibit CYP2D6, which converts tamoxifen to its active form endoxifen, possibly reducing tamoxifen's effect. Venlafaxine, gabapentin, clonidine and CBT are safer options. Systemic HRT is generally avoided after breast cancer.

Why not the others

- **A:** Clonidine is an option, though modestly effective.
- **B:** Gabapentin is an option.
- **C:** CBT helps flushes and is safe.
- **E:** Venlafaxine has little CYP2D6 inhibition and is preferred.

Key point: Avoid systemic HRT after breast cancer unless specialist advice is given.

Reference: Gynaecology by Ten Teachers — The menopause; Breast cancer survivors

MCQ 413 · Non-hormonal Treatment · **Moderate** · C3

A 52-year-old woman with a previous pulmonary embolism and a strong family history of breast cancer wants treatment for hot flushes but declines HRT.

Which treatment has evidence for reducing hot flushes?

A. Black cohosh with guaranteed safety
B. Evening primrose oil
C. Fluoxetine with tamoxifen
D. SSRI or SNRI such as citalopram or venlafaxine
E. Vitamin C

Answer: D. SSRI or SNRI such as citalopram or venlafaxine

SSRIs and SNRIs (such as citalopram, escitalopram, venlafaxine) reduce hot flushes by about half. Other options include gabapentin, clonidine, fezolinetant and CBT. Herbal products have uncertain benefit and safety.

Why not the others

- **A:** Black cohosh has variable quality and possible liver toxicity.
- **B:** Evening primrose oil has no proven effect.
- **C:** She is not on tamoxifen, and fluoxetine with tamoxifen should be avoided anyway.
- **E:** Vitamin C has no effect on flushes.

Key point: CBT is recommended for vasomotor symptoms and low mood in menopause.

Reference: Gynaecology by Ten Teachers — The menopause; NICE NG23

MCQ 414 · Genitourinary Syndrome · **Easy** · C3

A 61-year-old woman has vaginal dryness and painful intercourse. She has no hot flushes and does not want systemic HRT. She has a uterus.

What is the most appropriate treatment?

A. Combined oral HRT
B. Low-dose vaginal oestrogen
C. Oral oestrogen only
D. Tibolone
E. Vaginal oestrogen plus oral progestogen

Answer: B. Low-dose vaginal oestrogen

Low-dose vaginal oestrogen (cream, pessary or ring) treats genitourinary symptoms effectively with minimal systemic absorption. It can be used long term and does not need a progestogen. Moisturisers and lubricants also help.

Why not the others

- **A:** Systemic HRT is not needed for local symptoms.
- **C:** Oral oestrogen alone is unsafe with a uterus.
- **D:** Tibolone is systemic and not needed.
- **E:** A progestogen is not needed with low-dose vaginal oestrogen.

Key point: Vaginal oestrogen also reduces recurrent urinary infections after menopause.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 415 · HRT Side Effects · **Moderate** · C3

A 56-year-old woman started continuous combined HRT 9 months ago. She has had irregular light bleeding for the last 3 months. She is not on any other drugs.

What is the most appropriate next step?

A. Double the oestrogen dose
B. Reassure that bleeding is normal at any time on HRT
C. Stop HRT permanently
D. Switch to oestrogen-only HRT
E. Transvaginal ultrasound and endometrial assessment

Answer: E. Transvaginal ultrasound and endometrial assessment

Irregular bleeding is common in the first 3–6 months of continuous combined HRT. Bleeding that persists beyond 6 months, starts after a period of no bleeding, or is heavy needs investigation for endometrial pathology.

Why not the others

- **A:** More oestrogen may worsen bleeding.
- **B:** Bleeding beyond 6 months is not normal.
- **C:** Stopping without investigation misses pathology.
- **D:** Oestrogen alone is unsafe with a uterus.

Key point: Unscheduled bleeding on HRT: check adherence, interactions, smoking and the endometrium.

Reference: Gynaecology by Ten Teachers — The menopause; Malignant disease of the uterus

MCQ 416 · HRT Benefits · **Easy** · C2

A 52-year-old woman taking HRT asks about its effect on her bones.

What effect does HRT have on osteoporosis?

A. It has no effect on bone
B. It increases fracture risk
C. It is only effective after age 70
D. It reduces bone loss and fracture risk while taken
E. It replaces the need for vitamin D in all women

Answer: D. It reduces bone loss and fracture risk while taken

HRT prevents postmenopausal bone loss and reduces the risk of vertebral and hip fractures while it is taken. It is first-line for prevention of osteoporosis in women under 60 with menopausal symptoms.

Why not the others

- **A:** HRT protects bone.
- **B:** It reduces fractures.
- **C:** It is used mainly under 60 for this purpose.
- **E:** Vitamin D and calcium may still be needed.

Key point: The bone benefit wears off after stopping HRT.

Reference: Gynaecology by Ten Teachers — The menopause; Osteoporosis

MCQ 417 · Duration of HRT · **Moderate** · C3

A 58-year-old woman has used HRT for 7 years. She feels well and wants to continue because her flushes return when she stops. She has no new risk factors.

What is the most appropriate advice?

A. She can continue after an individual review of benefits and risks; there is no fixed time limit
B. She must stop at 60
C. She must stop now; 5 years is the maximum
D. She should switch to the combined pill
E. She should take double dose to stop flushes permanently

Answer: A. She can continue after an individual review of benefits and risks; there is no fixed time limit

There is no arbitrary limit on the duration of HRT. Women should have an annual review, and continuing is reasonable if benefits outweigh risks for the individual.

Why not the others

- **B:** Age 60 is not a fixed stopping point.
- **C:** There is no 5-year rule.
- **D:** The combined pill is not HRT at this age.
- **E:** Higher doses increase risk and do not cure flushes.

Key point: Stopping gradually or suddenly makes little difference to symptom recurrence long term.

Reference: Gynaecology by Ten Teachers — The menopause; NICE NG23

MCQ 418 · HRT Benefits · **Hard** · C2

A 50-year-old woman asks whether HRT harms or protects her heart.

What does current evidence suggest about HRT and cardiovascular disease?

A. HRT always causes heart attacks
B. HRT has no effect regardless of age
C. HRT is only safe after age 70
D. HRT is the main treatment for heart disease
E. HRT started before 60 does not increase, and may reduce, cardiovascular risk

Answer: E. HRT started before 60 does not increase, and may reduce, cardiovascular risk

The "timing hypothesis" suggests that HRT started under 60 or within 10 years of menopause does not increase, and may reduce, cardiovascular disease. Starting oral HRT much later carries more risk.

Why not the others

- **A:** Heart attack risk is not increased when started early.
- **B:** Effects depend on timing.
- **C:** Starting after 70 carries more risk.
- **D:** HRT is not a treatment for heart disease.

Key point: HRT should not be started solely to prevent cardiovascular disease.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 419 · Progestogen Component · **Moderate** · C3

A 50-year-old woman wants HRT and needs endometrial protection. She also has heavy periods and needs contraception.

Which progestogen option is most suitable?

A. Cyclical medroxyprogesterone with no contraception
B. LNG-IUS (52 mg) with oestrogen
C. No progestogen
D. Oral norethisterone with copper IUD
E. Tibolone

Answer: B. LNG-IUS (52 mg) with oestrogen

The 52 mg LNG-IUS provides endometrial protection for 5 years as part of HRT, controls heavy bleeding and gives contraception. Oestrogen is given by patch, gel or tablet.

Why not the others

- **A:** HRT is not contraceptive.
- **C:** A progestogen is essential with a uterus.
- **D:** A copper IUD may worsen heavy bleeding.
- **E:** Tibolone is not suitable for perimenopausal women.

Key point: HRT does not provide contraception; women need contraception until age 55 or as advised.

Reference: Gynaecology by Ten Teachers — The menopause; Contraception

MCQ 420 · Testosterone · **Hard** · C3

A 52-year-old woman on adequate HRT for 6 months has persistent low sexual desire that distresses her. Relationship and psychological factors have been considered.

Which additional treatment may help?

A. Higher-dose oestrogen
B. Progestogen-only pill
C. Sildenafil
D. Testosterone supplementation
E. Thyroxine

Answer: D. Testosterone supplementation

Testosterone can be considered for women with hypoactive sexual desire disorder if HRT alone is not effective. It is given transdermally at doses appropriate for women, with monitoring of levels.

Why not the others

- **A:** Higher oestrogen does not treat low desire.
- **B:** Progestogens may reduce desire.
- **C:** Sildenafil has no proven benefit in women.
- **E:** Thyroxine is for hypothyroidism.

Key point: Monitor testosterone levels to avoid androgenic side effects.

Reference: Gynaecology by Ten Teachers — The menopause; NICE NG23

MCQ 421 · Tibolone · **Moderate** · C2

A 57-year-old woman, 6 years postmenopausal, wants a no-bleed HRT that may also help libido.

What is tibolone?

A. A non-hormonal herbal product
B. A selective oestrogen receptor modulator only
C. A synthetic steroid with oestrogenic, progestogenic and androgenic activity
D. An aromatase inhibitor
E. Pure oestrogen

Answer: C. A synthetic steroid with oestrogenic, progestogenic and androgenic activity

Tibolone is a synthetic steroid whose metabolites have oestrogenic, progestogenic and androgenic effects. It relieves flushes, protects bone, may improve libido and does not stimulate the endometrium. It has a small increased risk of stroke in women over 60.

Why not the others

- **A:** Tibolone is a hormone.
- **B:** Raloxifene is a SERM.
- **D:** Aromatase inhibitors lower oestrogen.
- **E:** It is not pure oestrogen.

Key point: Tibolone is for women more than 12 months after their last period.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 422 · Surgical Menopause · **Moderate** · C3

A 44-year-old woman has had a total hysterectomy and bilateral salpingo-oophorectomy for benign disease. She has severe flushes 2 weeks later.

What is the most appropriate advice?

A. HRT is contraindicated after oophorectomy

B. Oestrogen-only HRT, continued at least until the average age of menopause

C. She needs combined HRT with progestogen

D. Vaginal oestrogen only

E. Wait until 51 before starting HRT

Answer: B. Oestrogen-only HRT, continued at least until the average age of menopause

Surgical menopause causes abrupt and often severe symptoms. Without a uterus she needs oestrogen only (unless she had endometriosis). HRT should be continued at least to the average age of natural menopause to protect bones and heart.

Why not the others

- **A:** HRT is recommended unless there is a specific contraindication.
- **C:** A progestogen is not needed after hysterectomy for benign disease.
- **D:** Vaginal oestrogen does not relieve flushes.
- **E:** Delaying leaves her at risk of osteoporosis.

Key point: If oophorectomy was for endometriosis, combined HRT may be preferred.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 423 · HRT and Contraception · **Moderate** · C2

A 47-year-old woman on sequential HRT patches has regular withdrawal bleeds. She asks whether HRT prevents pregnancy.

What is the correct advice?

A. HRT is a reliable contraceptive

B. HRT makes pregnancy impossible after 45

C. HRT protects only if taken continuously

D. She needs separate contraception (for example a progestogen-only pill or LNG-IUS)

E. She should stop HRT to use the combined pill

Answer: D. She needs separate contraception (for example a progestogen-only pill or LNG-IUS)

Standard HRT does not reliably suppress ovulation and is not a contraceptive. Women who may still ovulate need contraception. A POP or LNG-IUS can be combined with HRT.

Why not the others

- **A:** HRT is not contraceptive.
- **B:** Pregnancy is still possible after 45.
- **C:** Continuous HRT is still not contraceptive.
- **E:** Many women prefer to continue HRT with a compatible method.

Key point: The desogestrel POP can be used with HRT but does not protect the endometrium on its own.

Reference: Gynaecology by Ten Teachers — The menopause; Contraception

MCQ 424 · Osteoporosis · **Easy** · C2

A 64-year-old woman has a DEXA scan after a wrist fracture from a fall from standing height. Her lumbar spine T-score is −2.8.

What does this result indicate?

A. Normal bone density
B. Osteomalacia
C. Osteopenia
D. Osteoporosis
E. Paget's disease

Answer: D. Osteoporosis

WHO defines osteoporosis as a T-score of −2.5 or lower. A T-score between −1 and −2.5 is osteopenia. A fragility fracture plus osteoporosis on DEXA calls for treatment.

Why not the others

- **A:** Normal is −1 or above.
- **B:** Osteomalacia is a mineralisation defect from vitamin D deficiency.
- **C:** Osteopenia is between −1 and −2.5.
- **E:** Paget's disease shows increased bone turnover and is not diagnosed by T-score.

Key point: A fall from standing height that causes a fracture is a fragility fracture.

Reference: Gynaecology by Ten Teachers — The menopause; Osteoporosis

MCQ 425 · Osteoporosis · **Moderate** · C3

A 68-year-old woman with osteoporosis is prescribed weekly alendronic acid.

How should alendronic acid be taken?

A. At bedtime with milk
B. Crushed and mixed with food
C. On an empty stomach with a full glass of water, staying upright for 30 minutes before food
D. With calcium tablets at the same time
E. With orange juice after breakfast

Answer: C. On an empty stomach with a full glass of water, staying upright for 30 minutes before food

Alendronate is poorly absorbed and can cause oesophagitis. It is taken on an empty stomach with plain water, standing or sitting upright for at least 30 minutes, before food, drink or other medicines.

Why not the others

- **A:** Lying down increases oesophageal injury and milk reduces absorption.
- **B:** Food reduces absorption.
- **D:** Calcium binds the drug; separate them.
- **E:** Juice reduces absorption.

Key point: Ensure adequate calcium and vitamin D, taken at a different time of day.

Reference: Gynaecology by Ten Teachers — Osteoporosis

MCQ 426 · Osteoporosis · **Hard** · C3

A 72-year-old woman with osteoporosis cannot tolerate oral bisphosphonates because of oesophagitis and has reduced kidney function (eGFR 28 mL/min).

Which treatment is most appropriate?

A. Calcium alone
B. Denosumab with calcium and vitamin D
C. High-dose oral alendronate
D. Intravenous zoledronic acid
E. Oestrogen-only HRT started at 72

Answer: B. Denosumab with calcium and vitamin D

Denosumab, a RANKL antibody given by 6-monthly injection, is effective and can be used in renal impairment, unlike bisphosphonates (avoided below eGFR about 30–35). Stopping it suddenly causes rebound bone loss, so a plan for continuation is needed.

Why not the others

- **A:** Calcium alone is insufficient.
- **C:** She cannot tolerate oral bisphosphonates.
- **D:** Zoledronic acid is avoided with an eGFR under 35.
- **E:** Starting HRT at 72 carries more risk than benefit.

Key point: Check calcium before denosumab; hypocalcaemia can occur.

Reference: Gynaecology by Ten Teachers — Osteoporosis

MCQ 427 · Definitions · **Easy** · C2

A 43-year-old woman has had no periods for 14 months with hot flushes. FSH is raised on two occasions.

What is this called?

A. Early menopause
B. Late menopause
C. Normal menopause
D. Perimenopause
E. Premature ovarian insufficiency

Answer: A. Early menopause

Menopause between 40 and 45 is early menopause. Before 40 it is premature ovarian insufficiency. Both carry long-term risks to bone and heart, and HRT is advised at least until the average age of menopause.

Why not the others

- **B:** Late menopause is after about 55.
- **C:** Normal menopause is about 45–55 (average 51).
- **D:** She has had 12 months of amenorrhoea.
- **E:** POI is before 40.

Key point: Smoking brings menopause forward by about 1–2 years.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 428 · Osteoporosis · **Moderate** · C3

A 59-year-old woman is assessed for fracture risk. She smokes, her mother had a hip fracture, she took prednisolone for 2 years, and her BMI is 19 kg/m².

Which tool estimates her 10-year probability of major osteoporotic fracture?

A. APGAR
B. Bishop score
C. CHA2DS2-VASc
D. FRAX
E. Wells score

Answer: D. FRAX

FRAX calculates 10-year probability of hip and major osteoporotic fracture from clinical risk factors (age, BMI, prior fracture, parental hip fracture, smoking, glucocorticoids, alcohol, rheumatoid arthritis) with or without bone density.

Why not the others

- **A:** APGAR assesses newborns.
- **B:** Bishop score assesses the cervix.
- **C:** CHA2DS2-VASc assesses stroke risk in atrial fibrillation.
- **E:** Wells score assesses VTE probability.

Key point: Long-term glucocorticoids are a major cause of secondary osteoporosis.

Reference: Gynaecology by Ten Teachers — Osteoporosis

MCQ 429 · Osteoporosis · **Hard** · C3

A 64-year-old woman with osteoporosis and a strong family history of breast cancer cannot take bisphosphonates. She has no history of VTE and no flushes.

Which drug reduces vertebral fractures and also lowers the risk of invasive oestrogen receptor-positive breast cancer?

A. Calcitonin
B. Denosumab
C. Raloxifene
D. Strontium
E. Tibolone

Answer: C. Raloxifene

Raloxifene is a selective oestrogen receptor modulator that acts like oestrogen on bone (reducing vertebral fractures) but blocks oestrogen in the breast, reducing ER-positive breast cancer. It increases VTE risk and can worsen hot flushes.

Why not the others

- **A:** Calcitonin is rarely used and has no breast effect.
- **B:** Denosumab protects bone but has no breast cancer benefit.
- **D:** Strontium is no longer widely used.
- **E:** Tibolone may increase breast cancer recurrence in women with prior breast cancer.

Key point: Raloxifene does not reduce hip fractures.

Reference: Gynaecology by Ten Teachers — Osteoporosis

MCQ 430 · HRT Risks · **Moderate** · C2

A 55-year-old woman with a uterus asks why she cannot take oestrogen on its own.

What is the main risk of unopposed oestrogen in a woman with a uterus?

A. Breast cancer only
B. Cervical cancer
C. Endometrial hyperplasia and cancer
D. Ovarian torsion
E. Uterine fibroids becoming malignant

Answer: C. Endometrial hyperplasia and cancer

Oestrogen stimulates endometrial growth. Without a progestogen, it causes endometrial hyperplasia and increases endometrial cancer risk several-fold. A progestogen protects the endometrium.

Why not the others

- **A:** Breast risk is not the reason for adding a progestogen.
- **B:** Cervical cancer is HPV-related.
- **D:** Oestrogen does not cause torsion.
- **E:** Fibroids rarely become malignant.

Key point: The progestogen is for the endometrium, not for symptom relief.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 431 · HRT Side Effects · **Moderate** · C3

A 52-year-old woman on sequential HRT has bloating, breast tenderness and low mood only during the progestogen phase each month.

What is the most appropriate change?

A. Add a second progestogen
B. Increase the oestrogen dose
C. Stop HRT
D. Switch to an LNG-IUS or micronised progesterone
E. Switch to oestrogen-only HRT without endometrial protection

Answer: D. Switch to an LNG-IUS or micronised progesterone

These are progestogenic side effects. Changing the type or route of progestogen (micronised progesterone or the LNG-IUS, which has low systemic levels) often helps while keeping endometrial protection.

Why not the others

- **A:** More progestogen worsens symptoms.
- **B:** More oestrogen does not treat progestogenic effects.
- **C:** Stopping loses the benefits.
- **E:** Endometrial protection is essential with a uterus.

Key point: Oestrogenic side effects (breast tenderness, nausea, leg cramps) usually settle in 3 months.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 432 · Menopause and Mood · **Moderate** · C3

A 50-year-old woman has low mood, anxiety and irritability with hot flushes and night sweats since her periods became irregular. She has no history of depression.

What is the most appropriate first-line treatment for her mood symptoms?

A. Antipsychotic medication
B. Benzodiazepines
C. HRT, with CBT if needed
D. Lithium
E. SSRI as first line before considering HRT

Answer: C. HRT, with CBT if needed

Low mood arising with the menopause often improves with HRT, which also treats vasomotor symptoms. CBT helps. Antidepressants are considered if there is a clinical diagnosis of depression; there is no evidence they help menopausal low mood without depression.

Why not the others

- **A:** Antipsychotics are not indicated.
- **B:** Benzodiazepines cause dependence.
- **D:** Lithium is for bipolar disorder.
- **E:** SSRIs are not first-line for menopause-associated low mood without depression.

Key point: Always screen for depression and refer if severe.

Reference: Gynaecology by Ten Teachers — The menopause; NICE NG23

MCQ 433 · HRT Regimens · **Hard** · C3

A 51-year-old woman with a uterus uses oestradiol gel and wants to take micronised progesterone for endometrial protection on a sequential regimen.

What is the correct sequential dose of oral micronised progesterone?

A. 100 mg daily for 5 days a month
B. 200 mg daily for 12 days each 28-day cycle
C. 25 mg daily continuously
D. 400 mg once a month
E. No progesterone is needed with gel

Answer: B. 200 mg daily for 12 days each 28-day cycle

For sequential HRT, micronised progesterone 200 mg at night for 12 days of each 28-day cycle protects the endometrium. For continuous combined HRT the dose is 100 mg daily.

Why not the others

- **A:** Five days is too short.
- **C:** 25 mg is too low.
- **D:** A single monthly dose does not protect the endometrium.
- **E:** Gel is systemic oestrogen and needs progestogen.

Key point: Higher oestrogen doses may need higher progestogen doses.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 434 · HRT and Dementia · **Moderate** · C2

A 53-year-old woman whose mother had Alzheimer's disease asks whether HRT will prevent dementia.

What is the correct advice?

A. HRT causes dementia in all users
B. HRT cures Alzheimer's disease
C. HRT is not recommended to prevent dementia; current evidence does not show clear benefit
D. HRT prevents dementia in all women
E. She must start HRT now to prevent dementia

Answer: C. HRT is not recommended to prevent dementia; current evidence does not show clear benefit

Evidence on HRT and dementia is mixed and does not support using HRT to prevent dementia. HRT is used for symptom relief and bone protection, after individual discussion of risks and benefits.

Why not the others

- **A:** HRT does not cause dementia in all users.
- **B:** HRT does not treat Alzheimer's disease.
- **D:** There is no clear preventive benefit.
- **E:** There is no evidence-based reason to start HRT for this.

Key point: Brain fog in menopause often improves with treatment of sleep and flushes.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 435 · Genitourinary Syndrome · **Hard** · C3

A 60-year-old woman with oestrogen receptor-positive breast cancer takes letrozole. She has severe vaginal dryness and pain with intercourse despite regular moisturisers and lubricants.

What is the most appropriate next step?

A. Combined systemic HRT
B. Discuss low-dose vaginal oestrogen with her oncology team
C. Oral tibolone
D. Stop letrozole
E. Systemic oestrogen-only HRT

Answer: B. Discuss low-dose vaginal oestrogen with her oncology team

Aromatase inhibitors lower oestrogen to very low levels, causing severe vaginal atrophy. Non-hormonal treatments are first line. If they fail, low-dose vaginal oestrogen can be considered after discussion with the oncologist, because even small absorption may matter with aromatase inhibitors.

Why not the others

- **A:** Systemic HRT is generally avoided after breast cancer.
- **C:** Tibolone increases breast cancer recurrence.
- **D:** Stopping cancer treatment is not appropriate.
- **E:** Systemic oestrogen is avoided.

Key point: Vaginal DHEA (prasterone) is another option for some women.

Reference: Gynaecology by Ten Teachers — The menopause; Breast cancer survivors

MCQ 436 · Genitourinary Syndrome · **Moderate** · C3

A 66-year-old woman has had four urinary infections in a year. She has vaginal dryness. Urine cultures grow E. coli each time. Renal tract ultrasound is normal.

Which treatment most reduces recurrence?

A. Cranberry juice alone
B. Long-term ciprofloxacin
C. Oral oestrogen-only HRT
D. Vaginal oestrogen
E. Vitamin C

Answer: D. Vaginal oestrogen

Vaginal oestrogen restores the vaginal epithelium and lactobacilli and lowers vaginal pH, reducing recurrent urinary infections in postmenopausal women. Prophylactic antibiotics are considered if this is not enough.

Why not the others

- **A:** Cranberry has limited evidence.
- **B:** Long-term quinolones have serious side effects.
- **C:** Systemic HRT is less effective for this purpose.
- **E:** Vitamin C has no proven benefit.

Key point: Methenamine hippurate is a non-antibiotic option.

Reference: Gynaecology by Ten Teachers — The menopause; Urogynaecology

MCQ 437 · HRT in Medical Conditions · **Moderate** · C3

A 54-year-old woman with type 2 diabetes and well-controlled hypertension has severe hot flushes. She has a uterus.

What is the correct advice about HRT?

A. HRT can be used, preferably transdermal oestradiol with a progestogen
B. HRT is contraindicated in diabetes
C. HRT is contraindicated with treated hypertension
D. HRT is safe only after age 65
E. She must stop her diabetes drugs

Answer: A. HRT can be used, preferably transdermal oestradiol with a progestogen

Type 2 diabetes and controlled hypertension are not contraindications to HRT. Transdermal oestrogen is preferred to minimise VTE and stroke risk. A progestogen is needed because she has a uterus.

Why not the others

- **B:** Diabetes is not a contraindication.
- **C:** Controlled hypertension is not a contraindication.
- **D:** Starting at 65 carries more risk.
- **E:** Diabetes treatment continues.

Key point: Uncontrolled hypertension should be treated before starting HRT.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 438 · HRT Contraindications · **Moderate** · C2

A 53-year-old woman with severe flushes is being considered for HRT.

Which condition is a contraindication to systemic HRT?

A. Controlled hypertension
B. Current breast cancer
C. Family history of osteoporosis
D. Migraine without aura
E. Uterine fibroids

Answer: B. Current breast cancer

Current or suspected breast cancer is an absolute contraindication to systemic HRT. Others include undiagnosed vaginal bleeding, active VTE or arterial disease, and active liver disease.

Why not the others

- **A:** Controlled hypertension is not a contraindication.
- **C:** Family history of osteoporosis supports HRT use.
- **D:** Migraine is not a contraindication; transdermal is preferred.
- **E:** Fibroids may enlarge slightly but are not a contraindication.

Key point: A family history of breast cancer is not in itself a contraindication; it needs discussion.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 439 · Compounded Hormones · **Easy** · C2

A 51-year-old woman asks about "bioidentical" compounded hormones advertised by a private clinic, made individually based on saliva testing.

What is the correct advice?

A. Compounded hormones are proven safer than regulated HRT
B. Compounded hormones are tested and licensed
C. Regulated body-identical HRT (such as transdermal oestradiol and micronised progesterone) is recommended instead
D. Saliva testing reliably guides dosing
E. They do not need endometrial protection

Answer: C. Regulated body-identical HRT (such as transdermal oestradiol and micronised progesterone) is recommended instead

Compounded "bioidentical" hormones are not regulated or tested for safety and effectiveness, and saliva testing is unreliable. Regulated body-identical HRT products are available and recommended.

Why not the others

- **A:** There is no evidence they are safer.
- **B:** They are not licensed.
- **D:** Saliva hormone tests are unreliable.
- **E:** Unopposed oestrogen still risks endometrial cancer.

Key point: "Body-identical" licensed products are different from unregulated compounded ones.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 440 · HRT Risks · **Hard** · C2

A 56-year-old woman with a history of gallstones asks about HRT.

Which route of oestrogen is associated with a lower risk of gallbladder disease?

A. High-dose oral
B. Intramuscular depot
C. Oral conjugated equine
D. Oral oestradiol
E. Transdermal

Answer: E. Transdermal

Oral oestrogen increases the cholesterol saturation of bile via first-pass liver metabolism, increasing gallbladder disease. Transdermal oestradiol has less effect.

Why not the others

- **A:** High-dose oral increases risk.
- **B:** Depot oestrogen is not used in modern HRT.
- **C:** Oral conjugated oestrogen increases risk.
- **D:** Oral oestradiol also passes through the liver.

Key point: Transdermal is preferred whenever liver or clotting effects are a concern.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 441 · Menopause and Smoking · **Easy** · C2

A 40-year-old woman who smokes 25 cigarettes a day asks whether smoking affects her menopause.

What is the effect of smoking on menopause?

A. Menopause occurs about 1–2 years earlier
B. Menopause occurs about 5 years later
C. No effect
D. Smoking prevents hot flushes
E. Smoking protects bones

Answer: A. Menopause occurs about 1–2 years earlier

Smoking is toxic to ovarian follicles and brings menopause forward by about 1–2 years. It also worsens hot flushes and increases osteoporosis and cardiovascular risk.

Why not the others

- **B:** It does not delay menopause.
- **C:** There is a clear effect.
- **D:** Smoking worsens flushes.
- **E:** Smoking increases bone loss.

Key point: Stopping smoking at any age improves health outcomes.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 442 · HRT Benefits · **Moderate** · C2

A 51-year-old woman starting HRT asks which symptoms are most likely to improve.

Which symptom responds best to systemic HRT?

A. Hair loss
B. Hot flushes and night sweats
C. Memory loss from dementia
D. Urinary stress incontinence
E. Weight gain

Answer: B. Hot flushes and night sweats

Systemic HRT is the most effective treatment for vasomotor symptoms, reducing hot flushes and night sweats by about 75–90%. It also helps sleep, mood and joint aches in many women.

Why not the others

- **A:** Hair loss responds variably.
- **C:** HRT does not treat dementia.
- **D:** Systemic HRT may worsen stress incontinence.
- **E:** HRT does not cause or cure weight gain.

Key point: Most women notice benefit within 3 months.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 443 · HRT Routes · **Hard** · C3

A 50-year-old woman has a previous deep vein thrombosis after a long flight 10 years ago. She has severe hot flushes affecting her work and wants HRT after considering alternatives.

What is the most appropriate approach?

A. HRT is absolutely contraindicated forever
B. Oral combined HRT
C. Oral tibolone
D. Refer for specialist advice; transdermal oestradiol may be considered
E. She must start warfarin with HRT

Answer: D. Refer for specialist advice; transdermal oestradiol may be considered

In women with a previous VTE, oral HRT should be avoided. Transdermal oestradiol does not increase VTE risk and may be considered after specialist (haematology) advice and thrombophilia assessment if indicated.

Why not the others

- **A:** It is not absolutely contraindicated.
- **B:** Oral HRT increases VTE risk.
- **C:** Tibolone is not the safest choice.
- **E:** Anticoagulation is not routinely needed for HRT.

Key point: Previous VTE: consider transdermal HRT with specialist input.

Reference: Gynaecology by Ten Teachers — The menopause; NICE NG23

MCQ 444 · Postmenopausal Health · **Easy** · C2

A 58-year-old woman, 7 years past menopause, asks about lifestyle measures to protect her bones.

Which advice is most appropriate?

A. Avoid all dairy
B. Bed rest to avoid falls
C. Drink more alcohol
D. Regular weight-bearing exercise, adequate calcium and vitamin D, stop smoking
E. Start smoking to reduce weight

Answer: D. Regular weight-bearing exercise, adequate calcium and vitamin D, stop smoking

Weight-bearing and muscle-strengthening exercise, adequate calcium and vitamin D, stopping smoking and limiting alcohol all help maintain bone and reduce fracture risk.

Why not the others

- **A:** Dairy is a good source of calcium.
- **B:** Immobility worsens bone loss.
- **C:** Alcohol increases fracture risk.
- **E:** Smoking increases bone loss.

Key point: Falls prevention matters as much as bone density.

Reference: Gynaecology by Ten Teachers — Osteoporosis; The menopause

MCQ 445 · HRT Side Effects · **Moderate** · C3

A 52-year-old woman started oral oestradiol HRT 2 weeks ago. She has breast tenderness, nausea and leg cramps.

What is the most appropriate advice?

A. Add a second oestrogen
B. Stop HRT immediately and never restart
C. Switch to a higher dose
D. These oestrogenic side effects usually settle within 3 months; continue and review
E. These symptoms mean breast cancer

Answer: D. These oestrogenic side effects usually settle within 3 months; continue and review

Oestrogenic side effects are common at the start of HRT and usually settle within 3 months. If they persist, the dose, route or preparation can be changed.

Why not the others

- **A:** Adding more oestrogen worsens symptoms.
- **B:** Stopping is premature.
- **C:** A higher dose worsens symptoms.
- **E:** These are not signs of cancer.

Key point: Review HRT 3 months after starting, then annually.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 446 · Premature Ovarian Insufficiency · **Moderate** · C3

A 33-year-old woman with premature ovarian insufficiency asks whether she should use HRT or the combined pill.

What is the correct advice?

A. Both HRT and the combined pill are options; HRT may be better for bone and blood pressure, the pill gives contraception

B. Neither is needed

C. Only HRT can be used

D. Only the combined pill can be used

E. She should use oestrogen only despite having a uterus

Answer: A. Both HRT and the combined pill are options; HRT may be better for bone and blood pressure, the pill gives contraception

Women with POI need oestrogen replacement until at least age 51. HRT may have better effects on bone and blood pressure, while the combined pill provides contraception (POI has a 5–10% chance of spontaneous pregnancy). The choice depends on her needs.

Why not the others

- **B:** Oestrogen replacement is strongly recommended.
- **C:** The pill is also suitable.
- **D:** HRT is also suitable.
- **E:** A progestogen is needed with a uterus.

Key point: Women with POI need higher oestrogen doses than older menopausal women.

Reference: Gynaecology by Ten Teachers — The menopause; Amenorrhoea

MCQ 447 · Genitourinary Syndrome · **Moderate** · C2

A 62-year-old woman uses vaginal oestrogen pessaries twice weekly for vaginal atrophy. She has a uterus and asks if she needs a progestogen.

What is the correct advice?

A. No progestogen is needed with low-dose vaginal oestrogen

B. She must also take a progestogen

C. She must have yearly endometrial biopsies

D. She must stop after 3 months

E. Vaginal oestrogen is contraindicated with a uterus

Answer: A. No progestogen is needed with low-dose vaginal oestrogen

Low-dose vaginal oestrogen has minimal systemic absorption and does not need progestogen protection. It can be used long term. Any postmenopausal bleeding must still be investigated.

Why not the others

- **B:** A progestogen is not needed.
- **C:** Routine biopsies are not needed.
- **D:** It can be used long term.
- **E:** It is safe with a uterus.

Key point: Symptoms return when vaginal oestrogen is stopped.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 448 · Definitions · **Moderate** · C2

A 50-year-old woman on the combined pill wants to know if she has gone through the menopause.

Why is FSH testing unreliable in women on the combined pill?

A. FSH is raised by the pill
B. FSH is suppressed by the pill
C. FSH is unaffected by the pill
D. FSH testing is never used in menopause
E. The pill causes premature menopause

Answer: B. FSH is suppressed by the pill

Combined hormonal contraception suppresses FSH, so tests are unreliable. FSH is not needed to diagnose menopause over 45; women can switch to a progestogen-only method at 50 and use FSH testing then if needed.

Why not the others

- **A:** The pill lowers FSH.
- **C:** The pill does affect FSH.
- **D:** FSH is used in women under 45 and in some situations after 50.
- **E:** The pill does not cause menopause.

Key point: Two FSH levels over 30 IU/L 6 weeks apart on a POP can guide stopping contraception after 50.

Reference: Gynaecology by Ten Teachers — The menopause; Contraception

MCQ 449 · HRT Risks · **Moderate** · C2

A 55-year-old woman asks about stroke risk with HRT.

Which statement is correct?

A. All HRT doubles stroke risk
B. HRT reduces stroke risk
C. Oral oestrogen slightly increases stroke risk; transdermal at standard doses does not appear to
D. Stroke risk is only increased with vaginal oestrogen
E. Stroke risk is unaffected by HRT route

Answer: C. Oral oestrogen slightly increases stroke risk; transdermal at standard doses does not appear to

Oral oestrogen is associated with a small increase in ischaemic stroke risk, which is low in women under 60. Transdermal oestradiol at standard doses does not appear to increase stroke risk.

Why not the others

- **A:** Risk is not doubled for all HRT.
- **B:** HRT does not reduce stroke risk.
- **D:** Vaginal oestrogen does not increase stroke risk.
- **E:** Route matters.

Key point: Tibolone also increases stroke risk, especially over 60.

Reference: Gynaecology by Ten Teachers — The menopause

MCQ 450 · Postmenopausal Bleeding · **Easy** · C3

A 59-year-old woman, 8 years after menopause and not on HRT, has a single episode of vaginal spotting.

What is the most appropriate first investigation?

A. CA-125
B. Cervical screening only
C. Reassurance
D. Transvaginal ultrasound to measure endometrial thickness
E. Vaginal oestrogen

Answer: D. Transvaginal ultrasound to measure endometrial thickness

All postmenopausal bleeding needs investigation for endometrial cancer. Transvaginal ultrasound measuring endometrial thickness is the first step; 4 mm or more needs biopsy.

Why not the others

- **A:** CA-125 is not the first test for bleeding.
- **B:** Screening is not a diagnostic test for symptoms.
- **C:** Even a single episode must be investigated.
- **E:** Treatment without investigation could miss cancer.

Key point: About 5–10% of women with postmenopausal bleeding have endometrial cancer.

Reference: Gynaecology by Ten Teachers — The menopause; Malignant disease of the uterus

CHAPTER 10

Pelvic Infection and STIs

MCQ 451 · Pelvic Inflammatory Disease · **Moderate** · C3

A 22-year-old woman has lower abdominal pain, deep dyspareunia and offensive vaginal discharge for 5 days. Temperature is 38.0°C, pulse 92/min and BP 118/76 mmHg. There is cervical motion tenderness and bilateral adnexal tenderness with no mass. Urine pregnancy test is negative and ultrasound shows no collection.

What is the most appropriate management?

A. Diagnostic laparoscopy

B. Doxycycline 100 mg twice daily for 7 days

C. IM ceftriaxone single dose, then oral doxycycline and metronidazole for 14 days

D. Oral amoxicillin for 5 days

E. Oral metronidazole 400 mg twice daily for 7 days

Answer: C. IM ceftriaxone single dose, then oral doxycycline and metronidazole for 14 days

This is mild to moderate PID with no abscess, so outpatient treatment is appropriate. Treatment must cover gonorrhoea, chlamydia and anaerobes: a single IM dose of ceftriaxone, then doxycycline and metronidazole for 14 days. Start treatment on clinical suspicion without waiting for swab results.

Why not the others

- **A:** Laparoscopy is reserved for diagnostic doubt or failure to respond to antibiotics.
- **B:** Doxycycline alone for 7 days covers chlamydia only and is too short for PID.
- **D:** Amoxicillin does not cover chlamydia or gonorrhoea reliably.
- **E:** Metronidazole alone covers anaerobes and trichomonas only.

Key point: Admit for IV antibiotics if there is an abscess, pregnancy, severe illness or failure of oral treatment. Trace and treat partners.

Reference: Gynaecology by Ten Teachers — Pelvic infection; BASHH guideline

MCQ 452 · Chlamydia · **Easy** · C2

A 21-year-old woman has postcoital bleeding and a mucopurulent cervical discharge. Her new partner has dysuria. She has no pain or fever.

Which investigation is most appropriate to diagnose the commonest bacterial STI?

A. Blood culture
B. Gram stain of urine
C. High vaginal swab for culture
D. Nucleic acid amplification test (NAAT) on a vulvovaginal swab
E. Serology for chlamydia antibodies

Answer: D. Nucleic acid amplification test (NAAT) on a vulvovaginal swab

Chlamydia trachomatis is the commonest bacterial STI. A NAAT on a self-taken or clinician-taken vulvovaginal swab is the most sensitive test and usually also detects gonorrhoea.

Why not the others

- **A:** Blood cultures do not detect chlamydia.
- **B:** Chlamydia is not seen on Gram stain.
- **C:** Chlamydia does not grow on routine culture.
- **E:** Serology does not diagnose current infection.

Key point: Most women with chlamydia have no symptoms; screen sexually active young women.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology; Sexually transmitted infections

MCQ 453 · Chlamydia · **Easy** · C3

A 23-year-old woman tests positive for chlamydia on NAAT. She is not pregnant, has no pelvic pain and no allergies.

What is the first-line treatment?

A. Azithromycin 1 g single dose as first choice
B. Ceftriaxone 1 g IM
C. Doxycycline 100 mg twice daily for 7 days
D. Metronidazole 400 mg twice daily for 7 days
E. Penicillin injection

Answer: C. Doxycycline 100 mg twice daily for 7 days

Doxycycline 100 mg twice daily for 7 days is first-line for uncomplicated chlamydia, as it is more effective than single-dose azithromycin. Partners should be notified and treated, and sex avoided until treatment is complete.

Why not the others

- **A:** Azithromycin is now second line.
- **B:** Ceftriaxone treats gonorrhoea.
- **D:** Metronidazole treats BV and trichomonas.
- **E:** Penicillin does not treat chlamydia.

Key point: Doxycycline is contraindicated in pregnancy; use azithromycin or erythromycin instead.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections; BASHH guideline

MCQ 454 · Chlamydia · **Moderate** · C3

A 26-year-old woman at 12 weeks of pregnancy tests positive for chlamydia.

What is the most appropriate treatment and follow-up?

A. Azithromycin, with a test of cure at least 3 weeks later
B. Ciprofloxacin
C. Doxycycline for 7 days
D. No treatment until after delivery
E. Tetracycline

Answer: A. Azithromycin, with a test of cure at least 3 weeks later

Doxycycline and tetracyclines are avoided in pregnancy. Azithromycin (or erythromycin or amoxicillin) is used, with a test of cure at least 3 weeks after treatment because of lower efficacy and risk to the baby (neonatal conjunctivitis and pneumonia).

Why not the others

- **B:** Ciprofloxacin is not used for chlamydia in pregnancy.
- **C:** Doxycycline is avoided in pregnancy.
- **D:** Untreated infection risks neonatal infection and preterm birth.
- **E:** Tetracyclines stain fetal teeth and bones.

Key point: Partner treatment prevents reinfection.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 455 · Gonorrhoea · **Moderate** · C3

A 24-year-old woman has a positive NAAT for Neisseria gonorrhoeae. She has purulent discharge and dysuria.

What is the recommended treatment?

A. Azithromycin 1 g alone
B. Ceftriaxone 1 g intramuscularly as a single dose
C. Ciprofloxacin 500 mg orally for all
D. Doxycycline 7 days
E. Oral amoxicillin

Answer: B. Ceftriaxone 1 g intramuscularly as a single dose

Ceftriaxone 1 g IM is first-line for uncomplicated gonorrhoea when sensitivities are unknown, because of widespread resistance. A culture should be taken before treatment, and a test of cure is recommended.

Why not the others

- **A:** Azithromycin alone is not adequate.
- **C:** Ciprofloxacin is used only if the strain is known to be sensitive.
- **D:** Doxycycline does not reliably treat gonorrhoea.
- **E:** Amoxicillin resistance is common.

Key point: Always take a culture for sensitivity because of antimicrobial resistance.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections; BASHH guideline

MCQ 456 · Trichomoniasis · **Easy** · C2

A 30-year-old woman has a profuse, frothy, greenish-yellow vaginal discharge with vulval soreness. Speculum examination shows punctate haemorrhages on the cervix ("strawberry cervix"). Vaginal pH is 6.

What is the most likely diagnosis?

A. Bacterial vaginosis
B. Candidiasis
C. Chlamydia
D. Gonorrhoea
E. Trichomonas vaginalis infection

Answer: E. Trichomonas vaginalis infection

Trichomonas vaginalis is a flagellated protozoan causing frothy green-yellow discharge, soreness, raised pH and a strawberry cervix. It is sexually transmitted and treated with metronidazole, with treatment of partners.

Why not the others

- **A:** BV causes thin grey fishy discharge without soreness or strawberry cervix.
- **B:** Candida causes thick white discharge with normal pH.
- **C:** Chlamydia is often asymptomatic.
- **D:** Gonorrhoea causes purulent discharge without strawberry cervix.

Key point: Trichomonas is seen as motile organisms on wet mount; NAAT is more sensitive.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology

MCQ 457 · Bacterial Vaginosis · **Easy** · C2

A 28-year-old woman has a thin, white-grey, fishy-smelling discharge, worse after intercourse. There is no itching or soreness.

Which set of findings confirms bacterial vaginosis (Amsel criteria)?

A. Gram-negative diplococci on smear
B. Hyphae on microscopy and pH 4
C. Motile flagellates on wet mount
D. Normal pH with lactobacilli
E. Thin discharge, pH over 4.5, positive whiff test and clue cells

Answer: E. Thin discharge, pH over 4.5, positive whiff test and clue cells

Amsel criteria (3 of 4): thin homogeneous discharge, pH over 4.5, fishy odour with potassium hydroxide (whiff test) and clue cells on microscopy. Gram stain (Hay–Ison or Nugent) is also used.

Why not the others

- **A:** Gram-negative diplococci suggest gonorrhoea.
- **B:** Hyphae and normal pH suggest candida.
- **C:** Flagellates suggest trichomonas.
- **D:** Normal pH with lactobacilli is normal flora.

Key point: BV is not sexually transmitted in the usual sense; partners do not need treatment.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology

MCQ 458 · Bacterial Vaginosis · **Moderate** · C3

A 27-year-old woman has symptomatic bacterial vaginosis. She is not pregnant.

What is the first-line treatment?

A. Clotrimazole pessary
B. Doxycycline
C. Fluconazole
D. Metronidazole 400 mg twice daily for 5–7 days
E. Penicillin

Answer: D. Metronidazole 400 mg twice daily for 5–7 days

Oral metronidazole for 5–7 days is first line. Alternatives are metronidazole gel or clindamycin cream. Alcohol should be avoided with metronidazole because of a disulfiram-like reaction.

Why not the others

- **A:** Clotrimazole treats candida.
- **B:** Doxycycline treats chlamydia.
- **C:** Fluconazole treats candida.
- **E:** Penicillin is not effective for BV.

Key point: BV recurs in about half of women within 3 months.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology

MCQ 459 · Candidiasis · **Easy** · C2

A 29-year-old woman has intense vulval itching and a thick white curdy discharge after a course of antibiotics. The vulva is red and swollen. Vaginal pH is 4.2.

What is the most likely diagnosis?

A. Bacterial vaginosis
B. Lichen sclerosus
C. Trichomoniasis
D. Vulval cancer
E. Vulvovaginal candidiasis

Answer: E. Vulvovaginal candidiasis

Candida albicans causes itching, soreness and a thick white discharge with a normal pH. Antibiotics, pregnancy, diabetes and immunosuppression are risk factors.

Why not the others

- **A:** BV gives raised pH and fishy odour.
- **B:** Lichen sclerosus causes white plaques without discharge.
- **C:** Trichomonas gives frothy discharge with raised pH.
- **D:** Cancer gives a lump or ulcer.

Key point: Treatment: clotrimazole pessary or oral fluconazole 150 mg single dose.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology

MCQ 460 · Candidiasis · **Moderate** · C3

A 30-year-old woman at 20 weeks of pregnancy has vulvovaginal candidiasis.

What is the most appropriate treatment?

A. Ketoconazole tablets
B. Metronidazole
C. No treatment
D. Oral fluconazole 150 mg
E. Vaginal clotrimazole pessary for 7 days

Answer: E. Vaginal clotrimazole pessary for 7 days

Oral azoles such as fluconazole are avoided in pregnancy. Topical imidazoles (clotrimazole) are safe, and a longer course of 7 days is recommended.

Why not the others

- **A:** Oral ketoconazole is avoided.
- **B:** Metronidazole treats BV, not candida.
- **C:** Symptomatic infection should be treated.
- **D:** Oral fluconazole is avoided in pregnancy.

Key point: Candida is more common in pregnancy because of high oestrogen.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology

MCQ 461 · Candidiasis · **Hard** · C3

A 34-year-old woman has had five confirmed episodes of vulvovaginal candidiasis in a year. Her HbA1c is normal and she is not immunosuppressed.

What is the most appropriate management?

A. Avoid all intercourse
B. Induction with fluconazole followed by weekly fluconazole maintenance for 6 months
C. Long-term doxycycline
D. Metronidazole for 6 months
E. Single-dose fluconazole with each episode only

Answer: B. Induction with fluconazole followed by weekly fluconazole maintenance for 6 months

Recurrent candidiasis (4 or more episodes a year) is treated with an induction course of fluconazole (for example 150 mg every 72 hours for 3 doses) followed by weekly maintenance for 6 months. Culture and sensitivity should confirm species.

Why not the others

- **A:** Candida is not mainly sexually transmitted.
- **C:** Antibiotics worsen candida.
- **D:** Metronidazole does not treat candida.
- **E:** Single doses do not prevent recurrence.

Key point: Check glucose and consider non-albicans species if treatment fails.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology; BASHH guideline

MCQ 462 · Syphilis · **Moderate** · C2

A 32-year-old woman has a single painless, firm, clean-based ulcer on the labium minus for 10 days, with painless rubbery inguinal lymph nodes.

What is the most likely diagnosis?

A. Chancroid
B. Genital herpes
C. Lymphogranuloma venereum
D. Primary syphilis
E. Vulval carcinoma

Answer: D. Primary syphilis

Primary syphilis presents as a painless indurated ulcer (chancre) with painless regional lymphadenopathy, about 3 weeks after exposure. Dark-ground microscopy, PCR and serology confirm the diagnosis.

Why not the others

- **A:** Chancroid ulcers are painful with suppurative nodes.
- **B:** Herpes causes multiple painful ulcers.
- **C:** LGV causes a small transient ulcer followed by large painful nodes.
- **E:** Carcinoma occurs in older women and grows over months.

Key point: Treat with benzathine penicillin; test for HIV and other STIs.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 463 · Syphilis · **Hard** · C3

A 28-year-old woman is given benzathine penicillin for secondary syphilis. Four hours later she develops fever, headache, myalgia and worsening of her rash.

What is the most likely explanation?

A. Anaphylaxis to penicillin
B. Jarisch–Herxheimer reaction
C. Neurosyphilis
D. Serum sickness
E. Toxic shock syndrome

Answer: B. Jarisch–Herxheimer reaction

The Jarisch–Herxheimer reaction is an acute febrile reaction within 24 hours of treating syphilis, caused by release of bacterial products. It is self-limiting and treated with antipyretics. In pregnancy it may trigger preterm labour.

Why not the others

- **A:** Anaphylaxis occurs within minutes with wheeze, urticaria and hypotension.
- **C:** Neurosyphilis does not develop acutely after treatment.
- **D:** Serum sickness occurs after 1–2 weeks.
- **E:** TSS is associated with tampons or wounds.

Key point: Warn patients about this reaction before treatment.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 464 · Genital Herpes · **Easy** · C2

A 22-year-old woman has severe vulval pain, dysuria and multiple small painful shallow ulcers on the vulva for 3 days. She has fever and tender inguinal nodes. This is her first episode.

What is the most appropriate treatment?

A. Benzathine penicillin
B. Ceftriaxone
C. Metronidazole
D. Oral aciclovir for 5 days
E. Topical steroids

Answer: D. Oral aciclovir for 5 days

First-episode genital herpes (usually HSV-2 or HSV-1) is treated with oral aciclovir or valaciclovir within 5 days of onset, with analgesia, saline bathing and lidocaine gel. Urinary retention may need catheterisation.

Why not the others

- **A:** Penicillin treats syphilis.
- **B:** Ceftriaxone treats gonorrhoea.
- **C:** Metronidazole treats BV and trichomonas.
- **E:** Steroids may worsen viral infection.

Key point: Swab the lesions for HSV PCR to confirm and type the virus.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 465 · Genital Herpes · **Hard** · C3

A 30-year-old woman has a first episode of genital herpes at 36 weeks of pregnancy.

What is the recommended mode of delivery?

A. Caesarean section
B. Forceps delivery
C. Induction of labour at 37 weeks
D. Vaginal delivery with aciclovir only
E. Ventouse delivery

Answer: A. Caesarean section

A first episode of genital herpes in the third trimester (especially within 6 weeks of delivery) carries a high risk of neonatal herpes, because the mother has no antibodies to pass on. Caesarean section is recommended, with aciclovir until delivery.

Why not the others

- **B:** Instrumental delivery does not reduce transmission.
- **C:** Induction still involves vaginal birth.
- **D:** Recurrent herpes allows vaginal delivery; first episode near term does not.
- **E:** Ventouse does not reduce risk and may cause scalp injury.

Key point: Recurrent herpes at delivery: vaginal birth is usually acceptable.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections; Infections in pregnancy

MCQ 466 · Genital Warts · **Moderate** · C3

A 25-year-old woman has multiple small soft warts on the vulva. She is planning a pregnancy soon.

Which treatment should be avoided if she becomes pregnant?

A. Cryotherapy
B. Excision
C. Laser ablation
D. Podophyllotoxin
E. Trichloroacetic acid

Answer: D. Podophyllotoxin

Podophyllotoxin (and imiquimod, which has limited safety data) are avoided in pregnancy because of possible teratogenicity. Cryotherapy, excision, laser and trichloroacetic acid are safe in pregnancy.

Why not the others

- **A:** Cryotherapy is safe.
- **B:** Excision is safe.
- **C:** Laser is safe.
- **E:** TCA is safe.

Key point: Genital warts are caused mainly by HPV 6 and 11, prevented by the quadrivalent and 9-valent vaccines.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 467 · HIV · **Moderate** · C3

A 26-year-old woman was raped 18 hours ago by an unknown man. She attends a sexual assault centre.

Which HIV prevention is recommended?

A. HIV test now and treat only if positive
B. No action needed
C. Post-exposure prophylaxis (PEP) started as soon as possible, ideally within 24 hours and no later than 72 hours
D. Start PEP after 7 days
E. Vaccinate against HIV

Answer: C. Post-exposure prophylaxis (PEP) started as soon as possible, ideally within 24 hours and no later than 72 hours

PEP with antiretrovirals should be started as soon as possible after a high-risk exposure, within 72 hours, and continued for 28 days. She also needs emergency contraception, STI prophylaxis or testing, hepatitis B vaccination and psychological support.

Why not the others

- **A:** Waiting for a positive test misses the window.
- **B:** Action is needed.
- **D:** PEP is ineffective after 72 hours.
- **E:** There is no HIV vaccine.

Key point: Forensic examination should be offered with consent.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 468 · Pelvic Inflammatory Disease · **Moderate** · C2

A 24-year-old woman with PID has right upper quadrant pain worse on breathing. Liver function is normal. Laparoscopy shows "violin-string" adhesions between the liver capsule and the diaphragm.

What is this condition?

A. Budd–Chiari syndrome
B. Cholecystitis
C. Fitz-Hugh–Curtis syndrome
D. Hepatitis
E. Meigs' syndrome

Answer: C. Fitz-Hugh–Curtis syndrome

Fitz-Hugh–Curtis syndrome is perihepatitis from spread of chlamydial or gonococcal PID, causing right upper quadrant pain and adhesions between the liver capsule and diaphragm.

Why not the others

- **A:** Budd–Chiari is hepatic vein thrombosis.
- **B:** Cholecystitis affects the gallbladder.
- **D:** Hepatitis raises liver enzymes.
- **E:** Meigs' syndrome is ovarian fibroma with ascites and effusion.

Key point: Consider PID in a young woman with unexplained right upper quadrant pain.

Reference: Gynaecology by Ten Teachers — Pelvic infection

MCQ 469 · Pelvic Inflammatory Disease · **Hard** · C3

A 27-year-old woman with PID has had 48 hours of IV antibiotics but still has fever and severe pain. Ultrasound shows a 8 cm complex left adnexal mass.

What is the most appropriate management?

A. Change to oral antibiotics and discharge
B. Continue IV antibiotics and add drainage of the abscess (radiological or laparoscopic)
C. Hysterectomy and bilateral salpingo-oophorectomy
D. Observe without change
E. Stop antibiotics

Answer: B. Continue IV antibiotics and add drainage of the abscess (radiological or laparoscopic)

A tubo-ovarian abscess that fails to respond to IV antibiotics, or is large (over 7–8 cm), needs drainage by ultrasound-guided aspiration or laparoscopy, with continued antibiotics. Rupture is a surgical emergency.

Why not the others

- **A:** She is not responding; discharge is unsafe.
- **C:** Radical surgery is a last resort in young women.
- **D:** Observation risks rupture and sepsis.
- **E:** Stopping antibiotics is dangerous.

Key point: Ruptured tubo-ovarian abscess carries a high mortality.

Reference: Gynaecology by Ten Teachers — Pelvic infection

MCQ 470 · Pelvic Inflammatory Disease · **Moderate** · C2

A 25-year-old woman had PID treated 2 years ago. She asks about long-term effects.

Which complication is she at increased risk of?

A. Cervical cancer
B. Ectopic pregnancy
C. Endometrial cancer
D. Ovarian cancer
E. Uterine fibroids

Answer: B. Ectopic pregnancy

PID damages the fallopian tubes, increasing the risk of ectopic pregnancy (about 6–10 times), tubal subfertility and chronic pelvic pain. Risk increases with each episode.

Why not the others

- **A:** Cervical cancer is linked to HPV.
- **C:** Endometrial cancer is linked to unopposed oestrogen.
- **D:** Ovarian cancer is not clearly linked.
- **E:** Fibroids are not linked.

Key point: After one episode of PID about 1 in 10 women have tubal subfertility.

Reference: Gynaecology by Ten Teachers — Pelvic infection

MCQ 471 · Pelvic Inflammatory Disease · **Hard** · C3

A 23-year-old woman is diagnosed with PID. She is pregnant at 8 weeks, has a temperature of 39°C, vomiting and cannot tolerate oral drugs. Ultrasound shows no abscess.

What is the most appropriate management?

A. Admission for intravenous antibiotics
B. Laparoscopy immediately
C. Oral doxycycline and metronidazole at home
D. Termination of pregnancy
E. Wait for culture results

Answer: A. Admission for intravenous antibiotics

Admission for IV antibiotics is indicated for PID with pregnancy, severe illness, high fever, vomiting, abscess, or failure of oral treatment. Drugs safe in pregnancy are used and ectopic pregnancy must be excluded.

Why not the others

- **B:** Laparoscopy is not immediately needed without an abscess or diagnostic doubt.
- **C:** Doxycycline is contraindicated in pregnancy and she cannot take oral drugs.
- **D:** There is no reason to terminate.
- **E:** Treatment should start without waiting.

Key point: PID is uncommon in pregnancy; exclude ectopic and appendicitis.

Reference: Gynaecology by Ten Teachers — Pelvic infection

MCQ 472 · Pelvic Inflammatory Disease · **Moderate** · C3

A 35-year-old woman has had an IUD for 6 years. A cervical smear report mentions Actinomyces-like organisms. She has no pain, fever or discharge.

What is the most appropriate management?

A. Hysterectomy
B. Long-term penicillin
C. Reassure; no treatment or removal is needed if asymptomatic
D. Remove the IUD immediately
E. Repeat smear weekly

Answer: C. Reassure; no treatment or removal is needed if asymptomatic

Actinomyces-like organisms on a smear in an asymptomatic IUD user do not need treatment or removal. She should be told to report pain, discharge or bleeding, which may suggest pelvic actinomycosis.

Why not the others

- **A:** Hysterectomy is not indicated.
- **B:** Antibiotics are not needed without symptoms.
- **D:** Removal is needed only if symptomatic.
- **E:** Repeat smears are not needed.

Key point: Pelvic actinomycosis is rare but serious; it can mimic malignancy.

Reference: Gynaecology by Ten Teachers — Pelvic infection; Contraception

MCQ 473 · Toxic Shock Syndrome · **Hard** · C3

A 19-year-old woman using tampons during her period develops high fever, vomiting, diarrhoea, a widespread sunburn-like rash and hypotension. A tampon is found in the vagina that was inserted 3 days ago.

What is the most likely diagnosis?

A. Kawasaki disease
B. Meningococcal sepsis
C. Scarlet fever
D. Stevens–Johnson syndrome
E. Toxic shock syndrome

Answer: E. Toxic shock syndrome

Toxic shock syndrome is caused by toxins from Staphylococcus aureus (TSST-1) or streptococci, often linked to retained tampons. It presents with fever, diffuse erythematous rash, hypotension and multi-organ involvement, followed by desquamation.

Why not the others

- **A:** Kawasaki disease affects young children.
- **B:** Meningococcal rash is purpuric.
- **C:** Scarlet fever occurs in children with a sore throat.
- **D:** SJS is drug-induced with mucosal blistering.

Key point: Remove the tampon, resuscitate and give anti-staphylococcal antibiotics with clindamycin.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology

MCQ 474 · Mycoplasma genitalium · **Hard** · C3

A 26-year-old woman has PID that has not responded to standard treatment. A NAAT is positive for Mycoplasma genitalium. Chlamydia and gonorrhoea tests are negative.

Which antibiotic is recommended for M. genitalium PID?

A. Amoxicillin
B. Ceftriaxone alone
C. Metronidazole alone
D. Moxifloxacin for 14 days
E. Nitrofurantoin

Answer: D. Moxifloxacin for 14 days

Mycoplasma genitalium is increasingly recognised in PID and cervicitis. It is often resistant to macrolides. Moxifloxacin for 14 days is recommended for PID caused by M. genitalium.

Why not the others

- **A:** Amoxicillin is ineffective because M. genitalium has no cell wall.
- **B:** Ceftriaxone is ineffective against mycoplasma.
- **C:** Metronidazole is ineffective.
- **E:** Nitrofurantoin is for urinary infection.

Key point: Test for macrolide resistance where possible.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections; BASHH guideline

MCQ 475 · Lymphogranuloma Venereum · **Hard** · C2

A 30-year-old woman had a small painless genital ulcer that healed 2 weeks ago. She now has large painful matted inguinal nodes that have formed a groove above and below the inguinal ligament.

What is the most likely diagnosis?

A. Chancroid
B. Granuloma inguinale
C. Herpes simplex
D. Lymphogranuloma venereum
E. Primary syphilis

Answer: D. Lymphogranuloma venereum

Lymphogranuloma venereum (Chlamydia trachomatis serovars L1–L3) causes a transient painless ulcer followed by painful inguinal lymphadenopathy. The groove sign (nodes above and below the inguinal ligament) is characteristic. Treatment is doxycycline for 21 days.

Why not the others

- **A:** Chancroid ulcers remain painful with suppurative nodes.
- **B:** Granuloma inguinale causes beefy red ulcers without large nodes.
- **C:** Herpes ulcers are painful and multiple.
- **E:** Syphilitic nodes are painless and rubbery.

Key point: LGV can cause genital elephantiasis and rectal strictures if untreated.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 476 · Partner Notification · **Easy** · C3

A 22-year-old woman is diagnosed with chlamydia. She asks whether her husband needs to do anything.

What is the correct advice?

A. He does not need treatment if he has no symptoms
B. He needs testing and treatment, and they should avoid sex until both have completed treatment
C. He should be treated only if she becomes pregnant
D. Only she needs treatment
E. They should use condoms only

Answer: B. He needs testing and treatment, and they should avoid sex until both have completed treatment

Partner notification, testing and treatment are essential to prevent reinfection and further spread. Couples should avoid sex until both have completed treatment (7 days after doxycycline).

Why not the others

- **A:** Most infected men have no symptoms.
- **C:** Treatment is needed regardless of pregnancy.
- **D:** She will be reinfected if he is untreated.
- **E:** Condoms alone do not treat his infection.

Key point: Reinfection from an untreated partner is the commonest cause of persistent infection.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 477 · Pelvic Inflammatory Disease · **Easy** · C2

A 20-year-old woman has 4 days of lower abdominal pain. Bimanual examination shows cervical motion tenderness and bilateral adnexal tenderness. Pregnancy test is negative and there is no other obvious cause.

What is the most appropriate action?

A. Laparoscopy before any antibiotics
B. Reassure and review in a week
C. Start empirical antibiotic treatment for PID
D. Ultrasound only and no antibiotics
E. Wait for swab results before treating

Answer: C. Start empirical antibiotic treatment for PID

PID is a clinical diagnosis. Lower abdominal pain with cervical motion or adnexal tenderness in a sexually active woman, without another cause, should be treated empirically because delay increases the risk of tubal damage. Swabs are taken but treatment starts immediately.

Why not the others

- **A:** Laparoscopy is reserved for diagnostic doubt or failure to improve.
- **B:** Delay increases tubal damage.
- **D:** Ultrasound may help but should not delay antibiotics.
- **E:** Negative swabs do not exclude PID.

Key point: Low threshold for treatment: the consequences of untreated PID are serious.

Reference: Gynaecology by Ten Teachers — Pelvic infection; BASHH guideline

MCQ 478 · Pelvic Inflammatory Disease · **Moderate** · C2

A 23-year-old woman has right iliac fossa pain, fever and nausea. She is sexually active. Pregnancy test is negative. There is cervical motion tenderness but also rebound tenderness at McBurney's point.

Which condition is most important to exclude alongside PID?

A. Acute appendicitis
B. Endometriosis
C. Irritable bowel syndrome
D. Ovarian cancer
E. Urinary tract infection

Answer: A. Acute appendicitis

Appendicitis can mimic right-sided PID, and missing it risks perforation. Ectopic pregnancy (excluded by the negative test) and ovarian torsion are other key differentials. Imaging or laparoscopy may be needed.

Why not the others

- **B:** Endometriosis is chronic, not acute with fever.
- **C:** IBS does not cause fever and peritonism.
- **D:** Ovarian cancer does not present acutely like this.
- **E:** UTI does not usually cause cervical motion tenderness and rebound.

Key point: Laparoscopy is the gold standard for diagnosing PID but is not routinely needed.

Reference: Gynaecology by Ten Teachers — Pelvic infection; Acute gynaecology

MCQ 479 · Syphilis · **Moderate** · C2

A 30-year-old woman had syphilis treated adequately 5 years ago. Routine antenatal screening shows a positive treponemal antibody test (EIA) and a negative RPR.

What is the correct interpretation?

A. Active primary syphilis
B. Biological false positive
C. Congenital syphilis
D. Previously treated syphilis
E. Secondary syphilis needing urgent treatment

Answer: D. Previously treated syphilis

Treponemal tests (EIA, TPPA) usually stay positive for life after infection. A negative non-treponemal test (RPR or VDRL) indicates no active infection, consistent with adequately treated past syphilis.

Why not the others

- **A:** Active infection would usually give a positive RPR.
- **B:** A false positive is less likely with a known history.
- **C:** Congenital syphilis affects the baby, not her test.
- **E:** Secondary syphilis has a high RPR titre.

Key point: RPR titres are used to monitor response to treatment.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections; Infections in pregnancy

MCQ 480 · Syphilis · **Hard** · C3

A 25-year-old woman at 16 weeks of pregnancy has positive syphilis serology with a high RPR titre. She has no penicillin allergy.

What is the most appropriate treatment?

A. Azithromycin
B. Benzathine penicillin
C. Doxycycline
D. No treatment until after delivery
E. Oral amoxicillin

Answer: B. Benzathine penicillin

Penicillin is the only treatment proven to prevent congenital syphilis. Benzathine penicillin IM is given in pregnancy. Untreated syphilis causes miscarriage, stillbirth and congenital infection.

Why not the others

- **A:** Azithromycin resistance is common and it does not reliably prevent congenital syphilis.
- **C:** Doxycycline is avoided in pregnancy.
- **D:** Delay risks fetal infection.
- **E:** Oral amoxicillin is not adequate.

Key point: Women allergic to penicillin in pregnancy may need desensitisation.

Reference: Gynaecology by Ten Teachers — Infections in pregnancy; Sexually transmitted infections

MCQ 481 · Genital Herpes · **Moderate** · C3

A 32-year-old woman has 8 recurrences of genital herpes a year, each lasting 5 days and affecting her relationship.

What is the most appropriate management?

A. Daily suppressive aciclovir
B. Episodic treatment only for each recurrence
C. Long-term topical steroids
D. No treatment
E. Weekly penicillin

Answer: A. Daily suppressive aciclovir

Women with frequent recurrences (6 or more a year) benefit from daily suppressive antiviral therapy, which reduces recurrences and asymptomatic shedding. It is reviewed after about a year.

Why not the others

- **B:** Episodic treatment is suitable for infrequent recurrences.
- **C:** Steroids do not help.
- **D:** Treatment can greatly reduce recurrences.
- **E:** Penicillin does not treat herpes.

Key point: Herpes can be transmitted when there are no lesions (asymptomatic shedding).

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 482 · Gonorrhoea · **Hard** · C2

A 24-year-old woman develops fever, painful swollen right knee and wrist, and a few pustules on her hands. She has a new partner. Her cervical NAAT is positive for gonorrhoea.

What is the most likely diagnosis?

A. Disseminated gonococcal infection
B. Reactive arthritis
C. Rheumatoid arthritis
D. Septic arthritis from Staphylococcus aureus
E. Systemic lupus erythematosus

Answer: A. Disseminated gonococcal infection

Disseminated gonococcal infection causes fever, migratory polyarthritis or tenosynovitis, and pustular skin lesions. It is treated with IV ceftriaxone.

Why not the others

- **B:** Reactive arthritis follows chlamydia or gut infection, usually without pustules.
- **C:** Rheumatoid arthritis is chronic and symmetrical.
- **D:** Staphylococcal arthritis is usually monoarticular without pustules.
- **E:** SLE has other features.

Key point: Consider gonorrhoea in young sexually active patients with arthritis and skin lesions.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 483 · Neonatal Infection · **Moderate** · C2

A baby develops purulent conjunctivitis with swollen eyelids 3 days after a vaginal birth. The mother had no antenatal STI screening.

Which organism most commonly causes ophthalmia neonatorum appearing in the first 5 days?

A. Candida albicans
B. Chlamydia trachomatis
C. Herpes simplex
D. Neisseria gonorrhoeae
E. Staphylococcus epidermidis

Answer: D. Neisseria gonorrhoeae

Gonococcal ophthalmia neonatorum usually appears within 2–5 days of birth and can rapidly damage the cornea. Chlamydial conjunctivitis typically appears later, at 5–14 days. Both parents need STI testing and treatment.

Why not the others

- **A:** Candida is uncommon in the eye.
- **B:** Chlamydia usually appears at 5–14 days.
- **C:** Herpes is less common and causes vesicles.
- **E:** S. epidermidis is a skin commensal.

Key point: Gonococcal ophthalmia is an emergency needing systemic treatment.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections; Neonatal care

MCQ 484 · Ectoparasites · **Easy** · C3

A 26-year-old woman has intense pubic itching. Small grey lice and eggs attached to the pubic hair are seen.

What is the most appropriate treatment?

A. Antifungal cream
B. Metronidazole
C. Oral aciclovir
D. Permethrin or malathion lotion to the affected areas, repeated after 7 days
E. Topical steroid only

Answer: D. Permethrin or malathion lotion to the affected areas, repeated after 7 days

Pubic lice (Phthirus pubis) are treated with topical insecticides such as permethrin or malathion, repeated after 7 days. Sexual partners are treated, and bedding and clothing washed. Screening for other STIs is advised.

Why not the others

- **A:** Antifungals do not kill lice.
- **B:** Metronidazole treats protozoa and anaerobes.
- **C:** Aciclovir treats herpes.
- **E:** Steroids relieve itch but do not treat lice.

Key point: Pubic lice in eyelashes of a child may suggest abuse.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 485 · Bacterial Vaginosis · **Hard** · C3

A 28-year-old woman with a history of a preterm birth at 30 weeks is 14 weeks pregnant. She has symptomatic bacterial vaginosis.

What is the most appropriate management?

A. Clindamycin cream or oral metronidazole
B. Doxycycline
C. No treatment in pregnancy
D. Oral fluconazole
E. Penicillin

Answer: A. Clindamycin cream or oral metronidazole

BV in pregnancy is associated with preterm birth and late miscarriage. Symptomatic BV should be treated with oral metronidazole (safe in pregnancy) or clindamycin. Metronidazole high single-dose regimens are avoided in pregnancy.

Why not the others

- **B:** Doxycycline is avoided and does not treat BV.
- **C:** Symptomatic BV should be treated.
- **D:** Fluconazole treats candida and is avoided in pregnancy.
- **E:** Penicillin does not treat BV.

Key point: Routine screening for BV in low-risk pregnancy is not recommended.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology; Infections in pregnancy

MCQ 486 · STI Screening · **Easy** · C2

A 24-year-old woman with a new partner asks for a full sexual health check. She has no symptoms.

Which tests form a standard STI screen for an asymptomatic woman?

A. Cervical cytology only
B. Chlamydia and gonorrhoea NAAT, HIV and syphilis serology
C. High vaginal swab culture only
D. Pelvic ultrasound
E. Urine culture only

Answer: B. Chlamydia and gonorrhoea NAAT, HIV and syphilis serology

A standard asymptomatic screen includes a vulvovaginal NAAT for chlamydia and gonorrhoea, and blood tests for HIV and syphilis. Hepatitis B and C are added for those at risk.

Why not the others

- **A:** Cytology screens for cervical abnormalities, not STIs.
- **C:** Culture misses chlamydia and is less sensitive for gonorrhoea.
- **D:** Ultrasound does not detect STIs.
- **E:** Urine culture tests for UTI.

Key point: Offer hepatitis B vaccination to those at ongoing risk.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 487 · Bartholin Abscess · **Moderate** · C3

A 32-year-old woman has a 4 cm tender fluctuant Bartholin abscess. She has had one previously that was drained.

What is the most appropriate management?

A. Antibiotics only
B. Excision of the gland as first choice
C. Incision and drainage with Word catheter insertion or marsupialisation
D. Needle aspiration only
E. Observation

Answer: C. Incision and drainage with Word catheter insertion or marsupialisation

A Bartholin abscess is drained, either with a Word catheter left in place for 4 weeks or by marsupialisation (suturing the cyst wall edges to the skin). Both reduce recurrence compared with simple incision. Gland excision is for recurrent disease or suspected malignancy.

Why not the others

- **A:** Antibiotics alone rarely resolve a fluctuant abscess.
- **B:** Excision is not first line.
- **D:** Aspiration has a high recurrence rate.
- **E:** A painful abscess needs drainage.

Key point: Biopsy a Bartholin mass in women over 40.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology; Conditions affecting the vulva and vagina

MCQ 488 · Postoperative Infection · **Moderate** · C3

A 26-year-old woman is having a surgical termination of pregnancy at 9 weeks.

What is recommended to prevent post-abortion infection?

A. Antibiotic prophylaxis (for example doxycycline and metronidazole)
B. Antifungal prophylaxis
C. No prophylaxis
D. Penicillin for 4 weeks
E. Routine hysteroscopy after the procedure

Answer: A. Antibiotic prophylaxis (for example doxycycline and metronidazole)

Antibiotic prophylaxis at the time of surgical abortion reduces post-abortion infection, including PID. Screening for chlamydia is also advised.

Why not the others

- **B:** Antifungals do not prevent bacterial infection.
- **C:** Prophylaxis reduces infection.
- **D:** Long courses are unnecessary.
- **E:** Hysteroscopy is not routine.

Key point: Untreated chlamydia at the time of abortion increases PID risk.

Reference: Gynaecology by Ten Teachers — Pelvic infection

MCQ 489 · Postoperative Infection · **Moderate** · C2

A 50-year-old woman had a vaginal hysterectomy 5 days ago. She has a fever of 38.5°C, pelvic pain and a purulent vaginal discharge. Ultrasound shows no collection.

What is the most likely diagnosis?

A. Bladder injury
B. Deep vein thrombosis
C. Pulmonary embolism
D. Ureteric injury
E. Vaginal vault cellulitis

Answer: E. Vaginal vault cellulitis

Vault cellulitis is infection of the tissues at the vaginal vault after hysterectomy, presenting with fever, pain and purulent discharge without a collection. It is treated with antibiotics covering anaerobes and Gram-negative organisms.

Why not the others

- **A:** Bladder injury causes urine leakage or haematuria.
- **B:** DVT causes leg swelling.
- **C:** PE causes breathlessness and chest pain.
- **D:** Ureteric injury causes loin pain or watery leakage.

Key point: Prophylactic antibiotics at hysterectomy reduce vault infection.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 490 · Cervicitis · **Moderate** · C2

A 22-year-old woman has a red, friable cervix with mucopurulent discharge from the os. She has postcoital bleeding.

Which organisms are the commonest infective causes of mucopurulent cervicitis?

A. Candida and Trichomonas
B. Chlamydia trachomatis and Neisseria gonorrhoeae
C. Escherichia coli and Klebsiella
D. Lactobacillus and Gardnerella
E. Staphylococcus aureus and Streptococcus pyogenes

Answer: B. Chlamydia trachomatis and Neisseria gonorrhoeae

Chlamydia and gonorrhoea are the commonest causes of mucopurulent cervicitis. Mycoplasma genitalium and herpes are other causes.

Why not the others

- **A:** Candida and Trichomonas cause vaginitis rather than mucopurulent cervicitis.
- **C:** Coliforms cause urinary infection.
- **D:** Lactobacilli are normal; Gardnerella causes BV.
- **E:** These do not commonly cause cervicitis.

Key point: Postcoital bleeding in a young woman: test for chlamydia.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 491 · Chancroid · **Hard** · C2

A 28-year-old woman has several painful, ragged, deep ulcers on the vulva with a grey purulent base and painful unilateral inguinal nodes that are becoming fluctuant.

Which organism is the most likely cause?

A. Chlamydia trachomatis L serovar
B. Haemophilus ducreyi
C. Herpes simplex virus
D. Klebsiella granulomatis
E. Treponema pallidum

Answer: B. Haemophilus ducreyi

Chancroid, caused by Haemophilus ducreyi, gives painful, ragged ulcers with purulent bases and painful suppurative inguinal nodes (buboes). Treatment is azithromycin or ceftriaxone.

Why not the others

- **A:** LGV causes a transient painless ulcer.
- **C:** Herpes ulcers are small and shallow.
- **D:** Granuloma inguinale causes painless beefy red ulcers.
- **E:** Syphilis causes a painless ulcer.

Key point: Genital ulcers increase HIV transmission; test for HIV.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 492 · Granuloma Inguinale · **Hard** · C2

A 35-year-old woman has slowly enlarging painless, beefy-red ulcers on the vulva that bleed easily. There is no significant lymphadenopathy. Biopsy shows Donovan bodies.

What is the diagnosis?

A. Chancroid
B. Granuloma inguinale (donovanosis)
C. Lymphogranuloma venereum
D. Primary syphilis
E. Vulval carcinoma

Answer: B. Granuloma inguinale (donovanosis)

Donovanosis, caused by Klebsiella granulomatis, gives painless, progressive, beefy-red ulcers that bleed easily. Donovan bodies in macrophages on biopsy confirm it. Treatment is azithromycin for at least 3 weeks.

Why not the others

- **A:** Chancroid is painful with buboes.
- **C:** LGV causes large lymph nodes.
- **D:** Syphilis gives a single clean painless ulcer.
- **E:** Carcinoma must be excluded, but Donovan bodies confirm donovanosis.

Key point: Donovanosis can mimic cancer; biopsy is essential.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 493 · HPV Vaccination · **Easy** · C2

A mother asks when her daughter should receive the HPV vaccine to get the best protection against cervical cancer.

When is HPV vaccination most effective?

A. After cervical screening starts
B. After first pregnancy
C. After menopause
D. Before onset of sexual activity, ideally at 11–13 years
E. Only after an abnormal smear

Answer: D. Before onset of sexual activity, ideally at 11–13 years

HPV vaccines prevent infection rather than treat it, so they are most effective before exposure to HPV, ideally at age 11–13. They protect against high-risk types 16 and 18, and the 9-valent vaccine covers more types and genital warts.

Why not the others

- **A:** Many will already have been exposed.
- **B:** Many will already have been exposed.
- **C:** Benefit is very limited.
- **E:** The vaccine does not treat existing disease.

Key point: Vaccinated women still need cervical screening.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix; Sexually transmitted infections

MCQ 494 · Hepatitis B · **Moderate** · C3

A 25-year-old sex worker attends for a sexual health check. She has not been vaccinated against hepatitis B.

What is the most appropriate preventive measure?

A. Hepatitis A vaccine only
B. Hepatitis B vaccination
C. No action
D. Oral antivirals continuously
E. Yearly liver ultrasound

Answer: B. Hepatitis B vaccination

Hepatitis B is sexually transmissible and vaccination is recommended for people at increased risk, including sex workers, people who inject drugs and men who have sex with men. Test for HBsAg and immunity first.

Why not the others

- **A:** Hepatitis A vaccine does not protect against hepatitis B.
- **C:** She is at risk.
- **D:** Antivirals are for treatment, not prevention.
- **E:** Ultrasound does not prevent infection.

Key point: Hepatitis B is screened in all pregnant women.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 495 · HIV · **Moderate** · C2

A 28-year-old woman is diagnosed with HIV during routine antenatal screening at 12 weeks.

What is the most important intervention to prevent transmission to the baby?

A. Avoiding all antenatal care
B. Caesarean section regardless of viral load
C. Combination antiretroviral therapy to achieve an undetectable viral load
D. Early induction at 34 weeks
E. Formula feeding alone without treatment

Answer: C. Combination antiretroviral therapy to achieve an undetectable viral load

Effective antiretroviral therapy suppressing the viral load is the most important measure. With an undetectable viral load, mother-to-child transmission is under 0.5% and vaginal birth is possible. Infant prophylaxis and infant feeding advice are also important.

Why not the others

- **A:** Antenatal care is essential.
- **B:** Caesarean is needed only with a detectable viral load.
- **D:** Early delivery is not indicated.
- **E:** Feeding advice helps but treatment of the mother is key.

Key point: Screening for HIV in pregnancy allows treatment that almost eliminates transmission.

Reference: Gynaecology by Ten Teachers — Infections in pregnancy

MCQ 496 · Trichomoniasis · **Moderate** · C3

A 27-year-old woman at 24 weeks of pregnancy has trichomoniasis confirmed by NAAT.

What is the most appropriate treatment?

A. Clotrimazole
B. Doxycycline
C. Fluconazole
D. Metronidazole 400 mg twice daily for 7 days
E. No treatment in pregnancy

Answer: D. Metronidazole 400 mg twice daily for 7 days

Metronidazole is safe in pregnancy and treats trichomoniasis. A 7-day course is preferred. Partners should be treated and sex avoided until both are cured.

Why not the others

- **A:** Clotrimazole has low efficacy for trichomonas.
- **B:** Doxycycline is avoided and does not treat trichomonas.
- **C:** Fluconazole treats candida.
- **E:** Untreated infection may increase preterm birth.

Key point: Avoid alcohol with metronidazole.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology; Infections in pregnancy

MCQ 497 · Pelvic Inflammatory Disease · **Moderate** · C2

A 24-year-old woman with PID asks how she got the infection.

What is the usual route of infection in PID?

A. Ascending infection from the cervix and vagina
B. Blood spread from the lungs
C. Direct spread from the bladder
D. Lymphatic spread from the legs
E. Spread from the appendix in all cases

Answer: A. Ascending infection from the cervix and vagina

PID usually results from ascending infection from the cervix to the endometrium, tubes and ovaries. Sexually transmitted organisms (chlamydia, gonorrhoea, M. genitalium) start it, and anaerobes and other bacteria often follow.

Why not the others

- **B:** Blood spread explains genital tuberculosis, not typical PID.
- **C:** The bladder is not the source.
- **D:** Lymphatic spread from the legs is not a route.
- **E:** Appendicitis can cause pelvic infection but is not the usual route.

Key point: Instrumentation of the uterus (IUD, abortion, HSG) can introduce infection.

Reference: Gynaecology by Ten Teachers — Pelvic infection

MCQ 498 · Molluscum Contagiosum · **Easy** · C2

A 23-year-old woman has several small, firm, pearly, dome-shaped papules with a central dimple on the mons pubis.

What is the most likely diagnosis?

A. Condylomata lata
B. Genital warts
C. Herpes simplex
D. Molluscum contagiosum
E. Sebaceous cysts

Answer: D. Molluscum contagiosum

Molluscum contagiosum is a poxvirus infection giving small, pearly, umbilicated papules. In adults it can be sexually transmitted. It usually resolves on its own; cryotherapy is an option.

Why not the others

- **A:** Condylomata lata are flat moist papules of secondary syphilis.
- **B:** Warts are irregular and cauliflower-like.
- **C:** Herpes causes vesicles and ulcers.
- **E:** Sebaceous cysts are larger and lack a central dimple.

Key point: Extensive molluscum in adults may indicate immunosuppression such as HIV.

Reference: Gynaecology by Ten Teachers — Sexually transmitted infections

MCQ 499 · Pelvic Inflammatory Disease · **Hard** · C3

A 29-year-old woman with PID was started on outpatient oral antibiotics 72 hours ago. She feels no better, still has a fever of 38.3°C and pelvic tenderness.

What is the most appropriate next step?

A. Admit for IV antibiotics and imaging to look for an abscess
B. Continue the same oral antibiotics for another week
C. Discharge and review in 2 weeks
D. Hysterectomy
E. Stop antibiotics and observe

Answer: A. Admit for IV antibiotics and imaging to look for an abscess

Failure to improve within 72 hours of oral treatment is an indication for admission, IV antibiotics and imaging (ultrasound) to look for a tubo-ovarian abscess or another diagnosis. Laparoscopy may be needed.

Why not the others

- **B:** Continuing failed treatment is unsafe.
- **C:** Waiting risks complications.
- **D:** Radical surgery is not indicated.
- **E:** Stopping treatment is dangerous.

Key point: Review all women with PID at 72 hours.

Reference: Gynaecology by Ten Teachers — Pelvic infection; BASHH guideline

MCQ 500 · Vulvovaginal Infection · **Moderate** · C2

A 52-year-old woman with poorly controlled type 2 diabetes (HbA1c 11%) has recurrent vulval itching and soreness with a thick white discharge. She has had three courses of clotrimazole this year.

What is the most important step to prevent recurrence?

A. Avoid all underwear
B. Improve glucose control
C. Long-term doxycycline
D. Stop all treatment
E. Vaginal douching daily

Answer: B. Improve glucose control

Poorly controlled diabetes predisposes to recurrent candidiasis because glucose in secretions promotes fungal growth. Better glucose control is key. Non-albicans species such as C. glabrata are commoner in diabetes and may need different treatment.

Why not the others

- **A:** Cotton underwear helps but is not the main step.
- **C:** Antibiotics worsen candida.
- **D:** Symptomatic infection needs treatment.
- **E:** Douching disrupts normal flora.

Key point: SGLT2 inhibitors for diabetes also increase genital candidiasis.

Reference: Gynaecology by Ten Teachers — Infections in gynaecology

CHAPTER 11

Urogynaecology and Prolapse

MCQ 501 · Stress Urinary Incontinence · **Easy** · C3

A 45-year-old woman (para 4, all vaginal deliveries) leaks small amounts of urine when she coughs, sneezes or lifts heavy objects. She has no urgency or nocturia. Urine dipstick and culture are negative. Bladder diary shows normal frequency, and there is no prolapse on examination.

What is the most appropriate first-line treatment?

A. Colposuspension
B. Duloxetine
C. Mid-urethral synthetic sling
D. Oxybutynin
E. Supervised pelvic floor muscle training for at least 3 months

Answer: E. Supervised pelvic floor muscle training for at least 3 months

For stress urinary incontinence, supervised pelvic floor muscle training (at least 8 contractions, 3 times a day) for at least 3 months is first line. Surgery is considered only if conservative treatment fails.

Why not the others

- **A:** Colposuspension is a surgical option after failed conservative treatment.
- **B:** Duloxetine is a second-line option for women who decline or are unfit for surgery, and has side effects.
- **C:** A mid-urethral sling is surgical and second line; use is now restricted in many countries.
- **D:** Oxybutynin is an antimuscarinic for overactive bladder (urge incontinence).

Key point: Stress incontinence → pelvic floor training. Urge incontinence → bladder training, then antimuscarinic or mirabegron.

Reference: Gynaecology by Ten Teachers — Urogynaecology; NICE NG123

MCQ 502 · Types of Incontinence · **Easy** · C2

A 62-year-old woman has a sudden strong desire to pass urine and often leaks before reaching the toilet. She voids 12 times a day and twice at night. She does not leak on coughing.

What is the most likely type of incontinence?

A. Functional incontinence
B. Mixed incontinence
C. Overflow incontinence
D. Stress urinary incontinence
E. Urgency urinary incontinence (overactive bladder)

Answer: E. Urgency urinary incontinence (overactive bladder)

Urgency with or without leakage, frequency and nocturia is overactive bladder syndrome. Leakage preceded by urgency is urgency incontinence, usually caused by detrusor overactivity.

Why not the others

- **A:** Functional incontinence is caused by mobility or cognitive problems.
- **B:** Mixed incontinence needs both stress and urge leakage.
- **C:** Overflow causes dribbling with a large residual.
- **D:** Stress incontinence occurs with coughing or exertion.

Key point: Exclude UTI with a urine dipstick in every woman with urinary symptoms.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 503 · Assessment · **Easy** · C3

A 55-year-old woman has urinary leakage and frequency. Urine dipstick is negative.

Which initial assessment tool is most useful?

A. CT urogram
B. Cystoscopy
C. Pelvic MRI
D. Three-day bladder diary
E. Urodynamics before any treatment

Answer: D. Three-day bladder diary

A bladder diary over at least 3 days records fluid intake, voiding times, volumes and leakage. It identifies excess fluid intake, caffeine use, nocturnal polyuria and the type of problem. It guides conservative treatment.

Why not the others

- **A:** CT urogram is for haematuria.
- **B:** Cystoscopy is for haematuria or suspected bladder pathology.
- **C:** MRI is not needed.
- **E:** Urodynamics are not needed before conservative treatment.

Key point: Bladder diaries are cheap and very informative.

Reference: Gynaecology by Ten Teachers — Urogynaecology; NICE NG123

MCQ 504 · Assessment · **Moderate** · C3

A 58-year-old woman has mixed urinary symptoms. Pelvic floor training and bladder training have not helped. She now wants surgery for stress incontinence.

When are urodynamic studies indicated before surgery?

A. Never
B. Only after surgery fails
C. Only in women over 80
D. When stress incontinence alone is clearly shown
E. When symptoms are mixed or unclear, or previous surgery has been done

Answer: E. When symptoms are mixed or unclear, or previous surgery has been done

Urodynamics are recommended before surgery when the type of incontinence is unclear, there are mixed or urge symptoms, voiding dysfunction, anterior or apical prolapse, or previous surgery for stress incontinence. They are not needed for pure, clearly demonstrated stress incontinence.

Why not the others

- **A:** They are useful in selected women.
- **B:** They should be done before surgery in these situations.
- **C:** Age alone is not the indication.
- **D:** Pure SUI does not need urodynamics.

Key point: Surgery for SUI can worsen detrusor overactivity.

Reference: Gynaecology by Ten Teachers — Urogynaecology; NICE NG123

MCQ 505 · Overactive Bladder · **Easy** · C3

A 50-year-old woman has urgency and frequency. Her bladder diary shows she drinks 3.5 litres a day, including 6 cups of strong tea. Urine is clear.

What is the most appropriate first step?

A. Botulinum toxin injection
B. Mirabegron
C. Oxybutynin
D. Reduce fluid intake to about 1.5–2 litres and cut down caffeine, with bladder training
E. Sacral nerve stimulation

Answer: D. Reduce fluid intake to about 1.5–2 litres and cut down caffeine, with bladder training

Lifestyle changes (normalising fluid intake, reducing caffeine) and bladder training for at least 6 weeks are first-line for overactive bladder.

Why not the others

- **A:** Botox is used after drugs fail.
- **B:** Drugs are second line.
- **C:** Drugs are second line.
- **E:** Nerve stimulation is for refractory cases.

Key point: Bladder training gradually increases the time between voids.

Reference: Gynaecology by Ten Teachers — Urogynaecology; NICE NG123

MCQ 506 · Overactive Bladder · **Moderate** · C3

An 82-year-old woman with mild memory problems has overactive bladder that has not responded to bladder training.

Which drug should be avoided?

A. Mirabegron
B. Oxybutynin (immediate release)
C. Solifenacin
D. Topical vaginal oestrogen
E. Trospium

Answer: B. Oxybutynin (immediate release)

Oxybutynin (immediate release) is strongly anticholinergic, crosses the blood–brain barrier and can worsen confusion, especially in frail older women. Mirabegron or antimuscarinics with lower cognitive impact (trospium) are preferred.

Why not the others

- **A:** Mirabegron does not have anticholinergic effects.
- **C:** Solifenacin is more bladder-selective but anticholinergic burden still matters in frail older women.
- **D:** Vaginal oestrogen helps urgency in postmenopausal women.
- **E:** Trospium crosses the brain less.

Key point: Anticholinergic burden is linked to cognitive decline.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 507 · Overactive Bladder · **Moderate** · C2

A 60-year-old woman with overactive bladder is considering mirabegron.

What is the mechanism of action and main caution of mirabegron?

A. Alpha-blocker; causes hypotension
B. Antimuscarinic; causes dry mouth
C. Beta-3 adrenergic agonist; avoid in severe uncontrolled hypertension
D. Botulinum toxin; causes retention
E. Duloxetine; causes nausea

Answer: C. Beta-3 adrenergic agonist; avoid in severe uncontrolled hypertension

Mirabegron is a beta-3 agonist that relaxes the detrusor. It does not cause anticholinergic side effects but can raise blood pressure, so BP should be checked and it is avoided in severe uncontrolled hypertension.

Why not the others

- **A:** It is not an alpha-blocker.
- **B:** Antimuscarinics cause dry mouth.
- **D:** Botox is injected into the bladder.
- **E:** Duloxetine is for stress incontinence.

Key point: Mirabegron is useful when antimuscarinics are contraindicated or poorly tolerated.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 508 · Overactive Bladder · **Hard** · C3

A 58-year-old woman with refractory detrusor overactivity is offered botulinum toxin A injections into the bladder wall.

What must she be willing and able to do before treatment?

A. Avoid all fluids
B. Have a hysterectomy
C. Perform clean intermittent self-catheterisation if retention occurs
D. Stop all medications permanently
E. Use a urethral catheter permanently

Answer: C. Perform clean intermittent self-catheterisation if retention occurs

Botulinum toxin can cause urinary retention in about 5–10% of women. Women must be willing and able to perform clean intermittent self-catheterisation before treatment.

Why not the others

- **A:** Fluid restriction is not required.
- **B:** Hysterectomy is irrelevant.
- **D:** Other medications may continue.
- **E:** Permanent catheters are not required.

Key point: Effects last 6–12 months; repeat injections are needed.

Reference: Gynaecology by Ten Teachers — Urogynaecology; NICE NG123

MCQ 509 · Stress Incontinence · **Moderate** · C3

A 48-year-old woman with urodynamic stress incontinence has not improved after 3 months of supervised pelvic floor training. She wants surgery and has been told that synthetic mesh tapes are restricted.

Which procedure is an established non-mesh surgical option?

A. Anterior colporrhaphy
B. Botulinum toxin injection
C. Burch colposuspension or autologous fascial sling
D. Sacrocolpopexy
E. Vaginal hysterectomy

Answer: C. Burch colposuspension or autologous fascial sling

Burch colposuspension (open or laparoscopic) and the autologous rectus fascial sling are effective non-mesh operations for stress incontinence. Urethral bulking agents are a less invasive option with lower long-term success.

Why not the others

- **A:** Anterior repair treats prolapse, not stress incontinence.
- **B:** Botox treats overactive bladder.
- **D:** Sacrocolpopexy treats vault prolapse.
- **E:** Hysterectomy does not treat stress incontinence.

Key point: Discuss all options, including mesh risks, at a multidisciplinary team meeting.

Reference: Gynaecology by Ten Teachers — Urogynaecology; NICE NG123

MCQ 510 · Stress Incontinence · **Moderate** · C2

A 52-year-old woman with stress incontinence asks what causes it.

What is the main mechanism of stress urinary incontinence?

A. Bladder outlet obstruction
B. Detrusor overactivity
C. Fistula between bladder and vagina
D. Large post-void residual
E. Weak urethral support and/or intrinsic sphincter deficiency

Answer: E. Weak urethral support and/or intrinsic sphincter deficiency

Stress incontinence occurs when bladder pressure exceeds urethral closure pressure during exertion without detrusor contraction. This results from weak urethral support (hypermobility) and/or a weak urethral sphincter, often after vaginal childbirth.

Why not the others

- **A:** Outlet obstruction causes retention.
- **B:** Detrusor overactivity causes urge incontinence.
- **C:** A fistula causes continuous leakage.
- **D:** A large residual causes overflow.

Key point: Risk factors: vaginal delivery, obesity, chronic cough, constipation and ageing.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 511 · Stress Incontinence · **Hard** · C3

A 64-year-old woman with stress incontinence is unfit for major surgery because of heart disease. She wants a minimally invasive procedure.

Which treatment is most suitable?

A. Burch colposuspension
B. Open retropubic sling
C. Sacrocolpopexy
D. Total abdominal hysterectomy
E. Urethral bulking agent injection

Answer: E. Urethral bulking agent injection

Urethral bulking agents are injected around the urethra under local anaesthetic or sedation to improve closure. Success is lower and repeat injections may be needed, but they are suitable for women unfit for or declining bigger surgery.

Why not the others

- **A:** Colposuspension needs general anaesthesia and abdominal surgery.
- **B:** Open slings are major procedures.
- **C:** Sacrocolpopexy treats prolapse.
- **D:** Hysterectomy is unnecessary.

Key point: Bulking agents work less well long term than slings or colposuspension.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 512 · Mixed Incontinence · **Moderate** · C3

A 56-year-old woman leaks with coughing and also has urgency with leakage. The urgency symptoms bother her most.

How should mixed incontinence be managed first?

A. Botox first
B. Colposuspension first
C. Hysterectomy
D. Mid-urethral sling first
E. Treat the predominant symptom first, with conservative measures

Answer: E. Treat the predominant symptom first, with conservative measures

Mixed incontinence is managed by treating the predominant symptom first, starting with pelvic floor training, bladder training and lifestyle changes. Surgery for the stress component may not help urgency and can worsen it.

Why not the others

- **A:** Botox is for refractory OAB.
- **B:** Surgery should not be first.
- **C:** Hysterectomy does not treat incontinence.
- **D:** A sling may worsen urgency.

Key point: Pelvic floor training helps both stress and urge components.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 513 · Overflow Incontinence · **Moderate** · C2

A 70-year-old woman with long-standing diabetes has frequent dribbling of urine, a weak stream and a feeling of incomplete emptying. Post-void residual on bladder scan is 650 mL.

What is the most likely diagnosis?

A. Overactive bladder
B. Overflow incontinence due to an underactive (hypotonic) bladder
C. Stress incontinence
D. Urinary fistula
E. Urinary tract infection only

Answer: B. Overflow incontinence due to an underactive (hypotonic) bladder

Diabetic autonomic neuropathy can cause an underactive detrusor, chronic retention and overflow incontinence. Treatment is clean intermittent self-catheterisation; antimuscarinics should be avoided.

Why not the others

- **A:** OAB has small residuals.
- **C:** Stress incontinence occurs with exertion and normal emptying.
- **D:** Fistula causes continuous leakage with a normal residual.
- **E:** UTI can coexist but does not explain a large residual.

Key point: Check post-void residual in women with voiding symptoms.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 514 · Urogenital Fistula · **Easy** · C2

A 22-year-old woman from a remote village had a 3-day obstructed labour ending in a stillbirth 6 weeks ago. Since then she has had continuous leakage of urine day and night.

What is the most likely diagnosis?

A. Overactive bladder
B. Overflow incontinence
C. Stress incontinence
D. Urinary tract infection
E. Vesicovaginal fistula

Answer: E. Vesicovaginal fistula

Prolonged obstructed labour compresses the bladder base against the pubic bone, causing ischaemic necrosis and a vesicovaginal fistula. Continuous leakage day and night is typical. It remains common where emergency obstetric care is limited, including parts of Pakistan.

Why not the others

- **A:** OAB causes urgency, not continuous leakage.
- **B:** Overflow causes dribbling with a large residual.
- **C:** Stress leakage occurs only with exertion.
- **D:** UTI does not cause continuous leakage.

Key point: Prevention: access to timely caesarean section.

Reference: Gynaecology by Ten Teachers — Urogynaecology; Obstetric fistula

MCQ 515 · Urogenital Fistula · **Moderate** · C3

A 45-year-old woman has continuous watery vaginal leakage 10 days after an abdominal hysterectomy. A vaginal tampon test is done after instilling methylene blue into the bladder: the tampon stays white but becomes wet with clear fluid.

What is the most likely diagnosis?

A. Rectovaginal fistula
B. Stress incontinence
C. Ureterovaginal fistula
D. Vaginal vault infection
E. Vesicovaginal fistula

Answer: C. Ureterovaginal fistula

In the three-swab (dye) test, blue staining indicates a vesicovaginal fistula. Clear fluid without blue staining suggests urine is coming from the ureter, i.e. a ureterovaginal fistula. CT urogram confirms it.

Why not the others

- **A:** A rectovaginal fistula leaks faeces or gas.
- **B:** Stress incontinence is not continuous.
- **D:** Infection causes purulent, not watery, discharge.
- **E:** A vesicovaginal fistula would stain the tampon blue.

Key point: Ureteric fistulas are often managed with stents or reimplantation.

Reference: Gynaecology by Ten Teachers — Urogynaecology; Complications of surgery

MCQ 516 · Urogenital Fistula · **Hard** · C3

A 30-year-old woman has a small vesicovaginal fistula diagnosed 5 days after an obstructed labour. The tissues are healthy and there is no infection.

What is the most appropriate initial management?

A. Continuous bladder drainage with a urethral catheter for several weeks
B. Ileal conduit
C. Immediate abdominal repair
D. Long-term incontinence pads only
E. Ureteric reimplantation

Answer: A. Continuous bladder drainage with a urethral catheter for several weeks

Small, fresh fistulas, particularly from obstetric injury recognised early, may heal with continuous bladder drainage for several weeks. Larger or persistent fistulas need surgical repair, usually after tissues have healed (often 3 months).

Why not the others

- **B:** Urinary diversion is a last resort.
- **C:** Early repair in oedematous tissue has poorer success, except for some surgical fistulas.
- **D:** Pads do not treat the fistula.
- **E:** The ureter is not involved.

Key point: Most obstetric fistulas can be repaired vaginally by trained surgeons.

Reference: Gynaecology by Ten Teachers — Urogynaecology; Obstetric fistula

MCQ 517 · Prolapse · **Easy** · C2

A 60-year-old woman (para 5) has a feeling of a lump in the vagina, worse at the end of the day. Examination shows a bulge of the anterior vaginal wall descending to the hymen when she strains.

Which structure is prolapsing?

A. Bladder (cystocele)
B. Pouch of Douglas (enterocele)
C. Rectum (rectocele)
D. Urethra only
E. Uterus (uterine prolapse)

Answer: A. Bladder (cystocele)

A cystocele is prolapse of the bladder through the anterior vaginal wall. It may cause a lump, incomplete emptying and frequency.

Why not the others

- **B:** An enterocele bulges through the upper posterior wall.
- **C:** A rectocele is a posterior wall bulge.
- **D:** Urethral descent is part of anterior wall prolapse but the bladder is the main bulge.
- **E:** Uterine prolapse is descent of the cervix.

Key point: Anterior wall prolapse is the commonest type.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 518 · Prolapse · **Moderate** · C2

A 58-year-old woman has difficulty emptying her bowels and has to press on the back wall of her vagina to complete defecation.

Which type of prolapse is most likely?

A. Cystocele
B. Enterocele
C. Rectocele
D. Urethrocele
E. Vault prolapse

Answer: C. Rectocele

A rectocele is bulging of the rectum into the posterior vaginal wall. Women may need to splint (press on the vagina or perineum) to empty the bowel.

Why not the others

- **A:** A cystocele causes bladder symptoms.
- **B:** An enterocele contains small bowel and is higher up.
- **D:** A urethrocele involves the lower anterior wall.
- **E:** Vault prolapse occurs after hysterectomy.

Key point: Posterior repair can cause dyspareunia; discuss before surgery.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 519 · Prolapse · **Easy** · C2

A 65-year-old woman is asked about factors that may have caused her uterine prolapse.

Which is the most important risk factor for pelvic organ prolapse?

A. Caesarean delivery
B. Nulliparity
C. Oral contraceptive use
D. Vaginal childbirth
E. Young age

Answer: D. Vaginal childbirth

Vaginal childbirth, especially with large babies, prolonged second stage or instrumental delivery, is the major risk factor. Others include ageing, menopause, obesity, chronic cough, constipation and connective tissue disorders.

Why not the others

- **A:** Caesarean delivery is protective compared with vaginal birth.
- **B:** Nulliparity reduces risk.
- **C:** The pill is not a risk factor.
- **E:** Risk rises with age.

Key point: Each vaginal birth increases the risk of later prolapse.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 520 · Prolapse Staging · **Moderate** · C2

A 64-year-old woman is assessed using the POP-Q system. On straining, the most distal part of her prolapse is 3 cm beyond the hymen, but the vagina is not completely everted.

What is the POP-Q stage?

A. Stage 0
B. Stage I
C. Stage II
D. Stage III
E. Stage IV

Answer: D. Stage III

POP-Q stage III is when the leading edge is more than 1 cm below the hymen but not completely everted (less than total vaginal length minus 2 cm). Stage II is within 1 cm of the hymen; stage IV is complete eversion (procidentia).

Why not the others

- **A:** Stage 0 is no prolapse.
- **B:** Stage I is more than 1 cm above the hymen.
- **C:** Stage II is within 1 cm above or below the hymen.
- **E:** Stage IV is complete eversion.

Key point: POP-Q measures points in centimetres relative to the hymen.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 521 · Prolapse Management · **Easy** · C3

A 55-year-old woman has a mild (stage I) anterior wall prolapse causing occasional awareness of a bulge. She wants to avoid surgery.

What is the most appropriate first-line treatment?

A. Anterior repair
B. Long-term ring pessary
C. Sacrocolpopexy
D. Supervised pelvic floor muscle training for at least 16 weeks
E. Vaginal hysterectomy

Answer: D. Supervised pelvic floor muscle training for at least 16 weeks

Supervised pelvic floor muscle training for at least 16 weeks improves symptoms of mild to moderate prolapse. Weight loss, avoiding heavy lifting and treating constipation also help.

Why not the others

- **A:** Surgery is not needed for mild prolapse.
- **B:** A pessary is an option but not needed for mild symptoms first.
- **C:** Sacrocolpopexy is for vault prolapse.
- **E:** Hysterectomy is not indicated.

Key point: Vaginal oestrogen may help in postmenopausal women with atrophy.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse; NICE NG123

MCQ 522 · Prolapse Management · **Moderate** · C3

An 82-year-old woman with heart failure and COPD has a symptomatic stage III uterine prolapse. She is not fit for surgery.

What is the most appropriate management?

A. Abdominal sacrohysteropexy
B. Leave it alone
C. Manchester repair
D. Vaginal hysterectomy
E. Vaginal pessary (such as a ring or shelf)

Answer: E. Vaginal pessary (such as a ring or shelf)

Vaginal pessaries are effective for women of any age with prolapse, especially those unfit for or not wanting surgery. A ring pessary is tried first; a shelf or Gellhorn pessary is used if a ring will not stay in.

Why not the others

- **A:** Abdominal surgery is too risky.
- **B:** Symptomatic prolapse should be treated.
- **C:** Manchester repair needs surgery.
- **D:** Hysterectomy needs anaesthesia.

Key point: Change or clean pessaries every 4–6 months; vaginal oestrogen reduces ulceration.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 523 · Prolapse Management · **Moderate** · C2

A 78-year-old woman has used a ring pessary for 3 years. She has not been reviewed for 2 years. She now has blood-stained offensive discharge.

What is the most likely cause?

A. Cervical cancer in all cases
B. Endometriosis
C. Pessary-related vaginal ulceration or erosion
D. Prolapse has resolved
E. Urinary tract infection only

Answer: C. Pessary-related vaginal ulceration or erosion

Neglected pessaries can cause vaginal ulceration, erosion, infection and, rarely, fistula. The pessary should be removed, the vagina examined, and vaginal oestrogen given. Persistent lesions need biopsy.

Why not the others

- **A:** Cancer must be excluded, but ulceration is far more likely.
- **B:** Endometriosis is not relevant.
- **D:** Prolapse does not resolve and the discharge needs explanation.
- **E:** UTI does not cause bloody vaginal discharge.

Key point: Regular pessary review prevents complications.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 524 · Prolapse Management · **Hard** · C3

A 66-year-old woman had a vaginal hysterectomy 5 years ago. She now has a symptomatic stage III vaginal vault prolapse. She is fit and sexually active.

Which operation gives the most durable support for vault prolapse?

A. Anterior colporrhaphy
B. Colpocleisis
C. Laparoscopic or abdominal sacrocolpopexy
D. Posterior colporrhaphy
E. Vaginal hysterectomy

Answer: C. Laparoscopic or abdominal sacrocolpopexy

Sacrocolpopexy attaches the vault to the sacral promontory with mesh and has the lowest recurrence for vault prolapse. Sacrospinous fixation is a vaginal alternative. Colpocleisis closes the vagina and suits women not wanting intercourse.

Why not the others

- **A:** Anterior repair treats cystocele.
- **B:** Colpocleisis is unsuitable for a sexually active woman.
- **D:** Posterior repair treats rectocele.
- **E:** She has already had a hysterectomy.

Key point: Mesh at sacrocolpopexy is placed abdominally and is still used, with consent about risks.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 525 · Prolapse Management · **Moderate** · C3

An 80-year-old widow with complete uterine procidentia has a pessary that keeps falling out. She is fit for a short operation, is not sexually active and wants the most reliable cure with a quick recovery.

Which operation is most suitable?

A. Abdominal sacrocolpopexy
B. Anterior repair only
C. Colpocleisis
D. Manchester repair
E. Posterior repair only

Answer: C. Colpocleisis

Colpocleisis (closing the vagina) is a short, low-risk vaginal operation with a very high success rate. It suits elderly women who do not want vaginal intercourse in the future.

Why not the others

- **A:** Sacrocolpopexy is a longer abdominal operation.
- **B:** Anterior repair alone does not treat procidentia.
- **D:** The Manchester repair preserves the uterus but is less suited here.
- **E:** Posterior repair alone does not treat procidentia.

Key point: Confirm that she understands intercourse will no longer be possible.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 526 · Prolapse Management · **Hard** · C3

A 75-year-old woman has complete procidentia with a large ulcer on the exposed cervix. She is listed for surgery in 4 weeks.

What is the most appropriate preoperative management of the ulcer?

A. Biopsy only if it is still present after surgery
B. Immediate surgery without treatment
C. Leave it exposed to dry
D. Reduce the prolapse with a pack or pessary and apply vaginal oestrogen; biopsy if it does not heal
E. Systemic antibiotics for 6 weeks

Answer: D. Reduce the prolapse with a pack or pessary and apply vaginal oestrogen; biopsy if it does not heal

Decubitus ulcers are caused by friction and venous congestion. Reducing the prolapse and applying vaginal oestrogen usually heals them before surgery. A non-healing ulcer should be biopsied to exclude cancer.

Why not the others

- **A:** Biopsy should be done before surgery if it does not heal.
- **B:** Operating on an ulcerated cervix increases complications.
- **C:** Exposure worsens ulceration.
- **E:** Long antibiotics are not needed.

Key point: Procidentia can also cause hydronephrosis from ureteric kinking.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 527 · Prolapse Management · **Moderate** · C2

A 40-year-old woman with symptomatic uterine prolapse wants to keep her uterus for possible future pregnancy.

Which procedure preserves the uterus?

A. Colpocleisis
B. Laparoscopic sacrohysteropexy
C. Total abdominal hysterectomy
D. Vaginal hysterectomy
E. Vaginal hysterectomy with sacrospinous fixation

Answer: B. Laparoscopic sacrohysteropexy

Uterine-preserving surgery includes sacrohysteropexy (attaching the uterus to the sacrum with mesh) and sacrospinous hysteropexy. Pregnancy after prolapse surgery may need caesarean delivery and can cause recurrence, so surgery is often delayed until the family is complete.

Why not the others

- **A:** Colpocleisis closes the vagina.
- **C:** Hysterectomy removes the uterus.
- **D:** Hysterectomy removes the uterus.
- **E:** Hysterectomy removes the uterus.

Key point: A pessary is a good option until childbearing is complete.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 528 · Prolapse Surgery · **Hard** · C2

A 62-year-old woman had an anterior repair for a large cystocele. She had no incontinence before surgery. Now she leaks urine when she coughs.

What is the most likely explanation?

A. Detrusor overactivity

B. Mesh erosion

C. Occult stress incontinence unmasked by correcting the prolapse

D. Ureteric injury

E. Vesicovaginal fistula

Answer: C. Occult stress incontinence unmasked by correcting the prolapse

A large anterior prolapse can kink the urethra and hide stress incontinence. Once the prolapse is corrected, the incontinence appears (occult stress incontinence). Preoperative testing with the prolapse reduced can detect it.

Why not the others

- **A:** Detrusor overactivity causes urgency, not cough leakage.
- **B:** No mesh was used.
- **D:** Ureteric injury causes loin pain or continuous leakage.
- **E:** A fistula causes continuous leakage.

Key point: Counsel women before prolapse surgery about de novo stress incontinence.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse; Urogynaecology

MCQ 529 · Prolapse Surgery · **Moderate** · C3

A 68-year-old woman cannot pass urine 8 hours after a vaginal hysterectomy and pelvic floor repair. Bladder scan shows 900 mL.

What is the most appropriate management?

A. Antimuscarinic drug

B. Catheterise to drain the bladder, then trial without catheter

C. Encourage oral fluids and wait

D. Return to theatre

E. Suprapubic pressure only

Answer: B. Catheterise to drain the bladder, then trial without catheter

Postoperative urinary retention is common after vaginal surgery. Overdistension can damage the detrusor, so the bladder is drained with a catheter, followed by a trial without catheter, and teaching intermittent self-catheterisation if retention persists.

Why not the others

- **A:** Antimuscarinics worsen retention.
- **C:** Waiting risks overdistension injury.
- **D:** Theatre is not needed.
- **E:** Suprapubic pressure is ineffective and may harm.

Key point: Measure post-void residuals after pelvic surgery.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse; Complications of surgery

MCQ 530 · Mesh Complications · **Hard** · C2

A 55-year-old woman had a transvaginal mesh repair for prolapse 3 years ago. She now has pelvic pain, painful intercourse and a vaginal discharge. Examination shows exposed mesh in the anterior vaginal wall.

What is the most appropriate management?

A. Ignore the exposure
B. Long-term antibiotics only
C. Refer to a specialist mesh centre for assessment and possible removal
D. Repeat mesh insertion
E. Total hysterectomy

Answer: C. Refer to a specialist mesh centre for assessment and possible removal

Mesh exposure and pain are recognised complications of transvaginal mesh. Women should be referred to a specialist centre for multidisciplinary assessment. Treatment may include vaginal oestrogen for small exposures or partial or complete mesh removal.

Why not the others

- **A:** Exposure needs treatment.
- **B:** Antibiotics alone will not resolve it.
- **D:** More mesh is not appropriate.
- **E:** Hysterectomy does not treat mesh complications.

Key point: Transvaginal mesh for prolapse is now restricted in many countries because of complications.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse; Urogynaecology

MCQ 531 · Nocturia · **Moderate** · C2

A 72-year-old woman wakes 4 times a night to pass urine. Her bladder diary shows that more than a third of her 24-hour urine output is produced at night. She has ankle oedema.

What is the most likely cause of her nocturia?

A. Bladder cancer
B. Interstitial cystitis
C. Nocturnal polyuria
D. Stress incontinence
E. Vesicovaginal fistula

Answer: C. Nocturnal polyuria

Nocturnal polyuria is producing more than a third of the 24-hour urine at night (in older adults). Causes include heart failure, venous insufficiency with leg oedema, diabetes, sleep apnoea and evening fluids or diuretics.

Why not the others

- **A:** Bladder cancer causes haematuria.
- **B:** Interstitial cystitis causes pain with small volumes.
- **D:** Stress incontinence does not cause nocturnal polyuria.
- **E:** A fistula causes continuous leakage.

Key point: Desmopressin in older women risks hyponatraemia; check sodium.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 532 · Overactive Bladder · **Hard** · C3

A 60-year-old woman with refractory overactive bladder declines botulinum toxin because she does not want to self-catheterise.

Which treatment is an alternative?

A. Anterior repair
B. Burch colposuspension
C. Mid-urethral sling
D. Sacral nerve stimulation or percutaneous tibial nerve stimulation
E. Vaginal hysterectomy

Answer: D. Sacral nerve stimulation or percutaneous tibial nerve stimulation

Sacral neuromodulation (an implanted device) and percutaneous tibial nerve stimulation modulate bladder reflexes and are options for refractory overactive bladder when drugs fail and botox is unsuitable.

Why not the others

- **A:** Anterior repair treats prolapse.
- **B:** Colposuspension treats stress incontinence and may worsen urgency.
- **C:** A sling treats stress incontinence.
- **E:** Hysterectomy does not treat OAB.

Key point: Augmentation cystoplasty is a last resort.

Reference: Gynaecology by Ten Teachers — Urogynaecology; NICE NG123

MCQ 533 · Overactive Bladder · **Easy** · C2

A 58-year-old woman takes oxybutynin for urgency. She complains of side effects.

Which side effects are typical of antimuscarinic drugs?

A. Diarrhoea and hypersalivation
B. Dry mouth, constipation and blurred vision
C. Hypertension and tachycardia
D. Increased sweating
E. Weight loss

Answer: B. Dry mouth, constipation and blurred vision

Antimuscarinics block muscarinic receptors in the bladder and elsewhere, causing dry mouth, constipation, blurred vision and, in older people, confusion. They are contraindicated in uncontrolled narrow-angle glaucoma and myasthenia gravis.

Why not the others

- **A:** Antimuscarinics reduce saliva and cause constipation.
- **C:** Hypertension is linked to mirabegron.
- **D:** They reduce sweating.
- **E:** Weight loss is not typical.

Key point: Review antimuscarinic treatment after 4 weeks.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 534 · Stress Incontinence · **Moderate** · C2

A 50-year-old woman with stress incontinence declines surgery and asks about a tablet. Her doctor considers duloxetine.

Which side effect commonly limits duloxetine use?

A. Bradycardia
B. Hair loss
C. Hypoglycaemia
D. Nausea
E. Urinary retention in most women

Answer: D. Nausea

Duloxetine, a serotonin–noradrenaline reuptake inhibitor, increases urethral sphincter tone. Nausea is common and often causes women to stop. It is second line and not recommended as an alternative to surgery for women who want a cure.

Why not the others

- **A:** Bradycardia is not typical.
- **B:** Hair loss is not typical.
- **C:** Hypoglycaemia is not typical.
- **E:** Retention is uncommon.

Key point: Start with a low dose and increase slowly to reduce nausea.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 535 · Faecal Incontinence · **Moderate** · C2

A 32-year-old woman had a forceps delivery with a third-degree tear 6 months ago. She now has urgency to defecate and leaks flatus and loose stool.

What is the most likely cause?

A. Haemorrhoids
B. Irritable bowel syndrome
C. Rectal cancer
D. Rectovaginal fistula
E. Residual anal sphincter defect

Answer: E. Residual anal sphincter defect

Obstetric anal sphincter injury is the commonest cause of faecal incontinence in women. Even after repair, a residual defect or weakness can cause urgency and incontinence. Endoanal ultrasound shows the defect.

Why not the others

- **A:** Haemorrhoids cause bleeding and prolapse.
- **B:** IBS does not explain the timing after delivery.
- **C:** Cancer is unlikely at her age.
- **D:** A fistula would cause faeces or gas through the vagina.

Key point: Women with previous sphincter injury should be counselled about mode of future deliveries.

Reference: Gynaecology by Ten Teachers — Urogynaecology; Perineal trauma

MCQ 536 · Normal Bladder Function · **Easy** · C2

A 40-year-old woman keeps a bladder diary and asks what is normal.

Which finding falls within the normal range for an adult woman?

A. Daytime frequency of 15 voids
B. Functional bladder capacity of 400–600 mL
C. Nocturia of 4 times
D. Post-void residual of 300 mL
E. Total urine output of 5 litres a day

Answer: B. Functional bladder capacity of 400–600 mL

Normal adult bladder capacity is about 400–600 mL. Normal daytime frequency is up to about 7 voids, nocturia no more than once, and post-void residual under about 50–100 mL.

Why not the others

- **A:** Fifteen voids a day is increased frequency.
- **C:** Four times a night is nocturia.
- **D:** A residual of 300 mL is incomplete emptying.
- **E:** Five litres a day is polyuria.

Key point: Polyuria over 3 litres a day: check for diabetes.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 537 · Incontinence in Older Women · **Moderate** · C3

An 84-year-old woman in a care home has new urinary incontinence. She recently started furosemide, is constipated, and her mobility has worsened.

What is the most appropriate first step?

A. Address reversible causes such as medication timing, constipation, mobility and infection
B. Long-term catheter
C. Mid-urethral sling
D. Oxybutynin
E. Urodynamics

Answer: A. Address reversible causes such as medication timing, constipation, mobility and infection

New incontinence in older people often has reversible causes: drugs (diuretics, sedatives), constipation, infection, immobility, delirium and excess fluids. Addressing these first is the priority.

Why not the others

- **B:** Catheters are a last resort and cause infection.
- **C:** Surgery is not first line.
- **D:** Oxybutynin may cause confusion and constipation.
- **E:** Urodynamics are not the first step.

Key point: Mnemonic DIAPPERS: Delirium, Infection, Atrophic vaginitis, Pharmaceuticals, Psychological, Excess urine, Restricted mobility, Stool impaction.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 538 · Urinary Retention · **Moderate** · C2

A 28-year-old woman cannot pass urine 6 hours after a vaginal delivery with an epidural. Bladder scan shows 1,000 mL.

What is the most appropriate management?

A. Catheterise and leave an indwelling catheter for at least 24 hours, then trial without catheter

B. Encourage fluids and wait 12 more hours

C. Give oxybutynin

D. Return to theatre

E. Urodynamics immediately

Answer: A. Catheterise and leave an indwelling catheter for at least 24 hours, then trial without catheter

Postpartum urinary retention is common after epidural, prolonged labour, instrumental delivery and perineal trauma. Overdistension can permanently damage the detrusor, so the bladder is drained and left on free drainage before a trial without catheter.

Why not the others

- **B:** Waiting causes overdistension injury.
- **C:** Antimuscarinics worsen retention.
- **D:** Theatre is not indicated.
- **E:** Urodynamics are not needed acutely.

Key point: Women should pass urine within 6 hours of delivery.

Reference: Gynaecology by Ten Teachers — Urogynaecology; Postnatal care

MCQ 539 · Pessaries · **Easy** · C2

A 72-year-old woman with a stage II uterine prolapse has a ring pessary fitted. She asks about follow-up.

How often should a ring pessary be changed or cleaned?

A. Every 4–6 months

B. Every 5 years

C. Every day by a doctor

D. Never

E. Only if bleeding occurs

Answer: A. Every 4–6 months

Ring pessaries are usually changed or removed and cleaned every 4–6 months. Some women can learn to remove and reinsert them themselves. Vaginal oestrogen reduces erosion.

Why not the others

- **B:** Five years is too long and risks erosion.
- **C:** Daily change is not needed.
- **D:** Neglected pessaries cause ulceration and fistula.
- **E:** Review is needed even without bleeding.

Key point: Pessaries can be used long term with regular review.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 540 · Neurogenic Bladder · **Hard** · C2

A 38-year-old woman with multiple sclerosis has urgency, frequency and urge incontinence, and also a post-void residual of 250 mL.

What is the most likely urodynamic diagnosis?

A. Detrusor overactivity with detrusor–sphincter dyssynergia
B. Normal bladder
C. Pure stress incontinence
D. Urethral diverticulum
E. Vesicovaginal fistula

Answer: A. Detrusor overactivity with detrusor–sphincter dyssynergia

Spinal cord lesions above the sacral centre, as in MS, cause neurogenic detrusor overactivity and often detrusor–sphincter dyssynergia (the sphincter contracts with the detrusor), giving urgency plus incomplete emptying.

Why not the others

- **B:** The symptoms and residual are abnormal.
- **C:** Stress incontinence does not cause urgency and residual.
- **D:** A diverticulum is not likely.
- **E:** A fistula causes continuous leakage.

Key point: Combine antimuscarinics or botox with intermittent self-catheterisation.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 541 · Urogenital Fistula · **Hard** · C2

A 19-year-old woman has had constant dampness from urinary dribbling all her life, but she also voids normally. Examination shows no fistula, but there is a tiny opening near the urethra.

What is the most likely diagnosis?

A. Detrusor overactivity
B. Ectopic ureter opening below the sphincter
C. Overflow incontinence
D. Stress incontinence
E. Vesicovaginal fistula

Answer: B. Ectopic ureter opening below the sphincter

An ectopic ureter (often from a duplex kidney) opening into the vagina or urethra below the sphincter causes continuous dribbling since childhood, while normal voiding also occurs from the normal ureter. CT or MR urography shows it.

Why not the others

- **A:** Detrusor overactivity causes urgency.
- **C:** Overflow needs a large residual.
- **D:** Stress incontinence is with exertion only.
- **E:** A fistula would follow injury or surgery.

Key point: Lifelong continuous leakage with normal voiding = ectopic ureter.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 542 · Recurrent UTI · **Moderate** · C3

A 35-year-old woman has three culture-proven urinary infections in 6 months, each following intercourse. Renal ultrasound is normal.

Which preventive measure is reasonable?

A. Daily ciprofloxacin long-term
B. Hysterectomy
C. Mid-urethral sling
D. Post-coital single-dose antibiotic
E. Vaginal mesh repair

Answer: D. Post-coital single-dose antibiotic

For recurrent UTIs related to intercourse, a single dose of an antibiotic (such as trimethoprim or nitrofurantoin) after intercourse is effective. Hydration and voiding after sex are also advised.

Why not the others

- **A:** Long-term quinolones carry serious risks.
- **B:** Hysterectomy is not relevant.
- **C:** A sling treats stress incontinence.
- **E:** Mesh repair treats prolapse.

Key point: In postmenopausal women, vaginal oestrogen also reduces recurrence.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 543 · Prolapse · **Moderate** · C2

A 70-year-old woman with a complete procidentia has a raised creatinine. Ultrasound shows bilateral hydronephrosis. When the prolapse is reduced, the hydronephrosis improves.

What causes the hydronephrosis?

A. Bladder cancer
B. Kidney stones
C. Kinking and obstruction of the ureters by the prolapse
D. Pyelonephritis
E. Retroperitoneal fibrosis

Answer: C. Kinking and obstruction of the ureters by the prolapse

In complete procidentia the bladder base and ureters descend outside the vagina, kinking the ureters and causing obstruction. Reducing the prolapse (pessary or surgery) relieves it.

Why not the others

- **A:** Bladder cancer would not resolve on reduction.
- **B:** Stones would not resolve on reduction.
- **D:** Infection does not cause bilateral reversible obstruction.
- **E:** Fibrosis would not resolve on reduction.

Key point: Check renal function in women with severe prolapse.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 544 · Stress Incontinence · **Easy** · C3

A 45-year-old woman with stress incontinence has a BMI of 34 kg/m².

Which lifestyle advice is most likely to improve her symptoms?

A. Drink more caffeine
B. Increase heavy lifting
C. Lose weight
D. Smoke fewer cigarettes only
E. Stop all fluids after 2 pm

Answer: C. Lose weight

Weight loss of 5–10% reduces stress incontinence episodes significantly by lowering abdominal pressure on the pelvic floor. It is recommended alongside pelvic floor training.

Why not the others

- **A:** Caffeine worsens urgency.
- **B:** Heavy lifting increases strain on the pelvic floor.
- **D:** Stopping smoking helps cough but weight loss is most relevant here.
- **E:** Severe fluid restriction concentrates urine and irritates the bladder.

Key point: Treat chronic cough and constipation too.

Reference: Gynaecology by Ten Teachers — Urogynaecology; NICE NG123

MCQ 545 · Overactive Bladder · **Moderate** · C3

A 67-year-old woman with overactive bladder and vaginal atrophy asks for treatment. She prefers to avoid tablets.

Which treatment may improve both conditions?

A. Botulinum toxin
B. Duloxetine
C. Mid-urethral sling
D. Oral oestrogen-only HRT
E. Vaginal oestrogen

Answer: E. Vaginal oestrogen

Vaginal oestrogen improves symptoms of overactive bladder in postmenopausal women with vaginal atrophy, as well as treating the atrophy itself. Systemic HRT does not improve and may worsen incontinence.

Why not the others

- **A:** Botox is for refractory OAB.
- **B:** Duloxetine treats stress incontinence.
- **C:** A sling treats stress incontinence.
- **D:** Systemic HRT may worsen incontinence.

Key point: Vaginal oestrogen is safe long term at low doses.

Reference: Gynaecology by Ten Teachers — Urogynaecology; The menopause

MCQ 546 · Prolapse · **Moderate** · C2

A 59-year-old woman has a bulge in the upper posterior vagina after a hysterectomy. On rectal and vaginal examination, small bowel can be felt between the vagina and rectum.

What type of prolapse is this?

A. Cystocele
B. Enterocele
C. Rectocele
D. Urethrocele
E. Uterine prolapse

Answer: B. Enterocele

An enterocele is herniation of the pouch of Douglas, often containing small bowel, through the upper posterior vagina. It is common after hysterectomy and is often associated with vault prolapse.

Why not the others

- **A:** A cystocele is anterior.
- **C:** A rectocele is lower on the posterior wall and contains rectum.
- **D:** A urethrocele is anterior and low.
- **E:** She has no uterus.

Key point: Closing the pouch of Douglas at hysterectomy may reduce enterocele risk.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse

MCQ 547 · Assessment · **Hard** · C2

A 55-year-old woman has urodynamics. During bladder filling there are involuntary detrusor contractions with leakage and a strong urge. There is no leakage on coughing.

What is the urodynamic diagnosis?

A. Detrusor overactivity
B. Detrusor underactivity
C. Normal study
D. Urethral obstruction
E. Urodynamic stress incontinence

Answer: A. Detrusor overactivity

Involuntary detrusor contractions during filling, with urgency and leakage, define detrusor overactivity. Urodynamic stress incontinence is leakage with raised abdominal pressure and no detrusor contraction.

Why not the others

- **B:** Underactivity is poor contraction during voiding.
- **C:** The study is abnormal.
- **D:** Obstruction shows high pressure with low flow during voiding.
- **E:** There was no leakage on coughing.

Key point: Detrusor overactivity is treated medically, not surgically.

Reference: Gynaecology by Ten Teachers — Urogynaecology

MCQ 548 · Prolapse · **Easy** · C2

A 63-year-old woman has a uterine prolapse in which the cervix comes down to the hymen on straining but no further.

Which non-surgical treatment can be offered?

A. Antibiotics
B. Hormone implant
C. Mid-urethral sling
D. Pelvic floor muscle training or a vaginal pessary
E. Uterine artery embolisation

Answer: D. Pelvic floor muscle training or a vaginal pessary

Conservative options for prolapse are pelvic floor muscle training and vaginal pessaries. Many women prefer these to surgery, and they can be used long term.

Why not the others

- **A:** Antibiotics have no role.
- **B:** Hormone implants are not a prolapse treatment.
- **C:** A sling is surgery for stress incontinence.
- **E:** Embolisation treats fibroids.

Key point: Offer women all options: watchful waiting, pelvic floor training, pessary, surgery.

Reference: Gynaecology by Ten Teachers — Pelvic organ prolapse; NICE NG123

MCQ 549 · Urogenital Fistula · **Moderate** · C3

A 35-year-old woman with a 2 cm vesicovaginal fistula after obstructed labour 3 months ago is being planned for repair. The tissues have healed and there is no infection.

Which approach is usually used for obstetric vesicovaginal fistula repair?

A. Abdominal hysterectomy
B. Ileal conduit as first line
C. Long-term catheter
D. No surgery; pads only
E. Vaginal layered repair by an experienced fistula surgeon

Answer: E. Vaginal layered repair by an experienced fistula surgeon

Most obstetric fistulas can be repaired vaginally, closing the bladder and vagina in layers without tension. Success rates exceed 90% for first repairs by experienced surgeons. Postoperative bladder drainage is maintained for 10–14 days.

Why not the others

- **A:** Hysterectomy is not needed.
- **B:** Urinary diversion is for irreparable fistulas.
- **C:** A catheter does not close an established fistula.
- **D:** Repair is highly successful and transforms lives.

Key point: The first repair has the best chance of success.

Reference: Gynaecology by Ten Teachers — Urogynaecology; Obstetric fistula

MCQ 550 · Urethral Lesions · **Easy** · C2

A 70-year-old woman has spotting of blood on her underwear and mild dysuria. Examination shows a small, soft, red, fleshy polypoid lesion at the posterior lip of the urethral meatus. The vaginal walls are thin and pale.

What is the most likely diagnosis?

A. Bartholin cyst
B. Skene duct cyst
C. Urethral carcinoma
D. Urethral caruncle
E. Urethral diverticulum

Answer: D. Urethral caruncle

A urethral caruncle is a benign red fleshy lesion at the posterior urethral meatus in postmenopausal women, linked to oestrogen deficiency. It is treated with vaginal oestrogen; excision and biopsy are needed if it is atypical or does not respond.

Why not the others

- **A:** A Bartholin cyst is posterolateral at the vestibule.
- **B:** A Skene duct cyst is a cystic swelling beside the meatus.
- **C:** Carcinoma is rare and usually hard or ulcerated; biopsy if suspicious.
- **E:** A diverticulum is a swelling under the anterior vaginal wall.

Key point: Postmenopausal bleeding may come from the urethra; examine carefully.

Reference: Gynaecology by Ten Teachers — Urogynaecology; The menopause

CHAPTER 12

Cervical Screening and Cervical Cancer

MCQ 551 · Cervical Screening · **Moderate** · C3

A 30-year-old woman attends for routine cervical screening. Her sample is positive for high-risk HPV and reflex cytology is reported as normal (negative for dyskaryosis). She has no symptoms and the cervix looked healthy.

What is the most appropriate next step?

A. Immediate colposcopy
B. Large loop excision of the transformation zone
C. Repeat cytology in 6 months
D. Repeat HPV test in 12 months
E. Return to routine 3-yearly recall

Answer: D. Repeat HPV test in 12 months

Under HPV primary screening, an HPV-positive result with normal cytology is followed by a repeat HPV test in 12 months, because most infections clear spontaneously in that time.

Why not the others

- **A:** Immediate colposcopy is for HPV-positive results with any grade of abnormal cytology.
- **B:** LLETZ treats confirmed CIN 2 or 3; without colposcopy or histology it is overtreatment.
- **C:** Follow-up under HPV primary screening uses HPV testing, not repeat cytology.
- **E:** Routine recall is only for HPV-negative women.

Key point: HPV positive + normal cytology → repeat HPV at 12 months. HPV positive + abnormal cytology → colposcopy.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix; NHS Cervical Screening Programme

MCQ 552 · HPV · **Easy** · C2

A 30-year-old woman asks what causes cervical cancer.

Which human papillomavirus types cause about 70% of cervical cancers?

A. HPV 1 and 2
B. HPV 6 and 11
C. HPV 16 and 18
D. HPV 31 and 33
E. HPV 42 and 43

Answer: C. HPV 16 and 18

Persistent infection with high-risk HPV is necessary for almost all cervical cancers. HPV 16 and 18 cause about 70%. HPV 6 and 11 are low-risk types that cause genital warts.

Why not the others

- **A:** HPV 1 and 2 cause skin warts.
- **B:** HPV 6 and 11 cause genital warts.
- **D:** HPV 31 and 33 are high-risk but cause a smaller share.
- **E:** HPV 42 and 43 are low-risk.

Key point: Most HPV infections clear within 2 years; persistence leads to CIN.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 553 · HPV · **Moderate** · C2

A 27-year-old woman with persistent HPV 16 infection asks how the virus leads to cancer.

Which viral proteins inactivate p53 and retinoblastoma (Rb) tumour suppressor proteins?

A. E1 and E2
B. E6 and E7
C. Gag and Pol
D. L1 and L2
E. Reverse transcriptase

Answer: B. E6 and E7

High-risk HPV E6 protein promotes degradation of p53, and E7 binds and inactivates Rb. This removes cell-cycle control and allows accumulation of mutations, leading to CIN and cancer.

Why not the others

- **A:** E1 and E2 regulate viral replication; loss of E2 increases E6/E7 expression.
- **C:** Gag and Pol are retroviral genes.
- **D:** L1 and L2 are capsid proteins; L1 is used in vaccines.
- **E:** HPV is a DNA virus without reverse transcriptase.

Key point: HPV vaccines are made from L1 virus-like particles.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 554 · Screening · **Easy** · C2

A Pakistani community health programme with limited laboratory facilities wants to start cervical screening.

Which low-cost screening method does WHO support in low-resource settings?

A. Annual pelvic MRI
B. CA-125 testing
C. Endometrial biopsy
D. Transvaginal ultrasound
E. Visual inspection with acetic acid (VIA), or HPV testing, linked to treatment

Answer: E. Visual inspection with acetic acid (VIA), or HPV testing, linked to treatment

WHO recommends HPV DNA testing as the primary screening test, and in low-resource settings visual inspection with acetic acid (VIA) is used. A "screen-and-treat" approach with ablation (thermal ablation or cryotherapy) at the same visit reduces loss to follow-up.

Why not the others

- **A:** MRI is not a screening test.
- **B:** CA-125 is an ovarian marker.
- **C:** Endometrial biopsy does not screen the cervix.
- **D:** Ultrasound does not detect CIN.

Key point: WHO aims to eliminate cervical cancer through vaccination, screening and treatment (90-70-90 targets).

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 555 · Screening · **Moderate** · C3

A 32-year-old woman's cervical screening sample is reported as inadequate.

What is the correct management?

A. Colposcopy immediately
B. Hysterectomy
C. LLETZ
D. Repeat the test in 3 months
E. Return to routine recall

Answer: D. Repeat the test in 3 months

An inadequate sample should be repeated, usually after 3 months to allow the cervix to recover. Two consecutive inadequate samples lead to colposcopy.

Why not the others

- **A:** Colposcopy follows two inadequate samples.
- **B:** Hysterectomy is not indicated.
- **C:** Treatment needs an abnormal result.
- **E:** An inadequate test gives no result.

Key point: Common reasons: too few cells, blood or inflammation obscuring cells.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 556 · Screening · **Moderate** · C3

A 35-year-old woman has a cervical screening test showing HPV positive with high-grade dyskaryosis (moderate).

What is the most appropriate next step?

A. Hysterectomy
B. Repeat cytology in 6 months
C. Repeat HPV test in 12 months
D. Return to routine recall
E. Urgent referral for colposcopy within 2 weeks

Answer: E. Urgent referral for colposcopy within 2 weeks

High-grade dyskaryosis needs urgent colposcopy (within 2 weeks in the UK programme). Most women will have CIN 2 or 3, which is treated by LLETZ.

Why not the others

- **A:** Hysterectomy is not first-line for CIN.
- **B:** Waiting is inappropriate.
- **C:** Waiting is inappropriate for high-grade changes.
- **D:** Routine recall is only for HPV-negative results.

Key point: Low-grade dyskaryosis with HPV positive → colposcopy within 6 weeks.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 557 · Screening · **Hard** · C3

A 38-year-old woman tested HPV positive with normal cytology 2 years ago, and again at 12 months. Today, 24 months after the first test, she is still HPV positive with normal cytology.

What is the correct management?

A. Hysterectomy
B. LLETZ without colposcopy
C. Refer for colposcopy
D. Repeat the test in another 12 months
E. Return to routine recall

Answer: C. Refer for colposcopy

Persistent HPV positivity at 24 months, even with normal cytology, means a higher risk of underlying CIN. She should be referred for colposcopy.

Why not the others

- **A:** Hysterectomy is not indicated.
- **B:** Treatment requires colposcopic assessment.
- **D:** Further waiting is not recommended.
- **E:** Persistent HPV needs assessment.

Key point: HPV clearance at any repeat test returns her to routine recall.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 558 · Colposcopy · **Easy** · C2

During colposcopy, 5% acetic acid is applied to the cervix and an area turns white within a minute.

What does acetowhite change indicate?

A. Areas with high nuclear density, such as CIN
B. Glycogen-rich normal squamous epithelium
C. Healthy columnar epithelium
D. Nabothian follicles
E. Normal vaginal mucosa

Answer: A. Areas with high nuclear density, such as CIN

Acetic acid coagulates proteins in cells with a high nuclear-to-cytoplasm ratio, making abnormal (CIN) areas appear white. The density, edge and speed of whitening help grade the lesion.

Why not the others

- **B:** Glycogen-rich epithelium stains brown with iodine.
- **C:** Columnar epithelium shows only brief whitening.
- **D:** Nabothian follicles are yellowish cysts.
- **E:** Normal vaginal mucosa does not turn densely white.

Key point: Mosaicism and punctation are vascular patterns suggesting CIN.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 559 · Colposcopy · **Moderate** · C2

At colposcopy, Lugol's iodine is applied to the cervix. An area near the transformation zone fails to stain brown and stays pale yellow.

What does this indicate?

A. Abnormal epithelium lacking glycogen, such as CIN
B. Healthy mature squamous epithelium
C. Normal pregnancy change
D. Normal response in all women
E. Vaginal candidiasis only

Answer: A. Abnormal epithelium lacking glycogen, such as CIN

Normal mature squamous epithelium contains glycogen and stains dark brown with iodine (Schiller's test). Abnormal epithelium (CIN), columnar epithelium and atrophic epithelium do not stain.

Why not the others

- **B:** Healthy squamous epithelium stains brown.
- **C:** Pregnancy does not cause iodine-negative areas specifically.
- **D:** Normal epithelium stains.
- **E:** Candida does not cause iodine-negative areas.

Key point: Iodine helps define the margins of a lesion before excision.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 560 · CIN · **Moderate** · C3

A 26-year-old woman has colposcopy for low-grade dyskaryosis. Punch biopsy shows CIN 1.

What is the most appropriate management?

A. Cone biopsy
B. Hysterectomy
C. Immediate LLETZ
D. Radiotherapy
E. Repeat HPV and cytology in 12 months (surveillance)

Answer: E. Repeat HPV and cytology in 12 months (surveillance)

CIN 1 often regresses, especially in young women, and is usually managed by surveillance with repeat testing at 12 months. Treatment is considered if it persists for 2 years or progresses.

Why not the others

- **A:** Cone biopsy is excessive for CIN 1.
- **B:** Hysterectomy is not indicated.
- **C:** Immediate treatment is overtreatment and may harm future pregnancies.
- **D:** Radiotherapy is for cancer.

Key point: About 60% of CIN 1 regresses.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 561 · CIN · **Moderate** · C3

A 30-year-old woman has colposcopy showing a high-grade lesion. Biopsy confirms CIN 3. She has one child and wants more.

What is the most appropriate treatment?

A. Cryotherapy without histology
B. Hysterectomy
C. Large loop excision of the transformation zone (LLETZ)
D. Observation for 2 years
E. Radiotherapy

Answer: C. Large loop excision of the transformation zone (LLETZ)

LLETZ removes the transformation zone with the lesion, gives histology to check margins and exclude invasion, and is done under local anaesthetic. It is the standard treatment for CIN 2 and 3.

Why not the others

- **A:** Ablation needs prior histology and the whole lesion visible; excision is preferred for CIN 3.
- **B:** Hysterectomy is too radical.
- **D:** CIN 3 has a significant risk of progression.
- **E:** Radiotherapy is for invasive cancer.

Key point: Keep excision depth to the minimum needed to protect future pregnancies.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 562 · CIN · **Moderate** · C2

A 31-year-old woman had a LLETZ for CIN 3. She asks about the effect on future pregnancies.

Which complication in future pregnancy is linked to LLETZ?

A. Gestational diabetes
B. Placenta praevia
C. Pre-eclampsia
D. Preterm birth, especially after deep or repeat excisions
E. Rhesus disease

Answer: D. Preterm birth, especially after deep or repeat excisions

Excisional treatment, especially when deep (over 10 mm) or repeated, slightly increases the risk of preterm birth because of reduced cervical length.

Why not the others

- **A:** GDM is not linked.
- **B:** Placenta praevia is not linked.
- **C:** Pre-eclampsia is not linked.
- **E:** Rhesus disease is unrelated.

Key point: Cervical length scanning may be offered in pregnancy after deep excision.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 563 · CIN · **Moderate** · C3

A 33-year-old woman had a LLETZ for CIN 2 six months ago. Margins were clear.

What is the recommended follow-up (test of cure)?

A. Annual colposcopy for 10 years
B. Colposcopy every 3 months
C. HPV test with cytology about 6 months after treatment
D. Hysterectomy
E. No follow-up

Answer: C. HPV test with cytology about 6 months after treatment

A test of cure about 6 months after treatment uses HPV testing (with cytology). If HPV is negative, she returns to routine recall (often after 3 years). If positive, she has repeat colposcopy.

Why not the others

- **A:** Annual colposcopy is unnecessary.
- **B:** Three-monthly colposcopy is unnecessary.
- **D:** Hysterectomy is not indicated.
- **E:** Follow-up is needed.

Key point: HPV negative test of cure has a very high negative predictive value.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 564 · CIN · **Hard** · C3

A 29-year-old woman at 16 weeks of pregnancy has a screening test showing high-grade dyskaryosis.

What is the most appropriate management?

A. Colposcopy during pregnancy; treat CIN after delivery unless invasion is suspected
B. Defer colposcopy until 6 months after delivery
C. Immediate LLETZ
D. Radical hysterectomy
E. Terminate the pregnancy

Answer: A. Colposcopy during pregnancy; treat CIN after delivery unless invasion is suspected

Colposcopy is safe in pregnancy and aims to exclude invasive cancer. CIN does not progress significantly in pregnancy and can be treated after delivery. Biopsy is done only if invasion is suspected.

Why not the others

- **B:** Deferring colposcopy risks missing invasion.
- **C:** LLETZ in pregnancy risks bleeding and miscarriage.
- **D:** Radical surgery is for cancer.
- **E:** Termination is not needed.

Key point: Reassess 3 months after delivery.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 565 · CIN · **Hard** · C3

A 36-year-old woman's screening test shows a borderline glandular abnormality. Colposcopy is normal on the ectocervix. Endocervical sampling suggests cervical glandular intraepithelial neoplasia (CGIN).

What is the most appropriate management?

A. Cryotherapy

B. Excisional treatment (cone or LLETZ) to obtain histology of the endocervical canal

C. No action

D. Repeat cytology in 3 years

E. Thermal ablation

Answer: B. Excisional treatment (cone or LLETZ) to obtain histology of the endocervical canal

Glandular lesions often lie in the endocervical canal, are multifocal and may skip areas, so they cannot be seen fully at colposcopy. An excisional biopsy including the canal is needed; ablation is unsuitable.

Why not the others

- **A:** Ablation destroys tissue without histology.
- **C:** Glandular abnormalities need investigation.
- **D:** Delay is inappropriate.
- **E:** Ablation is unsuitable for glandular lesions.

Key point: Glandular abnormalities may also come from the endometrium; investigate if cervix is normal.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 566 · Screening · **Moderate** · C3

A 45-year-old woman had a total hysterectomy for fibroids 5 years ago. She never had abnormal screening results and histology of the cervix was normal.

Does she need cervical screening?

A. Annual vault smears

B. No further cervical screening is needed

C. Only if she becomes sexually active with a new partner

D. Screening every 3 years

E. Screening every 5 years until 64

Answer: B. No further cervical screening is needed

Women who have had a total hysterectomy (cervix removed) for benign disease with no history of CIN do not need further screening. Women with CIN in the specimen or a subtotal hysterectomy need vault or cervical follow-up.

Why not the others

- **A:** Annual smears are unnecessary.
- **C:** New partners do not change this.
- **D:** Routine screening is not needed without a cervix.
- **E:** Routine screening is not needed.

Key point: After hysterectomy with CIN present, vault cytology follow-up is needed.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 567 · Screening · **Moderate** · C2

A 32-year-old woman living with HIV asks how often she should have cervical screening.

What is recommended for women living with HIV?

A. Annual screening
B. Every 10 years
C. Every 5 years
D. No screening needed
E. Only if symptoms occur

Answer: A. Annual screening

Women living with HIV have higher rates of persistent HPV, CIN and cervical cancer. Annual cervical screening is recommended.

Why not the others

- **B:** Ten years is too long.
- **C:** Five years is too long.
- **D:** They are at higher risk.
- **E:** Screening is for asymptomatic women.

Key point: Other immunosuppressed women (transplant recipients) may also need more frequent screening.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 568 · Risk Factors · **Easy** · C2

A 40-year-old woman with persistent high-risk HPV asks what increases her risk of developing cervical cancer.

Which factor increases the risk of HPV persistence and progression?

A. Breastfeeding
B. Hepatitis A immunity
C. Smoking
D. Use of condoms
E. Vegetarian diet

Answer: C. Smoking

Smoking reduces local immunity in the cervix and increases HPV persistence and progression to CIN and cancer. Other risk factors include immunosuppression, long-term combined pill use, high parity and early first intercourse.

Why not the others

- **A:** Breastfeeding is not a risk factor.
- **B:** Hepatitis A immunity is irrelevant.
- **D:** Condoms reduce HPV transmission.
- **E:** Diet is not a recognised factor.

Key point: Stopping smoking helps clear HPV.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 569 · HPV Vaccination · **Moderate** · C2

A 13-year-old girl's mother asks which HPV vaccine protects against the most types.

Which vaccine covers HPV 6, 11, 16, 18, 31, 33, 45, 52 and 58?

A. BCG vaccine
B. Bivalent vaccine
C. Nonavalent (9-valent) vaccine
D. Quadrivalent vaccine
E. Rotavirus vaccine

Answer: C. Nonavalent (9-valent) vaccine

The 9-valent vaccine (Gardasil 9) protects against 7 high-risk types (16, 18, 31, 33, 45, 52, 58), which cause about 90% of cervical cancers, and against HPV 6 and 11 (genital warts).

Why not the others

- **A:** BCG is for tuberculosis.
- **B:** The bivalent vaccine covers 16 and 18.
- **D:** The quadrivalent covers 6, 11, 16 and 18.
- **E:** Rotavirus vaccine is unrelated.

Key point: WHO now supports single-dose HPV vaccination for girls aged 9–14.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 570 · Cervical Cancer · **Easy** · C2

A 48-year-old woman who has never had cervical screening has postcoital bleeding and an offensive blood-stained discharge for 3 months. Speculum examination shows an irregular, friable, ulcerated mass on the cervix.

What is the most likely diagnosis?

A. Cervical carcinoma
B. Cervical ectropion
C. Cervical polyp
D. Chlamydial cervicitis
E. Nabothian follicles

Answer: A. Cervical carcinoma

An irregular, friable, ulcerated cervical mass with postcoital bleeding and offensive discharge in an unscreened woman is cervical cancer until proved otherwise. She needs an urgent biopsy.

Why not the others

- **B:** An ectropion is a smooth red area.
- **C:** A polyp is a smooth, pedunculated lesion.
- **D:** Cervicitis does not form a mass.
- **E:** Nabothian follicles are small smooth cysts.

Key point: A screening test is not used for diagnosis when the cervix looks abnormal; biopsy instead.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 571 · Cervical Cancer · **Easy** · C2

A 45-year-old woman is diagnosed with cervical cancer on biopsy.

What is the commonest histological type?

A. Adenocarcinoma
B. Clear cell carcinoma
C. Neuroendocrine carcinoma
D. Sarcoma
E. Squamous cell carcinoma

Answer: E. Squamous cell carcinoma

Squamous cell carcinoma accounts for about 70–80% of cervical cancers, arising from the transformation zone. Adenocarcinoma accounts for most of the rest and is harder to detect by cytology.

Why not the others

- **A:** Adenocarcinoma is about 15–25%.
- **B:** Clear cell is rare and linked to in-utero DES exposure.
- **C:** Neuroendocrine tumours are rare and aggressive.
- **D:** Sarcomas are rare.

Key point: Adenocarcinoma is increasing relative to squamous cancer in screened populations.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 572 · Cervical Cancer Staging · **Moderate** · C2

A 42-year-old woman has a 3 cm cervical tumour confined to the cervix on MRI, with no nodes or distant spread.

What is the FIGO (2018) stage?

A. IA2
B. IB1
C. IB2
D. IIA1
E. IIB

Answer: C. IB2

FIGO 2018: IB1 is invasive tumour ≤2 cm, IB2 is >2 cm and ≤4 cm, and IB3 is >4 cm, all confined to the cervix. A 3 cm tumour is IB2.

Why not the others

- **A:** IA2 is microscopic invasion 3–5 mm deep.
- **B:** IB1 is up to 2 cm.
- **D:** IIA involves the upper two-thirds of the vagina.
- **E:** IIB involves the parametrium.

Key point: FIGO 2018 allows imaging and pathology to assign stage.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 573 · Cervical Cancer Staging · **Hard** · C2

A 50-year-old woman has cervical cancer. MRI shows tumour extending into the right parametrium but not to the pelvic side wall. The vagina, bladder and rectum are not involved, and there are no enlarged nodes.

What is the FIGO stage?

A. IB3
B. IIA2
C. IIB
D. IIIB
E. IVA

Answer: C. IIB

Parametrial invasion without extension to the pelvic side wall is stage IIB. It is usually treated with chemoradiation rather than surgery.

Why not the others

- **A:** IB3 is confined to the cervix and over 4 cm.
- **B:** IIA involves the upper vagina without parametrial invasion.
- **D:** IIIB involves the pelvic side wall or causes hydronephrosis.
- **E:** IVA involves bladder or rectal mucosa.

Key point: Hydronephrosis from tumour makes it stage IIIB.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 574 · Cervical Cancer Staging · **Hard** · C3

A 55-year-old woman with cervical cancer has a raised creatinine. CT shows the tumour extending to the left pelvic side wall with left hydronephrosis. There are no distant metastases.

What is the FIGO stage?

A. IIA
B. IIB
C. IIIB
D. IVA
E. IVB

Answer: C. IIIB

Extension to the pelvic side wall and/or hydronephrosis or a non-functioning kidney is stage IIIB. Treatment is chemoradiation. Ureteric stenting or nephrostomy may be needed for renal function.

Why not the others

- **A:** IIA involves the upper vagina only.
- **B:** IIB involves the parametrium without side wall involvement.
- **D:** IVA involves bladder or rectal mucosa.
- **E:** IVB is distant spread.

Key point: Untreated advanced cervical cancer often causes death from renal failure.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 575 · Cervical Cancer Treatment · **Moderate** · C3

A 38-year-old woman has a 2.5 cm squamous carcinoma of the cervix (FIGO IB2) with no nodal or distant spread on imaging. She has completed her family and is fit.

What is the standard treatment?

A. Chemotherapy alone
B. Cone biopsy only
C. Palliative care
D. Radical hysterectomy with pelvic lymphadenectomy
E. Simple hysterectomy

Answer: D. Radical hysterectomy with pelvic lymphadenectomy

Early-stage cervical cancer (IA2 to IB2, and some IIA1) is treated by radical hysterectomy (removing the uterus, parametria and upper vagina) with pelvic lymph node dissection. Chemoradiation is an equally effective alternative, chosen to avoid combining surgery and radiotherapy.

Why not the others

- **A:** Chemotherapy alone is not curative.
- **B:** Cone biopsy is for IA1 disease.
- **C:** The disease is curable.
- **E:** Simple hysterectomy does not remove the parametria.

Key point: Open radical hysterectomy had better survival than minimally invasive surgery in the LACC trial.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 576 · Cervical Cancer Treatment · **Moderate** · C3

A 47-year-old woman has a 6 cm cervical cancer (FIGO IB3) with no metastases.

What is the standard primary treatment?

A. Chemoradiation (external beam radiotherapy with weekly cisplatin, followed by brachytherapy)
B. Hormone therapy
C. LLETZ
D. Radical hysterectomy alone
E. Simple hysterectomy

Answer: A. Chemoradiation (external beam radiotherapy with weekly cisplatin, followed by brachytherapy)

Locally advanced cervical cancer (IB3 and above) is treated with concurrent chemoradiation: external beam pelvic radiotherapy with weekly cisplatin as a radiosensitiser, followed by intracavitary brachytherapy.

Why not the others

- **B:** Hormone therapy has no role.
- **C:** LLETZ is for CIN or microinvasion.
- **D:** Surgery alone often needs adjuvant radiotherapy, increasing morbidity.
- **E:** Simple hysterectomy is inadequate.

Key point: Brachytherapy delivers a high dose to the cervix while sparing bladder and rectum.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 577 · Cervical Cancer Treatment · **Moderate** · C3

A 29-year-old woman has a LLETZ for a high-grade lesion. Histology shows squamous cell carcinoma with 2 mm depth of invasion, no lymphovascular space invasion and clear margins. She wants children.

What is the most appropriate management?

A. Chemoradiation
B. No further surgery; follow-up as the LLETZ is adequate treatment
C. Radical hysterectomy
D. Radical trachelectomy
E. Simple hysterectomy

Answer: B. No further surgery; follow-up as the LLETZ is adequate treatment

Stage IA1 (invasion ≤3 mm) without lymphovascular invasion, completely excised with clear margins, is adequately treated by the cone or LLETZ. Fertility is preserved, with close follow-up.

Why not the others

- **A:** Chemoradiation is for advanced disease.
- **C:** Radical hysterectomy is excessive.
- **D:** Trachelectomy is for larger early tumours.
- **E:** Hysterectomy is unnecessary and ends fertility.

Key point: If LVSI is present, pelvic node assessment may be considered.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 578 · Cervical Cancer Treatment · **Hard** · C3

A 31-year-old nulliparous woman has a 1.5 cm squamous cervical cancer (FIGO IB1) with no nodal disease on MRI. She strongly wants to preserve fertility.

Which treatment can preserve her fertility?

A. Chemoradiation
B. Ovarian transposition with radiotherapy
C. Radical hysterectomy
D. Radical trachelectomy with pelvic lymphadenectomy
E. Total abdominal hysterectomy

Answer: D. Radical trachelectomy with pelvic lymphadenectomy

Radical trachelectomy removes the cervix, parametria and upper vagina but keeps the uterine body, with a cerclage at the isthmus. It is suitable for selected tumours of 2 cm or less. Future pregnancies are high-risk and delivered by caesarean section.

Why not the others

- **A:** Radiotherapy destroys fertility.
- **B:** Ovarian transposition preserves hormones but not the uterus for pregnancy.
- **C:** Radical hysterectomy removes the uterus.
- **E:** Hysterectomy removes the uterus.

Key point: Pregnancy after trachelectomy carries risks of mid-trimester loss and preterm birth.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 579 · Cervical Cancer Treatment · **Hard** · C3

A 33-year-old woman with locally advanced cervical cancer needs pelvic chemoradiation. She asks whether her ovaries can be protected.

Which procedure may preserve ovarian hormone function?

A. Bilateral oophorectomy
B. GnRH agonist alone
C. Laparoscopic ovarian transposition out of the radiation field
D. Ovarian drilling
E. Salpingectomy

Answer: C. Laparoscopic ovarian transposition out of the radiation field

Moving the ovaries laterally and upwards (ovarian transposition) out of the pelvic radiotherapy field can preserve hormone function in some women. Pregnancy would require a surrogate because the uterus is irradiated.

Why not the others

- **A:** Oophorectomy removes function.
- **B:** GnRH agonists do not protect against radiation.
- **D:** Drilling is for PCOS.
- **E:** Salpingectomy does not protect ovarian function.

Key point: Women who lose ovarian function after radiotherapy need HRT.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 580 · Cervical Cancer Treatment · **Moderate** · C2

A 45-year-old woman had a radical hysterectomy for cervical cancer 2 weeks ago. She cannot empty her bladder fully and has a large post-void residual.

What is the most likely cause?

A. Bladder cancer
B. Damage to the pelvic autonomic nerves during radical dissection
C. Overactive bladder
D. Ureteric injury
E. Urinary tract infection only

Answer: B. Damage to the pelvic autonomic nerves during radical dissection

Radical hysterectomy can damage the pelvic splanchnic and hypogastric nerves that supply the bladder, causing voiding dysfunction. Most recover over weeks to months with intermittent self-catheterisation. Nerve-sparing techniques reduce this.

Why not the others

- **A:** Bladder cancer does not explain this timing.
- **C:** OAB does not cause retention.
- **D:** Ureteric injury causes leakage or loin pain.
- **E:** Infection may coexist but does not explain a large residual.

Key point: Bowel and sexual dysfunction can also follow radical surgery.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix; Complications of surgery

MCQ 581 · Radiotherapy Effects · **Moderate** · C3

A 52-year-old woman completed chemoradiation for cervical cancer a year ago. She finds intercourse painful and the vagina feels short and narrow.

What is the most appropriate advice to prevent and treat this problem?

A. Avoid intercourse permanently
B. Hysterectomy
C. Regular use of vaginal dilators with vaginal oestrogen if appropriate
D. Repeat radiotherapy
E. Systemic antibiotics

Answer: C. Regular use of vaginal dilators with vaginal oestrogen if appropriate

Pelvic radiotherapy causes vaginal fibrosis and stenosis. Regular vaginal dilator use (or intercourse), lubricants and, where appropriate, vaginal oestrogen help keep the vagina open and allow follow-up examination.

Why not the others

- **A:** Intercourse or dilators help prevent stenosis.
- **B:** Hysterectomy does not treat stenosis.
- **D:** More radiotherapy worsens fibrosis.
- **E:** Antibiotics do not help.

Key point: Start dilator use a few weeks after radiotherapy finishes.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 582 · Radiotherapy Effects · **Hard** · C2

A 58-year-old woman had pelvic radiotherapy for cervical cancer 2 years ago. She now has rectal bleeding, urgency and mucus discharge. Colonoscopy shows telangiectasia of the rectal mucosa.

What is the most likely diagnosis?

A. Crohn's disease
B. Haemorrhoids
C. Radiation proctitis
D. Rectal cancer recurrence only
E. Ulcerative colitis

Answer: C. Radiation proctitis

Chronic radiation proctitis develops months to years after pelvic radiotherapy, with bleeding, urgency and telangiectasia. Treatment includes sucralfate enemas, argon plasma coagulation or hyperbaric oxygen.

Why not the others

- **A:** Crohn's disease has other features.
- **B:** Haemorrhoids do not cause telangiectasia.
- **D:** Recurrence must be excluded but telangiectasia is typical of radiation damage.
- **E:** UC has continuous mucosal inflammation.

Key point: Radiation cystitis similarly causes haematuria.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 583 · Cervical Cancer Investigation · **Moderate** · C2

A 44-year-old woman has a biopsy confirming invasive squamous carcinoma of the cervix. The clinician wants to assess tumour size, parametrial invasion and local spread.

Which investigation is best for local staging?

A. Abdominal X-ray

B. CA-125

C. MRI of the pelvis

D. Ultrasound of the abdomen

E. Urine cytology

Answer: C. MRI of the pelvis

Pelvic MRI best shows tumour size, parametrial and vaginal extension and pelvic lymph nodes. PET-CT is used for nodal and distant disease in locally advanced cancer.

Why not the others

- **A:** X-ray does not show the tumour.
- **B:** CA-125 is not used for cervical cancer.
- **D:** Ultrasound is less accurate for local staging.
- **E:** Urine cytology does not stage the cervix.

Key point: Examination under anaesthesia may also help staging.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 584 · Cervical Cancer in Pregnancy · **Hard** · C3

A 32-year-old woman at 24 weeks of pregnancy is diagnosed with a 1.5 cm squamous cervical cancer (FIGO IB1) with no nodal spread on MRI. She wants to continue the pregnancy.

What is the most appropriate approach?

A. Immediate radical hysterectomy with fetus in situ

B. Immediate termination

C. Multidisciplinary planning, possibly delaying treatment until fetal maturity, then caesarean section with radical hysterectomy

D. Radiotherapy now

E. Vaginal delivery at term followed by radiotherapy

Answer: C. Multidisciplinary planning, possibly delaying treatment until fetal maturity, then caesarean section with radical hysterectomy

Management depends on stage and gestation. For early-stage disease in mid-pregnancy, treatment can often be delayed until fetal maturity (or chemotherapy given) with close monitoring. Delivery is by caesarean section, often with radical hysterectomy at the same time.

Why not the others

- **A:** Immediate radical surgery would end the pregnancy.
- **B:** Termination is not required in early-stage disease diagnosed after 20 weeks.
- **D:** Radiotherapy would end the pregnancy.
- **E:** Vaginal delivery through a tumour risks haemorrhage and seeding the episiotomy.

Key point: Avoid vaginal delivery with cervical cancer.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 585 · Recurrent Cervical Cancer · **Hard** · C3

A 50-year-old woman had chemoradiation for cervical cancer 3 years ago. She now has a central pelvic recurrence involving the bladder but no disease elsewhere on PET-CT. She is fit.

Which treatment offers a chance of cure?

A. Hormone therapy
B. Palliative care only
C. Pelvic exenteration
D. Repeat chemoradiation
E. Simple hysterectomy

Answer: C. Pelvic exenteration

Central pelvic recurrence after radiotherapy without spread to the side wall or distant sites can sometimes be cured by pelvic exenteration (removal of bladder, uterus, vagina and/or rectum with reconstruction), in carefully selected fit patients.

Why not the others

- **A:** Hormone therapy has no role.
- **B:** There is still a curative option.
- **D:** Re-irradiation is limited by previous high doses.
- **E:** Simple hysterectomy is inadequate.

Key point: Side wall involvement usually makes exenteration unsuitable.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 586 · Advanced Cervical Cancer · **Moderate** · C2

A 60-year-old woman with advanced cervical cancer has severe pain radiating down the back of her right leg and swelling of the right leg.

What is the most likely cause?

A. Arthritis
B. Deep vein thrombosis alone in all cases
C. Pelvic side wall tumour invading nerves and compressing veins and lymphatics
D. Peripheral vascular disease
E. Sciatica from a disc only

Answer: C. Pelvic side wall tumour invading nerves and compressing veins and lymphatics

Spread of cervical cancer to the pelvic side wall can invade the lumbosacral plexus (causing sciatic pain) and compress veins and lymphatics (causing leg oedema). The triad of sciatic pain, leg oedema and hydronephrosis suggests side wall disease.

Why not the others

- **A:** Arthritis does not explain leg swelling.
- **B:** DVT should be excluded, but pain radiating like sciatica suggests nerve involvement.
- **D:** Vascular disease causes claudication.
- **E:** Disc disease does not cause leg oedema.

Key point: Palliative care focuses on pain, renal function and quality of life.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 587 · Cytology Terminology · **Moderate** · C2

A cervical cytology report from a laboratory using the Bethesda system says "HSIL".

What does HSIL correspond to?

A. Borderline changes only
B. High-grade dyskaryosis (moderate or severe), corresponding to CIN 2–3
C. Invasive cancer
D. Low-grade dyskaryosis
E. Normal cells

Answer: B. High-grade dyskaryosis (moderate or severe), corresponding to CIN 2–3

In the Bethesda system, HSIL (high-grade squamous intraepithelial lesion) corresponds to moderate or severe dyskaryosis and CIN 2–3. LSIL corresponds to low-grade changes and CIN 1. ASC-US means atypical cells of undetermined significance.

Why not the others

- **A:** Borderline changes correspond to ASC-US.
- **C:** HSIL is pre-invasive.
- **D:** Low-grade is LSIL.
- **E:** HSIL is abnormal.

Key point: HSIL needs urgent colposcopy.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 588 · Screen and Treat · **Moderate** · C3

A 35-year-old woman in a rural screening camp has a positive VIA test with a small acetowhite lesion fully visible, covering less than 75% of the cervix, with no suspicion of cancer.

What is the WHO-recommended management in a screen-and-treat programme?

A. Hysterectomy
B. Referral to a distant hospital with no treatment today
C. Repeat VIA in 5 years
D. Thermal ablation or cryotherapy at the same visit
E. Wait for HPV typing results

Answer: D. Thermal ablation or cryotherapy at the same visit

In screen-and-treat programmes, eligible VIA-positive women (lesion fully visible, under 75% of the cervix, no suspicion of cancer) are treated immediately with thermal ablation or cryotherapy. This avoids loss to follow-up.

Why not the others

- **A:** Hysterectomy is excessive.
- **B:** Referral without treatment leads to loss to follow-up.
- **C:** A positive test needs treatment.
- **E:** Waiting delays treatment in a setting where follow-up is difficult.

Key point: Lesions suspicious of cancer or not suitable for ablation need referral for LLETZ or biopsy.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 589 · Postcoital Bleeding · **Moderate** · C3

A 34-year-old woman has had persistent postcoital bleeding for 4 months. Her cervix looks normal on speculum examination. STI tests are negative. Her last screening test was normal.

What is the most appropriate next step?

A. Combined pill and reassure
B. Hysterectomy
C. No action
D. Referral for colposcopy
E. Repeat screening in 5 years

Answer: D. Referral for colposcopy

Persistent postcoital bleeding, even with a normal-looking cervix and negative swabs, warrants colposcopy to exclude cervical pathology, including adenocarcinoma, which can be missed by cytology.

Why not the others

- **A:** Starting the pill without assessment is not appropriate.
- **B:** Hysterectomy is not indicated.
- **C:** Persistent symptoms need investigation.
- **E:** Screening is not a diagnostic test.

Key point: Most women with postcoital bleeding do not have cancer, but it must be excluded.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 590 · Cervical Polyp · **Easy** · C3

A 42-year-old woman has intermenstrual spotting. Speculum examination shows a 1 cm smooth red polyp protruding from the external os on a thin stalk. Her screening is up to date.

What is the most appropriate management?

A. Cone biopsy
B. Hysterectomy
C. Leave it alone
D. Radiotherapy
E. Remove by twisting (avulsion) and send for histology

Answer: E. Remove by twisting (avulsion) and send for histology

Cervical polyps are common and usually benign. They can be removed in clinic by twisting with polyp forceps and sent for histology. If the base is broad or bleeding is heavy, removal in theatre may be needed.

Why not the others

- **A:** Cone biopsy is for CIN.
- **B:** Hysterectomy is excessive.
- **C:** Symptomatic polyps should be removed.
- **D:** Radiotherapy is for cancer.

Key point: Always send polyps for histology; rarely they contain malignancy.

Reference: Gynaecology by Ten Teachers — Benign conditions of the cervix

MCQ 591 · Cervical Cancer Prognosis · **Moderate** · C2

A 46-year-old woman had a radical hysterectomy for stage IB1 cervical cancer. Histology shows metastases in two pelvic lymph nodes.

What is the most appropriate further treatment?

A. Adjuvant chemoradiation
B. Hormone therapy
C. No further treatment
D. Repeat surgery
E. Vaginal brachytherapy only

Answer: A. Adjuvant chemoradiation

Positive pelvic lymph nodes (or positive margins or parametrial involvement) after radical hysterectomy are high-risk factors. Adjuvant chemoradiation improves survival.

Why not the others

- **B:** Hormone therapy has no role.
- **C:** Positive nodes need further treatment.
- **D:** Repeat surgery does not help.
- **E:** Brachytherapy alone does not treat nodal disease.

Key point: Lymph node status is the most important prognostic factor in early cervical cancer.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 592 · Screening · **Easy** · C2

A 23-year-old woman asks when she should start cervical screening under the UK programme.

At what age is cervical screening first offered in the UK?

A. 16
B. 18
C. 21
D. 25
E. 35

Answer: D. 25

The UK programme invites women and people with a cervix from age 25 to 64. Screening younger women detects many transient HPV infections and leads to overtreatment. WHO recommends starting HPV-based screening at 30 for the general population.

Why not the others

- **A:** Screening at 16 is not recommended.
- **B:** Screening at 18 is not recommended.
- **C:** Some countries start at 21, but not the UK.
- **E:** Starting at 35 would miss many cases.

Key point: Women under 25 with symptoms need examination, not screening.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 593 · HPV · **Moderate** · C2

A 28-year-old woman is told she has a high-risk HPV infection. She is distressed and asks whether her husband has been unfaithful.

What is the most accurate advice?

A. HPV always means recent infidelity

B. HPV can only be caught from blood

C. HPV can stay dormant for many years, so it is not possible to know when or from whom it was acquired

D. HPV is a sign of cancer

E. HPV is never sexually transmitted

Answer: C. HPV can stay dormant for many years, so it is not possible to know when or from whom it was acquired

HPV is very common and is sexually transmitted, but it can remain undetectable for years before reactivating. A positive test does not indicate recent infection or infidelity. Most infections clear naturally.

Why not the others

- **A:** Timing of infection cannot be determined.
- **B:** HPV is transmitted by skin-to-skin genital contact.
- **D:** Most HPV infections never cause cancer.
- **E:** HPV is mainly sexually transmitted.

Key point: About 80% of sexually active people acquire HPV at some point.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 594 · Adenocarcinoma in situ · **Hard** · C3

A 34-year-old woman has a cone biopsy for a glandular abnormality. Histology shows adenocarcinoma in situ (cervical glandular intraepithelial neoplasia, high-grade) with clear margins. She wants to have children.

What is the most appropriate management?

A. Close follow-up with HPV and cytology, considering hysterectomy after childbearing

B. Immediate radical hysterectomy

C. Pelvic radiotherapy

D. Repeat cone every 3 months

E. Thermal ablation

Answer: A. Close follow-up with HPV and cytology, considering hysterectomy after childbearing

Adenocarcinoma in situ with clear margins can be managed conservatively in women wanting fertility, with close follow-up including endocervical sampling and HPV testing. Hysterectomy may be considered once childbearing is complete because of skip lesions.

Why not the others

- **B:** Radical surgery is for invasive cancer.
- **C:** Radiotherapy is not indicated.
- **D:** Repeated cones are not needed with clear margins.
- **E:** Ablation is not suitable for glandular disease.

Key point: Positive margins in AIS need re-excision.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 595 · Cervical Cancer · **Moderate** · C2

A 55-year-old woman with untreated advanced cervical cancer develops anuria and confusion.

What is the most likely cause of death in untreated advanced cervical cancer?

A. Brain metastases
B. Liver failure
C. Myocardial infarction
D. Pulmonary embolism
E. Renal failure from bilateral ureteric obstruction

Answer: E. Renal failure from bilateral ureteric obstruction

Advanced cervical cancer commonly invades the parametria and obstructs both ureters, causing hydronephrosis and renal failure (uraemia). This was historically the commonest cause of death. Nephrostomy may relieve it in selected patients.

Why not the others

- **A:** Brain metastases are uncommon.
- **B:** Liver failure is less common.
- **C:** MI is not typical.
- **D:** PE occurs but is less common as a cause of death.

Key point: Discuss goals of care before decompressing the kidneys in end-stage disease.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 596 · HPV Vaccination · **Easy** · C3

A 26-year-old woman who was vaccinated against HPV at age 12 asks whether she still needs cervical screening.

What is the correct advice?

A. She can stop screening at 30
B. She never needs screening
C. She only needs screening if she has symptoms
D. She should continue routine cervical screening
E. She should have annual colposcopy

Answer: D. She should continue routine cervical screening

HPV vaccines do not cover all high-risk types, and some women may have been exposed before vaccination. Vaccinated women should continue routine screening.

Why not the others

- **A:** Screening continues throughout the programme ages.
- **B:** Screening is still needed.
- **C:** Screening is for women without symptoms.
- **E:** Annual colposcopy is not needed.

Key point: Vaccination greatly reduces, but does not eliminate, cervical cancer risk.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 597 · Cervical Cancer Treatment · **Moderate** · C2

A 49-year-old woman is having brachytherapy as part of treatment for cervical cancer.

What is brachytherapy?

A. Chemotherapy injected into the cervix
B. External beam radiotherapy
C. Hormone treatment
D. Radiation delivered by a source placed inside the uterus and vagina close to the tumour
E. Surgery using a laser

Answer: D. Radiation delivered by a source placed inside the uterus and vagina close to the tumour

Brachytherapy places a radioactive source in applicators inside the uterus and vagina, delivering a high dose to the cervix with rapid fall-off, sparing the bladder and rectum. It is essential to cure locally advanced cervical cancer.

Why not the others

- **A:** Chemotherapy is given intravenously.
- **B:** External beam comes from outside the body.
- **C:** Hormones are not used.
- **E:** Laser is not brachytherapy.

Key point: Omitting brachytherapy greatly reduces cure rates.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

MCQ 598 · Screening · **Hard** · C3

A 40-year-old woman's screening test shows HPV positive with borderline changes in squamous cells. Colposcopy is normal and the transformation zone is fully seen.

What is the most appropriate follow-up?

A. Hysterectomy
B. LLETZ
C. Repeat colposcopy every month
D. Repeat HPV test in 12 months, with return to routine recall if negative
E. Return to routine recall immediately without testing

Answer: D. Repeat HPV test in 12 months, with return to routine recall if negative

After a normal colposcopy for a low-grade or borderline result, women have a repeat HPV test at 12 months. If HPV is negative they return to routine recall; if still positive they are reassessed.

Why not the others

- **A:** Hysterectomy is not indicated.
- **B:** Treatment is not needed with a normal colposcopy.
- **C:** Monthly colposcopy is unnecessary.
- **E:** Follow-up HPV testing is still advised.

Key point: Avoid treating women with normal colposcopy for low-grade results.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 599 · Cervical Cancer · **Easy** · C2

A health worker asks which population most benefits from cervical screening programmes.

Why does cervical screening reduce cervical cancer deaths?

A. It cures HPV infection
B. It detects and treats pre-invasive disease (CIN) before cancer develops
C. It prevents HPV infection
D. It replaces vaccination
E. It treats advanced cancer

Answer: B. It detects and treats pre-invasive disease (CIN) before cancer develops

Cervical cancer develops slowly from CIN over years. Screening detects CIN, which can be treated simply, preventing progression to invasive cancer. Well-organised programmes reduce incidence and deaths by up to 80%.

Why not the others

- **A:** Screening does not cure HPV.
- **C:** Vaccination prevents infection, not screening.
- **D:** Screening complements vaccination.
- **E:** Screening aims to prevent cancer.

Key point: Coverage of the population is the key to programme success.

Reference: Gynaecology by Ten Teachers — Premalignant disease of the cervix

MCQ 600 · Cervical Cancer Staging · **Hard** · C2

A 57-year-old woman with cervical cancer has cystoscopy showing tumour invading the bladder mucosa. There are no distant metastases.

What is the FIGO stage?

A. IIB
B. IIIA
C. IIIC1
D. IVA
E. IVB

Answer: D. IVA

Invasion of the bladder or rectal mucosa (proven by biopsy) is stage IVA. Distant spread is IVB. Bullous oedema of the bladder alone does not make it stage IV.

Why not the others

- **A:** IIB is parametrial invasion.
- **B:** IIIA is lower third of the vagina.
- **C:** IIIC1 is pelvic lymph node involvement.
- **E:** IVB is distant metastasis.

Key point: Vesicovaginal fistula can develop from tumour or treatment.

Reference: Gynaecology by Ten Teachers — Malignant disease of the cervix

CHAPTER 13

Endometrial Cancer

MCQ 601 · Postmenopausal Bleeding · **Moderate** · C3

A 62-year-old woman, 10 years past menopause, has had two episodes of vaginal bleeding in the past month. She has type 2 diabetes and a BMI of 36 kg/m². She is not on HRT. Speculum examination shows a healthy cervix. Transvaginal ultrasound shows an endometrial thickness of 9 mm.

What is the most appropriate next step?

A. Hysteroscopy and endometrial biopsy
B. Oral progestogen for 3 months
C. Reassurance and repeat ultrasound in 6 months
D. Serum CA-125
E. Total hysterectomy and bilateral salpingo-oophorectomy

Answer: A. Hysteroscopy and endometrial biopsy

Postmenopausal bleeding with an endometrial thickness of 4 mm or more needs histology to exclude endometrial cancer. Obesity and diabetes raise her risk further. Hysteroscopy with biopsy (or outpatient Pipelle sampling) gives a tissue diagnosis.

Why not the others

- **B:** Starting progestogen without histology could mask a cancer.
- **C:** Waiting is unsafe when the endometrium is 4 mm or more.
- **D:** CA-125 is an ovarian tumour marker and does not assess the endometrium.
- **E:** Hysterectomy without a tissue diagnosis is premature; histology guides staging and surgery.

Key point: Postmenopausal bleeding: endometrium under 4 mm → low risk; 4 mm or more → biopsy. Persistent bleeding needs hysteroscopy whatever the thickness.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 602 · Risk Factors · **Easy** · C2

A 64-year-old woman with endometrial cancer asks what may have caused it. She has a BMI of 41 kg/m², type 2 diabetes, never had children, and had her menopause at 56.

Which is the most important modifiable risk factor for endometrial cancer?

A. Early menopause
B. Multiparity
C. Obesity
D. Smoking
E. Use of the combined pill

Answer: C. Obesity

Obesity is the strongest modifiable risk factor. Fat tissue converts androgens to oestrogen, exposing the endometrium to unopposed oestrogen. Each 5-unit rise in BMI increases risk substantially.

Why not the others

- **A:** Late, not early, menopause increases risk.
- **B:** Parity is protective.
- **D:** Smoking slightly lowers endometrial cancer risk but harms overall health.
- **E:** The combined pill reduces risk.

Key point: Other risk factors: nulliparity, PCOS, diabetes, tamoxifen, unopposed oestrogen and Lynch syndrome.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 603 · Risk Factors · **Moderate** · C2

A 45-year-old woman is diagnosed with endometrial cancer. Her mother had colon cancer at 48 and her aunt had endometrial cancer at 50. Tumour immunohistochemistry shows loss of MSH2 and MSH6.

Which inherited syndrome is most likely?

A. BRCA1 mutation
B. Cowden syndrome
C. Li–Fraumeni syndrome
D. Lynch syndrome
E. Peutz–Jeghers syndrome

Answer: D. Lynch syndrome

Lynch syndrome (hereditary non-polyposis colorectal cancer) is caused by mismatch repair gene mutations (MLH1, MSH2, MSH6, PMS2). Women have a 40–60% lifetime risk of endometrial cancer and increased risks of colorectal and ovarian cancer.

Why not the others

- **A:** BRCA1 mainly causes breast and ovarian cancer.
- **B:** Cowden syndrome (PTEN) causes breast, thyroid and endometrial cancer but not MMR loss.
- **C:** Li–Fraumeni (TP53) causes sarcomas, breast and brain tumours.
- **E:** Peutz–Jeghers causes hamartomatous polyps and pigmentation.

Key point: All endometrial cancers should be tested for mismatch repair deficiency.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 604 · Risk Factors · **Hard** · C3

A 36-year-old woman has confirmed Lynch syndrome (MSH6 mutation). She has two children and does not want more.

What is the most effective way to reduce her gynaecological cancer risk?

A. Annual CA-125 only
B. Annual transvaginal ultrasound alone
C. Combined pill until 50 alone
D. No action until symptoms develop
E. Risk-reducing hysterectomy and bilateral salpingo-oophorectomy (usually around 35–40 or after childbearing)

Answer: E. Risk-reducing hysterectomy and bilateral salpingo-oophorectomy (usually around 35–40 or after childbearing)

Risk-reducing hysterectomy with bilateral salpingo-oophorectomy after childbearing is complete is the most effective way to prevent endometrial and ovarian cancer in Lynch syndrome. HRT can be given afterwards until natural menopause age.

Why not the others

- **A:** CA-125 is not effective screening.
- **B:** Ultrasound screening is not proven to reduce deaths.
- **C:** The pill lowers risk but does not eliminate it.
- **D:** Waiting misses the chance of prevention.

Key point: Women with Lynch syndrome also need regular colonoscopy and may take aspirin.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 605 · Postmenopausal Bleeding · **Moderate** · C3

A 63-year-old woman has postmenopausal bleeding. Transvaginal ultrasound shows an endometrial thickness of 3 mm with a smooth outline. Bleeding has stopped.

What is the most appropriate management?

A. Endometrial biopsy in all women regardless
B. Hysterectomy
C. MRI pelvis
D. Reassure and advise her to return if bleeding recurs
E. Start HRT

Answer: D. Reassure and advise her to return if bleeding recurs

An endometrial thickness under 4 mm in a woman with a single episode of postmenopausal bleeding (not on HRT or tamoxifen) has a very low risk of cancer. She can be reassured, but persistent or recurrent bleeding needs hysteroscopy and biopsy.

Why not the others

- **A:** Biopsy is not routinely needed below 4 mm unless bleeding persists.
- **B:** Hysterectomy is not indicated.
- **C:** MRI is not needed.
- **E:** HRT is not the treatment for postmenopausal bleeding.

Key point: Recurrent bleeding needs further investigation even with a thin endometrium.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 606 · Postmenopausal Bleeding · **Moderate** · C2

A 68-year-old woman has postmenopausal bleeding. Outpatient endometrial sampling is attempted but the cervix is stenosed and no tissue is obtained. Ultrasound shows a 12 mm endometrium.

What is the most appropriate next step?

A. CA-125
B. Discharge
C. Hysteroscopy with endometrial biopsy (under anaesthesia if needed)
D. Repeat ultrasound in 1 year
E. Vaginal oestrogen

Answer: C. Hysteroscopy with endometrial biopsy (under anaesthesia if needed)

When outpatient sampling fails or is inadequate, hysteroscopy with directed biopsy is needed to obtain histology. A thick endometrium in postmenopausal bleeding must not be left uninvestigated.

Why not the others

- **A:** CA-125 does not diagnose endometrial cancer.
- **B:** Discharge risks missing cancer.
- **D:** Waiting is unsafe.
- **E:** Oestrogen may mask or worsen pathology.

Key point: Pipelle sampling is accurate but can miss focal lesions such as polyps.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 607 · Endometrial Hyperplasia · **Moderate** · C3

A 50-year-old woman has endometrial biopsy showing atypical hyperplasia (endometrial intraepithelial neoplasia). She has completed her family and is fit for surgery.

What is the recommended treatment?

A. Combined pill
B. Endometrial ablation
C. LNG-IUS with biopsy at 6 months
D. Repeat biopsy in 1 year without treatment
E. Total hysterectomy with bilateral salpingo-oophorectomy

Answer: E. Total hysterectomy with bilateral salpingo-oophorectomy

Atypical hyperplasia carries a high risk of coexisting or future endometrial cancer (up to 40% have cancer at hysterectomy). Total hysterectomy, with removal of tubes and usually ovaries in postmenopausal women, is recommended. Endometrial ablation is not appropriate.

Why not the others

- **A:** The pill is inadequate for atypical hyperplasia.
- **B:** Ablation leaves tissue and hides later disease.
- **C:** Progestogen is for women wanting fertility or unfit for surgery.
- **D:** Waiting is unsafe.

Key point: Do not use total ablation or subtotal hysterectomy for atypical hyperplasia.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 608 · Endometrial Hyperplasia · **Hard** · C3

A 32-year-old nulliparous woman with PCOS has atypical endometrial hyperplasia on biopsy. MRI shows no myometrial invasion. She strongly wants children.

What is the most appropriate management?

A. Endometrial ablation
B. High-dose progestogen (LNG-IUS or oral) with endometrial biopsy every 3 months
C. No treatment
D. Radiotherapy
E. Total hysterectomy now

Answer: B. High-dose progestogen (LNG-IUS or oral) with endometrial biopsy every 3 months

Women wanting fertility can be treated with high-dose progestogen (LNG-IUS preferred, or oral) with close surveillance biopsies every 3 months. Once regression is confirmed, conception should be attempted, with hysterectomy after childbearing.

Why not the others

- **A:** Ablation destroys fertility and hides disease.
- **C:** No treatment is unsafe.
- **D:** Radiotherapy is not indicated.
- **E:** Hysterectomy ends fertility; it is an option if she accepts that.

Key point: Weight loss helps regression and reduces recurrence.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 609 · Endometrial Hyperplasia · **Moderate** · C2

A 48-year-old woman has endometrial hyperplasia without atypia. She asks about her risk of cancer.

What is the approximate risk of progression to cancer over 20 years for hyperplasia without atypia?

A. Less than 5%
B. About 25%
C. About 50%
D. About 75%
E. 100%

Answer: A. Less than 5%

Hyperplasia without atypia has a low risk of progression (under 5% over 20 years) and most regresses spontaneously or with treatment. Atypical hyperplasia has a much higher risk.

Why not the others

- **B:** 25% is too high for non-atypical hyperplasia.
- **C:** 50% is far too high.
- **D:** 75% is far too high.
- **E:** Progression is not inevitable.

Key point: Treat with progestogen (LNG-IUS first) and remove risk factors.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 610 · Histological Types · **Moderate** · C2

A 72-year-old thin woman has endometrial cancer. Histology shows papillary architecture with high-grade nuclei and psammoma bodies, arising in an atrophic endometrium. p53 staining is abnormal.

What type of endometrial cancer is this?

A. Endometrioid adenocarcinoma grade 1
B. Leiomyosarcoma
C. Low-grade endometrial stromal sarcoma
D. Serous carcinoma
E. Squamous carcinoma

Answer: D. Serous carcinoma

Serous carcinoma (a "type II" cancer) is not oestrogen-driven, arises in atrophic endometrium in older women, has p53 mutations and behaves aggressively, often spreading outside the uterus early. Staging includes omentectomy, and chemotherapy is usually needed.

Why not the others

- **A:** Endometrioid cancers are oestrogen-related with better prognosis.
- **B:** Leiomyosarcoma arises from muscle.
- **C:** Stromal sarcomas arise from stroma.
- **E:** Squamous carcinoma of the endometrium is rare.

Key point: Type I (endometrioid) cancers are about 80% of cases and have a better outlook.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 611 · Molecular Classification · **Hard** · C2

A 58-year-old woman has endometrioid endometrial cancer. Molecular testing shows a POLE mutation.

What does a POLE-mutated endometrial cancer indicate?

A. Excellent prognosis, often allowing less adjuvant treatment
B. Hereditary breast cancer
C. Need for radical radiotherapy in all cases
D. Poor prognosis with early spread
E. Resistance to all treatment

Answer: A. Excellent prognosis, often allowing less adjuvant treatment

The molecular classification divides endometrial cancer into POLE-ultramutated (excellent prognosis), mismatch repair-deficient, p53-abnormal (poor prognosis) and no specific molecular profile. POLE-mutated tumours may need less adjuvant therapy.

Why not the others

- **B:** POLE mutation is somatic, not hereditary breast cancer.
- **C:** Treatment is often de-escalated.
- **D:** p53-abnormal tumours have poor prognosis.
- **E:** They respond well.

Key point: FIGO 2023 staging includes molecular subtype.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 612 · Staging · **Moderate** · C2

A 60-year-old woman has a hysterectomy for endometrioid endometrial cancer. Histology shows the tumour invades 30% of the myometrial thickness, with no cervical, adnexal or nodal involvement.

What is the FIGO stage (2009)?

A. IA
B. IB
C. II
D. IIIA
E. IIIC1

Answer: A. IA

FIGO stage IA is tumour confined to the uterus with less than 50% myometrial invasion. IB is 50% or more. Stage II involves the cervical stroma.

Why not the others

- **B:** IB is 50% or more myometrial invasion.
- **C:** Stage II involves cervical stroma.
- **D:** IIIA involves serosa or adnexa.
- **E:** IIIC1 involves pelvic nodes.

Key point: Most endometrial cancers present at stage I because of early bleeding.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 613 · Staging · **Hard** · C2

A 66-year-old woman with endometrial cancer has tumour confined to the uterus with 70% myometrial invasion, but pelvic sentinel lymph nodes contain metastases. Para-aortic nodes are negative.

What is the FIGO stage (2009)?

A. IB
B. II
C. IIIA
D. IIIC1
E. IVB

Answer: D. IIIC1

Pelvic lymph node involvement is stage IIIC1; para-aortic node involvement is IIIC2. Nodal involvement upstages the cancer regardless of myometrial invasion.

Why not the others

- **A:** IB has no nodal spread.
- **B:** Stage II involves the cervix.
- **C:** IIIA involves serosa or adnexa.
- **E:** IVB is distant spread.

Key point: Node-positive disease usually needs chemotherapy with or without radiotherapy.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 614 · Investigation · **Moderate** · C2

A 61-year-old woman has a biopsy confirming endometrioid endometrial cancer grade 2. Surgery is planned.

Which imaging is most useful to assess depth of myometrial invasion and cervical involvement before surgery?

A. Abdominal X-ray
B. Bone scan
C. Chest X-ray only
D. Mammogram
E. MRI of the pelvis

Answer: E. MRI of the pelvis

Pelvic MRI assesses myometrial invasion, cervical stromal involvement and pelvic nodes, helping plan surgery. A chest X-ray or CT is used to look for distant spread, especially in high-grade tumours.

Why not the others

- **A:** X-ray does not show the uterus in detail.
- **B:** Bone scan is not routine.
- **C:** Chest X-ray does not assess local spread.
- **D:** Mammography is unrelated.

Key point: CT chest, abdomen and pelvis is used for high-risk histological types.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 615 · Treatment · **Moderate** · C3

A 62-year-old woman with a BMI of 42 kg/m² has grade 1 endometrioid endometrial cancer, apparently confined to the uterus on MRI.

What is the standard surgical treatment?

A. Endometrial ablation
B. Radical hysterectomy with para-aortic lymphadenectomy in all cases
C. Subtotal hysterectomy
D. Total laparoscopic hysterectomy and bilateral salpingo-oophorectomy, with sentinel node assessment
E. Vaginal brachytherapy only

Answer: D. Total laparoscopic hysterectomy and bilateral salpingo-oophorectomy, with sentinel node assessment

Early endometrial cancer is treated by total hysterectomy and bilateral salpingo-oophorectomy, increasingly with sentinel lymph node biopsy. Laparoscopic surgery is preferred, especially in obese women, as it reduces wound complications and hospital stay with equal survival.

Why not the others

- **A:** Ablation is not a cancer treatment.
- **B:** Radical surgery is not needed for early endometrioid cancer.
- **C:** Subtotal hysterectomy leaves the cervix.
- **E:** Brachytherapy alone is for women unfit for surgery or as adjuvant.

Key point: Laparoscopic surgery is especially beneficial in obese women.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 616 · Treatment · **Hard** · C3

A 70-year-old woman had surgery for endometrioid endometrial cancer, stage IB grade 2, with no lymphovascular invasion and negative nodes.

Which adjuvant treatment is most commonly recommended?

A. External beam pelvic radiotherapy plus chemotherapy
B. No follow-up
C. Systemic chemotherapy alone
D. Tamoxifen
E. Vaginal vault brachytherapy

Answer: E. Vaginal vault brachytherapy

For intermediate-risk disease (such as IB grade 1–2), vaginal brachytherapy reduces vaginal vault recurrence with fewer side effects than external beam radiotherapy (PORTEC-2 trial). Molecular profiling increasingly guides decisions.

Why not the others

- **A:** Combined treatment is for high-risk or advanced disease.
- **B:** Follow-up is needed.
- **C:** Chemotherapy alone is for advanced or high-risk disease.
- **D:** Tamoxifen is not used.

Key point: The vaginal vault is the commonest site of recurrence.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 617 · Treatment · **Moderate** · C3

An 86-year-old woman with severe heart failure and COPD has grade 1 endometrioid endometrial cancer. She is unfit for anaesthesia.

Which treatment is most appropriate?

A. Chemotherapy
B. Hysterectomy under general anaesthesia
C. No treatment and no follow-up
D. Progestogen therapy (oral or LNG-IUS)
E. Total pelvic exenteration

Answer: D. Progestogen therapy (oral or LNG-IUS)

Women unfit for surgery with low-grade endometrioid cancer can be treated with progestogens (oral medroxyprogesterone or megestrol, or LNG-IUS), which control disease in many. Radiotherapy is another option.

Why not the others

- **A:** Chemotherapy is poorly tolerated and not first line here.
- **B:** She is unfit for anaesthesia.
- **C:** Treatment can control bleeding and disease.
- **E:** Exenteration is not appropriate.

Key point: Low-grade endometrioid tumours are often hormone receptor-positive.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 618 · Clinical Features · **Easy** · C2

A 60-year-old woman, 10 years after menopause, presents to her GP.

What is the commonest presenting symptom of endometrial cancer?

A. Ascites
B. Bowel obstruction
C. Postmenopausal bleeding
D. Urinary retention
E. Weight gain

Answer: C. Postmenopausal bleeding

About 90% of women with endometrial cancer present with abnormal bleeding, usually postmenopausal bleeding. Because this happens early, most cancers are diagnosed at stage I with good survival.

Why not the others

- **A:** Ascites suggests ovarian cancer.
- **B:** Obstruction is a late feature of advanced disease.
- **D:** Retention is not typical.
- **E:** Weight gain is not a symptom.

Key point: Any postmenopausal bleeding needs urgent investigation.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 619 · Clinical Features · **Moderate** · C3

An 80-year-old woman has a foul-smelling purulent vaginal discharge and lower abdominal discomfort. Ultrasound shows a fluid-filled uterine cavity. Dilatation of a stenosed cervix releases pus.

What must be excluded after drainage?

A. Bladder cancer
B. Endometrial (or cervical) cancer
C. Ovarian torsion
D. Pregnancy
E. Urinary tract infection only

Answer: B. Endometrial (or cervical) cancer

Pyometra in an older woman is often caused by cervical stenosis, but underlying endometrial or cervical cancer must be excluded by endometrial sampling or hysteroscopy once the infection has settled.

Why not the others

- **A:** Bladder cancer is not typically linked.
- **C:** Torsion is unrelated.
- **D:** Pregnancy is not possible.
- **E:** UTI does not explain pus in the uterus.

Key point: Pyometra is associated with malignancy in a significant proportion of cases.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 620 · Protective Factors · **Easy** · C2

A 30-year-old woman with a family history of endometrial cancer (not Lynch) asks what reduces her risk.

Which factor reduces endometrial cancer risk?

A. Late menopause
B. Nulliparity
C. Obesity
D. Tamoxifen use
E. Use of the combined oral contraceptive pill

Answer: E. Use of the combined oral contraceptive pill

The combined pill reduces endometrial cancer risk by about half, and the protection lasts for decades after stopping. Pregnancy, breastfeeding and the LNG-IUS are also protective.

Why not the others

- **A:** Late menopause increases risk.
- **B:** Nulliparity increases risk.
- **C:** Obesity increases risk.
- **D:** Tamoxifen increases risk.

Key point: Progestogens protect the endometrium.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 621 · Tamoxifen · **Moderate** · C3

A 55-year-old woman on tamoxifen for breast cancer has had no vaginal bleeding. Her oncologist asks if she needs routine endometrial screening.

What is the correct advice?

A. Annual endometrial biopsy
B. Annual hysteroscopy
C. Monthly ultrasound
D. Routine screening is not recommended; investigate any abnormal bleeding promptly
E. Stop tamoxifen

Answer: D. Routine screening is not recommended; investigate any abnormal bleeding promptly

Tamoxifen increases endometrial cancer risk, but routine ultrasound screening of asymptomatic women is not useful because tamoxifen thickens the endometrium. Women should report any bleeding, which needs prompt hysteroscopy and biopsy.

Why not the others

- **A:** Routine biopsy is not recommended.
- **B:** Routine hysteroscopy is not recommended.
- **C:** Ultrasound is unreliable on tamoxifen.
- **E:** Breast benefit outweighs endometrial risk.

Key point: Aromatase inhibitors do not increase endometrial cancer risk.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 622 · Lynch Syndrome · **Moderate** · C3

A 52-year-old woman has endometrial cancer. Immunohistochemistry shows loss of MLH1 and PMS2 expression.

What is the most appropriate next test?

A. BRCA testing
B. CA-125
C. MLH1 promoter methylation testing
D. Repeat biopsy
E. Serum oestradiol

Answer: C. MLH1 promoter methylation testing

Loss of MLH1 is often due to sporadic promoter hypermethylation rather than Lynch syndrome. Methylation testing distinguishes the two; if unmethylated, germline testing for Lynch syndrome is offered.

Why not the others

- **A:** BRCA is not relevant to MMR loss.
- **B:** CA-125 does not assess Lynch.
- **D:** Repeat biopsy is not needed.
- **E:** Oestradiol is irrelevant.

Key point: Loss of MSH2 or MSH6 strongly suggests Lynch syndrome.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 623 · Uterine Sarcoma · **Hard** · C2

A 68-year-old woman has postmenopausal bleeding and a large uterine mass. Histology after hysterectomy shows a biphasic tumour with malignant epithelial (carcinomatous) and malignant mesenchymal (sarcomatous) elements.

What is the diagnosis?

A. Adenomyoma
B. Carcinosarcoma (malignant mixed Müllerian tumour)
C. Endometrioid adenocarcinoma grade 1
D. Leiomyoma
E. Low-grade stromal sarcoma

Answer: B. Carcinosarcoma (malignant mixed Müllerian tumour)

Carcinosarcoma contains both malignant epithelial and malignant mesenchymal components. It is now regarded as a metaplastic high-grade carcinoma and has a poor prognosis. It is linked to previous pelvic radiotherapy and tamoxifen.

Why not the others

- **A:** Adenomyoma is benign.
- **C:** Grade 1 endometrioid cancer is purely epithelial.
- **D:** Leiomyoma is benign.
- **E:** Stromal sarcoma lacks a carcinomatous component.

Key point: Carcinosarcoma is treated like high-grade endometrial cancer.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 624 · Prognosis · **Moderate** · C2

A 59-year-old woman had surgery for stage IA grade 1 endometrioid endometrial cancer. She asks about her prognosis.

What is the approximate 5-year survival for stage I endometrial cancer?

A. Under 20%
B. About 40%
C. About 60%
D. Over 90%
E. 100% with no recurrence

Answer: D. Over 90%

Stage I endometrial cancer has a 5-year survival over 90%, especially for low-grade endometrioid tumours. Survival falls with higher stage, grade and aggressive histological types.

Why not the others

- **A:** Under 20% applies to advanced stage IV disease.
- **B:** 40% is too low for stage I.
- **C:** 60% is too low for stage I.
- **E:** Some recurrences still occur.

Key point: Follow-up focuses on symptoms such as vaginal bleeding.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 625 · Treatment · **Hard** · C3

A 55-year-old woman has recurrent endometrial cancer after surgery and chemotherapy. Her tumour is mismatch repair-deficient (dMMR).

Which treatment is particularly effective for dMMR endometrial cancer?

A. Bisphosphonates
B. Hormone replacement therapy
C. Immune checkpoint inhibitors (anti-PD-1 therapy)
D. Ovarian drilling
E. Tamoxifen alone

Answer: C. Immune checkpoint inhibitors (anti-PD-1 therapy)

Mismatch repair-deficient tumours have many mutations and are highly immunogenic. Immune checkpoint inhibitors such as dostarlimab or pembrolizumab, often combined with chemotherapy, produce good responses.

Why not the others

- **A:** Bisphosphonates treat bone loss.
- **B:** HRT is not a cancer treatment.
- **D:** Drilling is for PCOS.
- **E:** Tamoxifen alone is less effective in this setting.

Key point: Molecular profiling now guides treatment in endometrial cancer.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 626 · Investigation · **Moderate** · C2

A 64-year-old woman with postmenopausal bleeding has an outpatient endometrial biopsy with a Pipelle sampler.

What is the main limitation of Pipelle sampling?

A. It always needs general anaesthesia
B. It can miss focal lesions such as polyps or small cancers
C. It causes uterine perforation in most cases
D. It is less accurate than CA-125
E. It requires a hospital admission

Answer: B. It can miss focal lesions such as polyps or small cancers

Pipelle sampling samples only part of the endometrium and is good at detecting diffuse disease, but can miss focal lesions. Persistent bleeding or a thick endometrium with a benign Pipelle result needs hysteroscopy.

Why not the others

- **A:** It is an outpatient procedure.
- **C:** Perforation is rare.
- **D:** CA-125 does not diagnose endometrial cancer.
- **E:** It is done in clinic.

Key point: A negative Pipelle does not exclude cancer if symptoms persist.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 627 · Postmenopausal Bleeding · **Easy** · C2

A 62-year-old woman has postmenopausal bleeding. Investigations show a thin endometrium and pale, dry vaginal walls with petechiae. Biopsy is benign.

What is the commonest cause of postmenopausal bleeding?

A. Atrophic vaginitis or endometrial atrophy
B. Cervical cancer
C. Endometrial cancer
D. Fibroids
E. Ovarian cancer

Answer: A. Atrophic vaginitis or endometrial atrophy

Atrophy of the endometrium and vagina is the commonest cause of postmenopausal bleeding. Endometrial cancer accounts for about 5–10% of cases, so all women must still be investigated.

Why not the others

- **B:** Cervical cancer is a less common cause.
- **C:** Endometrial cancer is the most important cause to exclude but not the commonest.
- **D:** Fibroids usually shrink after menopause.
- **E:** Ovarian cancer rarely presents with bleeding.

Key point: Vaginal oestrogen treats atrophy once malignancy is excluded.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus; The menopause

MCQ 628 · Postmenopausal Bleeding · **Hard** · C3

A 58-year-old woman on continuous combined HRT for 3 years has a new episode of bleeding. Transvaginal ultrasound shows an endometrium of 6 mm.

What is the most appropriate next step?

A. Double the progestogen dose and review in 1 year
B. Endometrial biopsy
C. Reassure; 6 mm is normal on HRT
D. Stop HRT and no further tests
E. Switch to oestrogen-only HRT

Answer: B. Endometrial biopsy

New bleeding after a period of no bleeding on continuous combined HRT is abnormal. Endometrial assessment with biopsy (or hysteroscopy) is needed. Thresholds on HRT are less reliable, and many units sample above 4–5 mm.

Why not the others

- **A:** Changing the dose without biopsy could miss cancer.
- **C:** New bleeding needs investigation.
- **D:** Investigation is still needed.
- **E:** Oestrogen alone increases cancer risk with a uterus.

Key point: Women on sequential HRT expect monthly bleeds; unexpected bleeding still needs review.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus; The menopause

MCQ 629 · Staging · **Moderate** · C2

A 65-year-old woman's hysterectomy specimen shows endometrioid carcinoma invading the cervical stroma, with no spread outside the uterus.

What is the FIGO stage (2009)?

A. IA
B. IB
C. II
D. IIIB
E. IVA

Answer: C. II

Stage II endometrial cancer invades the cervical stroma but does not extend beyond the uterus. Involvement of only the cervical glands (not stroma) does not upstage the tumour.

Why not the others

- **A:** IA is confined to the uterine body with under 50% invasion.
- **B:** IB is 50% or more myometrial invasion.
- **D:** IIIB involves the vagina or parametrium.
- **E:** IVA involves bladder or bowel mucosa.

Key point: Stage II disease may need adjuvant radiotherapy.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 630 · Staging · **Hard** · C2

A 70-year-old woman with endometrial cancer has lung metastases on CT and malignant inguinal nodes.

What is the FIGO stage?

A. IIIA
B. IIIC1
C. IIIC2
D. IVA
E. IVB

Answer: E. IVB

Stage IVB includes distant metastases, including intra-abdominal disease, inguinal nodes and lung metastases. Treatment is systemic (chemotherapy, hormones, immunotherapy) with palliative intent.

Why not the others

- **A:** IIIA involves serosa or adnexa.
- **B:** IIIC1 involves pelvic nodes.
- **C:** IIIC2 involves para-aortic nodes.
- **D:** IVA involves bladder or bowel mucosa.

Key point: Hormone therapy (progestogens) can be useful for low-grade metastatic disease.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 631 · Treatment · **Hard** · C3

A 64-year-old woman has uterine serous carcinoma on biopsy. CT shows no obvious spread.

Which surgical staging is recommended?

A. Endometrial ablation
B. Hysterectomy only, keeping ovaries
C. Laparoscopic hysterectomy without nodal assessment
D. Total hysterectomy, bilateral salpingo-oophorectomy, omentectomy, peritoneal washings and nodal assessment
E. Vaginal hysterectomy only

Answer: D. Total hysterectomy, bilateral salpingo-oophorectomy, omentectomy, peritoneal washings and nodal assessment

Serous carcinoma behaves like ovarian cancer, spreading early to the peritoneum and omentum. Comprehensive staging includes omentectomy, washings and lymph node assessment. Adjuvant chemotherapy is usually given.

Why not the others

- **A:** Ablation is not cancer treatment.
- **B:** The ovaries should be removed.
- **C:** Nodal assessment is needed.
- **E:** Vaginal hysterectomy does not allow staging.

Key point: Even small serous cancers can have extrauterine spread.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 632 · Treatment · **Moderate** · C2

During laparoscopic surgery for endometrial cancer, indocyanine green dye is injected into the cervix and the first lymph nodes it reaches are removed.

What is this technique?

A. Brachytherapy
B. Hysteroscopic resection
C. Omentectomy
D. Sentinel lymph node biopsy
E. Washings cytology

Answer: D. Sentinel lymph node biopsy

Sentinel lymph node biopsy identifies the first nodes draining the tumour using dye injected into the cervix. It gives nodal staging with far less morbidity (lymphoedema) than full lymphadenectomy.

Why not the others

- **A:** Brachytherapy is a radiation treatment.
- **B:** Hysteroscopic resection removes intrauterine lesions.
- **C:** Omentectomy removes the omentum.
- **E:** Washings sample peritoneal fluid.

Key point: Full lymphadenectomy has more lymphoedema and does not improve survival in early disease.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 633 · Fertility-sparing Treatment · **Hard** · C3

A 33-year-old nulliparous woman has grade 1 endometrioid endometrial cancer. MRI shows no myometrial invasion and no extrauterine disease. She strongly wishes to conceive.

What is the most appropriate approach?

A. Chemotherapy
B. Endometrial ablation
C. High-dose progestogen (LNG-IUS with or without oral) with hysteroscopic surveillance, then hysterectomy after childbearing
D. No treatment
E. Radiotherapy

Answer: C. High-dose progestogen (LNG-IUS with or without oral) with hysteroscopic surveillance, then hysterectomy after childbearing

Fertility-sparing treatment can be offered for grade 1 endometrioid cancer without myometrial invasion. High-dose progestogen with 3-monthly hysteroscopy and biopsy is used. After childbearing, hysterectomy is recommended because recurrence is common.

Why not the others

- **A:** Chemotherapy is not used for this.
- **B:** Ablation is not a cancer treatment.
- **D:** Untreated cancer will progress.
- **E:** Radiotherapy destroys fertility.

Key point: Refer to a gynaecological oncology centre and offer fertility advice early.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 634 · Endometrial Hyperplasia · **Moderate** · C3

A 47-year-old woman with hyperplasia without atypia has been treated with an LNG-IUS for 6 months. A biopsy shows regression.

What is the recommended follow-up?

A. Hysterectomy now

B. Keep the LNG-IUS and repeat biopsy, aiming for two consecutive negative biopsies 6 months apart

C. No further biopsies

D. Remove the LNG-IUS immediately

E. Stop all treatment and repeat biopsy in 5 years

Answer: B. Keep the LNG-IUS and repeat biopsy, aiming for two consecutive negative biopsies 6 months apart

Follow-up biopsies are done at least every 6 months until two consecutive negative biopsies. The LNG-IUS is kept for at least 5 years where tolerated because it reduces relapse.

Why not the others

- **A:** Hysterectomy is not needed after regression.
- **C:** Follow-up is needed to confirm regression.
- **D:** Removing it increases relapse risk.
- **E:** Stopping treatment early risks recurrence.

Key point: Women at high risk of relapse (BMI ≥35, previous oral progestogen) may need yearly biopsies.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 635 · Endometrial Hyperplasia · **Moderate** · C3

A 55-year-old woman on oestrogen-only HRT (she has a uterus) for 2 years develops bleeding. Biopsy shows hyperplasia without atypia.

What is the most important step?

A. Add a progestogen or stop oestrogen-only HRT, and treat the hyperplasia

B. Continue oestrogen-only HRT unchanged

C. Double the oestrogen dose

D. Endometrial ablation

E. Start tamoxifen

Answer: A. Add a progestogen or stop oestrogen-only HRT, and treat the hyperplasia

Unopposed oestrogen in a woman with a uterus causes hyperplasia. The cause must be removed: stop oestrogen-only HRT or add a progestogen (LNG-IUS is ideal, both treating hyperplasia and protecting the endometrium).

Why not the others

- **B:** Continuing unopposed oestrogen worsens hyperplasia.
- **C:** More oestrogen worsens hyperplasia.
- **D:** Ablation is not used for hyperplasia.
- **E:** Tamoxifen stimulates the endometrium.

Key point: Women with a uterus must not be given oestrogen-only HRT.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus; The menopause

MCQ 636 · Investigation · **Moderate** · C3

A 60-year-old woman with no bleeding has a CT for another reason that reports an endometrial thickness of 8 mm. She is not on HRT or tamoxifen.

What is the most appropriate management?

A. Endometrial ablation

B. Hysterectomy

C. Immediate biopsy in all cases

D. Tranexamic acid

E. Transvaginal ultrasound and individual assessment of risk factors; biopsy is not routinely needed if she has no bleeding

Answer: E. Transvaginal ultrasound and individual assessment of risk factors; biopsy is not routinely needed if she has no bleeding

In asymptomatic postmenopausal women, an incidentally thickened endometrium carries a much lower cancer risk than in women with bleeding. Management is individualised; biopsy is considered for very thick endometrium (often over 11 mm) or with risk factors such as obesity, diabetes or fluid in the cavity.

Why not the others

- **A:** Ablation is not appropriate.
- **B:** Hysterectomy is not indicated.
- **C:** Routine biopsy of all asymptomatic women causes unnecessary procedures.
- **D:** Tranexamic acid is not indicated.

Key point: Advise her to report any bleeding promptly.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 637 · Prevention · **Moderate** · C2

A 45-year-old woman with a BMI of 48 kg/m² asks whether bariatric surgery would affect her cancer risk.

What is the effect of substantial weight loss after bariatric surgery on endometrial cancer risk?

A. It has no effect

B. It increases risk

C. It only affects breast cancer

D. It only affects risk in men

E. It reduces risk

Answer: E. It reduces risk

Obesity is a major cause of endometrial cancer through unopposed oestrogen and insulin resistance. Substantial weight loss after bariatric surgery is associated with a significant reduction in endometrial cancer risk.

Why not the others

- **A:** There is a clear effect.
- **B:** Risk falls, not rises.
- **C:** Endometrial risk is affected.
- **D:** It affects women's cancer risk.

Key point: Weight loss also improves fertility-sparing treatment outcomes.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 638 · Follow-up · **Moderate** · C2

A 66-year-old woman had a hysterectomy and BSO for stage IA endometrial cancer 18 months ago. She now has vaginal bleeding. Examination shows a 2 cm nodule at the vaginal vault.

What is the most likely diagnosis?

A. Granulation tissue only
B. Ovarian cancer
C. Prolapse
D. Urinary tract infection
E. Vaginal vault recurrence of endometrial cancer

Answer: E. Vaginal vault recurrence of endometrial cancer

The vaginal vault is the commonest site of endometrial cancer recurrence, usually within 3 years. Isolated vault recurrence in women who have not had radiotherapy can often be cured with radiotherapy.

Why not the others

- **A:** Granulation tissue occurs soon after surgery, not at 18 months.
- **B:** Her ovaries were removed.
- **C:** Prolapse does not cause a nodule with bleeding.
- **D:** UTI does not cause vault bleeding.

Key point: Teach women to report vaginal bleeding after treatment.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 639 · HRT after Cancer · **Hard** · C3

A 48-year-old woman had a hysterectomy and BSO for stage IA grade 1 endometrioid endometrial cancer. She has severe hot flushes.

What is the advice about HRT?

A. HRT can be considered after discussion, as evidence does not show increased recurrence in early-stage low-grade disease
B. HRT is absolutely contraindicated forever
C. Only testosterone can be used
D. She must wait 10 years
E. She should take high-dose oestrogen only

Answer: A. HRT can be considered after discussion, as evidence does not show increased recurrence in early-stage low-grade disease

Evidence suggests HRT does not increase recurrence in women treated for early-stage, low-grade endometrioid endometrial cancer, and it may be considered after discussion with the oncology team. Caution applies for high-grade or advanced disease.

Why not the others

- **B:** It is not absolutely contraindicated in early low-grade disease.
- **C:** Testosterone does not treat flushes.
- **D:** A fixed wait is not required.
- **E:** High dose is not needed.

Key point: Non-hormonal options remain available if she prefers.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus; The menopause

MCQ 640 · Treatment · **Moderate** · C2

A 62-year-old woman has stage III endometrial cancer after surgery and is starting adjuvant chemotherapy.

Which chemotherapy combination is standard for endometrial cancer?

A. Bleomycin, etoposide and cisplatin
B. Carboplatin and paclitaxel
C. Cyclophosphamide alone
D. Methotrexate and folinic acid
E. Tamoxifen and letrozole

Answer: B. Carboplatin and paclitaxel

Carboplatin and paclitaxel is the standard chemotherapy regimen for advanced or high-risk endometrial cancer, sometimes combined with radiotherapy or immunotherapy.

Why not the others

- **A:** BEP is for germ cell tumours.
- **C:** Single-agent cyclophosphamide is not standard.
- **D:** Methotrexate is for trophoblastic disease.
- **E:** These are hormone treatments, not chemotherapy.

Key point: Immunotherapy added to chemotherapy benefits dMMR tumours.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 641 · Investigation · **Hard** · C2

A 61-year-old woman with endometrioid endometrial cancer on biopsy has a CA-125 of 210 U/mL.

What does a raised CA-125 suggest in endometrial cancer?

A. Benign disease only
B. Coexisting fibroids only
C. Extrauterine spread is more likely
D. Lower grade tumour
E. The diagnosis is wrong

Answer: C. Extrauterine spread is more likely

A raised CA-125 in endometrial cancer is associated with extrauterine spread (nodes, peritoneum, adnexa) and may prompt CT imaging and more extensive staging.

Why not the others

- **A:** It is not a sign of benign disease.
- **B:** Fibroids rarely raise CA-125 this much.
- **D:** It does not indicate lower grade.
- **E:** The biopsy diagnosis stands.

Key point: CA-125 can be used to monitor advanced disease.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 642 · Uterine Sarcoma · **Hard** · C2

A 48-year-old woman has a hysterectomy for presumed fibroids. Histology shows a tumour of uniform small cells resembling proliferative endometrial stroma, with tongue-like infiltration of myometrium and vessels, and low mitotic activity. It is oestrogen and progesterone receptor-positive.

What is the diagnosis?

A. Adenomyosis
B. Carcinosarcoma
C. Leiomyoma
D. Low-grade endometrial stromal sarcoma
E. Serous carcinoma

Answer: D. Low-grade endometrial stromal sarcoma

Low-grade endometrial stromal sarcoma has cells resembling endometrial stroma that infiltrate the myometrium and vessels in a tongue-like pattern. It is hormone receptor-positive, often indolent, and treated with hysterectomy, BSO and sometimes hormonal therapy.

Why not the others

- **A:** Adenomyosis has benign glands and stroma.
- **B:** Carcinosarcoma has malignant epithelial elements.
- **C:** Leiomyoma is benign smooth muscle.
- **E:** Serous carcinoma is epithelial.

Key point: Avoid oestrogen HRT after ESS because it is hormone-sensitive.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 643 · Risk Factors · **Moderate** · C2

A 40-year-old woman with Cowden syndrome (PTEN mutation) asks about her cancer risks.

Which cancers is she at increased risk of?

A. Breast, thyroid and endometrial cancer
B. Colon cancer only
C. Leukaemia
D. Lung cancer
E. Melanoma only

Answer: A. Breast, thyroid and endometrial cancer

Cowden syndrome is caused by PTEN mutations and increases the risk of breast, thyroid (follicular) and endometrial cancer, with hamartomatous lesions of the skin and gut.

Why not the others

- **B:** Colon cancer risk is modest; Lynch is the main colon syndrome.
- **C:** Leukaemia is not typical.
- **D:** Lung cancer is not typical.
- **E:** Melanoma risk is modestly increased but not the main issue.

Key point: Women with Cowden syndrome may consider risk-reducing hysterectomy.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 644 · Clinical Features · **Moderate** · C3

A 50-year-old perimenopausal woman with a BMI of 39 kg/m² has had prolonged heavy irregular bleeding for 9 months. Her GP thought it was the menopause.

What is the most appropriate action?

A. Endometrial biopsy
B. Reassure that irregular bleeding is normal at 50
C. Start the combined pill
D. Tranexamic acid only
E. Wait until periods stop

Answer: A. Endometrial biopsy

Persistent irregular or heavy bleeding in women over 45, especially with obesity, needs endometrial sampling. Endometrial cancer can occur before menopause, and assuming bleeding is due to the menopause delays diagnosis.

Why not the others

- **B:** Persistent irregular bleeding is not assumed to be normal.
- **C:** Hormones without histology may hide cancer, and BMI makes the pill unsuitable.
- **D:** Tranexamic acid does not exclude cancer.
- **E:** Waiting delays diagnosis.

Key point: About a quarter of endometrial cancers occur before menopause.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 645 · Treatment · **Moderate** · C2

A 67-year-old woman has high-risk endometrial cancer (stage IB grade 3 with lymphovascular invasion) after surgery.

Which adjuvant treatment is most appropriate?

A. External beam pelvic radiotherapy with or without chemotherapy
B. No treatment
C. Progestogen only
D. Tamoxifen only
E. Vaginal oestrogen

Answer: A. External beam pelvic radiotherapy with or without chemotherapy

High-risk early endometrial cancer benefits from external beam pelvic radiotherapy, often with chemotherapy (PORTEC-3), to reduce pelvic and distant recurrence. Molecular profiling refines decisions.

Why not the others

- **B:** High-risk disease needs adjuvant treatment.
- **C:** Progestogens are for low-grade disease in unfit women.
- **D:** Tamoxifen is not standard.
- **E:** Vaginal oestrogen is not cancer treatment.

Key point: Grade 3 and LVSI are adverse prognostic factors.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 646 · Diabetes and Cancer · **Easy** · C2

A 56-year-old woman has type 2 diabetes, hypertension and obesity. She asks about her gynaecological cancer risk.

Which gynaecological cancer is most strongly linked with this combination?

A. Cervical cancer
B. Endometrial cancer
C. Fallopian tube cancer
D. Vaginal cancer
E. Vulval cancer

Answer: B. Endometrial cancer

Obesity, diabetes and hypertension (sometimes called the "corpus cancer syndrome") are classically associated with endometrial cancer, largely through obesity, unopposed oestrogen and insulin resistance.

Why not the others

- **A:** Cervical cancer is HPV-related.
- **C:** Tubal cancer is linked to BRCA.
- **D:** Vaginal cancer is HPV-related.
- **E:** Vulval cancer is linked to HPV and lichen sclerosus.

Key point: Advise her to report any postmenopausal bleeding immediately.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 647 · Investigation · **Easy** · C3

A 70-year-old woman has a single episode of postmenopausal bleeding. She is anxious and wants to know how quickly she will be seen.

How urgently should postmenopausal bleeding be investigated in a woman over 55?

A. Investigation only if she also has pain
B. Only after 3 episodes
C. Routine referral within 6 months
D. Urgent referral on a suspected cancer pathway
E. Wait 1 year and see if it recurs

Answer: D. Urgent referral on a suspected cancer pathway

Postmenopausal bleeding in women aged 55 or over is an indication for urgent suspected cancer referral, with transvaginal ultrasound as the first test.

Why not the others

- **A:** Pain is not required.
- **B:** A single episode warrants investigation.
- **C:** Routine referral delays diagnosis.
- **E:** Waiting delays diagnosis.

Key point: Most women with PMB do not have cancer, but early diagnosis improves outcome.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus; NICE NG12

MCQ 648 · Histological Types · **Moderate** · C2

A 55-year-old obese woman has endometrial cancer arising in a background of atypical hyperplasia. The tumour is oestrogen receptor-positive.

What is the most likely histological type?

A. Clear cell carcinoma
B. Endometrioid adenocarcinoma
C. Leiomyosarcoma
D. Serous carcinoma
E. Small cell carcinoma

Answer: B. Endometrioid adenocarcinoma

Endometrioid adenocarcinoma (type I) is the commonest type, about 80%. It arises from atypical hyperplasia under unopposed oestrogen, is usually hormone receptor-positive and low grade, with a good prognosis.

Why not the others

- **A:** Clear cell is a type II cancer, not linked with hyperplasia.
- **C:** Leiomyosarcoma arises from muscle.
- **D:** Serous carcinoma arises in atrophic endometrium.
- **E:** Small cell carcinoma is rare.

Key point: Type I = endometrioid, oestrogen-related, good prognosis.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 649 · Treatment · **Hard** · C3

A 73-year-old woman with recurrent low-grade endometrioid endometrial cancer has small lung metastases. Tumour is strongly progesterone receptor-positive. She wants to avoid chemotherapy side effects.

Which systemic treatment is a reasonable first choice?

A. Bleomycin
B. High-dose progestogen (such as medroxyprogesterone or megestrol)
C. Ovarian drilling
D. Radiotherapy to all organs
E. Tranexamic acid

Answer: B. High-dose progestogen (such as medroxyprogesterone or megestrol)

Hormone therapy with progestogens is effective in low-grade, receptor-positive recurrent endometrial cancer and is well tolerated. Responses are less likely in high-grade or receptor-negative tumours.

Why not the others

- **A:** Bleomycin is for germ cell tumours.
- **C:** Drilling is for PCOS.
- **D:** Whole-body radiotherapy is not used.
- **E:** Tranexamic acid does not treat cancer.

Key point: Progestogens can cause weight gain and thrombosis.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

MCQ 650 · Staging · **Moderate** · C2

A 63-year-old woman's endometrial cancer has spread to the right ovary, with no nodal or distant disease.

What is the FIGO stage (2009)?

A. IB
B. II
C. IIIA
D. IIIC1
E. IVB

Answer: C. IIIA

Stage IIIA endometrial cancer involves the uterine serosa and/or adnexa (ovary or tube). Stage IIIB involves the vagina or parametrium, and IIIC involves nodes.

Why not the others

- **A:** IB is confined to the uterus.
- **B:** Stage II involves the cervical stroma.
- **D:** IIIC1 involves pelvic nodes.
- **E:** IVB is distant spread.

Key point: Distinguish synchronous primary ovarian cancer from metastasis by histology.

Reference: Gynaecology by Ten Teachers — Malignant disease of the uterus

CHAPTER 14

Ovarian Tumours

MCQ 651 · Benign Ovarian Tumours · **Easy** · C2

A 25-year-old woman has a pelvic ultrasound for mild right-sided pelvic discomfort. It shows a 6 cm unilocular right ovarian cyst containing a bright echogenic nodule with acoustic shadowing and a fat–fluid level. Tumour markers are normal.

What is the most likely diagnosis?

A. Endometrioma
B. Haemorrhagic corpus luteum cyst
C. Mature cystic teratoma
D. Mucinous cystadenoma
E. Serous cystadenoma

Answer: C. Mature cystic teratoma

A mature cystic teratoma (dermoid cyst) contains fat, hair and teeth. On ultrasound this shows as an echogenic Rokitansky nodule with acoustic shadowing and a fat–fluid level. It is the commonest ovarian tumour in young women and is prone to torsion.

Why not the others

- **A:** An endometrioma shows homogeneous low-level "ground-glass" echoes.
- **B:** A haemorrhagic cyst shows a lace-like reticular pattern and resolves on repeat scan.
- **D:** A mucinous cystadenoma is usually large and multilocular.
- **E:** A serous cystadenoma is usually unilocular and anechoic, without fat or calcification.

Key point: Treat a dermoid by laparoscopic ovarian cystectomy, preserving ovarian tissue in young women.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 652 · Ovarian Cancer · **Hard** · C3

A 58-year-old woman, 8 years postmenopausal, has had abdominal bloating and early satiety for 3 months. Ultrasound shows bilateral multilocular ovarian cysts with solid areas and ascites. Serum CA-125 is 120 U/mL.

What is her Risk of Malignancy Index (RMI)?

A. 120
B. 360
C. 720
D. 1080
E. 3240

Answer: D. 1080

RMI = U × M × CA-125. She has four ultrasound features (multilocular, solid areas, bilateral, ascites); two or more features give U = 3. Postmenopausal gives M = 3. So RMI = 3 × 3 × 120 = 1080. An RMI above 200 needs referral to the gynae-oncology MDT.

Why not the others

- **A:** 120 ignores both the U and M scores.
- **B:** 360 includes only one multiplier of 3.
- **C:** 720 would need a multiplier of 6, which the formula does not use.
- **E:** 3240 uses U = 9; the maximum U score is 3, not the number of features.

Key point: U: 0 features = 0, 1 feature = 1, 2 or more = 3. M: premenopausal 1, postmenopausal 3. RMI over 200 = high risk.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary; RCOG guidance

MCQ 653 · Functional Cysts · **Easy** · C3

A 28-year-old woman has a pelvic scan for mild left iliac fossa discomfort. It shows a 4 cm thin-walled, unilocular, anechoic left ovarian cyst with no solid parts. She is otherwise well.

What is the most appropriate management?

A. CA-125 and laparoscopy
B. Laparoscopic oophorectomy
C. MRI scan
D. No follow-up needed; most such cysts resolve
E. Repeat scan every month for a year

Answer: D. No follow-up needed; most such cysts resolve

Simple cysts under 5 cm in premenopausal women are almost always functional (follicular) and resolve within 2–3 cycles. They need no follow-up. Simple cysts of 5–7 cm are rescanned yearly, and larger ones need MRI or surgery.

Why not the others

- **A:** CA-125 and surgery are not needed for a small simple cyst.
- **B:** Removing the ovary is unnecessary.
- **C:** MRI is for larger or uncertain cysts.
- **E:** Monthly scans are unnecessary.

Key point: CA-125 is not routinely needed for a simple cyst in a premenopausal woman.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary; RCOG guidance

MCQ 654 · Functional Cysts · **Moderate** · C2

A 25-year-old woman on day 24 of her cycle has sudden right lower abdominal pain after intercourse. She is stable. Pregnancy test is negative. Ultrasound shows a 3 cm cyst with a lace-like internal pattern and a small amount of free fluid.

What is the most likely diagnosis?

A. Dermoid cyst
B. Ectopic pregnancy
C. Endometrioma
D. Haemorrhagic corpus luteum cyst
E. Ovarian torsion

Answer: D. Haemorrhagic corpus luteum cyst

A haemorrhagic corpus luteum cyst in the luteal phase can bleed or rupture, often after intercourse or exercise. The reticular (lace-like) pattern is typical. Most settle with analgesia; surgery is needed only for heavy bleeding.

Why not the others

- **A:** A dermoid has echogenic fat and shadowing.
- **B:** The pregnancy test is negative.
- **C:** An endometrioma has ground-glass echoes.
- **E:** Torsion usually involves a larger mass with reduced flow.

Key point: Rescan in 6–8 weeks to confirm resolution.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 655 · Cyst Assessment · **Moderate** · C3

A 60-year-old woman, 10 years postmenopausal, has a 3 cm simple unilocular ovarian cyst on ultrasound. CA-125 is 12 U/mL. She has no symptoms.

What is the most appropriate management?

A. Bilateral salpingo-oophorectomy
B. Laparotomy and staging
C. PET scan
D. Refer urgently to gynae-oncology
E. Repeat ultrasound and CA-125 in 4–6 months

Answer: E. Repeat ultrasound and CA-125 in 4–6 months

Small (under 5 cm) simple cysts in postmenopausal women with a normal CA-125 have a very low risk of malignancy. Conservative management with repeat ultrasound and CA-125 in 4–6 months is appropriate; many resolve.

Why not the others

- **A:** Surgery is not needed for a low-risk cyst.
- **B:** Staging surgery is for suspected cancer.
- **C:** PET is not indicated.
- **D:** Low RMI does not need oncology referral.

Key point: RMI under 25 = low risk in postmenopausal women.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary; RCOG guidance

MCQ 656 · Cyst Assessment · **Hard** · C3

A 45-year-old woman has a 9 cm multilocular-solid ovarian mass with papillary projections, irregular solid areas and strong blood flow on Doppler. There is mild ascites.

Using IOTA simple rules, how is this mass classified?

A. Benign (B-features only)
B. Functional cyst
C. Inconclusive because she is premenopausal
D. Malignant (M-features present without B-features)
E. Normal ovary

Answer: D. Malignant (M-features present without B-features)

IOTA simple rules use 5 benign (B) and 5 malignant (M) features. M-features include an irregular solid tumour, ascites, at least 4 papillary structures, an irregular multilocular-solid tumour over 10 cm and very strong blood flow. M-features without B-features classify the mass as malignant.

Why not the others

- **A:** There are no benign features.
- **B:** A functional cyst is simple and small.
- **C:** Menopausal status does not make the rules inconclusive.
- **E:** This is a pathological mass.

Key point: Refer suspected malignant masses to a gynaecological oncology centre.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 657 · Ovarian Cancer Presentation · **Easy** · C3

A 56-year-old woman has had persistent bloating, early satiety and urinary frequency almost every day for 2 months. Her GP is considering ovarian cancer.

What is the most appropriate first test in primary care?

A. Abdominal X-ray
B. CA-125
C. Colonoscopy
D. CT chest
E. Upper GI endoscopy

Answer: B. CA-125

In women (especially over 50) with persistent bloating, early satiety, pelvic or abdominal pain, or urinary urgency or frequency, NICE recommends measuring CA-125. If it is 35 U/mL or more, arrange pelvic and abdominal ultrasound.

Why not the others

- **A:** X-ray does not assess the ovaries.
- **C:** Colonoscopy may be needed if bowel symptoms dominate, but not first here.
- **D:** CT chest is not the first test.
- **E:** Endoscopy does not assess the ovaries.

Key point: Ovarian cancer symptoms are often vague and mistaken for IBS.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary; NICE CG122

MCQ 658 · Epithelial Ovarian Cancer · **Easy** · C2

A 62-year-old woman is diagnosed with advanced ovarian cancer.

What is the commonest histological type of ovarian cancer?

A. Clear cell carcinoma
B. Dysgerminoma
C. Granulosa cell tumour
D. High-grade serous carcinoma
E. Mucinous carcinoma

Answer: D. High-grade serous carcinoma

Epithelial tumours make up about 90% of ovarian cancers, and high-grade serous carcinoma is the commonest, usually presenting at an advanced stage. Many are now thought to originate in the fallopian tube (serous tubal intraepithelial carcinoma).

Why not the others

- **A:** Clear cell is less common and linked to endometriosis.
- **B:** Dysgerminoma is a germ cell tumour of young women.
- **C:** Granulosa tumours are sex cord-stromal tumours.
- **E:** Mucinous carcinoma is uncommon.

Key point: About 75% of ovarian cancers present at stage III or IV.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 659 · Hereditary Ovarian Cancer · **Moderate** · C2

A 38-year-old woman's mother had ovarian cancer at 52 and her sister had breast cancer at 39. Genetic testing shows she carries a BRCA1 mutation.

What is her approximate lifetime risk of ovarian cancer?

A. 1–2%
B. 5%
C. About 40%
D. About 80%
E. 100%

Answer: C. About 40%

BRCA1 carriers have a lifetime ovarian cancer risk of about 40% (BRCA2 about 15–20%), compared with about 2% in the general population. Breast cancer risk is about 60–70%.

Why not the others

- **A:** 1–2% is the general population risk.
- **B:** 5% underestimates BRCA1 risk.
- **D:** 80% is too high for ovarian cancer.
- **E:** Not every carrier develops cancer.

Key point: Lynch syndrome also increases ovarian cancer risk (about 10%).

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 660 · Hereditary Ovarian Cancer · **Moderate** · C3

A 39-year-old woman with a BRCA1 mutation has completed her family.

What is the most effective way to reduce her ovarian cancer risk?

A. Annual CA-125 and ultrasound screening
B. Combined pill until menopause only
C. Hysterectomy alone
D. Risk-reducing bilateral salpingo-oophorectomy at about 35–40
E. Tamoxifen

Answer: D. Risk-reducing bilateral salpingo-oophorectomy at about 35–40

Risk-reducing bilateral salpingo-oophorectomy reduces ovarian and tubal cancer risk by about 80–90% and is recommended at 35–40 for BRCA1 carriers (40–45 for BRCA2), after childbearing. HRT until natural menopause is advised if she has not had breast cancer.

Why not the others

- **A:** Screening has not been shown to reduce deaths.
- **B:** The pill reduces risk but much less.
- **C:** Hysterectomy alone does not remove the ovaries and tubes.
- **E:** Tamoxifen does not prevent ovarian cancer.

Key point: Removing the tubes is essential because many "ovarian" cancers start there.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 661 · Screening · **Moderate** · C2

A 55-year-old woman with no family history asks to be screened for ovarian cancer every year with CA-125 and ultrasound.

What does current evidence show about population screening for ovarian cancer?

A. It detects all cancers at stage I
B. It halves deaths
C. It has not been shown to reduce ovarian cancer deaths
D. It is recommended for all women over 50
E. It replaces surgery

Answer: C. It has not been shown to reduce ovarian cancer deaths

The large UKCTOCS trial found that annual screening with CA-125 or ultrasound did not reduce ovarian cancer deaths in the general population. Screening is therefore not recommended.

Why not the others

- **A:** Screening detects some earlier cancers but most are still advanced.
- **B:** There was no mortality reduction.
- **D:** It is not recommended.
- **E:** Screening does not replace treatment.

Key point: Awareness of symptoms and early investigation are key.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 662 · Staging · **Moderate** · C2

A 58-year-old woman has ovarian cancer with peritoneal deposits over 2 cm in the upper abdomen and on the omentum. There are no liver parenchymal or lung metastases and no pleural effusion.

What is the FIGO stage?

A. IA
B. IIB
C. IIIA1
D. IIIC
E. IVB

Answer: D. IIIC

Stage III is spread to peritoneum outside the pelvis and/or retroperitoneal nodes. IIIC is macroscopic peritoneal metastases over 2 cm beyond the pelvis (including capsule of liver or spleen without parenchymal involvement).

Why not the others

- **A:** IA is confined to one ovary.
- **B:** IIB is extension to other pelvic tissues.
- **C:** IIIA1 is retroperitoneal nodes only.
- **E:** IVB is parenchymal or extra-abdominal metastases.

Key point: Most women present at stage IIIC.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 663 · Staging · **Hard** · C2

A 64-year-old woman with ovarian cancer has a right pleural effusion. Aspiration shows malignant cells.

What is the FIGO stage?

A. IIIA
B. IIIB
C. IIIC
D. IVA
E. IVB

Answer: D. IVA

Stage IVA is a malignant pleural effusion with positive cytology. IVB is parenchymal metastases (liver, spleen) and extra-abdominal spread including inguinal nodes.

Why not the others

- **A:** IIIA is microscopic peritoneal spread or nodes.
- **B:** IIIB is peritoneal deposits up to 2 cm.
- **C:** IIIC is peritoneal deposits over 2 cm.
- **E:** IVB is parenchymal or distant organ spread.

Key point: A pleural effusion must have positive cytology to define stage IVA.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 664 · Treatment · **Moderate** · C3

A 60-year-old woman has stage IIIC high-grade serous ovarian cancer. She is fit and imaging suggests all disease can be removed.

What is the standard primary treatment?

A. Chemotherapy with no surgery at any point
B. Hormone therapy
C. Palliative care only
D. Primary cytoreductive surgery aiming for no visible residual disease, followed by carboplatin and paclitaxel
E. Radiotherapy to the abdomen

Answer: D. Primary cytoreductive surgery aiming for no visible residual disease, followed by carboplatin and paclitaxel

Advanced ovarian cancer is treated with surgery to remove all visible disease (complete cytoreduction) plus platinum-based chemotherapy (carboplatin and paclitaxel). Neoadjuvant chemotherapy with interval surgery is used when complete resection is unlikely upfront or the woman is less fit.

Why not the others

- **A:** Surgery is a key part of treatment.
- **B:** Hormone therapy is not standard first-line.
- **C:** Advanced disease is treatable with good responses.
- **E:** Radiotherapy has little role.

Key point: No residual disease after surgery is the strongest predictor of survival.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 665 · Treatment · **Hard** · C3

A 56-year-old woman with stage IIIC ovarian cancer and a BRCA1 mutation has a complete response to surgery and chemotherapy.

Which maintenance treatment significantly improves progression-free survival?

A. Aromatase inhibitor alone
B. Methotrexate
C. PARP inhibitor (such as olaparib)
D. Radiotherapy
E. Tamoxifen

Answer: C. PARP inhibitor (such as olaparib)

PARP inhibitors such as olaparib or niraparib exploit defective DNA repair in BRCA-mutated or homologous recombination-deficient tumours. Maintenance after response to platinum chemotherapy greatly improves progression-free survival.

Why not the others

- **A:** Aromatase inhibitors are used in low-grade serous disease.
- **B:** Methotrexate is for trophoblastic disease.
- **D:** Radiotherapy is not used.
- **E:** Tamoxifen has limited use.

Key point: Test all women with non-mucinous epithelial ovarian cancer for BRCA mutations.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 666 · Borderline Tumours · **Moderate** · C3

A 28-year-old nulliparous woman has a 7 cm left ovarian cyst. Histology after laparoscopic cystectomy shows a serous borderline tumour with no invasion.

What is the most appropriate management?

A. Bilateral oophorectomy and hysterectomy
B. Fertility-sparing surgery with follow-up
C. Full chemotherapy
D. No follow-up
E. Radiotherapy

Answer: B. Fertility-sparing surgery with follow-up

Borderline ovarian tumours have an excellent prognosis. In young women wanting fertility, conservative surgery (cystectomy or unilateral salpingo-oophorectomy) with staging and follow-up is appropriate. Recurrence is often borderline and treatable.

Why not the others

- **A:** Radical surgery is not needed.
- **C:** Chemotherapy does not help borderline tumours.
- **D:** Follow-up is needed because of recurrence risk.
- **E:** Radiotherapy is not used.

Key point: Cystectomy has a higher recurrence than salpingo-oophorectomy, but preserves more tissue.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 667 · Mucinous Tumours · **Hard** · C2

A 45-year-old woman has a 20 cm multilocular cystic ovarian mass. At surgery there is gelatinous material throughout the peritoneal cavity. Histology shows a mucinous tumour.

Which organ must be examined as the likely primary source?

A. Appendix
B. Bladder
C. Kidney
D. Spleen
E. Thyroid

Answer: A. Appendix

Pseudomyxoma peritonei (gelatinous ascites) usually arises from a mucinous tumour of the appendix, with secondary ovarian involvement. The appendix should be removed and examined. Immunohistochemistry (CK7/CK20) helps distinguish primary sites.

Why not the others

- **B:** The bladder is not a typical source.
- **C:** The kidney is not a source.
- **D:** The spleen is not a source.
- **E:** The thyroid is not a source.

Key point: Remove the appendix at surgery for a mucinous ovarian tumour.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 668 · Metastatic Tumours · **Hard** · C2

A 42-year-old woman has bilateral solid ovarian masses. She has had epigastric pain and weight loss. Histology shows signet-ring cells infiltrating the ovarian stroma.

What is the most likely diagnosis?

A. Brenner tumour
B. Dysgerminoma
C. Granulosa cell tumour
D. Krukenberg tumour
E. Serous cystadenoma

Answer: D. Krukenberg tumour

Krukenberg tumours are ovarian metastases, typically bilateral, containing mucin-filled signet-ring cells. The commonest primary is the stomach, followed by colon and breast.

Why not the others

- **A:** Brenner tumours contain transitional epithelium.
- **B:** Dysgerminoma has large clear cells and lymphocytes.
- **C:** Granulosa tumours have Call–Exner bodies.
- **E:** Serous cystadenomas are cystic and benign.

Key point: Bilateral solid ovarian masses: consider metastases.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 669 · Germ Cell Tumours · **Moderate** · C2

A 19-year-old woman has a rapidly growing 12 cm solid unilateral ovarian mass. Serum LDH is markedly raised; AFP and hCG are normal.

What is the most likely diagnosis?

A. Choriocarcinoma
B. Dysgerminoma
C. Granulosa cell tumour
D. Serous carcinoma
E. Yolk sac tumour

Answer: B. Dysgerminoma

Dysgerminoma is the commonest malignant germ cell tumour, typically in young women. LDH (and sometimes hCG) is raised. It is very sensitive to chemotherapy, so fertility-sparing surgery with BEP chemotherapy gives excellent cure rates.

Why not the others

- **A:** Choriocarcinoma raises hCG markedly.
- **C:** Granulosa tumours raise inhibin.
- **D:** Serous carcinoma occurs in older women and raises CA-125.
- **E:** Yolk sac tumours raise AFP.

Key point: Measure AFP, hCG and LDH in women under 40 with a complex mass.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 670 · Germ Cell Tumours · **Moderate** · C2

A 17-year-old girl has abdominal pain and a large solid ovarian mass. Serum alpha-fetoprotein is very high. Histology shows Schiller–Duval bodies.

What is the diagnosis?

A. Dysgerminoma
B. Granulosa cell tumour
C. Mature cystic teratoma
D. Mucinous cystadenoma
E. Yolk sac (endodermal sinus) tumour

Answer: E. Yolk sac (endodermal sinus) tumour

Yolk sac tumours secrete AFP and have characteristic Schiller–Duval bodies. They grow rapidly but respond well to BEP chemotherapy after fertility-sparing surgery.

Why not the others

- **A:** Dysgerminoma raises LDH.
- **B:** Granulosa tumours raise inhibin.
- **C:** A mature teratoma is benign and does not raise AFP.
- **D:** Mucinous tumours do not raise AFP.

Key point: AFP is used to monitor treatment response and recurrence.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 671 · Germ Cell Tumours · **Hard** · C3

A 22-year-old unmarried woman has stage IC dysgerminoma of the left ovary. The right ovary and uterus are normal. She wants to preserve fertility.

What is the most appropriate management?

A. Bilateral salpingo-oophorectomy and hysterectomy
B. Left salpingo-oophorectomy with staging, followed by BEP chemotherapy
C. Observation only
D. Radiotherapy to the whole pelvis
E. Right oophorectomy

Answer: B. Left salpingo-oophorectomy with staging, followed by BEP chemotherapy

Malignant germ cell tumours are usually unilateral and very chemosensitive. Fertility-sparing surgery (unilateral salpingo-oophorectomy with staging) followed by BEP chemotherapy gives cure rates over 90% with preserved fertility in most.

Why not the others

- **A:** Radical surgery is unnecessary.
- **C:** Stage IC needs treatment.
- **D:** Radiotherapy destroys fertility.
- **E:** The right ovary is normal.

Key point: Fertility is usually preserved after BEP chemotherapy.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 672 · Sex Cord-Stromal Tumours · **Moderate** · C2

A 6-year-old girl has breast development and vaginal bleeding. Ultrasound shows a 7 cm solid right ovarian mass. Serum oestradiol and inhibin are raised. LH and FSH are suppressed.

What is the most likely diagnosis?

A. Dysgerminoma
B. Juvenile granulosa cell tumour
C. Mature cystic teratoma
D. McCune–Albright syndrome
E. Yolk sac tumour

Answer: B. Juvenile granulosa cell tumour

Juvenile granulosa cell tumours secrete oestrogen, causing peripheral (gonadotrophin-independent) precocious puberty in children. Inhibin is a tumour marker. Treatment is surgical removal.

Why not the others

- **A:** Dysgerminomas do not secrete oestrogen.
- **C:** Teratomas rarely cause precocious puberty.
- **D:** McCune–Albright gives cysts, not a large solid mass.
- **E:** Yolk sac tumours raise AFP.

Key point: Adult granulosa tumours cause postmenopausal bleeding and endometrial hyperplasia.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 673 · Sex Cord-Stromal Tumours · **Hard** · C2

A 58-year-old woman has a solid right ovarian mass, ascites and a right pleural effusion. Cytology of both fluids is negative. After removal of the mass, the ascites and effusion resolve. Histology shows a benign spindle cell tumour.

What is the diagnosis?

A. Brenner tumour
B. Krukenberg tumour
C. Meigs' syndrome (ovarian fibroma)
D. Pseudo-Meigs from carcinoma
E. Stage IV ovarian cancer

Answer: C. Meigs' syndrome (ovarian fibroma)

Meigs' syndrome is the triad of a benign ovarian fibroma, ascites and pleural effusion, which resolve after tumour removal. It can mimic advanced cancer, so cytology is important.

Why not the others

- **A:** Brenner tumours rarely cause this triad.
- **B:** Krukenberg tumours are metastatic carcinoma.
- **D:** Pseudo-Meigs is with other tumours; this is a fibroma.
- **E:** Cytology is negative and the fluid resolves after removal.

Key point: CA-125 can be raised in Meigs' syndrome.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 674 · Germ Cell Tumours · **Hard** · C2

A 35-year-old woman has palpitations, weight loss and heat intolerance. TSH is suppressed. Thyroid scan shows low uptake in the neck. She has a 6 cm complex ovarian mass containing fat and calcification.

What is the most likely diagnosis?

A. Choriocarcinoma
B. Graves' disease
C. Struma ovarii
D. Thyroid storm
E. Toxic multinodular goitre

Answer: C. Struma ovarii

Struma ovarii is a teratoma composed mainly of thyroid tissue, which can secrete thyroid hormone and cause hyperthyroidism. The neck uptake is low because the ovarian tissue is the source. Removal is curative.

Why not the others

- **A:** Choriocarcinoma raises hCG.
- **B:** Graves' disease shows high neck uptake.
- **D:** Thyroid storm is a clinical emergency, not a diagnosis of the source.
- **E:** A toxic goitre shows high neck uptake.

Key point: Low radioiodine uptake in the neck with hyperthyroidism: think thyroiditis, exogenous thyroxine or struma ovarii.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 675 · Ovarian Cysts in Pregnancy · **Moderate** · C3

A 26-year-old woman at 12 weeks of pregnancy has a 5 cm simple ovarian cyst seen on her dating scan. She has no pain.

What is the most appropriate management?

A. Aspirate the cyst under ultrasound
B. Immediate laparoscopic cystectomy
C. Laparotomy and oophorectomy
D. Reassurance; most such cysts are corpus luteum cysts that resolve by 16 weeks
E. Terminate the pregnancy

Answer: D. Reassurance; most such cysts are corpus luteum cysts that resolve by 16 weeks

Simple cysts in early pregnancy are usually corpus luteum cysts that resolve by the second trimester. Conservative management with a repeat scan is appropriate unless there is pain, torsion or suspicious features.

Why not the others

- **A:** Aspiration is not needed.
- **B:** Surgery in pregnancy carries risks and is not needed.
- **C:** Removing the ovary is unnecessary and may remove the corpus luteum.
- **E:** There is no reason to terminate.

Key point: If surgery is needed in pregnancy, the second trimester is the safest time.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 676 · Benign Ovarian Tumours · **Moderate** · C2

A 40-year-old woman has a 15 cm thin-walled multilocular cyst with numerous septa and thick mucoid content. CA-125 is normal. Histology shows a benign tumour lined by mucin-secreting columnar epithelium.

What is the diagnosis?

A. Endometrioma
B. Mature cystic teratoma
C. Mucinous cystadenoma
D. Serous cystadenoma
E. Theca lutein cyst

Answer: C. Mucinous cystadenoma

Mucinous cystadenomas are typically large and multilocular, with mucin-secreting epithelium. They can become very large. Surgery should avoid rupture, which can spill mucin.

Why not the others

- **A:** An endometrioma has ground-glass content.
- **B:** A dermoid contains fat and hair.
- **D:** Serous cystadenomas are usually unilocular.
- **E:** Theca lutein cysts occur with high hCG.

Key point: Mucinous tumours can be extremely large.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 677 · Benign Ovarian Tumours · **Easy** · C2

A 24-year-old woman with a known 7 cm dermoid cyst has sudden severe one-sided pelvic pain with vomiting.

What is the commonest acute complication of a dermoid cyst?

A. Haemorrhage
B. Infection
C. Malignant change
D. Rupture
E. Torsion

Answer: E. Torsion

Dermoid cysts are heavy because of their fat and tissue content and often lie on a pedicle, so torsion is the commonest complication. Rupture is rare but causes chemical peritonitis. Malignant change (usually squamous) is rare and occurs in older women.

Why not the others

- **A:** Haemorrhage is uncommon.
- **B:** Infection is rare.
- **C:** Malignant change occurs in under 2%.
- **D:** Rupture is rare.

Key point: Sudden pain with a known dermoid = torsion until proved otherwise.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 678 · Benign Ovarian Tumours · **Hard** · C2

A 65-year-old woman has a 10 cm ovarian mass with fat and calcification but also a large solid enhancing area. Histology after removal shows squamous cell carcinoma arising within a mature cystic teratoma.

What does this represent?

A. Immature teratoma
B. Krukenberg tumour
C. Malignant transformation of a mature cystic teratoma
D. Metastatic cervical cancer
E. Struma ovarii

Answer: C. Malignant transformation of a mature cystic teratoma

Rarely (under 2%), a mature cystic teratoma undergoes malignant transformation, most often to squamous cell carcinoma, usually in postmenopausal women. Prognosis depends on stage.

Why not the others

- **A:** Immature teratomas contain embryonic neural tissue and occur in young women.
- **B:** Krukenberg tumours are metastatic signet-ring carcinoma.
- **D:** The tumour arises within the teratoma.
- **E:** Struma ovarii is a teratoma of thyroid tissue.

Key point: A solid enhancing component in a dermoid in an older woman needs careful assessment.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary; Malignant disease of the ovary

MCQ 679 · Germ Cell Tumours · **Hard** · C2

A 16-year-old girl has a large solid and cystic ovarian mass. Histology shows a teratoma containing immature neuroectodermal (neural) tissue.

What is the diagnosis?

A. Dermoid cyst
B. Dysgerminoma
C. Immature teratoma
D. Mature cystic teratoma
E. Struma ovarii

Answer: C. Immature teratoma

Immature teratomas are malignant germ cell tumours containing immature embryonic tissue, usually neuroectoderm. They occur in children and young women. Grade depends on the amount of immature neural tissue. Higher-grade tumours need chemotherapy.

Why not the others

- **A:** A dermoid (mature teratoma) contains only mature tissue.
- **B:** Dysgerminoma has a different histology.
- **D:** Mature teratomas lack immature tissue.
- **E:** Struma ovarii contains thyroid tissue.

Key point: Fertility-sparing surgery is usually possible.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 680 · Sex Cord-Stromal Tumours · **Moderate** · C2

A 52-year-old woman had a granulosa cell tumour removed 12 years ago. She now has abdominal discomfort and a pelvic mass. Inhibin B is raised.

What is characteristic of adult granulosa cell tumours?

A. They never recur
B. They occur only in children
C. They produce AFP
D. They recur late, sometimes decades after treatment
E. They secrete androgens mainly

Answer: D. They recur late, sometimes decades after treatment

Adult granulosa cell tumours have a long natural history and can recur many years or decades after initial treatment. Long-term follow-up with inhibin measurement is needed.

Why not the others

- **A:** They can recur.
- **B:** Adult type occurs mainly in perimenopausal and postmenopausal women.
- **C:** AFP is a yolk sac tumour marker.
- **E:** They mainly secrete oestrogen.

Key point: Call–Exner bodies and coffee-bean nuclei are characteristic histological features.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 681 · Germ Cell Tumours · **Hard** · C2

A 20-year-old woman who has never been pregnant has an ovarian mass and a very high serum hCG. She has never had sex and pregnancy is excluded.

Which ovarian tumour is most likely?

A. Dysgerminoma
B. Granulosa cell tumour
C. Non-gestational choriocarcinoma
D. Serous cystadenoma
E. Yolk sac tumour

Answer: C. Non-gestational choriocarcinoma

Non-gestational choriocarcinoma of the ovary is a rare germ cell tumour secreting high levels of hCG. It is distinguished from gestational choriocarcinoma by genetic analysis and responds to multi-agent chemotherapy.

Why not the others

- **A:** Dysgerminoma may raise hCG mildly but mainly LDH.
- **B:** Granulosa tumours raise inhibin.
- **D:** Serous cystadenomas are benign and do not raise hCG.
- **E:** Yolk sac tumours raise AFP.

Key point: Germ cell markers: AFP (yolk sac), hCG (choriocarcinoma), LDH (dysgerminoma).

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 682 · Benign Ovarian Tumours · **Moderate** · C2

A 32-year-old woman with a molar pregnancy has bilateral enlarged multilocular ovarian cysts.

What are these cysts?

A. Dermoid cysts
B. Endometriomas
C. Mucinous cystadenomas
D. Serous cystadenocarcinoma
E. Theca lutein cysts

Answer: E. Theca lutein cysts

Theca lutein cysts are caused by very high hCG stimulating the ovaries, as in molar pregnancy, multiple pregnancy or ovarian hyperstimulation. They regress as hCG falls and need no surgery unless torted.

Why not the others

- **A:** Dermoids are not caused by hCG.
- **B:** Endometriomas are unrelated.
- **C:** Mucinous tumours are unrelated.
- **D:** Cancer is unlikely.

Key point: Avoid unnecessary surgery; they resolve with falling hCG.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary; Gestational trophoblastic disease

MCQ 683 · Benign Ovarian Tumours · **Easy** · C2

At laparoscopy for a 5 cm adnexal cyst, a 34-year-old woman is found to have a thin-walled cyst separate from the ovary, lying between the tube and the ovary in the broad ligament.

What is this cyst?

A. Corpus luteum cyst
B. Dermoid cyst
C. Endometrioma
D. Follicular cyst
E. Paraovarian (paratubal) cyst

Answer: E. Paraovarian (paratubal) cyst

Paraovarian cysts arise from Wolffian or Müllerian remnants in the broad ligament, separate from the ovary. They are usually benign and can be removed laparoscopically if large or symptomatic.

Why not the others

- **A:** A corpus luteum cyst is within the ovary.
- **B:** A dermoid is within the ovary.
- **C:** An endometrioma is within the ovary.
- **D:** A follicular cyst is within the ovary.

Key point: Seeing a normal ovary separate from the cyst on scan suggests a paraovarian cyst.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 684 · Protective Factors · **Easy** · C2

A 30-year-old woman whose aunt died of ovarian cancer asks what lowers her risk.

Which factor reduces the risk of epithelial ovarian cancer?

A. Endometriosis
B. Infertility treatment
C. Long-term combined oral contraceptive use
D. Nulliparity
E. Obesity

Answer: C. Long-term combined oral contraceptive use

The combined pill reduces ovarian cancer risk by about 20% for every 5 years of use, with protection lasting decades. Pregnancy, breastfeeding, tubal ligation and salpingectomy are also protective.

Why not the others

- **A:** Endometriosis slightly increases clear cell and endometrioid cancer risk.
- **B:** Infertility itself may increase risk slightly.
- **D:** Nulliparity increases risk.
- **E:** Obesity slightly increases risk.

Key point: Incessant ovulation theory: fewer ovulations = lower risk.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 685 · Origin of Ovarian Cancer · **Hard** · C2

A 40-year-old BRCA2 carrier has risk-reducing salpingo-oophorectomy. Histology of the fimbria shows serous tubal intraepithelial carcinoma (STIC) with no invasive cancer.

What does this finding support?

A. High-grade serous "ovarian" cancer often originates in the fallopian tube
B. Ovarian cancer arises only from the ovarian surface
C. Salpingectomy has no role in prevention
D. STIC is always benign
E. The tubes should be kept at hysterectomy

Answer: A. High-grade serous "ovarian" cancer often originates in the fallopian tube

STIC lesions in the fimbriae are now considered the precursor of many high-grade serous cancers. This supports removing the tubes (opportunistic salpingectomy) during other pelvic surgery to reduce ovarian cancer risk.

Why not the others

- **B:** Many cancers arise from the tube.
- **C:** Salpingectomy reduces risk.
- **D:** STIC is a precursor of cancer.
- **E:** Removing the tubes is recommended.

Key point: Women with STIC need oncology review and may need staging.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 686 · Treatment · **Moderate** · C3

A 72-year-old woman has stage IV ovarian cancer with a large tumour burden and poor performance status. Biopsy confirms high-grade serous carcinoma.

What is the most appropriate initial treatment?

A. Immediate ultra-radical surgery
B. Neoadjuvant chemotherapy followed by interval debulking surgery if she responds
C. Pelvic radiotherapy
D. Tamoxifen alone
E. Watchful waiting

Answer: B. Neoadjuvant chemotherapy followed by interval debulking surgery if she responds

For women unlikely to have complete resection upfront or who are not fit for major surgery, neoadjuvant carboplatin and paclitaxel (usually 3 cycles), then interval debulking surgery and further chemotherapy, gives similar survival with less surgical morbidity.

Why not the others

- **A:** Ultra-radical surgery is risky in a frail woman.
- **C:** Radiotherapy has little role.
- **D:** Tamoxifen is not first line.
- **E:** Treatment can improve survival and symptoms.

Key point: Histological diagnosis (biopsy) is needed before neoadjuvant chemotherapy.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 687 · Follow-up · **Hard** · C3

A 60-year-old woman finished chemotherapy for ovarian cancer 14 months ago. Her CA-125 has risen from 12 to 45 U/mL, but she has no symptoms and CT shows no measurable disease.

What is the most appropriate management?

A. Discuss options; early treatment based on CA-125 alone has not been shown to improve survival
B. Hysterectomy
C. Immediate chemotherapy in all women
D. PET scan every week
E. Radiotherapy

Answer: A. Discuss options; early treatment based on CA-125 alone has not been shown to improve survival

A trial (MRC OV05) showed that starting chemotherapy based on a rising CA-125 alone, before symptoms, did not improve survival and reduced quality of life time. Options are discussed with the woman; imaging and clinical review continue.

Why not the others

- **B:** Hysterectomy has already been done or is not relevant.
- **C:** Immediate treatment does not improve survival.
- **D:** Weekly scans are not appropriate.
- **E:** Radiotherapy is not standard.

Key point: Recurrence more than 6 months after platinum (platinum-sensitive) responds well to platinum again.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 688 · Treatment · **Moderate** · C2

A 63-year-old woman's ovarian cancer recurs 18 months after carboplatin and paclitaxel.

How is this recurrence classified and treated?

A. Platinum-refractory; avoid platinum
B. Platinum-resistant; use radiotherapy only
C. Platinum-sensitive; platinum-based chemotherapy is likely to work again
D. Primary cancer; repeat staging surgery always
E. Untreatable

Answer: C. Platinum-sensitive; platinum-based chemotherapy is likely to work again

Recurrence more than 6 months after finishing platinum chemotherapy is platinum-sensitive and is usually treated with platinum-based chemotherapy again, sometimes followed by PARP inhibitor maintenance. Secondary surgery may be considered in selected cases.

Why not the others

- **A:** Refractory disease progresses during treatment.
- **B:** Resistant disease recurs within 6 months.
- **D:** It is a recurrence, not a new primary.
- **E:** Treatment can control disease for years.

Key point: Time since last platinum is the key factor in choosing treatment.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 689 · Palliative Care · **Moderate** · C3

A 68-year-old woman with advanced ovarian cancer has tense ascites causing breathlessness and abdominal discomfort.

What is the most appropriate symptomatic treatment?

A. Fluid restriction alone
B. High-dose diuretics as first line
C. Laparotomy
D. Therapeutic paracentesis
E. Whole abdomen radiotherapy

Answer: D. Therapeutic paracentesis

Draining malignant ascites by paracentesis quickly relieves symptoms. Recurrent ascites may need repeated drainage or an indwelling peritoneal catheter. Diuretics are less effective for malignant ascites.

Why not the others

- **A:** Fluid restriction does not relieve tense ascites.
- **B:** Diuretics have limited effect.
- **C:** Laparotomy is not needed for symptom control.
- **E:** Radiotherapy is not used for ascites.

Key point: Malignant bowel obstruction is another common palliative problem.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 690 · Surgery · **Moderate** · C2

During laparoscopic removal of a 6 cm ovarian cyst in a 55-year-old woman, the cyst ruptures. Final histology shows stage I high-grade serous carcinoma confined to that ovary.

How does intraoperative rupture affect staging?

A. It has no effect
B. It makes it stage IIA
C. It makes it stage IIIC
D. It upstages to IC1 (surgical spill)
E. It upstages to stage IV

Answer: D. It upstages to IC1 (surgical spill)

Intraoperative rupture (surgical spill) of a cancer confined to the ovary upstages it to IC1, which usually means adjuvant chemotherapy is needed. This is why suspicious masses should be removed intact, often in a bag.

Why not the others

- **A:** Rupture changes the stage.
- **B:** IIA is extension to the uterus or tubes.
- **C:** IIIC is extensive peritoneal disease.
- **E:** Stage IV is distant spread.

Key point: Remove suspicious masses intact, in an endobag.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 691 · Low-grade Serous Carcinoma · **Hard** · C2

A 45-year-old woman has a low-grade serous ovarian carcinoma, oestrogen receptor-positive, with residual disease after surgery.

What is characteristic of low-grade serous carcinoma?

A. It always has BRCA mutations
B. It arises from germ cells
C. It is highly sensitive to chemotherapy
D. It is identical to high-grade serous carcinoma
E. It is slow-growing, relatively chemoresistant and often hormone-sensitive

Answer: E. It is slow-growing, relatively chemoresistant and often hormone-sensitive

Low-grade serous carcinoma is a different disease from high-grade serous. It often arises from borderline tumours, grows slowly, responds poorly to chemotherapy, often has KRAS/BRAF mutations, and may respond to hormone therapy such as letrozole.

Why not the others

- **A:** BRCA mutations are typical of high-grade serous cancer.
- **B:** It is epithelial.
- **C:** It is relatively chemoresistant.
- **D:** It differs in genetics and behaviour.

Key point: Aromatase inhibitors are used as maintenance in some patients.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 692 · Tumour Markers · **Moderate** · C2

A 50-year-old woman has a large complex mucinous-looking ovarian mass. CA-125 is normal but CEA and CA19-9 are raised.

What do raised CEA and CA19-9 with a normal CA-125 suggest?

A. Endometrioma
B. Germ cell tumour
C. Granulosa cell tumour
D. Mucinous tumour, or metastasis from the gastrointestinal tract
E. Serous carcinoma

Answer: D. Mucinous tumour, or metastasis from the gastrointestinal tract

Mucinous ovarian tumours and gastrointestinal metastases often raise CEA and CA19-9 rather than CA-125. A raised CEA should prompt assessment of the bowel to exclude a primary gastrointestinal cancer.

Why not the others

- **A:** Endometriomas can raise CA-125 and CA19-9 but not usually CEA.
- **B:** Germ cell tumours raise AFP, hCG or LDH.
- **C:** Granulosa tumours raise inhibin.
- **E:** Serous carcinomas usually raise CA-125.

Key point: A CA-125:CEA ratio under 25 suggests a gastrointestinal origin.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 693 · Germ Cell Tumours · **Moderate** · C3

A 24-year-old woman with a malignant ovarian germ cell tumour needs chemotherapy after surgery.

Which chemotherapy regimen is standard?

A. BEP (bleomycin, etoposide, cisplatin)
B. Carboplatin and paclitaxel
C. Letrozole
D. Methotrexate alone
E. Tamoxifen

Answer: A. BEP (bleomycin, etoposide, cisplatin)

BEP is the standard regimen for malignant germ cell tumours, with cure rates over 90%. Bleomycin can cause lung toxicity, so lung function is monitored.

Why not the others

- **B:** Carboplatin and paclitaxel are for epithelial cancer.
- **C:** Letrozole is hormone therapy.
- **D:** Methotrexate alone is for low-risk GTN.
- **E:** Tamoxifen is not used.

Key point: Germ cell tumours are among the most curable cancers in young women.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 694 · Risk of Malignancy Index · **Moderate** · C3

A 47-year-old premenopausal woman has a 7 cm multilocular ovarian cyst with no solid areas. CA-125 is 40 U/mL. Her RMI is calculated as 120.

How should she be managed?

A. Gynae-oncology centre surgery is mandatory

B. Laparoscopic management in a general gynaecology unit with appropriate expertise

C. No follow-up

D. Palliative care

E. Repeat scan in 5 years

Answer: B. Laparoscopic management in a general gynaecology unit with appropriate expertise

An RMI of 25–250 is moderate risk. Many of these women can be managed by a gynaecologist with appropriate expertise. RMI over 250 (or over 200 in some guidance) suggests high risk and referral to a gynae-oncology team.

Why not the others

- **A:** Oncology referral is for high-risk masses.
- **C:** A symptomatic or complex 7 cm cyst needs management.
- **D:** There is no evidence of advanced cancer.
- **E:** Five years is too long.

Key point: Use RMI together with clinical judgement and ultrasound features.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 695 · Fertility-sparing Surgery · **Hard** · C3

A 29-year-old woman has stage IA grade 1 endometrioid ovarian cancer confined to the right ovary after full staging. The left ovary, uterus and peritoneal biopsies are normal. She wants children.

What is the most appropriate management?

A. Chemotherapy and bilateral oophorectomy

B. Completion hysterectomy and BSO immediately

C. Fertility-sparing surgery (keep uterus and left ovary) with close follow-up

D. Pelvic radiotherapy

E. Watch without any surgery

Answer: C. Fertility-sparing surgery (keep uterus and left ovary) with close follow-up

Women with stage IA low-grade epithelial ovarian cancer who want fertility can keep the uterus and other ovary after careful staging. Completion surgery is discussed after childbearing.

Why not the others

- **A:** Chemotherapy is not usually needed for IA grade 1.
- **B:** Radical surgery is not required for this low-risk case.
- **D:** Radiotherapy is not used.
- **E:** She has already had surgery and staging; follow-up continues.

Key point: Careful staging is essential before fertility-sparing management.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

MCQ 696 · Benign Ovarian Tumours · **Easy** · C2

A 52-year-old woman has a 5 cm solid ovarian mass. Histology shows a benign tumour composed of fibroblasts and lipid-laden theca cells, producing oestrogen. She had postmenopausal bleeding.

What is the diagnosis?

A. Brenner tumour
B. Dysgerminoma
C. Serous cystadenoma
D. Thecoma
E. Yolk sac tumour

Answer: D. Thecoma

Thecomas are benign sex cord-stromal tumours of postmenopausal women that may produce oestrogen, causing endometrial hyperplasia and bleeding. Endometrial assessment is needed.

Why not the others

- **A:** Brenner tumours contain transitional epithelium.
- **B:** Dysgerminoma is a germ cell tumour of young women.
- **C:** Serous cystadenoma is cystic and epithelial.
- **E:** Yolk sac tumours occur in young women and raise AFP.

Key point: Oestrogen-secreting ovarian tumours can cause endometrial cancer.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 697 · Benign Ovarian Tumours · **Moderate** · C2

An incidental 2 cm solid ovarian nodule is removed during hysterectomy in a 60-year-old woman. Histology shows nests of transitional (urothelial-type) epithelium with coffee-bean nuclei in a fibrous stroma.

What is the diagnosis?

A. Brenner tumour
B. Granulosa cell tumour
C. Krukenberg tumour
D. Mucinous cystadenoma
E. Sertoli–Leydig cell tumour

Answer: A. Brenner tumour

Brenner tumours are usually small, benign, solid tumours containing transitional epithelium in a fibrous stroma. They are often found incidentally.

Why not the others

- **B:** Granulosa tumours also have coffee-bean nuclei but form Call–Exner bodies without transitional nests.
- **C:** Krukenberg tumours have signet-ring cells.
- **D:** Mucinous tumours are cystic with mucinous epithelium.
- **E:** Sertoli–Leydig tumours have tubules and Leydig cells.

Key point: Brenner tumours are sometimes associated with mucinous tumours.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 698 · Surgery · **Easy** · C3

A 30-year-old woman needs surgery for a 7 cm dermoid cyst. She wants to keep her fertility.

What is the preferred surgical approach?

A. Laparoscopic ovarian cystectomy, preserving the ovary
B. Laparotomy and bilateral oophorectomy
C. Leave the cyst until menopause
D. Total hysterectomy
E. Ultrasound-guided aspiration

Answer: A. Laparoscopic ovarian cystectomy, preserving the ovary

Laparoscopic cystectomy with preservation of normal ovarian tissue is the preferred treatment for benign cysts such as dermoids in young women. Spillage should be minimised and the specimen removed in a bag.

Why not the others

- **B:** Removing both ovaries ends fertility.
- **C:** A 7 cm dermoid risks torsion.
- **D:** Hysterectomy is not indicated.
- **E:** Aspiration of dermoids causes spillage and recurrence.

Key point: Spillage of dermoid contents can cause chemical peritonitis; wash out thoroughly.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary

MCQ 699 · Ovarian Cancer Presentation · **Moderate** · C3

A 52-year-old woman's CA-125 is 85 U/mL after she presented with bloating. Ultrasound shows a 6 cm complex ovarian mass and ascites.

What is the most appropriate next step?

A. Laparoscopic cystectomy in a general unit
B. Reassure; CA-125 is often raised
C. Repeat CA-125 in 1 year
D. Start the combined pill
E. Urgent referral to a gynaecological oncology team with CT imaging

Answer: E. Urgent referral to a gynaecological oncology team with CT imaging

A complex ovarian mass with ascites and raised CA-125 in a woman over 50 strongly suggests ovarian cancer. She needs urgent referral to a gynaecological oncology multidisciplinary team, with CT chest, abdomen and pelvis to stage the disease.

Why not the others

- **A:** Laparoscopic cystectomy risks spill and inadequate staging.
- **B:** These features need urgent investigation.
- **C:** Waiting is unsafe.
- **D:** The pill is not a treatment.

Key point: Treatment in specialist centres improves ovarian cancer survival.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary; NICE CG122

MCQ 700 · Hereditary Ovarian Cancer · **Moderate** · C2

A 42-year-old woman with a BRCA2 mutation asks when she should consider risk-reducing salpingo-oophorectomy.

What is the usual recommended age range for BRCA2 carriers?

A. 20–25
B. 25–30
C. 30–35
D. 40–45
E. 60–65

Answer: D. 40–45

Because BRCA2-related ovarian cancer tends to occur later, risk-reducing salpingo-oophorectomy is usually recommended at 40–45 (35–40 for BRCA1), after childbearing.

Why not the others

- **A:** Too early; risk is very low.
- **B:** Too early for BRCA2.
- **C:** Slightly early for BRCA2; appropriate for BRCA1 from 35.
- **E:** Too late; risk has accumulated.

Key point: Discuss HRT, bone health and heart health after surgical menopause.

Reference: Gynaecology by Ten Teachers — Malignant disease of the ovary

CHAPTER 15

Vulval and Vaginal Disease

MCQ 701 · Lichen Sclerosus · **Moderate** · C3

A 66-year-old woman has had intense vulval itching for a year, worse at night. Examination shows white, thin, shiny, wrinkled skin in a figure-of-eight pattern around the vulva and anus, with fusion of the labia minora and narrowing of the introitus. There is no ulcer or lump.

What is the most appropriate first-line treatment?

A. Clobetasol propionate 0.05% ointment
B. Oral fluconazole
C. Simple vulvectomy
D. Topical imiquimod cream
E. Topical oestrogen cream

Answer: A. Clobetasol propionate 0.05% ointment

This is lichen sclerosus, a chronic inflammatory skin condition. An ultrapotent topical steroid (clobetasol propionate 0.05%), given as a reducing course over 3 months and then for flares, controls symptoms and may lower the risk of cancer. Long-term follow-up is needed because about 3–5% develop vulval squamous cell carcinoma.

Why not the others

- **B:** Fluconazole treats candidiasis, which gives red inflamed skin with discharge, not white atrophic plaques.
- **C:** Vulvectomy is for invasive cancer, not lichen sclerosus.
- **D:** Imiquimod is used for vulval intraepithelial neoplasia and warts.
- **E:** Topical oestrogen treats atrophic vaginitis but does not control lichen sclerosus.

Key point: Biopsy any lichen sclerosus area that ulcerates, thickens or fails to respond to steroids, to exclude squamous cell carcinoma.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina; BAD guideline

MCQ 702 · Lichen Sclerosus · **Moderate** · C2

A 7-year-old girl has vulval itching, soreness and painful constipation. Examination shows white, wrinkled skin around the vulva and anus with small bruises (purpura). Her parents are worried about abuse.

What is the most likely diagnosis?

A. Candidiasis
B. Lichen sclerosus
C. Pinworm infestation
D. Psoriasis
E. Sexual abuse with no skin disease

Answer: B. Lichen sclerosus

Lichen sclerosus occurs in prepubertal girls, causing itch, white atrophic skin in a figure-of-eight, purpura and fissures that can cause painful defecation. The bruising can be mistaken for abuse; careful assessment is needed. Treatment is potent topical steroid.

Why not the others

- **A:** Candida is uncommon in prepubertal girls and does not cause white atrophic skin.
- **C:** Pinworms cause perianal itch at night without skin atrophy.
- **D:** Psoriasis causes well-defined red plaques.
- **E:** Abuse must always be considered, but the skin findings indicate lichen sclerosus.

Key point: Lichen sclerosus can coexist with abuse; assess sensitively.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina; Paediatric gynaecology

MCQ 703 · Lichen Sclerosus · **Moderate** · C3

A 60-year-old woman with lichen sclerosus has been well controlled on clobetasol ointment. She asks about long-term follow-up.

What is the most important long-term advice?

A. Annual vulvectomy
B. Long-term follow-up with self-examination; report any new lump, ulcer or persistent soreness
C. No follow-up needed after symptoms settle
D. Stop steroids permanently once itch settles
E. Use soap daily to clean the area

Answer: B. Long-term follow-up with self-examination; report any new lump, ulcer or persistent soreness

Lichen sclerosus carries a lifetime risk of vulval squamous cell carcinoma of about 3–5%. Women should continue maintenance steroid as needed, check their vulva regularly and report any new lump, ulcer or non-healing area for biopsy.

Why not the others

- **A:** Vulvectomy is not indicated.
- **C:** Follow-up is needed because of cancer risk.
- **D:** Many need ongoing maintenance treatment.
- **E:** Soaps irritate; emollients and soap substitutes are advised.

Key point: Good control with steroids may reduce cancer risk.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 704 · Lichen Planus · **Hard** · C2

A 55-year-old woman has painful erosions of the vulva and vagina, with bleeding after intercourse. She also has painful mouth ulcers and white lace-like streaks on the buccal mucosa. The vagina is narrowed by adhesions.

What is the most likely diagnosis?

A. Behçet's disease
B. Erosive lichen planus
C. Lichen sclerosus
D. Lichen simplex chronicus
E. Pemphigus vulgaris

Answer: B. Erosive lichen planus

Erosive lichen planus affects mucosal surfaces, causing painful erosions of the vulva and vagina with scarring and adhesions. Oral involvement with Wickham's striae (vulvovaginal-gingival syndrome) is typical. Treatment is potent topical steroids and dilators.

Why not the others

- **A:** Behçet's causes recurrent ulcers but not Wickham's striae or vaginal adhesions.
- **C:** Lichen sclerosus rarely involves the vagina.
- **D:** Lichen simplex causes thickened skin from scratching.
- **E:** Pemphigus causes flaccid blisters.

Key point: Lichen planus involves the vagina; lichen sclerosus usually spares it.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 705 · Lichen Simplex Chronicus · **Moderate** · C2

A 40-year-old woman has severe vulval itching for a year, worse at night and with stress. The labia majora show thickened, leathery skin with exaggerated skin markings. There is no whitening or scarring.

What is the most likely diagnosis?

A. Lichen planus
B. Lichen sclerosus
C. Lichen simplex chronicus
D. Paget's disease
E. Vulval intraepithelial neoplasia

Answer: C. Lichen simplex chronicus

Lichen simplex chronicus results from an itch–scratch cycle, causing thickened (lichenified) skin. It is treated by breaking the cycle with topical steroids, emollients, avoiding irritants and sedating antihistamines at night.

Why not the others

- **A:** Lichen planus causes erosions or purple papules.
- **B:** Lichen sclerosus causes white, thin skin and scarring.
- **D:** Paget's disease gives red velvety plaques.
- **E:** VIN causes raised or pigmented lesions; biopsy if unsure.

Key point: Look for an underlying trigger such as eczema or candida.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 706 · Vulvodynia · **Moderate** · C2

A 28-year-old woman has burning pain at the vaginal entrance during intercourse and when inserting tampons for 2 years. The vulva looks normal. Light touch with a cotton bud at the vestibule reproduces sharp pain.

What is the most likely diagnosis?

A. Candidiasis
B. Genital herpes
C. Lichen sclerosus
D. Provoked vestibulodynia
E. Vaginismus only

Answer: D. Provoked vestibulodynia

Provoked vestibulodynia is pain at the vestibule on touch, with a normal-looking vulva and a positive cotton-swab test. It is a type of vulvodynia (vulval pain for over 3 months with no clear cause).

Why not the others

- **A:** Candida causes itching and discharge; swabs would be positive.
- **B:** Herpes causes ulcers.
- **C:** Lichen sclerosus has visible skin changes.
- **E:** Vaginismus is involuntary muscle spasm; it may coexist but does not explain the vestibular tenderness.

Key point: Vulvodynia is a diagnosis of exclusion; check for infection and skin disease.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 707 · Vulvodynia · **Moderate** · C3

A 35-year-old woman has constant unprovoked burning vulval pain for 1 year. Examination and swabs are normal. Topical treatments have not helped.

Which treatment is most appropriate?

A. Long-term antifungals
B. Low-dose amitriptyline (or other neuropathic agents) with a multidisciplinary approach
C. Potent topical steroid for life
D. Surgical vulvectomy
E. Systemic antibiotics

Answer: B. Low-dose amitriptyline (or other neuropathic agents) with a multidisciplinary approach

Generalised vulvodynia is neuropathic pain. Treatment includes neuropathic drugs (amitriptyline, gabapentin, pregabalin), pelvic floor physiotherapy, psychosexual therapy and avoiding irritants. A multidisciplinary approach works best.

Why not the others

- **A:** Antifungals do not help without infection.
- **C:** Steroids do not treat neuropathic pain.
- **D:** Vulvectomy is not appropriate.
- **E:** Antibiotics are not indicated.

Key point: Vestibulectomy is reserved for selected women with provoked vestibulodynia.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 708 · Vulval Intraepithelial Neoplasia · **Moderate** · C2

A 38-year-old woman who smokes has multifocal raised white and pigmented plaques on the labia. She had CIN 3 treated 5 years ago. Biopsy shows high-grade squamous intraepithelial lesion of the vulva (usual-type VIN).

Which factor is most strongly associated with this type of VIN?

A. Candida infection
B. High-risk HPV infection
C. Lichen sclerosus
D. Obesity
E. Psoriasis

Answer: B. High-risk HPV infection

Usual-type VIN (HSIL) is related to high-risk HPV, especially type 16, and occurs in younger women, often with multifocal genital tract disease (CIN, VAIN) and smoking. Differentiated VIN is associated with lichen sclerosus in older women.

Why not the others

- **A:** Candida is not a cause.
- **C:** Lichen sclerosus is linked to differentiated VIN.
- **D:** Obesity is not a key factor.
- **E:** Psoriasis is not linked.

Key point: Stopping smoking improves outcomes.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 709 · Vulval Intraepithelial Neoplasia · **Hard** · C3

A 42-year-old woman has a 2 cm area of biopsy-proven usual-type VIN (HSIL) on the left labium minus, with no invasion. She is keen to avoid disfiguring surgery.

Which treatments are appropriate?

A. Chemotherapy
B. Pelvic radiotherapy
C. Radical vulvectomy
D. Topical imiquimod or local excision
E. Total hysterectomy

Answer: D. Topical imiquimod or local excision

VIN can be treated by local excision (which gives histology to exclude invasion), laser ablation, or topical imiquimod (an immune modifier), particularly for multifocal usual-type VIN. Long-term follow-up is needed because of recurrence.

Why not the others

- **A:** Chemotherapy is not used.
- **B:** Radiotherapy is not used.
- **C:** Radical surgery is for cancer.
- **E:** Hysterectomy does not treat VIN.

Key point: Differentiated VIN should be excised because of a higher risk of cancer.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 710 · Vulval Cancer · **Easy** · C2

A 76-year-old woman has a painful, bleeding ulcer on the right labium majus for 3 months. She has had vulval itching for years. Biopsy confirms cancer.

What is the commonest histological type of vulval cancer?

A. Adenocarcinoma
B. Basal cell carcinoma
C. Melanoma
D. Sarcoma
E. Squamous cell carcinoma

Answer: E. Squamous cell carcinoma

About 90% of vulval cancers are squamous cell carcinomas. Most occur in older women and are associated with lichen sclerosus (differentiated VIN) or, in younger women, HPV-related VIN.

Why not the others

- **A:** Adenocarcinoma (e.g. Bartholin gland) is rare.
- **B:** Basal cell carcinoma is uncommon.
- **C:** Melanoma is the second commonest but rare.
- **D:** Sarcoma is very rare.

Key point: Any non-healing vulval lesion needs biopsy.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 711 · Vulval Cancer · **Moderate** · C3

A 70-year-old woman has a 3 cm unifocal squamous cell carcinoma of the right labium majus, 2 cm from the midline. There are no palpable groin nodes and imaging shows no nodal disease.

What is the most appropriate surgical management?

A. Bilateral inguinofemoral lymphadenectomy and radical vulvectomy
B. Laser ablation
C. Radical wide local excision with sentinel lymph node biopsy of the right groin
D. Simple excision only
E. Topical imiquimod

Answer: C. Radical wide local excision with sentinel lymph node biopsy of the right groin

Early-stage vulval cancer under 4 cm, unifocal, with clinically negative nodes is treated by radical wide local excision with clear margins and sentinel node biopsy (ipsilateral for lateral tumours). This avoids the high morbidity of full groin dissection.

Why not the others

- **A:** Radical vulvectomy and full lymphadenectomy carry high morbidity and are not needed.
- **B:** Laser is for VIN.
- **D:** Simple excision without node assessment is inadequate.
- **E:** Imiquimod is for VIN.

Key point: Full inguinofemoral lymphadenectomy causes lymphoedema and wound breakdown in many women.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 712 · Vulval Cancer · **Hard** · C3

A 72-year-old woman has a 1.5 cm squamous carcinoma of the vulva with only 0.8 mm depth of invasion after excision with clear margins.

Is groin node assessment needed?

A. Bilateral full lymphadenectomy
B. Groin radiotherapy
C. No; stage IA tumours (≤2 cm and ≤1 mm invasion) have negligible nodal risk
D. Pelvic node dissection
E. Yes, sentinel node biopsy in all cases

Answer: C. No; stage IA tumours (≤2 cm and ≤1 mm invasion) have negligible nodal risk

Stage IA vulval cancer (≤2 cm diameter and stromal invasion ≤1 mm) has a negligible risk of nodal spread, so groin node assessment is not required. Wide local excision alone is adequate.

Why not the others

- **A:** Lymphadenectomy is unnecessary.
- **B:** Radiotherapy is unnecessary.
- **D:** Pelvic nodes are not the first station.
- **E:** Sentinel biopsy is needed when invasion exceeds 1 mm.

Key point: Depth of invasion determines the need for groin assessment.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 713 · Vulval Cancer · **Moderate** · C2

A 74-year-old woman had bilateral inguinofemoral lymphadenectomy for vulval cancer 3 months ago. Both legs are now swollen.

What is the most likely cause?

A. Cellulitis only
B. Deep vein thrombosis in both legs
C. Heart failure
D. Hypoalbuminaemia
E. Lymphoedema

Answer: E. Lymphoedema

Lymphoedema is a common long-term complication of groin node dissection (up to 30–60%). Sentinel node biopsy reduces this risk. Treatment includes compression, skin care and lymphatic drainage.

Why not the others

- **A:** Cellulitis may complicate lymphoedema but does not explain bilateral swelling alone.
- **B:** Bilateral DVT is possible but less likely; it should be excluded if acute.
- **C:** Heart failure is less likely here.
- **D:** Hypoalbuminaemia causes generalised oedema.

Key point: Wound breakdown and infection are early complications of groin surgery.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 714 · Paget's Disease · **Hard** · C2

A 68-year-old woman has a well-defined red, velvety, eczema-like plaque on the vulva with white islands, not responding to steroid creams for a year. Biopsy shows large pale cells with abundant cytoplasm in the epidermis.

What is the diagnosis?

A. Candidiasis
B. Extramammary Paget's disease of the vulva
C. Lichen planus
D. Lichen simplex chronicus
E. Psoriasis

Answer: B. Extramammary Paget's disease of the vulva

Extramammary Paget's disease is an intraepithelial adenocarcinoma presenting as a red, velvety, eczema-like plaque. It may be associated with an underlying adenocarcinoma (skin adnexa, bladder, bowel or breast). Wide excision is needed but recurrence is common.

Why not the others

- **A:** Candida responds to antifungals and shows hyphae.
- **C:** Lichen planus has different histology.
- **D:** Lichen simplex has thickened epidermis without Paget cells.
- **E:** Psoriasis has different histology.

Key point: Biopsy any vulval "eczema" that does not respond to treatment.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 715 · Vulval Melanoma · **Hard** · C2

A 60-year-old woman has a pigmented lesion on the labium minus that has enlarged and become irregular in colour over 6 months.

What is the most appropriate management?

A. Cryotherapy
B. Excision biopsy with a narrow margin for diagnosis
C. Laser ablation
D. Reassure and review in 2 years
E. Topical steroid

Answer: B. Excision biopsy with a narrow margin for diagnosis

A changing pigmented vulval lesion needs excision biopsy to exclude melanoma. Vulval melanoma is the second commonest vulval cancer, often presenting late with a poor prognosis. Destructive treatments must not be used.

Why not the others

- **A:** Cryotherapy destroys tissue without histology.
- **C:** Laser destroys tissue without histology.
- **D:** Delay is dangerous.
- **E:** Steroids do not treat pigmented lesions.

Key point: Remember the ABCDE of pigmented lesions (asymmetry, border, colour, diameter, evolution).

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 716 · Vulval Ulcers · **Moderate** · C2

A 26-year-old woman has recurrent painful vulval ulcers, recurrent mouth ulcers, and an episode of painful red eye (uveitis). Herpes swabs are negative.

What is the most likely diagnosis?

A. Behçet's disease
B. Crohn's disease
C. Lichen sclerosus
D. Primary syphilis
E. Recurrent herpes

Answer: A. Behçet's disease

Behçet's disease is a vasculitis causing recurrent oral and genital ulcers, eye inflammation (uveitis) and skin lesions. Genital ulcers may scar. Treatment includes topical steroids, colchicine and immunosuppressants.

Why not the others

- **B:** Crohn's disease causes knife-cut fissures and perianal disease.
- **C:** Lichen sclerosus does not cause oral ulcers or uveitis.
- **D:** Syphilis causes a single painless ulcer.
- **E:** Herpes swabs are negative.

Key point: Behçet's is more common along the old Silk Road, including the Middle East.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 717 · Vulval Ulcers · **Hard** · C2

A 14-year-old girl, who has never been sexually active, develops a sudden, very painful, deep vulval ulcer a week after a flu-like illness with sore throat. Herpes and syphilis tests are negative.

What is the most likely diagnosis?

A. Behçet's disease
B. Chancroid
C. Lipschütz ulcer (acute genital ulceration)
D. Primary herpes
E. Sexual abuse with syphilis

Answer: C. Lipschütz ulcer (acute genital ulceration)

Lipschütz ulcers are acute, painful, non-sexually acquired genital ulcers in young girls, often after a viral illness such as Epstein–Barr virus. They heal within weeks with analgesia and care, without scarring.

Why not the others

- **A:** Behçet's is recurrent with oral ulcers.
- **B:** Chancroid is sexually transmitted.
- **D:** Herpes tests are negative.
- **E:** Tests are negative; abuse should still be considered sensitively.

Key point: Lipschütz ulcers are not sexually transmitted.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina; Paediatric gynaecology

MCQ 718 · Hidradenitis Suppurativa · **Moderate** · C2

A 30-year-old obese woman who smokes has recurrent painful nodules, abscesses and sinus tracts with scarring in both groins, the labia majora and the armpits.

What is the most likely diagnosis?

A. Bartholin abscess
B. Furunculosis only
C. Hidradenitis suppurativa
D. Lymphogranuloma venereum
E. Sebaceous cysts

Answer: C. Hidradenitis suppurativa

Hidradenitis suppurativa is a chronic inflammatory disease of hair follicles in the groins, vulva, buttocks and armpits, with recurrent nodules, abscesses, sinus tracts and scarring. Smoking and obesity worsen it. Treatment includes weight loss, stopping smoking, antibiotics, biologics and surgery.

Why not the others

- **A:** A Bartholin abscess is single and in the vestibule.
- **B:** Boils do not form sinus tracts in multiple sites.
- **D:** LGV causes nodes, not recurrent axillary disease.
- **E:** Sebaceous cysts are not inflamed sinus tracts.

Key point: Involvement of the armpits as well as groins is a clue.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 719 · Contact Dermatitis · **Easy** · C3

A 32-year-old woman has vulval redness, burning and itching since she started using scented wipes and a new soap. There is no discharge and swabs are negative.

What is the most appropriate management?

A. Antifungal cream
B. Biopsy
C. Oral antibiotics
D. Stop irritants, use emollient soap substitutes and a short course of mild topical steroid
E. Vulvectomy

Answer: D. Stop irritants, use emollient soap substitutes and a short course of mild topical steroid

Irritant or allergic contact dermatitis is common on the vulva. Stopping soaps, wipes and perfumed products, using emollients as soap substitutes, and a short course of topical steroid usually settles it.

Why not the others

- **A:** There is no candida.
- **B:** Biopsy is not needed for a typical picture that responds.
- **C:** Antibiotics are not needed.
- **E:** Surgery is not indicated.

Key point: Many vulval problems are worsened by over-washing.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 720 · Vaginal Cancer · **Moderate** · C2

A 68-year-old woman has vaginal bleeding. Examination shows a 2 cm firm, ulcerated lesion on the upper posterior vaginal wall. She had a hysterectomy for benign disease 20 years ago.

Which statement about vaginal cancer is correct?

A. It is the commonest gynaecological cancer
B. It never needs biopsy
C. It occurs mainly in teenagers
D. Metastases to the vagina from other sites are more common than primary vaginal cancer
E. Primary vaginal cancer is usually adenocarcinoma

Answer: D. Metastases to the vagina from other sites are more common than primary vaginal cancer

Primary vaginal cancer is rare (about 1–2% of gynaecological cancers); most are squamous, HPV-related and occur in older women. Secondary spread from the cervix, endometrium, vulva, bladder or bowel is more common. Biopsy is essential.

Why not the others

- **A:** It is one of the rarest gynaecological cancers.
- **B:** Biopsy is essential.
- **C:** It occurs mainly in older women.
- **E:** Most primary vaginal cancers are squamous.

Key point: Clear cell adenocarcinoma of the vagina is linked to in-utero DES exposure.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vagina

MCQ 721 · Female Genital Mutilation · **Moderate** · C2

A 24-year-old woman from a country where female genital mutilation is common has difficulty with intercourse and urination. Examination shows that the labia have been cut and sewn together, leaving a small opening.

Which WHO type of female genital mutilation is this?

A. Type 1
B. Type 2
C. Type 3 (infibulation)
D. Type 4
E. Not FGM

Answer: C. Type 3 (infibulation)

WHO type 3 FGM (infibulation) narrows the vaginal opening by cutting and joining the labia, with or without removal of the clitoris. It causes urinary problems, painful intercourse and obstructed labour. Deinfibulation can be performed.

Why not the others

- **A:** Type 1 is removal of the clitoral glans and/or prepuce.
- **B:** Type 2 is removal of the clitoris and labia minora without narrowing.
- **D:** Type 4 includes other harmful procedures such as pricking or cutting.
- **E:** This is FGM.

Key point: FGM is a human rights violation and is illegal in many countries; document and follow local safeguarding law.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 722 · Vaginal Discharge · **Easy** · C2

A 19-year-old woman asks whether her white vaginal discharge is normal. It varies with her cycle, is clear or white, not itchy and has no smell.

What is the most appropriate response?

A. Antibiotics
B. Antifungal treatment
C. Colposcopy
D. Physiological discharge; reassure
E. Vaginal douching

Answer: D. Physiological discharge; reassure

Physiological discharge is clear or white, varies with the menstrual cycle (more around ovulation and in pregnancy or on the pill), and has no itch, smell or soreness. Reassurance is appropriate.

Why not the others

- **A:** There is no infection.
- **B:** There is no candida.
- **C:** Colposcopy is not indicated.
- **E:** Douching disrupts normal flora and increases infection.

Key point: Offer STI testing if she has risk factors.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 723 · Vulval Varicosities · **Easy** · C2

A 30-year-old woman at 30 weeks of pregnancy has a soft, bluish, compressible swelling of the right labium majus that is worse on standing and disappears when she lies down.

What is the most likely diagnosis?

A. Bartholin cyst
B. Inguinal hernia
C. Vulval cancer
D. Vulval haematoma
E. Vulval varicosities

Answer: E. Vulval varicosities

Vulval varicosities are common in pregnancy due to increased venous pressure and progesterone. They usually improve after delivery. Supportive underwear helps.

Why not the others

- **A:** A Bartholin cyst is in the posterior vestibule and not compressible.
- **B:** A hernia has a cough impulse and bowel sounds.
- **C:** Cancer is unlikely in pregnancy and is firm.
- **D:** A haematoma is tense and painful after trauma.

Key point: Varicosities rarely cause problems in labour.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 724 · Vulval Biopsy · **Moderate** · C3

A 70-year-old woman with long-standing lichen sclerosus has developed a new 1 cm raised, firm area on the right labium minus that has not responded to 4 weeks of steroid treatment.

What is the most appropriate next step?

A. Biopsy the lesion
B. Increase steroid strength and review in 1 year
C. Laser ablation
D. Reassure
E. Stop all treatment

Answer: A. Biopsy the lesion

A new raised, thickened, ulcerated or non-healing area in lichen sclerosus must be biopsied to exclude differentiated VIN or squamous cell carcinoma.

Why not the others

- **B:** Delay could miss cancer.
- **C:** Ablation destroys tissue without diagnosis.
- **D:** Reassurance is unsafe.
- **E:** Stopping treatment does not address the lesion.

Key point: Biopsy under local anaesthetic is simple and quick.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 725 · Lichen Sclerosus · **Easy** · C2

A 58-year-old woman with lichen sclerosus asks which areas the condition affects.

Which area is usually spared by lichen sclerosus?

A. Clitoral hood
B. Labia minora
C. Perianal skin
D. Perineum
E. Vagina

Answer: E. Vagina

Lichen sclerosus affects the vulval and perianal skin in a figure-of-eight pattern, but almost never the vagina. Vaginal involvement suggests lichen planus.

Why not the others

- **A:** The clitoral hood is commonly affected, sometimes burying the clitoris.
- **B:** The labia minora are commonly affected and may resorb.
- **C:** Perianal skin is commonly affected.
- **D:** The perineum is commonly affected.

Key point: Lichen sclerosus = skin; lichen planus = skin and mucosa (vagina, mouth).

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 726 · Lichen Sclerosus · **Moderate** · C3

A 62-year-old woman with newly diagnosed lichen sclerosus is starting clobetasol propionate 0.05% ointment.

What is a typical initial regimen?

A. A single application only
B. Apply once daily for 4 weeks, then alternate days for 4 weeks, then twice weekly for 4 weeks
C. Apply only during flares lasting more than a year
D. Apply three times daily indefinitely
E. Apply weekly for 1 year

Answer: B. Apply once daily for 4 weeks, then alternate days for 4 weeks, then twice weekly for 4 weeks

The usual regimen is clobetasol once daily for a month, then alternate days for a month, then twice weekly for a month, then as needed for maintenance. A 30 g tube should last about 3 months. Used correctly, side effects on vulval skin are rare.

Why not the others

- **A:** One application is insufficient.
- **C:** Untreated disease risks scarring.
- **D:** Three times daily indefinitely risks skin atrophy.
- **E:** Weekly use is too infrequent initially.

Key point: Emollients and soap substitutes are used alongside steroids.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina; BAD guideline

MCQ 727 · Vulval Skin Disease · **Moderate** · C2

A 35-year-old woman has well-defined, symmetrical, white patches on the vulva with no itching, no scarring and normal skin texture. She has similar patches on her hands.

What is the most likely diagnosis?

A. Lichen planus
B. Lichen sclerosus
C. Psoriasis
D. Vitiligo
E. Vulval intraepithelial neoplasia

Answer: D. Vitiligo

Vitiligo causes depigmented white patches with normal skin texture, no itch and no scarring. Lichen sclerosus causes itchy, thin, crinkled, fragile skin with scarring.

Why not the others

- **A:** Lichen planus causes erosions or purple papules.
- **B:** Lichen sclerosus is itchy with textural change and scarring.
- **C:** Vulval psoriasis is red and well-defined.
- **E:** VIN is raised and may be pigmented.

Key point: Vitiligo needs no treatment on the vulva; reassure.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 728 · Vulval Skin Disease · **Moderate** · C2

A 40-year-old woman with plaque psoriasis on her elbows has itchy, well-defined bright red plaques on the labia majora and in the natal cleft, without silvery scale.

What is the most likely diagnosis?

A. Candidiasis
B. Lichen sclerosus
C. Paget's disease
D. Psoriasis
E. Tinea cruris

Answer: D. Psoriasis

Genital and flexural psoriasis appear as well-defined red plaques, often without scale because of moisture. Psoriasis elsewhere supports the diagnosis. Treatment is mild to moderate topical steroids and vitamin D analogues.

Why not the others

- **A:** Candida has satellite lesions and discharge.
- **B:** Lichen sclerosus causes white skin.
- **C:** Paget's disease is usually in older women and unresponsive to steroids.
- **E:** Tinea has an active scaly edge.

Key point: Natal cleft involvement is a clue to psoriasis.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 729 · Vulval Skin Disease · **Hard** · C2

A 26-year-old woman with known Crohn's disease has painful vulval swelling with linear "knife-cut" fissures in the skin folds and perianal skin tags.

What is the most likely diagnosis?

A. Behçet's disease
B. Genital herpes
C. Hidradenitis suppurativa
D. Lichen planus
E. Vulval Crohn's disease

Answer: E. Vulval Crohn's disease

Crohn's disease can affect the vulva by direct spread or as "metastatic" disease, causing swelling, linear knife-cut ulcers, fissures, fistulas and skin tags. Biopsy shows non-caseating granulomas.

Why not the others

- **A:** Behçet's causes round ulcers with oral ulcers.
- **B:** Herpes causes small painful vesicles.
- **C:** Hidradenitis causes nodules and sinuses in follicular areas.
- **D:** Lichen planus causes erosions and white striae.

Key point: Vulval Crohn's disease may precede bowel symptoms.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 730 · Normal Variants · **Easy** · C3

A 24-year-old woman is worried about tiny, soft, symmetrical finger-like projections on the inner labia minora. They are not itchy and each projection arises separately from the skin.

What is the most likely diagnosis?

A. Condylomata lata
B. Genital warts
C. Molluscum contagiosum
D. Vestibular papillomatosis
E. Vulval cancer

Answer: D. Vestibular papillomatosis

Vestibular papillomatosis is a normal anatomical variant: symmetrical, soft, separate papillae on the inner labia minora and vestibule. It is often mistaken for warts. No treatment is needed.

Why not the others

- **A:** Condylomata lata are flat moist papules of syphilis.
- **B:** Warts are asymmetrical, with several projections arising from a common base.
- **C:** Molluscum are pearly umbilicated papules.
- **E:** Cancer is unlikely in a young woman with symmetrical papillae.

Key point: Avoid unnecessary wart treatment for normal variants.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 731 · Vulval Cancer · **Hard** · C3

A 71-year-old woman had wide local excision of a 3 cm vulval squamous cancer. The right groin sentinel node contains a 4 mm metastasis.

What is the most appropriate further management?

A. Chemotherapy alone
B. No further treatment
C. Pelvic exenteration
D. Right inguinofemoral lymphadenectomy or groin radiotherapy (with or without chemotherapy)
E. Topical imiquimod

Answer: D. Right inguinofemoral lymphadenectomy or groin radiotherapy (with or without chemotherapy)

A positive sentinel node needs further treatment of the groin. Metastases over 2 mm are usually treated with full inguinofemoral lymphadenectomy and/or chemoradiation, as observation leads to high groin recurrence.

Why not the others

- **A:** Chemotherapy alone is not standard.
- **B:** Groin recurrence is often fatal.
- **C:** Exenteration is not indicated.
- **E:** Imiquimod is for VIN.

Key point: Groin recurrence of vulval cancer is very hard to treat.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 732 · Vulval Cancer · **Hard** · C3

An 80-year-old woman has a 7 cm vulval cancer involving the lower urethra and lower vagina, with fixed, ulcerated groin nodes.

What is the most appropriate primary treatment?

A. Chemoradiation, with surgery considered after

B. Laser ablation

C. Radical vulvectomy with urethral resection as the only option

D. Simple excision under local anaesthetic

E. Topical steroids

Answer: A. Chemoradiation, with surgery considered after

Locally advanced vulval cancer with fixed nodes is usually treated with chemoradiation, which may shrink the tumour and avoid exenterative surgery. Surgery may follow if residual disease is resectable.

Why not the others

- **B:** Laser is for VIN.
- **C:** Radical surgery would be very mutilating and may not clear fixed nodes.
- **D:** Simple excision is inadequate.
- **E:** Steroids do not treat cancer.

Key point: Fixed or ulcerated groin nodes make it stage IVA.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 733 · Vulval Cancer · **Moderate** · C2

A 75-year-old woman asks why vulval cancer is often diagnosed late.

What is the commonest reason for delayed diagnosis?

A. It always spreads to the lungs first

B. It causes no symptoms

C. It is only found at post-mortem

D. It only occurs in the vagina

E. Itching and soreness are often treated as infection for a long time without examination or biopsy

Answer: E. Itching and soreness are often treated as infection for a long time without examination or biopsy

Vulval cancer often presents with long-standing itching, soreness or a lump. Embarrassment and treatment of symptoms as "thrush" without examination lead to delay. Any persistent vulval symptom should be examined and suspicious lesions biopsied.

Why not the others

- **A:** Spread is usually to groin nodes first.
- **B:** It usually causes symptoms.
- **C:** It is diagnosed clinically and by biopsy.
- **D:** It occurs on the vulva.

Key point: Always examine women with persistent vulval symptoms.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 734 · Bartholin Gland Carcinoma · **Hard** · C3

A 58-year-old woman has a painless, firm 3 cm swelling in the region of the left Bartholin gland for 4 months. It has not responded to antibiotics.

What is the most appropriate next step?

A. Antibiotics for another month
B. Biopsy or excision of the gland for histology
C. Marsupialisation without histology
D. Reassure
E. Word catheter insertion

Answer: B. Biopsy or excision of the gland for histology

A new Bartholin swelling in women over 40, especially if firm or persistent, must be biopsied or excised to exclude Bartholin gland carcinoma, which is rare but often diagnosed late.

Why not the others

- **A:** Antibiotics delay diagnosis.
- **C:** Marsupialisation without histology may miss cancer.
- **D:** Reassurance is unsafe.
- **E:** A Word catheter is for simple cysts or abscesses.

Key point: Bartholin gland cancers include adenocarcinoma and squamous carcinoma.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 735 · Vaginal Intraepithelial Neoplasia · **Moderate** · C2

A 52-year-old woman had a hysterectomy 3 years ago for CIN 3 with incomplete excision. Vault cytology now shows high-grade dyskaryosis.

What is the most likely diagnosis?

A. Endometrial cancer
B. Ovarian cancer
C. Vaginal atrophy only
D. Vaginal intraepithelial neoplasia (VAIN)
E. Vulval cancer

Answer: D. Vaginal intraepithelial neoplasia (VAIN)

Women with CIN at hysterectomy, especially with incomplete excision, are at risk of VAIN at the vaginal vault. Follow-up vault cytology and colposcopy are needed. Treatment includes excision, laser or imiquimod.

Why not the others

- **A:** Endometrial cancer cannot occur without a uterus.
- **B:** Ovarian cancer does not cause abnormal vault cytology.
- **C:** Atrophy can give abnormal cells, but high-grade dyskaryosis needs colposcopy.
- **E:** Vulval cancer is not shown by vault cytology.

Key point: VAIN is often associated with HPV and other genital tract neoplasia.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vagina

MCQ 736 · Vaginal Cancer · **Hard** · C2

A 22-year-old woman has vaginal bleeding. A biopsy of a vaginal lesion shows clear cell adenocarcinoma. Her mother took a drug in pregnancy to prevent miscarriage in the 1970s.

Which drug exposure in utero is linked to clear cell adenocarcinoma of the vagina?

A. Diethylstilboestrol
B. Folic acid
C. Methyldopa
D. Paracetamol
E. Thalidomide

Answer: A. Diethylstilboestrol

In-utero exposure to diethylstilboestrol (DES), used until the early 1970s, is linked to vaginal adenosis, clear cell adenocarcinoma in young women, and uterine and cervical anomalies.

Why not the others

- **B:** Folic acid prevents neural tube defects.
- **C:** Methyldopa is safe in pregnancy.
- **D:** Paracetamol is not linked.
- **E:** Thalidomide causes limb defects.

Key point: DES is no longer used in pregnancy.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vagina

MCQ 737 · Vaginal Cancer · **Moderate** · C3

A 70-year-old woman has a 3 cm primary squamous cell carcinoma of the upper vagina, without spread beyond the vaginal wall on MRI.

What is the usual primary treatment?

A. Chemotherapy alone
B. Hormone therapy
C. Observation
D. Radiotherapy (external beam with brachytherapy)
E. Topical imiquimod

Answer: D. Radiotherapy (external beam with brachytherapy)

Most primary vaginal cancers are treated with radiotherapy (external beam and brachytherapy), often with chemotherapy, because surgery would require removing the vagina and possibly bladder or rectum. Small upper vaginal tumours may be treated surgically.

Why not the others

- **A:** Chemotherapy alone is not curative.
- **B:** Hormones have no role.
- **C:** Cancer needs treatment.
- **E:** Imiquimod is for VAIN.

Key point: Vaginal cancer is managed in gynae-oncology centres.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vagina

MCQ 738 · Vaginal Discharge · **Moderate** · C3

A 35-year-old woman has a very offensive brown vaginal discharge for 2 weeks. She thinks she forgot to remove a tampon after her period.

What is the most appropriate management?

A. Antifungal cream
B. Colposcopy
C. Hysteroscopy
D. Remove the tampon and advise; watch for signs of toxic shock syndrome
E. Start long-term antibiotics

Answer: D. Remove the tampon and advise; watch for signs of toxic shock syndrome

A retained tampon causes offensive discharge. Removal usually resolves symptoms. Women should be warned to seek help urgently if they develop fever, rash, vomiting or feeling unwell, which may indicate toxic shock syndrome.

Why not the others

- **A:** Antifungals do not treat a foreign body.
- **B:** Colposcopy is not needed.
- **C:** Hysteroscopy is not needed.
- **E:** Long-term antibiotics are not needed.

Key point: Retained condoms and pessaries also cause offensive discharge.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 739 · Vaginitis · **Hard** · C2

A 50-year-old woman has a purulent yellow vaginal discharge with burning and painful intercourse. Vaginal pH is 6. Microscopy shows many white cells and parabasal cells, with no clue cells, trichomonas or yeasts. She is not atrophic on HRT.

What is the most likely diagnosis?

A. Bacterial vaginosis
B. Candidiasis
C. Desquamative inflammatory vaginitis
D. Physiological discharge
E. Trichomoniasis

Answer: C. Desquamative inflammatory vaginitis

Desquamative inflammatory vaginitis causes purulent discharge, raised pH, many white cells and parabasal cells without infection. It responds to topical clindamycin or hydrocortisone.

Why not the others

- **A:** BV has clue cells and few white cells.
- **B:** Candida shows yeasts and normal pH.
- **D:** Physiological discharge has no inflammation.
- **E:** Trichomonas would be seen or detected by NAAT.

Key point: Exclude trichomonas with NAAT before diagnosing DIV.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 740 · Female Genital Mutilation · **Moderate** · C3

A 26-year-old woman with type 3 female genital mutilation (infibulation) is 20 weeks pregnant. Examination shows the opening is too small to allow vaginal examination.

What is the recommended management?

A. Caesarean section is mandatory
B. Deinfibulation, ideally in the second trimester, after counselling
C. Leave it until labour without planning
D. Re-infibulation after delivery on request
E. Terminate the pregnancy

Answer: B. Deinfibulation, ideally in the second trimester, after counselling

Deinfibulation is recommended for women with type 3 FGM, ideally antenatally (around 20 weeks) or early in labour, after counselling. It allows vaginal examination and vaginal birth. Re-infibulation is illegal in many countries and harmful.

Why not the others

- **A:** Caesarean is not needed because of FGM alone.
- **C:** Planning ahead reduces complications.
- **D:** Re-infibulation is harmful and often illegal.
- **E:** There is no reason to terminate.

Key point: Follow national safeguarding laws for FGM, including the risk to daughters.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 741 · Vulval Cysts · **Easy** · C2

A 45-year-old woman has several small, firm, yellow-white, painless nodules on the labia majora. Some have a central punctum and release cheesy material when squeezed.

What is the most likely diagnosis?

A. Bartholin cysts
B. Epidermoid (sebaceous) cysts
C. Hidradenitis suppurativa
D. Molluscum contagiosum
E. Vulval cancer

Answer: B. Epidermoid (sebaceous) cysts

Epidermoid cysts are common on the labia majora, containing keratin. They are harmless and need no treatment unless infected or troublesome, when they can be excised.

Why not the others

- **A:** Bartholin cysts are in the posterior vestibule.
- **C:** Hidradenitis causes painful nodules and sinuses.
- **D:** Molluscum are pearly umbilicated papules.
- **E:** Cancer is single and growing.

Key point: Multiple small cysts on the labia majora are common and benign.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 742 · Vulval Haematoma · **Moderate** · C3

A 28-year-old woman has a rapidly expanding, very painful 8 cm vulval haematoma 2 hours after a vaginal delivery. She is tachycardic.

What is the most appropriate management?

A. Antibiotics only
B. Apply ice and wait 48 hours
C. Evacuate the haematoma and ligate bleeding vessels in theatre, with resuscitation
D. Needle aspiration on the ward
E. Reassure

Answer: C. Evacuate the haematoma and ligate bleeding vessels in theatre, with resuscitation

Large or expanding vulval haematomas after delivery need surgical evacuation and haemostasis under anaesthesia, with resuscitation and blood if needed. Small stable haematomas can be managed conservatively.

Why not the others

- **A:** Antibiotics do not stop bleeding.
- **B:** Waiting risks major blood loss.
- **D:** Aspiration does not stop bleeding.
- **E:** An expanding haematoma is an emergency.

Key point: Check for vaginal extension of the haematoma.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina; Postnatal care

MCQ 743 · Vulval Cancer · **Moderate** · C2

A 70-year-old woman with lichen sclerosus develops vulval squamous cell carcinoma. The pathologist identifies the precursor lesion.

Which precursor lesion is associated with lichen sclerosus?

A. CIN 3
B. Differentiated VIN (HPV-independent)
C. Paget cells
D. Usual-type VIN (HPV-related)
E. VAIN

Answer: B. Differentiated VIN (HPV-independent)

In older women, vulval cancer often arises from differentiated VIN (dVIN) in a background of lichen sclerosus and is HPV-independent with p53 mutations. Usual-type VIN is HPV-related and occurs in younger women.

Why not the others

- **A:** CIN is cervical.
- **C:** Paget cells indicate Paget's disease.
- **D:** Usual-type VIN is HPV-related, mainly in younger women.
- **E:** VAIN is vaginal.

Key point: dVIN is subtle clinically and progresses to cancer faster than usual-type VIN.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 744 · Vulval Basal Cell Carcinoma · **Hard** · C2

An 80-year-old woman has a slowly growing 1.5 cm pearly nodule with rolled edges and telangiectasia on the labium majus. Groin nodes are not enlarged.

What is the most likely diagnosis and treatment?

A. Basal cell carcinoma treated by local excision
B. Melanoma treated by radiotherapy
C. Paget's disease treated by imiquimod
D. Squamous carcinoma treated by radical vulvectomy
E. Wart treated by cryotherapy

Answer: A. Basal cell carcinoma treated by local excision

Basal cell carcinoma of the vulva is uncommon, slow-growing and rarely metastasises. It presents as a pearly nodule with rolled edges. Local excision with clear margins is curative.

Why not the others

- **B:** Melanoma is pigmented and treated surgically.
- **C:** Paget's is a red velvety plaque.
- **D:** Radical vulvectomy is not needed.
- **E:** This is not a wart.

Key point: Groin node assessment is not needed for BCC.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 745 · Vulval Disease · **Moderate** · C3

A 40-year-old woman has had vulval itching for 6 months. Her GP has given four courses of antifungal cream without improvement. Swabs have been negative.

What is the most appropriate next step?

A. Another antifungal course
B. Careful examination of the vulva, with biopsy if any abnormality
C. Long-term oral fluconazole
D. Reassure that it is thrush
E. Stop all creams and review in a year

Answer: B. Careful examination of the vulva, with biopsy if any abnormality

Persistent vulval itching that does not respond to antifungals with negative swabs is unlikely to be candida. Careful examination is needed to look for lichen sclerosus, lichen simplex, dermatitis, VIN or cancer, with biopsy if uncertain.

Why not the others

- **A:** Repeating failed treatment delays diagnosis.
- **C:** Without candida, fluconazole is not appropriate.
- **D:** Negative swabs and no response argue against thrush.
- **E:** Waiting delays diagnosis.

Key point: "Recurrent thrush" with negative swabs is often a skin condition.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 746 · Vulval Cancer Staging · **Hard** · C2

A 68-year-old woman has a 3 cm squamous cell carcinoma of the vulva with 4 mm depth of invasion, confined to the vulva. Groin nodes are negative.

What is the FIGO stage (2021)?

A. IA
B. IB
C. II
D. IIIA
E. IVA

Answer: B. IB

FIGO stage IB vulval cancer is confined to the vulva or perineum, either over 2 cm or with stromal invasion over 1 mm, with negative nodes. Stage IA is 2 cm or less and invasion of 1 mm or less.

Why not the others

- **A:** IA requires ≤2 cm and ≤1 mm invasion.
- **C:** Stage II involves the lower urethra, vagina or anus.
- **D:** IIIA involves upper urethra or vagina, bladder or rectal mucosa, or small nodal metastases.
- **E:** IVA involves fixed nodes or pelvic bone.

Key point: Staging is based on surgical pathology.

Reference: Gynaecology by Ten Teachers — Malignant disease of the vulva

MCQ 747 · Lichen Sclerosus · **Hard** · C3

A 55-year-old woman with long-standing lichen sclerosus has severe narrowing of the introitus from scarring, making intercourse impossible. Her disease is now quiet on maintenance steroids.

What is the most appropriate treatment for the narrowing?

A. Laser ablation of the vulval skin
B. Perineoplasty or division of adhesions, with continued steroid treatment
C. Radical vulvectomy
D. Radiotherapy
E. Systemic antibiotics

Answer: B. Perineoplasty or division of adhesions, with continued steroid treatment

When lichen sclerosus is controlled but scarring narrows the introitus, surgical division of adhesions or a perineoplasty can restore function. Steroids continue after surgery to prevent recurrence.

Why not the others

- **A:** Laser does not treat scarring and is not standard.
- **C:** Vulvectomy is for cancer.
- **D:** Radiotherapy is harmful.
- **E:** Antibiotics do not treat scarring.

Key point: Operate only when the disease is well controlled.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 748 · Vulval Pain · **Moderate** · C2

A 30-year-old woman has pain at the vaginal entrance during intercourse. Examination shows tight, tender pelvic floor muscles and involuntary tightening when an examination is attempted. The vulval skin is normal.

Which treatment is most appropriate?

A. Antifungal cream
B. Hysterectomy
C. Pelvic floor physiotherapy with relaxation and graded vaginal trainers
D. Topical clobetasol
E. Vestibulectomy as first line

Answer: C. Pelvic floor physiotherapy with relaxation and graded vaginal trainers

Pelvic floor muscle overactivity (vaginismus) often accompanies vulval pain. Pelvic floor physiotherapy, relaxation techniques, graded vaginal trainers and psychosexual therapy help. Surgery is not first line.

Why not the others

- **A:** There is no infection.
- **B:** Hysterectomy does not help.
- **D:** Steroids treat inflammatory skin disease.
- **E:** Vestibulectomy is for selected refractory provoked vestibulodynia.

Key point: Many women with vulval pain also have pelvic floor dysfunction.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina; Psychosexual medicine

MCQ 749 · Vulval Lesions · **Moderate** · C2

A 33-year-old woman has a soft, painless, pedunculated, skin-coloured 1 cm lesion on the labium majus that has been present for years and has not changed.

What is the most likely diagnosis?

A. Acrochordon (skin tag)
B. Melanoma
C. Squamous cell carcinoma
D. Syphilitic chancre
E. Vulval intraepithelial neoplasia

Answer: A. Acrochordon (skin tag)

Skin tags (acrochordons, fibroepithelial polyps) are soft, pedunculated, benign lesions that are common on the vulva. They can be removed if bothersome.

Why not the others

- **B:** Melanoma is pigmented and changing.
- **C:** SCC is firm, ulcerated and growing.
- **D:** A chancre is an ulcer.
- **E:** VIN is a flat or raised plaque, not pedunculated.

Key point: Remove lesions that change, bleed or are uncertain, and send for histology.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina

MCQ 750 · Vulval Ulcers · **Easy** · C3

A 23-year-old woman has a painful vulval ulcer. She is sexually active with a new partner.

Which test should be done first?

A. CT pelvis
B. HSV PCR swab from the ulcer, with syphilis serology
C. Pelvic MRI
D. Tumour markers
E. Vulval biopsy under general anaesthesia

Answer: B. HSV PCR swab from the ulcer, with syphilis serology

The commonest cause of genital ulcers in sexually active young women is herpes simplex. A swab for HSV PCR, plus syphilis serology (and other STI tests), is the first step.

Why not the others

- **A:** CT is not needed.
- **C:** MRI is not needed.
- **D:** Tumour markers are not relevant.
- **E:** Biopsy is for persistent or atypical ulcers.

Key point: Painful ulcer = usually herpes. Painless ulcer = consider syphilis.

Reference: Gynaecology by Ten Teachers — Conditions affecting the vulva and vagina; Sexually transmitted infections

Gynaecological Emergencies

MCQ 751 · Ovarian Torsion · **Moderate** · C3

A 19-year-old unmarried girl has sudden severe right iliac fossa pain with vomiting for 4 hours. A 7 cm right ovarian dermoid cyst was found on a scan 2 months ago. She is tender in the right iliac fossa with a tender adnexal mass. Pregnancy test is negative. Doppler shows reduced flow to the right ovary.

What is the most appropriate management?

A. Analgesia and repeat ultrasound in 24 hours
B. CT scan of the abdomen and pelvis
C. Laparoscopic detorsion and ovarian cystectomy
D. Laparoscopic right salpingo-oophorectomy
E. Laparotomy and right oophorectomy

Answer: C. Laparoscopic detorsion and ovarian cystectomy

Ovarian torsion is a surgical emergency. Urgent laparoscopy with untwisting of the ovary and removal of the cyst preserves fertility. Even a dark, congested ovary usually recovers after detorsion, so conservation is preferred in young women.

Why not the others

- **A:** Delay risks infarction and loss of the ovary.
- **B:** CT delays surgery and adds radiation; diagnosis is clinical and ultrasound-supported.
- **D:** Removing the ovary is unnecessary in a young woman; detorsion with conservation is preferred.
- **E:** Laparotomy and oophorectomy are more invasive and needlessly remove the ovary.

Key point: Normal Doppler flow does not exclude torsion. If clinical suspicion is high, go to laparoscopy.

Reference: Gynaecology by Ten Teachers — Benign conditions of the ovary; Acute gynaecology

MCQ 752 · Acute Pelvic Pain · **Easy** · C3

A 24-year-old woman attends the emergency department with lower abdominal pain for 6 hours. She is sexually active. Her last period was 6 weeks ago.

What is the most important first investigation?

A. Abdominal X-ray
B. CA-125
C. CT abdomen
D. Pregnancy test
E. Urine culture

Answer: D. Pregnancy test

A pregnancy test should be done in every woman of reproductive age with abdominal pain, to identify ectopic pregnancy, which is a life-threatening cause. It also guides imaging and drug choice.

Why not the others

- **A:** X-ray rarely helps in pelvic pain.
- **B:** CA-125 is not useful acutely.
- **C:** CT involves radiation and is not first line.
- **E:** Urine culture may help but is not the most important first test.

Key point: "Any woman of reproductive age with abdominal pain is pregnant until proved otherwise."

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 753 · Ovarian Torsion · **Moderate** · C2

A 25-year-old woman has sudden-onset severe left iliac fossa pain with nausea and vomiting for 3 hours. She has a known 6 cm left ovarian cyst. Pain comes in waves. She has low-grade fever.

Which factor most increases the risk of ovarian torsion?

A. An ovarian mass of 5 cm or more
B. Hypothyroidism
C. Previous caesarean section
D. Small ovaries
E. Use of the combined pill

Answer: A. An ovarian mass of 5 cm or more

Ovarian torsion is most likely with an ovarian mass of 5 cm or more, such as a dermoid or functional cyst, which acts as a lead point. Other risk factors include ovarian stimulation, pregnancy and a long infundibulopelvic ligament in children.

Why not the others

- **B:** Hypothyroidism is not a risk factor.
- **C:** Caesarean section is not a risk factor.
- **D:** Small ovaries are less likely to twist.
- **E:** The pill reduces functional cysts.

Key point: Torsion can occur with normal ovaries in children.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Benign conditions of the ovary

MCQ 754 · Ovarian Torsion · **Hard** · C3

A 14-year-old girl has sudden severe right lower abdominal pain with vomiting. Ultrasound shows an enlarged right ovary (6 cm) with peripheral follicles and a "whirlpool" sign. Doppler shows some arterial flow.

What is the most appropriate management?

A. Analgesia and discharge

B. CT scan and review in the morning

C. MRI and observe for 48 hours

D. Urgent laparoscopy with detorsion

E. Urgent laparotomy and oophorectomy

Answer: D. Urgent laparoscopy with detorsion

The whirlpool sign and enlarged oedematous ovary with peripheral follicles strongly suggest torsion. Doppler flow does not exclude it. Urgent laparoscopy with untwisting preserves the ovary in most cases, even if it looks dark.

Why not the others

- **A:** Discharge risks loss of the ovary.
- **B:** Delay risks infarction.
- **C:** Delay risks infarction.
- **E:** Oophorectomy is rarely needed; conserve the ovary.

Key point: Even a dark, congested ovary usually recovers after detorsion.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Paediatric gynaecology

MCQ 755 · Ovarian Torsion · **Hard** · C3

A 30-year-old woman at 10 weeks of pregnancy after IVF has sudden severe right-sided pelvic pain with vomiting. Ultrasound shows a 9 cm hyperstimulated right ovary with reduced flow.

What is the most appropriate management?

A. Conservative management until 20 weeks

B. Laparoscopic detorsion

C. Methotrexate

D. Terminate the pregnancy

E. Ultrasound-guided aspiration only

Answer: B. Laparoscopic detorsion

Ovarian torsion in pregnancy, particularly after ovarian stimulation, needs urgent surgery. Laparoscopy is safe in pregnancy and allows detorsion with ovarian preservation. Removing the corpus luteum before 10 weeks would require progesterone support.

Why not the others

- **A:** Delay risks ovarian loss and peritonitis.
- **C:** Methotrexate is for ectopic pregnancy.
- **D:** There is no reason to end the pregnancy.
- **E:** Aspiration alone does not untwist the ovary.

Key point: Torsion is more common in early pregnancy and after IVF.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Assisted conception

MCQ 756 · Haemorrhagic Cyst · **Moderate** · C3

A 28-year-old woman on warfarin for a mechanical heart valve has sudden abdominal pain on day 22 of her cycle. Pulse is 115/min and BP 90/60 mmHg. Pregnancy test is negative. Ultrasound shows a large amount of free fluid and a ruptured right corpus luteum cyst. INR is 4.2.

What is the most appropriate management?

A. Discharge with analgesia
B. Increase warfarin
C. Oral contraceptive and review in 1 week
D. Resuscitation, reversal of anticoagulation with specialist advice, and laparoscopy to control bleeding
E. Ultrasound in 6 weeks

Answer: D. Resuscitation, reversal of anticoagulation with specialist advice, and laparoscopy to control bleeding

Ruptured corpus luteum cysts can cause significant haemoperitoneum, especially in anticoagulated women. She is shocked, so she needs resuscitation, careful reversal of anticoagulation (with cardiology advice given her valve), and surgery to stop the bleeding.

Why not the others

- **A:** She is haemodynamically unstable.
- **B:** More anticoagulation worsens bleeding.
- **C:** The pill does not stop active bleeding.
- **E:** Delay is dangerous.

Key point: Women on long-term anticoagulants may benefit from ovulation suppression to prevent recurrence.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 757 · Uterine Perforation · **Moderate** · C3

During a surgical evacuation for incomplete miscarriage at 10 weeks, the dilator passes much further than expected and perforation is suspected. No suction has been applied. The patient is stable.

What is the most appropriate management?

A. Continue suction evacuation blindly
B. Discharge immediately
C. Hysterectomy
D. Laparotomy in all cases
E. Stop the procedure, observe and consider laparoscopy (with completion under direct vision if needed)

Answer: E. Stop the procedure, observe and consider laparoscopy (with completion under direct vision if needed)

If perforation is suspected, stop. A small fundal perforation by a blunt instrument without suction in a stable woman can be observed with antibiotics. Laparoscopy is done to check for bleeding or bowel injury, especially if suction was used, and evacuation completed under laparoscopic vision.

Why not the others

- **A:** Continuing blindly risks bowel and vessel injury.
- **B:** She needs observation.
- **C:** Hysterectomy is rarely needed.
- **D:** Laparotomy is needed only if there is major bleeding or bowel injury.

Key point: Perforation with suction applied risks bowel injury and needs laparoscopy.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Complications of surgery

MCQ 758 · Hysteroscopy Complications · **Hard** · C3

During hysteroscopic resection of a submucous fibroid using monopolar diathermy and 1.5% glycine, the fluid deficit reaches 1,200 mL. The patient becomes confused and nauseated. Sodium is 122 mmol/L.

What is the most likely complication?

A. Air embolism
B. Anaphylaxis
C. Fluid overload with dilutional hyponatraemia
D. Hypoglycaemia
E. Uterine perforation

Answer: C. Fluid overload with dilutional hyponatraemia

Absorption of hypotonic glycine during hysteroscopic surgery causes fluid overload and dilutional hyponatraemia, leading to confusion, nausea, seizures and cerebral oedema. The procedure should stop at a deficit of about 1,000 mL with glycine (2,500 mL with saline in bipolar systems).

Why not the others

- **A:** Air embolism causes sudden cardiovascular collapse.
- **B:** Anaphylaxis causes rash, wheeze and hypotension.
- **D:** Glucose is not affected.
- **E:** Perforation causes sudden fluid loss and bleeding, not hyponatraemia.

Key point: Monitor fluid deficit continuously during operative hysteroscopy.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 759 · Laparoscopy Complications · **Hard** · C3

During insertion of the primary laparoscopic trocar in a thin 25-year-old woman, there is sudden hypotension and blood is seen through the trocar. The camera shows a rapidly expanding retroperitoneal haematoma.

What is the most appropriate immediate action?

A. Continue the planned procedure

B. Immediate laparotomy, apply pressure and call a vascular surgeon

C. Insert more ports and observe

D. Remove the trocar and end the operation without exploring

E. Wait for a CT scan

Answer: B. Immediate laparotomy, apply pressure and call a vascular surgeon

Major vascular injury (aorta, iliac vessels) is a life-threatening complication of primary port entry, more likely in thin women. Immediate midline laparotomy with direct pressure, resuscitation and vascular surgical help is needed.

Why not the others

- **A:** Continuing is dangerous.
- **C:** Delay is fatal.
- **D:** Removing the trocar may increase bleeding; exploration is needed.
- **E:** CT would delay life-saving surgery.

Key point: Thin women have a short distance from umbilicus to aorta; angle trocars carefully.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 760 · Laparoscopy Complications · **Hard** · C2

A 35-year-old woman had a laparoscopic cystectomy 3 days ago and was discharged on day 1. She now has increasing abdominal pain, fever of 38.7°C, tachycardia and a distended tender abdomen.

What complication must be suspected?

A. Gas pain from the procedure

B. Normal postoperative recovery

C. Shoulder tip pain

D. Unrecognised bowel injury with peritonitis

E. Urinary retention

Answer: D. Unrecognised bowel injury with peritonitis

After laparoscopy, patients should feel better each day. Worsening pain, fever and tachycardia 2–4 days later suggest unrecognised bowel injury (often thermal) with peritonitis. Urgent CT and laparoscopy or laparotomy are needed.

Why not the others

- **A:** Gas pain settles and does not cause fever.
- **B:** Normal recovery is steady improvement.
- **C:** Shoulder tip pain is from gas and settles.
- **E:** Retention does not cause peritonitis.

Key point: "Patients should get better, not worse, after laparoscopy."

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 761 · Postoperative Haemorrhage · **Moderate** · C3

A 45-year-old woman is 4 hours after an abdominal hysterectomy. Her pulse has risen to 125/min, BP is 88/50 mmHg and the abdomen is distended. Drain output is minimal. Haemoglobin has fallen from 12 to 8 g/dL.

What is the most likely diagnosis and management?

A. Anaphylaxis; adrenaline

B. Primary or reactionary haemorrhage; resuscitate and return to theatre

C. Pulmonary embolism; anticoagulate

D. Sepsis; antibiotics only

E. Vasovagal; reassure

Answer: B. Primary or reactionary haemorrhage; resuscitate and return to theatre

Bleeding within 24 hours of surgery (reactionary haemorrhage) often comes from a slipped ligature or a vessel that opened as BP recovered. A falling haemoglobin with shock needs resuscitation and return to theatre. A drain may not show bleeding if blocked.

Why not the others

- **A:** There are no signs of anaphylaxis.
- **C:** PE causes hypoxia; anticoagulation would worsen bleeding.
- **D:** Sepsis at 4 hours is unlikely and does not explain falling haemoglobin.
- **E:** This is a serious bleed.

Key point: Secondary haemorrhage occurs 7–14 days later, usually from infection.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 762 · Postoperative VTE · **Moderate** · C3

A 52-year-old woman is 7 days after a laparotomy for an ovarian mass. She suddenly develops pleuritic chest pain, breathlessness and a pulse of 112/min. SpO2 is 90% on air.

What is the most appropriate immediate management?

A. Antibiotics only

B. Chest physiotherapy

C. Start therapeutic low molecular weight heparin and arrange CT pulmonary angiography

D. Wait for D-dimer result

E. Withhold anticoagulation for 2 weeks

Answer: C. Start therapeutic low molecular weight heparin and arrange CT pulmonary angiography

Pulmonary embolism is a leading cause of death after gynaecological surgery, particularly for cancer. If PE is suspected, start treatment-dose anticoagulation without delay (unless contraindicated) and confirm with CTPA.

Why not the others

- **A:** Antibiotics do not treat PE.
- **B:** Physiotherapy does not treat PE.
- **D:** D-dimer is unhelpful after surgery because it is usually raised.
- **E:** Withholding treatment is dangerous.

Key point: Extended thromboprophylaxis (28 days) is advised after major surgery for pelvic cancer.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 763 · Postoperative VTE · **Easy** · C2

A 60-year-old obese woman is having a laparotomy for an ovarian mass suspicious of cancer.

Which VTE prophylaxis is most appropriate?

A. Aspirin only
B. Early mobilisation only
C. Mechanical (stockings or compression) plus low molecular weight heparin, extended for 28 days
D. No prophylaxis
E. Warfarin started before surgery

Answer: C. Mechanical (stockings or compression) plus low molecular weight heparin, extended for 28 days

Women having major pelvic surgery for cancer are at high risk of VTE. Mechanical prophylaxis with LMWH, continued for 28 days after surgery, is recommended.

Why not the others

- **A:** Aspirin is not adequate.
- **B:** Mobilisation alone is not adequate for high risk.
- **D:** She is at high risk.
- **E:** Warfarin is not used for perioperative prophylaxis.

Key point: Risk factors: cancer, age, obesity, immobility, long surgery.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery

MCQ 764 · Sepsis · **Easy** · C3

A 32-year-old woman has PID. Temperature is 39.4°C, pulse 125/min, BP 86/52 mmHg, respiratory rate 26/min and she is confused. Lactate is 4.5 mmol/L.

What is the most important immediate management?

A. Arrange outpatient follow-up
B. Await blood culture results before antibiotics
C. Oral antibiotics and discharge
D. Sepsis Six within 1 hour: oxygen, cultures, IV antibiotics, IV fluids, lactate and urine output monitoring
E. Ultrasound before any treatment

Answer: D. Sepsis Six within 1 hour: oxygen, cultures, IV antibiotics, IV fluids, lactate and urine output monitoring

She has septic shock. The Sepsis Six bundle within the first hour (give oxygen, take blood cultures, give IV antibiotics, give IV fluids, measure lactate, monitor urine output) improves survival. Source control (such as drainage) follows.

Why not the others

- **A:** She is critically ill.
- **B:** Antibiotics must not be delayed.
- **C:** Oral treatment is inadequate.
- **E:** Imaging should not delay treatment.

Key point: Escalate early to critical care if hypotension persists after fluids.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 765 · Urinary Retention · **Moderate** · C2

A 27-year-old woman at 13 weeks of pregnancy cannot pass urine and has lower abdominal pain. Bimanual examination shows a retroverted gravid uterus filling the pelvis, with the cervix pushed up behind the pubic symphysis.

What is the most appropriate management?

A. Caesarean section
B. Catheterise the bladder; the uterus usually rises out of the pelvis within days
C. Laparotomy
D. Termination of pregnancy
E. Ventouse

Answer: B. Catheterise the bladder; the uterus usually rises out of the pelvis within days

An incarcerated retroverted gravid uterus at 12–14 weeks can compress the urethra and cause retention. Catheterisation (sometimes for a few days) allows the uterus to rise out of the pelvis. Manual repositioning is rarely needed.

Why not the others

- **A:** Caesarean is irrelevant in early pregnancy.
- **C:** Laparotomy is not needed.
- **D:** There is no reason to terminate.
- **E:** Ventouse is for delivery.

Key point: Unrelieved retention can cause bladder damage.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 766 · Genital Trauma · **Moderate** · C3

A 22-year-old woman has heavy vaginal bleeding after her first intercourse. She is tachycardic. Speculum examination shows a 4 cm laceration in the posterior fornix with active bleeding.

What is the most appropriate management?

A. Antibiotics only
B. Hormonal treatment
C. Reassure and send home
D. Resuscitation and repair of the laceration under anaesthesia
E. Vaginal tampon at home

Answer: D. Resuscitation and repair of the laceration under anaesthesia

Coital lacerations, often in the posterior fornix, can bleed heavily. Active bleeding with tachycardia needs resuscitation and suturing under anaesthesia. Consider the possibility of non-consensual intercourse and ask sensitively.

Why not the others

- **A:** Antibiotics do not stop bleeding.
- **B:** Hormones do not stop traumatic bleeding.
- **C:** She needs treatment.
- **E:** Packing at home is unsafe.

Key point: Rarely, lacerations extend into the peritoneal cavity.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 767 · Sexual Assault · **Moderate** · C3

A 23-year-old woman attends 36 hours after being raped. She is not using contraception.

Which emergency care is needed?

A. Emergency contraception, STI prophylaxis or testing, HIV PEP, hepatitis B vaccination, forensic examination with consent, and psychological support

B. Forensic examination only

C. HIV test only

D. Pregnancy test in 6 weeks only

E. Reassurance and discharge

Answer: A. Emergency contraception, STI prophylaxis or testing, HIV PEP, hepatitis B vaccination, forensic examination with consent, and psychological support

Care after sexual assault includes emergency contraception (copper IUD or oral), HIV post-exposure prophylaxis within 72 hours, STI prophylaxis or follow-up testing, hepatitis B vaccination, forensic examination with consent, documentation and psychological support.

Why not the others

- **B:** Forensic examination alone misses medical needs.
- **C:** An HIV test alone misses prophylaxis.
- **D:** Waiting misses emergency contraception.
- **E:** She needs comprehensive care.

Key point: Offer referral to a specialist sexual assault service.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Sexually transmitted infections

MCQ 768 · Necrotising Infection · **Hard** · C3

A 58-year-old woman with poorly controlled diabetes had a Bartholin abscess drained 3 days ago. She now has spreading purple discolouration of the vulva and perineum, pain out of proportion to signs, crepitus, fever and hypotension.

What is the most appropriate management?

A. Bed rest

B. Oral antibiotics

C. Resuscitation, broad-spectrum IV antibiotics and urgent surgical debridement

D. Topical antiseptic

E. Warm baths at home

Answer: C. Resuscitation, broad-spectrum IV antibiotics and urgent surgical debridement

Necrotising fasciitis of the vulva and perineum is a surgical emergency, with high mortality. Diabetes is a major risk factor. Treatment is resuscitation, IV antibiotics (including clindamycin) and urgent, radical debridement, often repeated.

Why not the others

- **A:** Bed rest is inappropriate.
- **B:** Oral antibiotics are inadequate.
- **D:** Topical treatment is inadequate.
- **E:** Home care is dangerous.

Key point: Pain out of proportion to signs and crepitus are warning signs.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 769 · Vault Dehiscence · **Hard** · C3

A 44-year-old woman had a total laparoscopic hysterectomy 8 weeks ago. During her first intercourse since surgery she felt a sudden pain and noticed a bulge at the vulva. Examination shows small bowel protruding through the vaginal vault.

What is the most appropriate management?

A. Antibiotics and review in a week
B. Cover the bowel with warm moist packs, resuscitate and arrange urgent surgical repair
C. Discharge home
D. Push the bowel back and send her home
E. Vaginal pessary

Answer: B. Cover the bowel with warm moist packs, resuscitate and arrange urgent surgical repair

Vaginal vault dehiscence with evisceration is a surgical emergency. The bowel is protected with warm saline-soaked packs, and the woman is taken to theatre to inspect the bowel and repair the vault. It is more common after laparoscopic hysterectomy.

Why not the others

- **A:** Delay risks bowel ischaemia.
- **C:** She needs urgent surgery.
- **D:** Pushing back without assessment risks missing bowel injury.
- **E:** A pessary is not appropriate.

Key point: Advise avoiding intercourse until the vault has healed (usually 6–8 weeks or more).

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 770 · Acute Bleeding from Cervical Cancer · **Hard** · C3

A 50-year-old woman with known advanced cervical cancer presents with heavy vaginal bleeding. Pulse is 120/min. A bleeding exophytic tumour is seen.

What is the most appropriate immediate management?

A. Cone biopsy
B. Discharge with iron tablets
C. Radical hysterectomy tonight
D. Resuscitation, firm vaginal packing (with tranexamic acid) and urgent radiotherapy (or embolisation if bleeding persists)
E. Topical steroid

Answer: D. Resuscitation, firm vaginal packing (with tranexamic acid) and urgent radiotherapy (or embolisation if bleeding persists)

Bleeding from advanced cervical cancer is controlled by resuscitation, firm vaginal packing (sometimes soaked with Monsel's solution or tranexamic acid) and urgent haemostatic radiotherapy. Uterine artery embolisation is used if bleeding continues.

Why not the others

- **A:** Cone biopsy is for diagnosis of early disease.
- **B:** She is bleeding acutely.
- **C:** Radical surgery is not appropriate in advanced disease.
- **E:** Steroids do not stop bleeding.

Key point: Discuss goals of care in advanced disease.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Malignant disease of the cervix

MCQ 771 · Mittelschmerz · **Easy** · C2

A 22-year-old woman has mild one-sided lower abdominal pain on day 14 of a regular 28-day cycle, lasting a few hours each month. Examination and pregnancy test are normal.

What is the most likely diagnosis?

A. Appendicitis
B. Ectopic pregnancy
C. Endometriosis
D. Mittelschmerz (ovulation pain)
E. Ovarian torsion

Answer: D. Mittelschmerz (ovulation pain)

Mittelschmerz is mid-cycle pain from follicle rupture at ovulation, often with a small amount of fluid in the pelvis. It is self-limiting and treated with simple analgesia or ovulation suppression if troublesome.

Why not the others

- **A:** Appendicitis is progressive with fever.
- **B:** The pregnancy test is negative.
- **C:** Endometriosis pain is usually around menses.
- **E:** Torsion is severe and constant.

Key point: Timing in the cycle is the clue.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 772 · Massive Haemorrhage · **Moderate** · C3

A 30-year-old woman with a ruptured ectopic pregnancy has lost an estimated 2.5 litres of blood. She is in theatre and the major haemorrhage protocol has been activated.

Which transfusion strategy is recommended?

A. Crystalloid only, no blood
B. Packed red cells with fresh frozen plasma (and platelets as needed), guided by clinical state and coagulation tests
C. Platelets only
D. Red cells only, without plasma, even after 10 units
E. Wait for a full blood count before any transfusion

Answer: B. Packed red cells with fresh frozen plasma (and platelets as needed), guided by clinical state and coagulation tests

In major haemorrhage, red cells are given with fresh frozen plasma early (often in a ratio around 1:1 initially), with platelets, cryoprecipitate (fibrinogen) and tranexamic acid guided by bleeding and coagulation tests, to prevent coagulopathy.

Why not the others

- **A:** Crystalloid alone dilutes clotting factors.
- **C:** Platelets alone are insufficient.
- **D:** Red cells alone cause dilutional coagulopathy.
- **E:** Waiting is dangerous.

Key point: Keep the patient warm; hypothermia worsens coagulopathy.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 773 · Postoperative Complications · **Moderate** · C2

A 60-year-old woman is 6 days after a midline laparotomy for ovarian cancer. She notices a sudden gush of salmon-pink serous fluid from the wound after coughing.

What does this sign most likely indicate?

A. Haematoma
B. Impending abdominal wound dehiscence
C. Normal healing
D. Superficial wound infection
E. Urinary fistula

Answer: B. Impending abdominal wound dehiscence

A sudden discharge of serosanguinous (salmon-pink) fluid from a laparotomy wound around day 5–8 is a warning sign of fascial dehiscence (burst abdomen). The wound should be assessed and usually closed again in theatre.

Why not the others

- **A:** A haematoma gives dark blood.
- **C:** This is not normal.
- **D:** Infection gives pus and redness.
- **E:** A urinary fistula gives clear urine-like fluid.

Key point: Risk factors: obesity, malnutrition, cancer, infection, steroids and coughing.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 774 · Postoperative Complications · **Moderate** · C2

A 50-year-old woman is 4 days after an abdominal hysterectomy. She has abdominal distension, nausea and no flatus. There is no pain, bowel sounds are absent and there is no fever. X-ray shows dilated small and large bowel with gas throughout.

What is the most likely diagnosis?

A. Anastomotic leak
B. Bowel perforation
C. Mechanical small bowel obstruction from adhesions
D. Paralytic ileus
E. Volvulus

Answer: D. Paralytic ileus

Paralytic ileus is common after abdominal surgery, with distension, absent bowel sounds and gas throughout the bowel. It is managed with fluids, electrolyte correction (especially potassium), nasogastric decompression if vomiting, and early mobilisation.

Why not the others

- **A:** There is no bowel anastomosis.
- **B:** Perforation causes peritonitis and free gas.
- **C:** Obstruction causes colicky pain, high-pitched sounds and a transition point.
- **E:** Volvulus causes a specific pattern on X-ray and pain.

Key point: Check potassium and magnesium in ileus.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 775 · Intraoperative Injury · **Moderate** · C3

During an abdominal hysterectomy in a woman with two previous caesarean sections, the surgeon makes a 2 cm hole in the bladder dome while dissecting the bladder off the lower segment. The ureteric orifices are well away from the injury.

What is the most appropriate management?

A. Close the abdomen and ignore it
B. Ileal conduit
C. Immediate two-layer repair with urinary catheter drainage for 7–14 days
D. Nephrostomy
E. Ureteric reimplantation

Answer: C. Immediate two-layer repair with urinary catheter drainage for 7–14 days

A bladder injury recognised at surgery is repaired in two layers with absorbable sutures. The bladder is drained with a catheter for 7–14 days, and a cystogram may be done before removal. Urology help is sought for complex injuries or those near the trigone.

Why not the others

- **A:** Unrepaired injury causes a fistula.
- **B:** Diversion is not needed.
- **D:** Nephrostomy is for ureteric obstruction.
- **E:** The ureters are not involved.

Key point: Previous caesarean sections increase bladder injury risk.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 776 · Postoperative Complications · **Hard** · C3

A 48-year-old woman is 3 days after a laparoscopic hysterectomy. She has right loin pain, fever and rising creatinine. Ultrasound shows right hydronephrosis and a fluid collection in the pelvis.

What is the most likely diagnosis and next step?

A. Bladder injury; catheter only
B. Pyelonephritis; oral antibiotics and discharge
C. Ureteric injury; CT urogram and urology referral for stenting or nephrostomy
D. Vault haematoma; reassure
E. Wound infection; dressing change

Answer: C. Ureteric injury; CT urogram and urology referral for stenting or nephrostomy

Loin pain, fever, hydronephrosis and a pelvic collection (urinoma) after hysterectomy suggest ureteric injury, often from thermal damage. CT urogram confirms it, and urology treats it with stenting, nephrostomy or reimplantation.

Why not the others

- **A:** A bladder injury does not cause hydronephrosis.
- **B:** This is not simple pyelonephritis.
- **D:** A haematoma does not explain hydronephrosis.
- **E:** The wound is not the problem.

Key point: Ureteric injuries are often missed at the time of surgery.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 777 · Local Anaesthetic Toxicity · **Hard** · C3

During a paracervical block before an outpatient procedure, a woman complains of tingling around her mouth, tinnitus and a metallic taste, then has a seizure.

What is the most likely cause and specific treatment?

A. Anaphylaxis; adrenaline only

B. Hypoglycaemia; glucose

C. Local anaesthetic systemic toxicity; airway support, stop injection, and intravenous lipid emulsion

D. Vasovagal attack; lie flat only

E. Water intoxication; fluid restriction

Answer: C. Local anaesthetic systemic toxicity; airway support, stop injection, and intravenous lipid emulsion

Accidental intravascular injection of local anaesthetic causes systemic toxicity: perioral tingling, tinnitus, metallic taste, then seizures and cardiac arrhythmia. Management is to stop injecting, call for help, support the airway, control seizures and give 20% lipid emulsion.

Why not the others

- **A:** Anaphylaxis causes rash, wheeze and hypotension.
- **B:** Hypoglycaemia does not cause perioral tingling and metallic taste.
- **D:** Vasovagal attacks do not cause these neurological symptoms.
- **E:** Water intoxication is a hysteroscopy complication.

Key point: Aspirate before injecting local anaesthetic and respect maximum doses.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 778 · Vasovagal Reaction · **Easy** · C3

During insertion of an intrauterine device, a 25-year-old woman becomes pale, sweaty and faint. Pulse is 42/min and BP 80/50 mmHg. There is no rash or wheeze.

What is the most appropriate management?

A. Adrenaline 0.5 mg intramuscularly

B. Chest compressions

C. Continue the procedure quickly

D. Sit her upright

E. Stop the procedure, lie her flat with legs raised; give atropine if bradycardia persists

Answer: E. Stop the procedure, lie her flat with legs raised; give atropine if bradycardia persists

Cervical stimulation can cause a vasovagal reaction with bradycardia and hypotension. Stop the procedure, lie her flat with legs raised and give oxygen. Atropine is given if bradycardia persists. Most recover quickly.

Why not the others

- **A:** Adrenaline is for anaphylaxis.
- **B:** She has a pulse.
- **C:** Continuing worsens the reflex.
- **D:** Sitting up reduces brain blood flow.

Key point: Have atropine and resuscitation equipment available where IUDs are fitted.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Contraception

MCQ 779 · Anaphylaxis · **Moderate** · C3

A 32-year-old woman receiving intravenous co-amoxiclav for PID develops urticaria, facial swelling, wheeze and a BP of 70/40 mmHg within minutes.

What is the first drug to give?

A. Adrenaline 0.5 mg (500 micrograms) intramuscularly
B. Chlorphenamine orally
C. Hydrocortisone IV first
D. Oral prednisolone
E. Salbutamol nebuliser only

Answer: A. Adrenaline 0.5 mg (500 micrograms) intramuscularly

Anaphylaxis is treated first with intramuscular adrenaline 0.5 mg into the anterolateral thigh, repeated after 5 minutes if needed, with stopping the drug, airway support, high-flow oxygen and IV fluids.

Why not the others

- **B:** Antihistamines are not first-line and do not treat shock.
- **C:** Steroids act too slowly for first treatment.
- **D:** Oral steroids are too slow.
- **E:** Salbutamol helps wheeze but not shock.

Key point: Record the allergy clearly afterwards.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 780 · Laparoscopy Complications · **Moderate** · C2

A 28-year-old woman has severe shoulder tip pain on the day after a diagnostic laparoscopy. Her observations are normal and her abdomen is soft.

What is the most likely cause?

A. Bowel perforation
B. Diaphragmatic irritation from residual carbon dioxide
C. Myocardial infarction
D. Pulmonary embolism
E. Ruptured spleen

Answer: B. Diaphragmatic irritation from residual carbon dioxide

Residual CO2 under the diaphragm irritates the phrenic nerve, causing referred shoulder tip pain after laparoscopy. It settles within 1–2 days. Simple analgesia and mobilisation help.

Why not the others

- **A:** Perforation causes worsening abdominal pain and fever.
- **C:** MI would cause chest pain and ECG changes.
- **D:** PE causes breathlessness and hypoxia.
- **E:** Splenic injury is very rare and causes shock.

Key point: Expel as much gas as possible at the end of laparoscopy.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery

MCQ 781 · Laparoscopy Complications · **Hard** · C2

During laparoscopic insertion of the Veress needle and insufflation, a 35-year-old woman suddenly develops hypotension, a "mill-wheel" murmur and a sharp fall in end-tidal CO2.

What is the most likely diagnosis?

A. Bowel perforation
B. Carbon dioxide gas embolism
C. Pneumothorax
D. Tension pneumoperitoneum only
E. Vasovagal response

Answer: B. Carbon dioxide gas embolism

Gas embolism occurs if the Veress needle enters a vessel. CO2 enters the right heart, causing hypotension, a mill-wheel murmur and a sudden change in end-tidal CO2. Treatment: stop insufflation, release the pneumoperitoneum, place the patient head-down and left side down, and resuscitate.

Why not the others

- **A:** Bowel injury does not cause these cardiovascular signs.
- **C:** Pneumothorax causes reduced breath sounds.
- **D:** High pressure can reduce venous return, but the murmur suggests embolism.
- **E:** Vasovagal reactions cause bradycardia without a murmur.

Key point: Check needle position before insufflating.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 782 · Positioning Injury · **Hard** · C2

A 50-year-old woman had a 6-hour laparoscopic operation in the lithotomy position with steep head-down tilt. Afterwards she has severe calf pain, a tense swollen calf and pain on passive stretching of the toes. Pulses are present.

What is the most likely diagnosis?

A. Cellulitis
B. Compartment syndrome
C. Deep vein thrombosis only
D. Femoral nerve injury
E. Muscle cramp

Answer: B. Compartment syndrome

Prolonged lithotomy reduces leg perfusion and can cause compartment syndrome, with severe pain, tense compartments and pain on passive stretch. Pulses may be present. Urgent fasciotomy is needed to prevent muscle death and kidney injury.

Why not the others

- **A:** Cellulitis develops more slowly with redness and fever.
- **C:** DVT does not cause pain on passive stretch and tense compartments in this way.
- **D:** Femoral nerve injury causes weakness and numbness, not a tense calf.
- **E:** Cramp is brief and does not cause a tense calf.

Key point: Limit time in lithotomy and reposition the legs during long procedures.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 783 · Postoperative Fever · **Moderate** · C2

A 45-year-old woman develops a fever of 38.0°C on the first day after an abdominal hysterectomy. She is otherwise well, with reduced breath sounds at both lung bases.

What is the most likely cause of fever on day 1?

A. Atelectasis or the normal inflammatory response to surgery
B. Deep vein thrombosis
C. Pelvic abscess
D. Urinary tract infection
E. Wound infection

Answer: A. Atelectasis or the normal inflammatory response to surgery

Fever in the first 24–48 hours after surgery is most often caused by atelectasis or the inflammatory response to surgery. Breathing exercises and mobilisation help. Infections (wound, urinary, pelvic) and VTE usually cause fever later.

Why not the others

- **B:** DVT usually causes fever later, around day 5–7.
- **C:** Abscesses take days to form.
- **D:** UTI is more likely after day 2–3 with a catheter.
- **E:** Wound infection usually appears around day 3–7.

Key point: Always examine the chest, wound, urine, legs and pelvis in postoperative fever.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 784 · Septic Pelvic Thrombophlebitis · **Hard** · C2

A 30-year-old woman has persistent spiking fevers 5 days after surgery for a tubo-ovarian abscess, despite appropriate antibiotics. Imaging shows no collection. CT with contrast shows a thrombus in the right ovarian vein.

What is the most appropriate treatment?

A. Add anticoagulation to antibiotics
B. Hysterectomy
C. Laparotomy to drain
D. Oral antibiotics and discharge
E. Stop all treatment

Answer: A. Add anticoagulation to antibiotics

Septic pelvic thrombophlebitis causes persistent fever despite antibiotics after pelvic infection or surgery. Ovarian vein thrombosis may be seen on imaging. Treatment is anticoagulation added to antibiotics.

Why not the others

- **B:** Hysterectomy is not needed.
- **C:** There is no collection to drain.
- **D:** She needs IV antibiotics and anticoagulation.
- **E:** Treatment is needed.

Key point: Think of it when fever persists without a source.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 785 · Retained Products · **Moderate** · C3

A 27-year-old woman had a medical abortion 10 days ago. She now has heavy bleeding with clots, cramps and a temperature of 37.9°C. The cervical os is open and ultrasound shows retained tissue of 35 mm.

What is the most appropriate management?

A. Antibiotics and surgical evacuation of retained products
B. Discharge with iron
C. Expectant management for 6 weeks
D. Methotrexate
E. Oral contraceptive

Answer: A. Antibiotics and surgical evacuation of retained products

Retained products with infection and heavy bleeding need antibiotics and surgical evacuation (vacuum aspiration). Further misoprostol may be used in some stable cases without infection.

Why not the others

- **B:** She needs treatment.
- **C:** Waiting with infection risks sepsis.
- **D:** Methotrexate is for ectopic pregnancy.
- **E:** The pill does not empty the uterus.

Key point: Infection with retained tissue can lead to sepsis and Asherman syndrome.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Early pregnancy problems

MCQ 786 · Molar Pregnancy · **Hard** · C3

During suction evacuation of a large complete molar pregnancy (uterus 20 weeks size), the woman becomes acutely breathless and hypoxic with crackles on both lungs.

What is the most likely cause?

A. Anaphylaxis
B. Asthma
C. Pneumothorax
D. Trophoblastic embolisation and/or fluid overload
E. Vasovagal attack

Answer: D. Trophoblastic embolisation and/or fluid overload

Evacuation of a large mole can release trophoblastic tissue into the circulation, causing acute respiratory distress (trophoblastic embolisation). Fluid overload, pre-eclampsia and thyrotoxicosis can contribute. Supportive care with oxygen and critical care input is needed.

Why not the others

- **A:** Anaphylaxis causes rash and hypotension.
- **B:** Asthma causes wheeze, not crackles.
- **C:** Pneumothorax causes reduced breath sounds on one side.
- **E:** Vasovagal reactions do not cause hypoxia with crackles.

Key point: Large moles should be evacuated by experienced staff with blood available.

Reference: Gynaecology by Ten Teachers — Gestational trophoblastic disease

MCQ 787 · Acute Abdomen · **Moderate** · C3

A 19-year-old woman has 24 hours of periumbilical pain that has moved to the right iliac fossa, with fever and anorexia. Pregnancy test is negative. There is no cervical motion tenderness and the vagina is normal.

What is the most likely diagnosis?

A. Acute appendicitis
B. Ectopic pregnancy
C. Mittelschmerz
D. Ovarian torsion
E. Pelvic inflammatory disease

Answer: A. Acute appendicitis

Migrating periumbilical to right iliac fossa pain with anorexia and fever is typical of appendicitis. The negative pregnancy test and normal pelvic examination make gynaecological causes less likely.

Why not the others

- **B:** The pregnancy test is negative.
- **C:** Mittelschmerz does not cause fever or migrating pain.
- **D:** Torsion is sudden with vomiting.
- **E:** PID usually has cervical motion tenderness and discharge.

Key point: Work closely with general surgeons in young women with right iliac fossa pain.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 788 · Hydrosalpinx Torsion · **Hard** · C2

A 33-year-old woman with a history of PID has sudden severe right pelvic pain with vomiting. Ultrasound shows a normal right ovary with normal Doppler flow, but a twisted, dilated, tubular structure next to it.

What is the most likely diagnosis?

A. Appendicitis
B. Ectopic pregnancy
C. Isolated torsion of a hydrosalpinx
D. Ovarian torsion
E. Ruptured corpus luteum

Answer: C. Isolated torsion of a hydrosalpinx

Isolated tubal torsion, usually of a hydrosalpinx, causes sudden pain like ovarian torsion, but the ovary looks normal. Laparoscopy confirms and treats it, usually by salpingectomy.

Why not the others

- **A:** Appendicitis has a different pattern.
- **B:** Pregnancy is not mentioned and the tube is dilated with fluid.
- **D:** The ovary is normal with good flow.
- **E:** There is no free fluid or cyst.

Key point: Consider tubal torsion when the ovary looks normal.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 789 · Heavy Bleeding · **Moderate** · C3

A 16-year-old girl attends with very heavy menstrual bleeding for 7 days. She is pale, pulse 115/min and BP 95/60 mmHg. Haemoglobin is 6.5 g/dL. Pregnancy test is negative.

What is the most appropriate initial management?

A. Endometrial ablation

B. Hysterectomy

C. IV access, resuscitation and blood transfusion, with high-dose hormonal treatment and tranexamic acid; screen for a bleeding disorder

D. Oral iron and discharge

E. Reassure and review in a month

Answer: C. IV access, resuscitation and blood transfusion, with high-dose hormonal treatment and tranexamic acid; screen for a bleeding disorder

Acute heavy bleeding with haemodynamic compromise needs resuscitation and transfusion. Bleeding is controlled with high-dose hormones (such as combined pill or progestogen regimens) and tranexamic acid. Screen for von Willebrand disease before transfusion where possible.

Why not the others

- **A:** Ablation is inappropriate in a teenager.
- **B:** Hysterectomy is a last resort.
- **D:** She is unstable.
- **E:** She needs urgent care.

Key point: Take coagulation and vWF samples before transfusion if possible.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Disorders of the menstrual cycle

MCQ 790 · Hysteroscopy Complications · **Hard** · C2

During operative hysteroscopy, a 40-year-old woman suddenly develops hypotension, hypoxia, a fall in end-tidal CO2 and a mill-wheel murmur.

What is the most likely diagnosis?

A. Air embolism

B. Anaphylaxis

C. Glycine toxicity

D. Haemorrhage

E. Vasovagal reaction

Answer: A. Air embolism

Air (or gas) embolism can occur when air enters open uterine veins during hysteroscopy, particularly when air is not purged from the tubing. It causes sudden cardiovascular collapse with a fall in end-tidal CO2. Stop the procedure, lie the patient left side down and head-down, give 100% oxygen and resuscitate.

Why not the others

- **B:** Anaphylaxis causes rash and wheeze.
- **C:** Glycine toxicity causes hyponatraemia and confusion over time.
- **D:** Haemorrhage causes bleeding without a murmur.
- **E:** Vasovagal reactions cause bradycardia without hypoxia.

Key point: Purge air from the fluid system before starting hysteroscopy.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 791 · Electrosurgery · **Moderate** · C2

After an abdominal hysterectomy using monopolar diathermy, a woman is found to have a burn on her buttock where it was resting against the metal edge of the operating table.

What is the most likely cause?

A. Allergic reaction
B. Alternate-site burn from current passing through a point of contact with metal
C. Chemical burn from skin prep only
D. Pressure sore
E. Surgical wound infection

Answer: B. Alternate-site burn from current passing through a point of contact with metal

With monopolar diathermy, current should exit through the return electrode pad. If the patient touches metal, current can exit there, causing an alternate-site burn. Correct pad placement and avoiding contact with metal prevents this.

Why not the others

- **A:** Allergic reactions do not cause localised burns at contact points.
- **C:** Alcohol-based skin prep can ignite, but the contact with metal points to an alternate-site burn.
- **D:** A pressure sore develops differently.
- **E:** Infection is in the wound.

Key point: Bipolar diathermy reduces stray current injuries.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery

MCQ 792 · OHSS Emergency · **Moderate** · C3

A 29-year-old woman 7 days after IVF egg collection has severe abdominal distension, vomiting, breathlessness and reduced urine output. Haematocrit is 48% and sodium 128 mmol/L. Ultrasound shows large ovaries and tense ascites.

What is the most appropriate management?

A. Admit, monitor fluid balance and haematocrit, give thromboprophylaxis, and consider paracentesis
B. Discharge with analgesia
C. Diuretics to remove fluid
D. Laparotomy to remove the ovaries
E. Restrict all fluids completely

Answer: A. Admit, monitor fluid balance and haematocrit, give thromboprophylaxis, and consider paracentesis

Severe OHSS needs admission, careful fluid balance, daily weight and girth, thromboprophylaxis, analgesia (avoiding NSAIDs) and paracentesis for tense ascites or breathing difficulty. Diuretics worsen intravascular depletion.

Why not the others

- **B:** She is severely unwell.
- **C:** Diuretics worsen haemoconcentration.
- **D:** Surgery is only for torsion or rupture.
- **E:** Complete fluid restriction worsens kidney function.

Key point: Critical OHSS may need intensive care.

Reference: Gynaecology by Ten Teachers — Assisted conception; Acute gynaecology

MCQ 793 · Ectopic Pregnancy · **Easy** · C2

A 30-year-old woman with 7 weeks of amenorrhoea has left iliac fossa pain, brown vaginal spotting and shoulder tip pain. She is stable. Pregnancy test is positive.

What does shoulder tip pain suggest in this setting?

A. Anxiety
B. Blood in the peritoneal cavity irritating the diaphragm
C. Gallstones
D. Muscle strain
E. Pneumonia

Answer: B. Blood in the peritoneal cavity irritating the diaphragm

Shoulder tip pain in a woman with a positive pregnancy test suggests haemoperitoneum irritating the diaphragm (referred via the phrenic nerve), raising suspicion of ruptured or leaking ectopic pregnancy. She needs urgent assessment.

Why not the others

- **A:** Anxiety does not cause this pattern.
- **C:** Gallstones cause right upper quadrant pain.
- **D:** Muscle strain is not linked to pregnancy.
- **E:** Pneumonia causes cough and fever.

Key point: Diarrhoea and painful defecation can also signal blood in the pouch of Douglas.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Early pregnancy problems

MCQ 794 · Bartholin Abscess · **Easy** · C3

A 30-year-old woman has a 5 cm tense, very painful, fluctuant swelling in the right posterior vestibule with surrounding redness. She is otherwise well.

What is the most appropriate management?

A. Drainage with Word catheter or marsupialisation
B. Hysterectomy
C. Long-term antibiotics only
D. Observation for 2 weeks
E. Radical vulvectomy

Answer: A. Drainage with Word catheter or marsupialisation

A Bartholin abscess is drained, either with a Word catheter (in clinic under local anaesthetic) or by marsupialisation. Antibiotics alone rarely resolve a fluctuant abscess.

Why not the others

- **B:** Hysterectomy is irrelevant.
- **C:** Antibiotics alone usually fail.
- **D:** Waiting prolongs pain.
- **E:** Vulvectomy is for cancer.

Key point: Biopsy if over 40 or if the mass persists.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 795 · IUD Complications · **Moderate** · C2

A 26-year-old woman had a copper IUD inserted 6 weeks postpartum. She now has abdominal pain. The threads are not visible and ultrasound shows no IUD in the uterus. Abdominal X-ray shows the IUD in the upper abdomen.

What is the most appropriate management?

A. Hysterectomy
B. Insert a second IUD
C. Laparoscopic removal
D. Leave it in the abdomen
E. Oral antibiotics only

Answer: C. Laparoscopic removal

A perforated IUD in the abdomen should be removed, usually laparoscopically, because copper devices can cause adhesions and bowel injury. Alternative contraception is needed meanwhile.

Why not the others

- **A:** Hysterectomy is not needed.
- **B:** A new device is not inserted until the first is removed.
- **D:** Leaving it risks adhesions and organ injury.
- **E:** Antibiotics do not remove the device.

Key point: Perforation risk is higher when breastfeeding and in the first months after delivery.

Reference: Gynaecology by Ten Teachers — Contraception; Acute gynaecology

MCQ 796 · Acute Pelvic Pain · **Moderate** · C3

A 26-year-old woman has lower abdominal pain. Pregnancy test is negative. She is stable. The cause is unclear after examination and ultrasound, and pain persists.

Which procedure is both diagnostic and therapeutic for unexplained acute pelvic pain?

A. Colposcopy
B. Hysterosalpingography
C. Hysteroscopy
D. Laparoscopy
E. Pelvic MRI only

Answer: D. Laparoscopy

Laparoscopy allows direct inspection of the pelvis and treatment of many causes, such as torsion, cysts, ectopic pregnancy, endometriosis or appendicitis, when the diagnosis remains uncertain.

Why not the others

- **A:** Colposcopy examines the cervix.
- **B:** HSG assesses tubal patency.
- **C:** Hysteroscopy examines the uterine cavity.
- **E:** MRI may help diagnosis but cannot treat.

Key point: Do not delay laparoscopy if torsion is suspected.

Reference: Gynaecology by Ten Teachers — Acute gynaecology

MCQ 797 · Retained Swab · **Hard** · C2

A 40-year-old woman has persistent fever, pelvic pain and a malodorous vaginal discharge 3 weeks after a vaginal delivery with perineal repair. Examination shows a foreign body high in the vagina.

What is the most likely cause?

A. Cervical cancer
B. Endometritis only
C. Rectovaginal fistula
D. Retained vaginal swab or tampon
E. Vulval haematoma

Answer: D. Retained vaginal swab or tampon

A retained swab or tampon after vaginal repair causes offensive discharge, fever and pain. Removal and antibiotics if needed resolve it. Swab counts before and after repair prevent this "never event".

Why not the others

- **A:** Cancer is unlikely and the foreign body is visible.
- **B:** Endometritis does not explain a foreign body.
- **C:** A fistula causes faeces or gas.
- **E:** A haematoma causes swelling, not a foreign body.

Key point: Always count swabs before and after perineal repair.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Postnatal care

MCQ 798 · Postoperative Urinary Infection · **Easy** · C2

A 55-year-old woman had a vaginal repair with a urinary catheter for 2 days. On day 4 she has dysuria, frequency and a fever of 38.2°C. Urine dipstick shows nitrites and leucocytes.

What is the most likely diagnosis?

A. Catheter-associated urinary tract infection
B. Pelvic abscess
C. Pulmonary embolism
D. Ureteric injury
E. Wound infection

Answer: A. Catheter-associated urinary tract infection

Urinary catheters increase the risk of UTI. Dysuria, frequency, fever and a positive dipstick support the diagnosis. Send urine for culture and start antibiotics.

Why not the others

- **B:** An abscess causes pelvic pain and swinging fever.
- **C:** PE causes breathlessness.
- **D:** Ureteric injury causes loin pain and leakage.
- **E:** Vaginal wound infection causes local pain and discharge.

Key point: Remove catheters as early as possible.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery

MCQ 799 · Ruptured Tubo-ovarian Abscess · **Hard** · C3

A 30-year-old woman being treated for a tubo-ovarian abscess suddenly develops severe generalised abdominal pain, rigidity, fever of 39.5°C and hypotension.

What is the most appropriate management?

A. Continue oral antibiotics
B. Increase analgesia and observe
C. Interventional radiology drainage only, next week
D. Resuscitation, IV antibiotics and emergency laparotomy (or laparoscopy) for washout and drainage
E. Ultrasound in 48 hours

Answer: D. Resuscitation, IV antibiotics and emergency laparotomy (or laparoscopy) for washout and drainage

Rupture of a tubo-ovarian abscess causes generalised peritonitis and septic shock. It is a surgical emergency needing resuscitation, broad-spectrum IV antibiotics and urgent surgery with washout and drainage.

Why not the others

- **A:** Oral antibiotics are inadequate.
- **B:** Delay is fatal.
- **C:** Delayed radiological drainage is inadequate for rupture.
- **E:** Delay is fatal.

Key point: Ruptured TOA carries a high mortality without urgent surgery.

Reference: Gynaecology by Ten Teachers — Acute gynaecology; Pelvic infection

MCQ 800 · Postoperative Oliguria · **Moderate** · C3

A 50-year-old woman is 10 hours after an abdominal hysterectomy. Her urine output has been 10 mL/h for 3 hours. Pulse is 105/min and BP 110/70 mmHg. She feels thirsty. The catheter bag has not been emptied recently.

What is the most appropriate first step?

A. Check the catheter is not blocked and assess fluid status, giving a fluid bolus if hypovolaemic
B. Give furosemide
C. Immediate dialysis
D. Return to theatre immediately
E. Start a dopamine infusion

Answer: A. Check the catheter is not blocked and assess fluid status, giving a fluid bolus if hypovolaemic

Low urine output after surgery is most often due to a blocked catheter or hypovolaemia. Flush or check the catheter, assess fluid status and blood loss, and give a fluid challenge if she is dry. Persistent oliguria needs further assessment for bleeding or kidney or ureteric injury.

Why not the others

- **B:** Diuretics worsen hypovolaemia.
- **C:** Dialysis is not indicated.
- **D:** Theatre is needed only if bleeding or injury is suspected.
- **E:** Dopamine has no role in renal protection.

Key point: Aim for urine output of at least 0.5 mL/kg/h after surgery.

Reference: Gynaecology by Ten Teachers — Gynaecological surgery; Complications of surgery