FINAL YEAR MBBS · SINGLE BEST ANSWER

Obstetrics MCQs for MBBS

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

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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

Physiology of Pregnancy and Antenatal Care

MCQ 1 · Cardiovascular Physiology · **Easy** · C2

A 26-year-old primigravida at 24 weeks asks why she feels her heart beating faster. Her pulse is 92/min and BP 104/62 mmHg. She has no symptoms of heart disease.

Which cardiovascular change is normal by mid-pregnancy?

A. Cardiac output falls by 20%
B. Cardiac output rises by about 40%
C. Diastolic BP rises in the second trimester
D. Peripheral vascular resistance rises
E. Stroke volume falls

Answer: B. Cardiac output rises by about 40%

Cardiac output rises by about 40% by 20–24 weeks, through increases in stroke volume and heart rate. Peripheral resistance falls because of progesterone and placental vasodilators, so BP (especially diastolic) falls in the second trimester and returns to normal at term.

Why not the others

- **A:** Cardiac output rises, not falls.
- **C:** Diastolic BP falls in the second trimester.
- **D:** Peripheral resistance falls.
- **E:** Stroke volume rises.

Key point: A soft ejection systolic murmur is common in normal pregnancy.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 2 · Haematological Physiology · **Easy** · C2

A 28-year-old woman at 28 weeks has a haemoglobin of 108 g/L with a normal MCV and ferritin. She feels well.

What best explains the fall in haemoglobin in normal pregnancy?

A. Bone marrow suppression
B. Haemolysis
C. Iron deficiency in all women
D. Plasma volume rises more than red cell mass
E. Vitamin B12 deficiency

Answer: D. Plasma volume rises more than red cell mass

Plasma volume rises by about 50% while red cell mass rises by only 20–30%, causing haemodilution (physiological anaemia). Anaemia is defined as Hb under 110 g/L in the first trimester and under 105 g/L in the second and third trimesters.

Why not the others

- **A:** The marrow is active, not suppressed.
- **B:** There is no haemolysis.
- **C:** Her ferritin is normal.
- **E:** B12 deficiency would raise the MCV.

Key point: Haemodilution lowers blood viscosity and helps placental perfusion.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 3 · Haematological Physiology · **Moderate** · C2

A 31-year-old woman at 34 weeks asks why she must have heparin after her planned caesarean section.

Which change makes pregnancy a hypercoagulable state?

A. Fall in fibrinogen
B. Fall in platelet count to zero
C. Increase in clotting factors (such as fibrinogen and factor VIII) and reduced fibrinolysis
D. Increase in protein S
E. Increased antithrombin activity

Answer: C. Increase in clotting factors (such as fibrinogen and factor VIII) and reduced fibrinolysis

Pregnancy raises clotting factors (fibrinogen, VII, VIII, X) and reduces fibrinolysis and protein S, preparing for blood loss at delivery. Together with venous stasis from uterine compression, this increases VTE risk about 4–6 times, especially after caesarean section.

Why not the others

- **A:** Fibrinogen rises.
- **B:** Platelets may fall slightly but not to zero.
- **D:** Protein S falls.
- **E:** Antithrombin is unchanged or slightly reduced.

Key point: VTE is a leading direct cause of maternal death in the UK.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 4 · Renal Physiology · **Moderate** · C2

A 30-year-old woman at 26 weeks has routine blood tests. Her creatinine is 82 µmol/L, which the lab reports as within the non-pregnant normal range.

How should this result be interpreted?

A. Creatinine always rises in pregnancy
B. It is normal for pregnancy and needs no action
C. It is raised for pregnancy because GFR increases by about 50%, lowering normal creatinine
D. It shows dehydration only
E. It suggests normal pregnancy diuresis

Answer: C. It is raised for pregnancy because GFR increases by about 50%, lowering normal creatinine

Glomerular filtration rate rises by about 50% in pregnancy, so creatinine and urea fall. A creatinine above about 77 µmol/L in pregnancy may indicate renal impairment and needs assessment.

Why not the others

- **A:** Creatinine falls.
- **B:** It should not be accepted as normal.
- **D:** Dehydration is not the only cause and should not be assumed.
- **E:** Increased GFR lowers creatinine.

Key point: Use pregnancy-specific reference ranges.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 5 · Renal Physiology · **Moderate** · C2

A 25-year-old woman at 30 weeks has a renal ultrasound for loin pain. It shows mild dilatation of the right renal pelvis and ureter. Urine culture is negative.

What is the most likely explanation?

A. Kidney stone in all cases
B. Physiological hydronephrosis of pregnancy
C. Polycystic kidney disease
D. Renal tumour
E. Ureteric stricture

Answer: B. Physiological hydronephrosis of pregnancy

Progesterone relaxes smooth muscle and the enlarging uterus compresses the ureters at the pelvic brim, causing physiological dilatation, more on the right (dextrorotation of the uterus and the right ovarian vein crossing). This also predisposes to pyelonephritis.

Why not the others

- **A:** Stones can occur but mild right dilatation is usually physiological.
- **C:** PKD shows multiple cysts.
- **D:** There is no mass.
- **E:** Stricture is uncommon.

Key point: Asymptomatic bacteriuria is screened and treated because of this risk.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 6 · Respiratory Physiology · **Hard** · C2

A 29-year-old woman at 32 weeks has an arterial blood gas. pH 7.44, PaCO2 4.0 kPa, bicarbonate 19 mmol/L, PaO2 13.5 kPa. She is well.

What does this result show?

A. Acute respiratory acidosis
B. Compensated respiratory alkalosis, normal in pregnancy
C. Diabetic ketoacidosis
D. Metabolic alkalosis from vomiting
E. Type 2 respiratory failure

Answer: B. Compensated respiratory alkalosis, normal in pregnancy

Progesterone stimulates the respiratory centre, increasing tidal volume and minute ventilation by about 40%, lowering PaCO2 to around 4 kPa. The kidneys compensate by lowering bicarbonate, giving a compensated respiratory alkalosis. Respiratory rate is largely unchanged.

Why not the others

- **A:** PaCO2 is low, not high.
- **C:** pH is not acidotic.
- **D:** Bicarbonate is low, not high.
- **E:** PaCO2 is low.

Key point: A "normal" PaCO2 of 5.3 kPa in a breathless pregnant woman may indicate impending respiratory failure.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 7 · Endocrine Physiology · **Moderate** · C2

A 24-year-old woman at 9 weeks with severe nausea has a TSH of 0.08 mU/L with a normal free T4. She has no symptoms of thyrotoxicosis.

What is the most likely explanation?

A. Graves' disease
B. hCG stimulating the thyroid in the first trimester
C. Pituitary failure
D. Subclinical hypothyroidism
E. Thyroid cancer

Answer: B. hCG stimulating the thyroid in the first trimester

hCG peaks at 9–12 weeks and stimulates the TSH receptor, slightly raising thyroid hormones and lowering TSH. A low TSH with normal free T4 in the first trimester is usually physiological.

Why not the others

- **A:** Graves' would have raised free T4 and symptoms or antibodies.
- **C:** Pituitary failure would give low T4.
- **D:** Hypothyroidism raises TSH.
- **E:** Cancer does not cause this pattern.

Key point: Total T4 rises in pregnancy because thyroid-binding globulin rises; measure free T4.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 8 · Metabolic Physiology · **Moderate** · C2

A 30-year-old woman asks why gestational diabetes develops in the second half of pregnancy.

Which placental hormone mainly causes insulin resistance in pregnancy?

A. Human chorionic gonadotrophin
B. Human placental lactogen
C. Oxytocin
D. Prolactin
E. Relaxin

Answer: B. Human placental lactogen

Human placental lactogen (with progesterone, cortisol and placental growth hormone) causes increasing maternal insulin resistance, sparing glucose for the fetus. Women who cannot increase insulin secretion enough develop gestational diabetes.

Why not the others

- **A:** hCG peaks early and is not the main cause.
- **C:** Oxytocin causes uterine contractions.
- **D:** Prolactin prepares the breasts.
- **E:** Relaxin softens ligaments.

Key point: Insulin resistance resolves soon after delivery of the placenta.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy; Diabetes in pregnancy

MCQ 9 · Supine Hypotension · **Easy** · C3

A 26-year-old woman at 36 weeks becomes dizzy, pale and sweaty while lying flat on her back for an ultrasound scan. BP falls from 120/70 to 85/50 mmHg.

What is the most appropriate immediate action?

A. Give adrenaline
B. Give IV fluids and keep her supine
C. Raise her head only
D. Sit her upright and give oxygen
E. Turn her onto her left side

Answer: E. Turn her onto her left side

Supine hypotension is caused by the uterus compressing the inferior vena cava, reducing venous return and cardiac output. Turning her to the left lateral position (or tilting 15–30°) relieves it.

Why not the others

- **A:** Adrenaline is not needed.
- **B:** Keeping her supine maintains compression.
- **C:** Raising the head does not relieve caval compression.
- **D:** Sitting upright alone may not relieve compression as well as left tilt.

Key point: Use left lateral tilt in all pregnant women lying down, including during resuscitation.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 10 · Physiological Changes · **Easy** · C2

A 32-year-old woman at 30 weeks notices a dark line down the middle of her abdomen and brown patches on her cheeks.

What causes these skin changes?

A. Addison's disease
B. Hormone-related increase in melanocyte activity
C. Liver disease
D. Systemic lupus
E. Vitamin deficiency

Answer: B. Hormone-related increase in melanocyte activity

Oestrogen, progesterone and melanocyte-stimulating hormone increase pigmentation in pregnancy, causing the linea nigra, chloasma (melasma) and darkening of the areolae. They usually fade after delivery.

Why not the others

- **A:** Addison's disease is pathological and rare.
- **C:** Liver disease does not cause this pattern.
- **D:** Lupus causes a malar rash, not pigmentation.
- **E:** Vitamin deficiency does not cause this.

Key point: Sun protection reduces chloasma.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 11 · Laboratory Values · **Moderate** · C2

A 33-year-old woman at 34 weeks has liver function tests. Alkaline phosphatase is three times the non-pregnant upper limit. ALT, bilirubin and bile acids are normal, and she is well.

What is the most likely explanation?

A. Acute fatty liver of pregnancy
B. Bone metastases
C. Hepatitis
D. Intrahepatic cholestasis
E. Placental production of alkaline phosphatase

Answer: E. Placental production of alkaline phosphatase

The placenta produces alkaline phosphatase, so ALP can rise two to four times in the third trimester. ALT, AST, bilirubin and bile acids should remain normal. Albumin falls because of haemodilution.

Why not the others

- **A:** AFLP causes vomiting, raised ALT and coagulopathy.
- **B:** Bone metastases are unlikely.
- **C:** Hepatitis raises ALT.
- **D:** Cholestasis raises bile acids and causes itch.

Key point: A raised ALT in pregnancy is always abnormal.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 12 · Dating · **Easy** · C3

A 25-year-old woman with regular 28-day cycles has a first day of her last menstrual period on 10 March 2026.

Using Naegele's rule, what is her estimated date of delivery?

A. 3 December 2026
B. 10 December 2026
C. 17 December 2026
D. 24 November 2026
E. 31 December 2026

Answer: C. 17 December 2026

Naegele's rule: add 9 months and 7 days to the first day of the last menstrual period (or subtract 3 months and add 7 days, then add a year). 10 March + 9 months = 10 December, + 7 days = 17 December 2026.

Why not the others

- **A:** 3 December subtracts instead of adds 7 days.
- **B:** 10 December forgets the 7 days.
- **D:** 24 November is too early.
- **E:** 31 December adds 3 weeks instead of 7 days.

Key point: The dating ultrasound is more accurate than LMP.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 13 · Dating · **Moderate** · C3

A 28-year-old woman has her first ultrasound at 12 weeks by her dates. The crown–rump length suggests 13 weeks + 2 days. Her cycles are irregular.

How should the pregnancy be dated?

A. Average the two dates
B. By crown–rump length on the ultrasound
C. By fundal height
D. By LMP because she is sure
E. Wait until 20 weeks to decide

Answer: B. By crown–rump length on the ultrasound

Crown–rump length between 45 and 84 mm (about 11+2 to 14+1 weeks) is the most accurate way to date a pregnancy and is used in preference to LMP. After 14 weeks, head circumference is used.

Why not the others

- **A:** Averaging is not recommended.
- **C:** Fundal height is too imprecise.
- **D:** Ultrasound is more accurate than LMP, especially with irregular cycles.
- **E:** Later scans are less accurate for dating.

Key point: Accurate dating reduces unnecessary induction for "post-dates".

Reference: Obstetrics by Ten Teachers — Antenatal care; NICE NG201

MCQ 14 · Antenatal Care · **Easy** · C2

A 24-year-old woman with a positive pregnancy test asks when she should see the midwife for her booking appointment.

When should the booking appointment ideally take place?

A. By 10 weeks
B. At 16 weeks
C. At 20 weeks
D. At 28 weeks
E. Only when she feels movements

Answer: A. By 10 weeks

The booking appointment should ideally be by 10 weeks, so that screening (including for sickle cell and thalassaemia) and the dating scan can be arranged in time, and lifestyle advice given early.

Why not the others

- **B:** 16 weeks is too late for early screening.
- **C:** 20 weeks is the anomaly scan.
- **D:** 28 weeks is far too late.
- **E:** Movements are felt at 16–20 weeks.

Key point: Late booking is linked to worse outcomes.

Reference: Obstetrics by Ten Teachers — Antenatal care; NICE NG201

MCQ 15 · Antenatal Screening · **Easy** · C2

A 26-year-old primigravida attends her booking visit at 9 weeks.

Which blood tests are routinely offered at booking?

A. Blood group and antibodies, FBC, HIV, hepatitis B, syphilis, and haemoglobinopathy screening
B. CA-125 and AFP
C. Liver biopsy
D. Thyroid antibodies for all
E. Toxoplasma and CMV serology for all

Answer: A. Blood group and antibodies, FBC, HIV, hepatitis B, syphilis, and haemoglobinopathy screening

Routine booking bloods include full blood count, blood group and red cell antibodies, screening for HIV, hepatitis B and syphilis, and sickle cell and thalassaemia screening. Urine is cultured for asymptomatic bacteriuria.

Why not the others

- **B:** These are not routine pregnancy tests.
- **C:** Liver biopsy is not a screening test.
- **D:** Thyroid antibodies are not routinely tested.
- **E:** Toxoplasma and CMV screening is not routinely recommended.

Key point: Thalassaemia carrier screening is particularly important in Pakistan.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 16 · Antenatal Screening · **Moderate** · C3

A 27-year-old woman at 12 weeks has a routine urine culture that grows more than 10^5 E. coli/mL. She has no urinary symptoms.

What is the most appropriate management?

A. No treatment because she has no symptoms
B. Repeat culture after delivery
C. Treat only if she develops a fever
D. Treat with an appropriate antibiotic and recheck culture
E. Wait until 28 weeks

Answer: D. Treat with an appropriate antibiotic and recheck culture

Asymptomatic bacteriuria in pregnancy is treated because, untreated, it leads to pyelonephritis in up to 30% and is associated with preterm birth. A test of cure is done after treatment.

Why not the others

- **A:** Untreated bacteriuria risks pyelonephritis.
- **B:** Waiting is unsafe.
- **C:** Treatment should not wait for fever.
- **E:** Waiting is unsafe.

Key point: Nitrofurantoin is avoided near term; trimethoprim is avoided in the first trimester.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 17 · Folic Acid · **Easy** · C3

A 30-year-old woman planning pregnancy has a BMI of 34 kg/m² and no other medical problems.

What dose of folic acid is recommended?

A. 400 micrograms after 12 weeks
B. 400 micrograms daily before conception and until 12 weeks
C. 5 mg daily before conception and until 12 weeks
D. 5 mg daily only in the third trimester
E. No folic acid is needed

Answer: C. 5 mg daily before conception and until 12 weeks

Higher-dose folic acid (5 mg) is recommended for women at increased risk of neural tube defects: BMI 30 or more, diabetes, antiepileptic drugs, sickle cell disease, thalassaemia, or a previous child or family history of NTD. It is taken from before conception until 12 weeks.

Why not the others

- **A:** Starting after 12 weeks is too late; the neural tube closes by 28 days.
- **B:** 400 micrograms is for low-risk women.
- **D:** Third trimester is too late.
- **E:** Folic acid is recommended.

Key point: The neural tube closes by about day 28 after conception.

Reference: Obstetrics by Ten Teachers — Antenatal care; Pre-pregnancy care

MCQ 18 · Supplements · **Easy** · C2

A 25-year-old woman with darker skin who wears a full body covering when outdoors is 10 weeks pregnant.

Which supplement is recommended for her throughout pregnancy?

A. High-dose vitamin A
B. Iodine megadose
C. Iron for all women regardless of haemoglobin
D. Vitamin D 10 micrograms daily
E. Vitamin E

Answer: D. Vitamin D 10 micrograms daily

Vitamin D 10 micrograms (400 IU) daily is recommended for all pregnant and breastfeeding women, especially those with darker skin or limited sun exposure, to prevent maternal and neonatal deficiency.

Why not the others

- **A:** High-dose vitamin A is teratogenic.
- **B:** Iodine megadoses are not recommended.
- **C:** Routine iron is not recommended if Hb is normal.
- **E:** Vitamin E is not routinely recommended.

Key point: Avoid liver and liver products because of high vitamin A content.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 19 · Food Safety · **Easy** · C2

A 23-year-old primigravida asks which foods to avoid in pregnancy.

Which food carries a risk of Listeria infection?

A. Cooked chicken
B. Hard pasteurised cheese such as cheddar
C. Pasteurised milk
D. Soft mould-ripened cheese (such as brie) and pâté
E. Well-cooked eggs

Answer: D. Soft mould-ripened cheese (such as brie) and pâté

Listeria can cause miscarriage, stillbirth and neonatal sepsis. Pregnant women should avoid unpasteurised milk, soft mould-ripened or blue-veined cheeses, and pâté. Undercooked meat and handling cat litter risk toxoplasmosis.

Why not the others

- **A:** Cooked chicken is safe.
- **B:** Hard pasteurised cheese is safe.
- **C:** Pasteurised milk is safe.
- **E:** Well-cooked eggs are safe.

Key point: Thorough cooking kills Listeria.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 20 · Lifestyle · **Easy** · C3

A 28-year-old woman at 8 weeks asks how much alcohol is safe in pregnancy.

What is the current advice?

A. Alcohol is only harmful in the third trimester
B. Avoid alcohol altogether; there is no known safe amount
C. Up to 1 unit daily is safe
D. Up to 2 units weekly is safe after 12 weeks
E. Wine is safe but not spirits

Answer: B. Avoid alcohol altogether; there is no known safe amount

No safe level of alcohol in pregnancy is known. Alcohol can cause fetal alcohol spectrum disorder, growth restriction and miscarriage. The safest approach is not to drink at all.

Why not the others

- **A:** Alcohol harms at all stages, especially early.
- **C:** No amount is known to be safe.
- **D:** No amount is known to be safe.
- **E:** All alcohol is harmful.

Key point: Fetal alcohol spectrum disorder causes lifelong learning and behavioural problems.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 21 · Smoking · **Moderate** · C3

A 22-year-old woman at 10 weeks smokes 15 cigarettes a day. A carbon monoxide breath test is high.

What is the most appropriate advice?

A. Cut down to 5 a day only
B. E-cigarettes are more harmful than cigarettes
C. Refer to stop-smoking services; nicotine replacement can be used
D. Smoking does not affect the fetus
E. Stop smoking only after 20 weeks

Answer: C. Refer to stop-smoking services; nicotine replacement can be used

Smoking increases the risks of miscarriage, growth restriction, preterm birth, stillbirth and sudden infant death. All smokers should be referred to stop-smoking services. Nicotine replacement therapy is safer than smoking.

Why not the others

- **A:** Any smoking is harmful.
- **B:** E-cigarettes are less harmful than smoking.
- **D:** Smoking harms the fetus.
- **E:** Stopping early has the most benefit.

Key point: Carbon monoxide monitoring at booking identifies smokers and passive exposure.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 22 · Pre-eclampsia Prevention · **Moderate** · C3

A 38-year-old primigravida at 11 weeks has a BMI of 36 kg/m² and her mother had pre-eclampsia.

What is the most appropriate preventive treatment?

A. Calcium only after 30 weeks
B. Low molecular weight heparin
C. Low-dose aspirin (75–150 mg) daily from 12 weeks until delivery
D. No preventive treatment
E. Vitamin C and E

Answer: C. Low-dose aspirin (75–150 mg) daily from 12 weeks until delivery

Women with one high-risk factor (such as chronic hypertension, kidney disease, diabetes, autoimmune disease, previous hypertensive disease in pregnancy) or two or more moderate risk factors (first pregnancy, age 40 or more, BMI 35 or more, family history, interval over 10 years, multiple pregnancy) should take aspirin 75–150 mg daily from 12 weeks.

Why not the others

- **A:** Calcium may help in low-calcium diets but is not the main preventive treatment.
- **B:** Heparin does not prevent pre-eclampsia.
- **D:** She has multiple moderate risk factors.
- **E:** Vitamins C and E do not help.

Key point: Many guidelines now use 150 mg aspirin at night.

Reference: Obstetrics by Ten Teachers — Antenatal care; Hypertensive disorders of pregnancy

MCQ 23 · Abdominal Examination · **Easy** · C2

A 27-year-old woman by sure dates is 20 weeks pregnant. On abdominal palpation the doctor assesses the fundal height.

Where is the uterine fundus usually felt at 20 weeks?

A. At the level of the umbilicus
B. At the xiphisternum
C. Halfway between symphysis and umbilicus
D. Just above the symphysis pubis
E. Not palpable

Answer: A. At the level of the umbilicus

The fundus is just palpable above the symphysis at 12 weeks, at the umbilicus at 20 weeks, and at the xiphisternum around 36 weeks. From 24 weeks, symphysis–fundal height in cm approximately equals gestation in weeks (±2 cm).

Why not the others

- **B:** The xiphisternum is reached at about 36 weeks.
- **C:** Halfway is about 16 weeks.
- **D:** Just above the symphysis is 12 weeks.
- **E:** The uterus is palpable at 20 weeks.

Key point: Plot SFH on a customised growth chart from 24 weeks.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 24 · Abdominal Examination · **Moderate** · C2

A 30-year-old woman at 38 weeks is examined. The fetal long axis is parallel to the mother's. The head is in the pelvis, and only two-fifths of the head can be felt above the pelvic brim.

How should the findings be described?

A. Breech presentation, not engaged
B. Longitudinal lie, cephalic presentation, head engaged
C. Oblique lie, cephalic, not engaged
D. Transverse lie, head free
E. Unstable lie

Answer: B. Longitudinal lie, cephalic presentation, head engaged

Lie is the relationship of the fetal long axis to the mother's (longitudinal). Presentation is the part over the pelvic inlet (cephalic). The head is engaged when its widest diameter has passed the pelvic brim, clinically when 2/5 or less is palpable abdominally.

Why not the others

- **A:** The head presents, not the breech.
- **C:** The lie is longitudinal.
- **D:** The lie is longitudinal.
- **E:** The lie is stable and longitudinal.

Key point: Head 3/5 or more palpable = not engaged.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 25 · Obstetric Terminology · **Easy** · C2

A 32-year-old woman is pregnant for the fifth time. She has two children born at term, one born at 26 weeks who survived, and one miscarriage at 9 weeks.

How should her gravidity and parity be written?

A. G4 P3+1
B. G5 P2+2
C. G5 P3+1
D. G5 P4+0
E. G6 P3+1

Answer: C. G5 P3+1

Gravidity is the total number of pregnancies including the current one (5). Parity counts births after 24 weeks, live or stillborn (3: two at term, one at 26 weeks). The +1 is pregnancy losses before 24 weeks (the miscarriage).

Why not the others

- **A:** Gravidity includes the current pregnancy, so it is 5.
- **B:** The 26-week birth counts as parity, not as a loss.
- **D:** The miscarriage is not counted in parity.
- **E:** She has had 5 pregnancies, not 6.

Key point: In the UK, 24 weeks is the threshold for parity.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 26 · Anaemia · **Easy** · C3

A 25-year-old woman at 20 weeks has a haemoglobin of 92 g/L, MCV 72 fL and ferritin 8 µg/L. She is tired but well. Haemoglobinopathy screening is negative.

What is the most appropriate management?

A. Blood transfusion
B. Intravenous iron immediately
C. Oral iron with a repeat haemoglobin in 2–3 weeks
D. Reassure; this is physiological
E. Vitamin B12 injections

Answer: C. Oral iron with a repeat haemoglobin in 2–3 weeks

This is iron deficiency anaemia (low MCV and ferritin). Oral iron is first-line, with a check of response in 2–3 weeks. Intravenous iron is used if oral iron is not tolerated or fails, or later in pregnancy when time is short.

Why not the others

- **A:** Transfusion is for severe symptomatic anaemia or bleeding.
- **B:** IV iron is second line at this gestation.
- **D:** Hb 92 is below the threshold of 105 g/L for the second trimester.
- **E:** B12 deficiency causes a high MCV.

Key point: Take oral iron with vitamin C, not with tea or calcium.

Reference: Obstetrics by Ten Teachers — Antenatal care; Medical disorders in pregnancy

MCQ 27 · Minor Disorders · **Easy** · C3

A 28-year-old woman at 32 weeks has burning retrosternal discomfort after meals and at night. She has no epigastric tenderness, BP is normal and urine has no protein.

What is the most appropriate first-line management?

A. Endoscopy
B. Lifestyle advice and antacids or alginates
C. Proton pump inhibitor is contraindicated
D. Stop eating after 4 pm
E. Urgent admission

Answer: B. Lifestyle advice and antacids or alginates

Heartburn is common in pregnancy because progesterone relaxes the lower oesophageal sphincter and the uterus raises intra-abdominal pressure. Small meals, avoiding late eating, raising the head of the bed and antacids or alginates help. H2 blockers or PPIs can be used if needed.

Why not the others

- **A:** Endoscopy is not needed for typical symptoms.
- **C:** PPIs can be used in pregnancy if needed.
- **D:** Extreme fasting is not needed.
- **E:** Admission is not needed.

Key point: Epigastric pain with high BP may be pre-eclampsia, not heartburn.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 28 · Minor Disorders · **Easy** · C2

A 30-year-old woman at 34 weeks has tingling and numbness of the thumb, index and middle fingers of both hands, worse at night. Her ankles are swollen.

What is the most likely diagnosis?

A. Carpal tunnel syndrome
B. Cervical rib
C. Multiple sclerosis
D. Raynaud's phenomenon
E. Ulnar nerve palsy

Answer: A. Carpal tunnel syndrome

Fluid retention in pregnancy compresses the median nerve in the carpal tunnel. Wrist splints at night help, and symptoms usually resolve after delivery.

Why not the others

- **B:** A cervical rib is rare and causes other symptoms.
- **C:** MS is not suggested.
- **D:** Raynaud's causes colour change with cold.
- **E:** Ulnar palsy affects the little finger.

Key point: Carpal tunnel syndrome affects up to a third of pregnant women.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 29 · Minor Disorders · **Moderate** · C3

A 29-year-old woman at 28 weeks has pain over the symphysis pubis and both sacroiliac joints, worse when walking, climbing stairs and turning in bed.

What is the most appropriate management?

A. Bed rest until delivery
B. Caesarean section at 34 weeks
C. Opioids for the rest of pregnancy
D. Physiotherapy assessment with advice and supports
E. X-ray of the pelvis

Answer: D. Physiotherapy assessment with advice and supports

Pelvic girdle pain is caused by hormonal ligament laxity (relaxin) and altered posture. Physiotherapy, advice on movement, pelvic support belts and crutches help. Most women can have a vaginal birth.

Why not the others

- **A:** Bed rest worsens deconditioning and VTE risk.
- **B:** Caesarean is not indicated.
- **C:** Long-term opioids are not first line.
- **E:** X-ray is not needed.

Key point: Keep knees together when turning in bed and getting out of a car.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 30 · Minor Disorders · **Easy** · C3

A 26-year-old woman at 30 weeks has hard, infrequent stools. She takes oral iron.

What is the most appropriate first-line advice?

A. Enemas daily
B. Increase dietary fibre and fluids, with a bulk-forming laxative if needed
C. Stimulant laxatives every day
D. Stop all iron permanently
E. Surgery

Answer: B. Increase dietary fibre and fluids, with a bulk-forming laxative if needed

Progesterone slows bowel transit and iron worsens constipation. Increasing fibre and fluid intake, exercise and bulk-forming laxatives (such as ispaghula) are first line.

Why not the others

- **A:** Daily enemas are not needed.
- **C:** Stimulant laxatives are second line.
- **D:** Iron is needed for her anaemia; a different preparation may help.
- **E:** Surgery is not indicated.

Key point: Constipation worsens haemorrhoids in pregnancy.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 31 · Vaccination · **Moderate** · C3

A 27-year-old woman at 20 weeks asks which vaccines she should have during pregnancy.

Which vaccination is recommended in pregnancy to protect the newborn?

A. BCG
B. Measles, mumps and rubella (MMR)
C. Pertussis (whooping cough), ideally between 16 and 32 weeks
D. Varicella
E. Yellow fever

Answer: C. Pertussis (whooping cough), ideally between 16 and 32 weeks

Pertussis vaccination (usually from 16 weeks, ideally by 32 weeks) passes antibodies to the baby, protecting against whooping cough in the first months of life. Influenza (any trimester), COVID-19 and RSV vaccines are also recommended where available.

Why not the others

- **A:** BCG is live and not given in pregnancy.
- **B:** MMR is live and avoided in pregnancy.
- **D:** Varicella is live and avoided.
- **E:** Yellow fever is live; given only if travel is unavoidable.

Key point: Live vaccines are avoided in pregnancy.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 32 · Drugs in Pregnancy · **Moderate** · C2

A 32-year-old woman with a mechanical heart valve becomes pregnant while taking warfarin.

Which fetal problem is linked to warfarin exposure between 6 and 12 weeks?

A. Grey baby syndrome
B. Neural tube defects
C. Phocomelia
D. Renal agenesis
E. Warfarin embryopathy (nasal hypoplasia and stippled epiphyses)

Answer: E. Warfarin embryopathy (nasal hypoplasia and stippled epiphyses)

Warfarin in the first trimester (especially 6–12 weeks) can cause embryopathy, with nasal hypoplasia and stippled epiphyses. Later it can cause fetal intracranial bleeding. Management of mechanical valves in pregnancy needs specialist care.

Why not the others

- **A:** Grey baby syndrome is caused by chloramphenicol.
- **B:** Valproate and carbamazepine cause NTDs.
- **C:** Thalidomide causes phocomelia.
- **D:** ACE inhibitors affect the fetal kidney later in pregnancy.

Key point: Mechanical valves carry high thrombosis risk; careful anticoagulation planning is vital.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 33 · Drugs in Pregnancy · **Moderate** · C3

A 34-year-old woman with hypertension on lisinopril finds she is 7 weeks pregnant.

What is the most appropriate management?

A. Continue lisinopril throughout pregnancy
B. Recommend termination
C. Stop all antihypertensives
D. Switch to labetalol (or nifedipine/methyldopa)
E. Switch to losartan

Answer: D. Switch to labetalol (or nifedipine/methyldopa)

ACE inhibitors and angiotensin receptor blockers are associated with fetal renal damage, oligohydramnios and skull defects, especially in the second and third trimesters. They should be stopped and replaced with labetalol, nifedipine or methyldopa.

Why not the others

- **A:** ACE inhibitors are unsafe in pregnancy.
- **B:** First-trimester exposure carries low risk; termination is not needed.
- **C:** Hypertension still needs control.
- **E:** ARBs carry the same risks.

Key point: Women on ACE inhibitors planning pregnancy should switch before or as soon as pregnancy is confirmed.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 34 · Drugs in Pregnancy · **Easy** · C2

A 22-year-old woman with severe acne wants to start oral isotretinoin.

What is essential before and during treatment?

A. Avoid sunlight only
B. Effective contraception with a pregnancy prevention programme
C. Folic acid only
D. Monthly ultrasound
E. No precautions

Answer: B. Effective contraception with a pregnancy prevention programme

Isotretinoin is highly teratogenic, causing craniofacial, cardiac and central nervous system malformations. Women must use effective contraception and follow a pregnancy prevention programme with regular pregnancy tests.

Why not the others

- **A:** Sunlight is not the main concern.
- **C:** Folic acid does not prevent isotretinoin harm.
- **D:** Ultrasound does not prevent harm.
- **E:** Strict precautions are needed.

Key point: Contraception continues for 1 month after stopping isotretinoin.

Reference: Obstetrics by Ten Teachers — Antenatal care; Drugs in pregnancy

MCQ 35 · Imaging in Pregnancy · **Moderate** · C3

A 29-year-old woman at 16 weeks has a suspected fractured wrist after a fall. She is worried about an X-ray.

What is the correct advice?

A. All X-rays cause miscarriage
B. An X-ray of the wrist gives negligible radiation to the fetus and should be done if needed
C. CT abdomen is safer
D. Wait until after delivery
E. X-rays are only safe in the first trimester

Answer: B. An X-ray of the wrist gives negligible radiation to the fetus and should be done if needed

Radiation to the fetus from an X-ray of a limb or chest is negligible, far below the levels associated with harm. Necessary imaging should not be withheld; abdominal shielding may be used.

Why not the others

- **A:** Limb X-rays do not cause miscarriage.
- **C:** CT abdomen gives more fetal radiation.
- **D:** Delaying care for a fracture is harmful.
- **E:** Necessary X-rays are safe at any gestation.

Key point: Diagnostic doses under 50 mGy are not associated with fetal harm.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 36 · Travel · **Easy** · C3

A 26-year-old woman with an uncomplicated singleton pregnancy at 30 weeks wants to fly to visit family. The flight is 6 hours.

What is the most appropriate advice?

A. Flying is forbidden after 20 weeks
B. She can fly; she should stay mobile, drink fluids and wear compression stockings
C. She must take warfarin
D. She needs a caesarean before flying
E. She should only travel by sea

Answer: B. She can fly; she should stay mobile, drink fluids and wear compression stockings

Air travel is generally safe in uncomplicated pregnancy up to about 36 weeks (32 weeks for twins). Long flights increase VTE risk, so women should keep mobile, stay hydrated and wear graduated compression stockings.

Why not the others

- **A:** Flying is allowed until about 36 weeks.
- **C:** Anticoagulation is not routinely needed.
- **D:** Caesarean is irrelevant.
- **E:** Sea travel is not required.

Key point: Check the airline's policy and carry a letter confirming gestation.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 37 · Signs of Pregnancy · **Easy** · C2

A 24-year-old woman with 8 weeks of amenorrhoea is examined. The cervix and vagina have a bluish discolouration.

What is this sign called?

A. Chadwick's sign
B. Cullen's sign
C. Hegar's sign
D. Murphy's sign
E. Trousseau's sign

Answer: A. Chadwick's sign

Chadwick's sign is bluish discolouration of the cervix, vagina and vulva from increased blood flow in early pregnancy (around 6–8 weeks). Hegar's sign is softening of the uterine isthmus.

Why not the others

- **B:** Cullen's sign is periumbilical bruising.
- **C:** Hegar's sign is softening of the lower uterine segment.
- **D:** Murphy's sign suggests cholecystitis.
- **E:** Trousseau's sign suggests hypocalcaemia.

Key point: Ultrasound and hCG have replaced clinical signs for diagnosis.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 38 · Fetal Movements · **Easy** · C2

A 22-year-old primigravida at 18 weeks has not yet felt her baby move and is worried.

When are fetal movements usually first felt by a first-time mother?

A. 10–12 weeks
B. 14 weeks
C. 18–20 weeks
D. 28 weeks
E. 36 weeks

Answer: C. 18–20 weeks

First-time mothers usually feel movements (quickening) at about 18–20 weeks, and multiparous women a little earlier (about 16 weeks). Not feeling movements at 18 weeks in a primigravida is not concerning.

Why not the others

- **A:** Too early to feel.
- **B:** Too early for most first-time mothers.
- **D:** Movements should be felt well before 28 weeks.
- **E:** Far too late.

Key point: After 24 weeks, reduced movements need same-day assessment.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 39 · Fetal Circulation · **Hard** · C2

A medical student asks how oxygenated blood from the placenta reaches the fetal brain.

Which fetal structure carries oxygenated blood from the umbilical vein past the liver to the inferior vena cava?

A. Ductus arteriosus
B. Ductus venosus
C. Foramen ovale
D. Ligamentum teres
E. Umbilical arteries

Answer: B. Ductus venosus

Oxygenated blood travels from the placenta in the umbilical vein; the ductus venosus shunts it past the liver into the IVC. It then passes through the foramen ovale to the left heart and to the brain. The ductus arteriosus shunts blood from the pulmonary artery to the aorta.

Why not the others

- **A:** The ductus arteriosus bypasses the lungs.
- **C:** The foramen ovale is between the atria.
- **D:** The ligamentum teres is the remnant of the umbilical vein after birth.
- **E:** Umbilical arteries carry deoxygenated blood to the placenta.

Key point: Ductus venosus Doppler is used to assess fetal compromise.

Reference: Obstetrics by Ten Teachers — Fetal physiology

MCQ 40 · Placental Transfer · **Moderate** · C2

A mother with immunity to measles asks how her newborn will be protected in the first months of life.

Which immunoglobulin crosses the placenta?

A. IgA
B. IgD
C. IgE
D. IgG
E. IgM

Answer: D. IgG

IgG is actively transported across the placenta, especially in the third trimester, giving the newborn passive immunity. This is also how maternal antibodies cause rhesus disease and neonatal autoimmune conditions.

Why not the others

- **A:** IgA is passed in breast milk, not across the placenta.
- **B:** IgD does not cross.
- **C:** IgE does not cross.
- **E:** IgM is too large; raised IgM in the newborn suggests fetal infection.

Key point: Maternal vaccination in pregnancy uses this transfer to protect babies.

Reference: Obstetrics by Ten Teachers — Fetal physiology

MCQ 41 · Antenatal Care · **Moderate** · C2

A 23-year-old healthy primigravida with an uncomplicated pregnancy asks how many antenatal appointments she will have.

How many appointments are typically recommended for a nulliparous woman with an uncomplicated pregnancy in UK guidance?

A. 2
B. 4
C. 7
D. 10
E. 20

Answer: D. 10

NICE recommends about 10 appointments for nulliparous women and 7 for parous women with uncomplicated pregnancies. WHO recommends at least 8 contacts.

Why not the others

- **A:** Two is far too few.
- **B:** Four was the old WHO focused model.
- **C:** Seven is for parous women.
- **E:** Twenty is more than needed.

Key point: Each visit includes BP and urine checks.

Reference: Obstetrics by Ten Teachers — Antenatal care; NICE NG201

MCQ 42 · Mental Health · **Moderate** · C3

At her booking visit, a 30-year-old woman says she has felt down and lost interest in things for the past month. She has a past history of bipolar disorder.

What is the most appropriate action?

A. Advise her to stop all medication
B. Ignore it as normal pregnancy emotion
C. Reassure and review after delivery
D. Refer to perinatal mental health services
E. Start lithium immediately in primary care

Answer: D. Refer to perinatal mental health services

Women with past or current serious mental illness, especially bipolar disorder, are at high risk of relapse and postpartum psychosis. They should be referred to specialist perinatal mental health services for planning.

Why not the others

- **A:** Stopping medication suddenly risks relapse.
- **B:** Low mood should not be dismissed.
- **C:** Waiting misses the chance to plan care.
- **E:** Lithium decisions need specialist input.

Key point: Ask about mental health at booking and postnatally.

Reference: Obstetrics by Ten Teachers — Antenatal care; Mental health in pregnancy

MCQ 43 · Domestic Abuse · **Moderate** · C3

At an antenatal visit, a 25-year-old woman has bruises on her arms and seems fearful. Her husband insists on staying with her during the consultation.

What is the most appropriate action?

A. Ask about abuse in front of her husband
B. Ensure she is seen alone at some point and ask sensitively about domestic abuse
C. Ignore the bruises
D. Report her husband to the police without her consent in all cases
E. Tell her to leave him immediately

Answer: B. Ensure she is seen alone at some point and ask sensitively about domestic abuse

Domestic abuse often starts or worsens in pregnancy. All women should be seen alone at least once and asked sensitively. If abuse is disclosed, offer support, safety planning and referral, and follow safeguarding procedures.

Why not the others

- **A:** Asking in front of the partner is unsafe.
- **C:** Signs should be explored.
- **D:** Action depends on risk and local law; her safety and autonomy come first.
- **E:** Telling her to leave may increase danger.

Key point: Professional interpreters, not family members, should be used.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 44 · Antenatal Care · **Moderate** · C3

A 31-year-old woman at 30 weeks has a symphysis–fundal height of 25 cm, which is below the 10th centile on her customised chart.

What is the most appropriate next step?

A. Admit for bed rest
B. Deliver immediately
C. Reassure because SFH is unreliable
D. Repeat measurement in 4 weeks
E. Ultrasound for fetal growth, amniotic fluid and umbilical artery Doppler

Answer: E. Ultrasound for fetal growth, amniotic fluid and umbilical artery Doppler

An SFH below the 10th centile or a slowing growth trajectory should prompt an ultrasound for fetal biometry, amniotic fluid and umbilical artery Doppler to assess for fetal growth restriction.

Why not the others

- **A:** Bed rest does not help growth.
- **B:** Delivery decisions need assessment first.
- **C:** SFH is a useful screening tool.
- **D:** Waiting may miss growth restriction.

Key point: Women with risk factors may need serial growth scans instead of SFH.

Reference: Obstetrics by Ten Teachers — Antenatal care; Fetal growth

MCQ 45 · Physiological Changes · **Easy** · C2

A 33-year-old woman at 36 weeks has bilateral ankle swelling that is worse at the end of the day. BP is 112/70 mmHg and urine shows no protein.

What is the most likely cause?

A. Deep vein thrombosis
B. Heart failure
C. Nephrotic syndrome
D. Physiological oedema of pregnancy
E. Pre-eclampsia

Answer: D. Physiological oedema of pregnancy

Dependent oedema is common in late pregnancy due to fluid retention and venous compression by the uterus. With normal BP and no proteinuria it is physiological. Sudden facial or hand swelling with high BP suggests pre-eclampsia.

Why not the others

- **A:** DVT is usually unilateral.
- **B:** Heart failure has breathlessness and other signs.
- **C:** Nephrotic syndrome has heavy proteinuria.
- **E:** BP and urine are normal.

Key point: Unilateral swelling in pregnancy needs Doppler to exclude DVT (commoner on the left).

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 46 · Weight Gain · **Easy** · C2

A 25-year-old woman with a BMI of 22 kg/m² at booking asks how much weight she should gain in pregnancy.

What is the typical recommended weight gain for a woman with normal BMI?

A. 2–3 kg
B. 5 kg
C. About 11–16 kg
D. 25–30 kg
E. No gain

Answer: C. About 11–16 kg

For women with a normal BMI, a gain of about 11–16 kg (Institute of Medicine) is typical, made up of the fetus, placenta, amniotic fluid, uterus, breasts, blood volume and fat stores. Women with obesity are advised to gain less.

Why not the others

- **A:** Too little.
- **B:** Too little.
- **D:** Excessive.
- **E:** Some weight gain is expected.

Key point: Dieting to lose weight in pregnancy is not recommended.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 47 · Obesity · **Moderate** · C3

A 29-year-old woman has a booking BMI of 38 kg/m². She has no other medical problems.

Which additional antenatal care is recommended?

A. Caesarean section at 37 weeks
B. No change from routine care
C. Oral glucose tolerance test at 24–28 weeks, folic acid 5 mg, aspirin assessment and anaesthetic review
D. Weekly scans from 12 weeks
E. Weight loss diet to lose 10 kg in pregnancy

Answer: C. Oral glucose tolerance test at 24–28 weeks, folic acid 5 mg, aspirin assessment and anaesthetic review

Obesity increases risks of gestational diabetes, pre-eclampsia, VTE, macrosomia, stillbirth and anaesthetic difficulty. Care includes 5 mg folic acid, vitamin D, GDM screening, pre-eclampsia risk assessment, VTE risk assessment and anaesthetic review if BMI is 40 or more.

Why not the others

- **A:** Obesity alone is not an indication for caesarean.
- **B:** Additional care is needed.
- **D:** Weekly scans are unnecessary; growth scans may be used later.
- **E:** Weight-loss diets are not recommended in pregnancy.

Key point: Advise healthy eating and activity, not weight loss.

Reference: Obstetrics by Ten Teachers — Antenatal care

MCQ 48 · Physiological Changes · **Moderate** · C2

A 27-year-old woman at 28 weeks has a full blood count. Her white cell count is 13.5 × 10^9/L with neutrophilia. She has no symptoms or signs of infection.

What is the most likely explanation?

A. Acute leukaemia
B. Chorioamnionitis
C. Normal physiological rise in neutrophils in pregnancy
D. Pneumonia
E. Urinary tract infection

Answer: C. Normal physiological rise in neutrophils in pregnancy

The white cell count rises in pregnancy (up to about 15 × 10^9/L, and higher in labour) mainly from neutrophils. Without clinical signs of infection this is physiological.

Why not the others

- **A:** Leukaemia has abnormal cells and other findings.
- **B:** There are no signs of infection.
- **D:** There are no chest symptoms.
- **E:** There are no urinary symptoms.

Key point: Interpret raised white cells together with clinical signs in pregnancy.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 49 · Placental Function · **Moderate** · C2

A student asks which hormone is detected by urine pregnancy tests and what it does.

What is the main early function of human chorionic gonadotrophin?

A. Causing uterine contractions
B. Maintaining the corpus luteum to produce progesterone
C. Stimulating milk production
D. Suppressing fetal growth
E. Triggering labour

Answer: B. Maintaining the corpus luteum to produce progesterone

hCG is made by the syncytiotrophoblast and maintains the corpus luteum, which produces progesterone until the placenta takes over at about 8–10 weeks. hCG doubles every 48 hours in early pregnancy and peaks at 8–12 weeks.

Why not the others

- **A:** Oxytocin and prostaglandins cause contractions.
- **C:** Prolactin stimulates milk.
- **D:** hCG does not suppress growth.
- **E:** hCG does not trigger labour.

Key point: Very high hCG suggests multiple or molar pregnancy.

Reference: Obstetrics by Ten Teachers — Physiological changes in pregnancy

MCQ 50 · Antenatal Care · **Hard** · C3

A 35-year-old woman at 10 weeks takes sodium valproate for epilepsy, which is well controlled. She did not plan the pregnancy.

What is the most appropriate management?

A. Continue valproate unchanged without review
B. Refer urgently to neurology to review medication, start 5 mg folic acid, and arrange detailed fetal anomaly scanning
C. Stop valproate immediately without advice
D. Switch to phenytoin by herself
E. Terminate the pregnancy

Answer: B. Refer urgently to neurology to review medication, start 5 mg folic acid, and arrange detailed fetal anomaly scanning

Valproate carries a high risk of neural tube defects and other malformations (about 10%) and neurodevelopmental problems (30–40%). Urgent specialist review is needed to consider switching to a safer drug, with 5 mg folic acid and detailed anomaly scanning. Stopping abruptly risks seizures.

Why not the others

- **A:** Valproate exposure needs specialist review.
- **C:** Sudden withdrawal risks status epilepticus.
- **D:** Changes must be made by specialists.
- **E:** Termination is her choice after counselling, not a required step.

Key point: Lamotrigine and levetiracetam are safer antiepileptic drugs in pregnancy.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

CHAPTER 2

Prenatal Screening and Diagnosis

MCQ 51 · Screening Tests · **Easy** · C2

A 30-year-old woman at 12 weeks asks about screening for Down syndrome.

What does the first-trimester combined test include?

A. AFP, hCG, oestriol and inhibin A at 18 weeks

B. Amniocentesis at 16 weeks

C. Cell-free DNA only

D. Nuchal translucency, free beta-hCG and PAPP-A at 11–14 weeks

E. Umbilical artery Doppler

Answer: D. Nuchal translucency, free beta-hCG and PAPP-A at 11–14 weeks

The combined test uses maternal age, nuchal translucency measured on ultrasound, and serum free beta-hCG and pregnancy-associated plasma protein A (PAPP-A), performed at 11+2 to 14+1 weeks. It screens for trisomies 21, 18 and 13.

Why not the others

- **A:** This is the quadruple test, used at 15–20 weeks.
- **B:** Amniocentesis is a diagnostic test.
- **C:** cfDNA testing is a different (contingent or primary) screening test.
- **E:** Doppler assesses placental function.

Key point: Screening gives a risk, not a diagnosis.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 52 · Screening Tests · **Moderate** · C2

A 35-year-old woman has a combined test at 12 weeks. Nuchal translucency is 3.8 mm.

Which serum pattern is typical of trisomy 21 in the first trimester?

A. High free beta-hCG and high PAPP-A

B. High free beta-hCG and low PAPP-A

C. Low free beta-hCG and high PAPP-A

D. Low free beta-hCG and low PAPP-A

E. Normal levels of both

Answer: B. High free beta-hCG and low PAPP-A

In trisomy 21, free beta-hCG is typically raised and PAPP-A reduced, with increased nuchal translucency. In trisomies 18 and 13, both hCG and PAPP-A are typically low.

Why not the others

- **A:** High PAPP-A is not typical of trisomy 21.
- **C:** This is not a typical aneuploidy pattern.
- **D:** Both low suggests trisomy 18 or 13.
- **E:** Abnormal levels are typical.

Key point: Low PAPP-A alone is also linked to growth restriction and pre-eclampsia.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 53 · Screening Tests · **Moderate** · C2

A 28-year-old woman books late at 17 weeks and wants screening for Down syndrome.

Which serum test is used in the second trimester?

A. Combined test
B. Glucose tolerance test
C. Quadruple test (AFP, hCG, unconjugated oestriol and inhibin A)
D. Serum ferritin
E. Thyroid antibodies

Answer: C. Quadruple test (AFP, hCG, unconjugated oestriol and inhibin A)

The quadruple test is used from 14+2 to 20+0 weeks. In trisomy 21, AFP and oestriol are low while hCG and inhibin A are high.

Why not the others

- **A:** The combined test is only valid up to 14+1 weeks.
- **B:** GTT screens for diabetes.
- **D:** Ferritin assesses iron.
- **E:** Thyroid antibodies are not used for aneuploidy screening.

Key point: The quadruple test is less sensitive than the combined test.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 54 · Cell-free DNA · **Moderate** · C3

A 37-year-old woman's combined test gives a high chance (1 in 80) of trisomy 21. She is worried about miscarriage from invasive testing.

What is the most appropriate option to offer?

A. Cell-free DNA (NIPT) screening, or diagnostic testing (CVS or amniocentesis) if she prefers
B. Immediate termination
C. No further testing is possible
D. Repeat combined test
E. Wait for the 20-week scan only

Answer: A. Cell-free DNA (NIPT) screening, or diagnostic testing (CVS or amniocentesis) if she prefers

Women with a higher-chance result can choose non-invasive prenatal testing (cell-free DNA), which has a detection rate of about 99% for trisomy 21 with a very low false-positive rate and no miscarriage risk, or a diagnostic invasive test. Counselling should be non-directive.

Why not the others

- **B:** A screening result is not a diagnosis.
- **C:** Further options exist.
- **D:** Repeating the combined test does not help.
- **E:** The anomaly scan does not diagnose Down syndrome.

Key point: cfDNA is a screening test; a high-chance result needs confirmation by invasive testing before decisions about the pregnancy.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 55 · Cell-free DNA · **Hard** · C2

A 33-year-old woman has a cfDNA result showing high chance of trisomy 13. Amniocentesis shows a normal fetal karyotype.

What is the most likely explanation for the discordant results?

A. Amniocentesis is always wrong
B. Confined placental mosaicism
C. Fetal sex mismatch
D. Maternal diabetes
E. Twin pregnancy in all cases

Answer: B. Confined placental mosaicism

Cell-free DNA in maternal blood comes mainly from the placenta (trophoblast), not the fetus. If the placenta has a chromosomal abnormality not present in the fetus (confined placental mosaicism), cfDNA can give a false-positive result. Maternal conditions (such as a maternal tumour) can also cause discordance.

Why not the others

- **A:** Amniocentesis reflects the fetus and is more reliable.
- **C:** Fetal sex does not explain this.
- **D:** Diabetes does not cause discordance.
- **E:** A vanishing twin can cause discordance, but placental mosaicism is the usual explanation.

Key point: Confined placental mosaicism can be linked to fetal growth restriction; monitor growth.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 56 · Invasive Testing · **Easy** · C2

A 36-year-old woman at 12 weeks wants a diagnostic test for Down syndrome as early as possible.

Which diagnostic test can be done earliest?

A. Amniocentesis
B. Cell-free DNA
C. Chorionic villus sampling
D. Cordocentesis
E. Quadruple test

Answer: C. Chorionic villus sampling

Chorionic villus sampling can be done from 11 weeks, sampling the placenta. Amniocentesis is done from 15 weeks. Both carry a procedure-related miscarriage risk of about 0.5% or less.

Why not the others

- **A:** Amniocentesis is done from 15 weeks.
- **B:** cfDNA is a screening test, not diagnostic.
- **D:** Cordocentesis is done later, from about 18–20 weeks.
- **E:** The quadruple test is screening.

Key point: CVS before 10 weeks has been linked to limb defects; avoid.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 57 · Invasive Testing · **Moderate** · C2

A 34-year-old woman is counselled about amniocentesis at 16 weeks.

What is the approximate additional miscarriage risk from amniocentesis?

A. Under 0.5%
B. 5%
C. 10%
D. 25%
E. No risk

Answer: A. Under 0.5%

The additional procedure-related miscarriage risk of amniocentesis and CVS is now estimated at under 0.5% (RCOG). Other risks include infection and, rarely, membrane rupture. Anti-D is given if she is RhD-negative.

Why not the others

- **B:** 5% is much too high.
- **C:** 10% is much too high.
- **D:** 25% is far too high.
- **E:** There is a small risk.

Key point: Results of rapid testing (QF-PCR) for common trisomies come in 2–3 days.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 58 · Invasive Testing · **Hard** · C3

A CVS sample at 12 weeks for high-chance screening shows mosaicism for trisomy 21 (some cells normal, some trisomic).

What is the most appropriate next step?

A. Accept the result and terminate
B. Amniocentesis to check whether the mosaicism is in the fetus
C. No further testing
D. Repeat CVS immediately
E. Wait for the newborn exam only

Answer: B. Amniocentesis to check whether the mosaicism is in the fetus

CVS samples the placenta, so mosaicism may be confined to the placenta (about 1–2% of CVS). Amniocentesis, which samples fetal cells, clarifies whether the fetus is affected.

Why not the others

- **A:** Decisions should not be based on an uncertain result.
- **C:** Clarification is needed.
- **D:** Repeat CVS samples the same placenta.
- **E:** Waiting removes choices.

Key point: Discuss results with genetics specialists.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 59 · Anomaly Scan · **Easy** · C2

A 25-year-old woman is booked for her routine fetal anomaly ultrasound.

When is the routine anomaly scan performed?

A. 8–10 weeks
B. 11–14 weeks
C. 18+0 to 20+6 weeks
D. 28 weeks
E. 36 weeks

Answer: C. 18+0 to 20+6 weeks

The mid-pregnancy anomaly scan is done between 18+0 and 20+6 weeks to look for structural abnormalities, assess placental position and measure growth.

Why not the others

- **A:** Too early for anatomy.
- **B:** This is the dating and nuchal scan.
- **D:** Too late for decisions about anomalies.
- **E:** Far too late.

Key point: Some major anomalies, such as anencephaly, can be seen at the 12-week scan.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 60 · Neural Tube Defects · **Moderate** · C2

At the anomaly scan, the fetal skull has a "lemon" shape and the cerebellum is curved like a "banana". There is ventriculomegaly.

What is the most likely underlying abnormality?

A. Anencephaly
B. Encephalocele
C. Holoprosencephaly
D. Microcephaly
E. Open spina bifida

Answer: E. Open spina bifida

The lemon sign (frontal bone scalloping) and banana sign (cerebellum pulled into the foramen magnum, Chiari II) indicate open spina bifida. Maternal serum AFP is often raised.

Why not the others

- **A:** Anencephaly shows absent skull vault above the orbits.
- **B:** Encephalocele shows brain herniation through a skull defect.
- **C:** Holoprosencephaly shows fused ventricles.
- **D:** Microcephaly shows a small head.

Key point: Folic acid before conception prevents most NTDs.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 61 · Neural Tube Defects · **Moderate** · C2

A 26-year-old woman has a quadruple test at 16 weeks. Maternal serum AFP is 3.0 multiples of the median. Dates are confirmed by scan.

Which condition does a raised AFP most suggest?

A. Down syndrome
B. Edwards syndrome
C. Open neural tube defect
D. Triploidy
E. Turner syndrome

Answer: C. Open neural tube defect

Raised maternal serum AFP suggests an open neural tube defect or abdominal wall defect, or other causes such as multiple pregnancy, wrong dates or fetal death. Detailed ultrasound follows.

Why not the others

- **A:** AFP is low in Down syndrome.
- **B:** AFP is low in Edwards syndrome.
- **D:** Triploidy causes variable markers.
- **E:** Turner syndrome is not mainly detected by AFP.

Key point: Ultrasound has largely replaced AFP for NTD detection.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 62 · Abdominal Wall Defects · **Moderate** · C2

An anomaly scan shows bowel loops floating freely in amniotic fluid, protruding to the right of a normally inserted umbilical cord, with no covering membrane. The mother is 19.

What is the most likely diagnosis?

A. Bladder exstrophy
B. Congenital diaphragmatic hernia
C. Exomphalos (omphalocele)
D. Gastroschisis
E. Umbilical hernia

Answer: D. Gastroschisis

Gastroschisis is a full-thickness defect to the right of the cord with free-floating bowel without a membrane. It is commoner in young mothers, is usually isolated and has a good prognosis after surgery.

Why not the others

- **A:** Bladder exstrophy shows an absent bladder.
- **B:** CDH shows abdominal organs in the chest.
- **C:** Exomphalos is covered by a membrane and the cord inserts into it.
- **E:** An umbilical hernia is skin-covered and small.

Key point: Gastroschisis is linked to growth restriction; monitor growth.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 63 · Abdominal Wall Defects · **Hard** · C3

An anomaly scan shows a midline abdominal wall defect with liver and bowel covered by a membrane, with the umbilical cord inserting into the sac.

What is the most important next investigation?

A. Fetal karyotype (invasive testing) and detailed scan including fetal echocardiogram
B. Maternal glucose tolerance test
C. No further tests
D. Repeat scan in 4 weeks only
E. TORCH serology

Answer: A. Fetal karyotype (invasive testing) and detailed scan including fetal echocardiogram

Exomphalos is associated with chromosomal abnormalities (especially trisomy 18 and 13) in up to 30–50% and with other anomalies, including cardiac defects and Beckwith–Wiedemann syndrome. Karyotyping and detailed assessment are recommended.

Why not the others

- **B:** GTT is not relevant.
- **C:** Further tests are important.
- **D:** Delay misses information for decisions.
- **E:** Infections are not typically linked.

Key point: Gastroschisis = isolated; exomphalos = look for associated problems.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 64 · Fetal Anomalies · **Moderate** · C2

A 32-year-old woman at 28 weeks has polyhydramnios. Ultrasound shows a "double bubble" sign in the fetal abdomen.

What is the most likely diagnosis and associated condition?

A. Duodenal atresia, associated with Down syndrome
B. Gastroschisis, associated with young maternal age
C. Oesophageal atresia, associated with Turner syndrome
D. Pyloric stenosis, associated with diabetes
E. Renal agenesis, associated with oligohydramnios

Answer: A. Duodenal atresia, associated with Down syndrome

The double bubble (dilated stomach and duodenum) indicates duodenal atresia. It causes polyhydramnios because the fetus cannot absorb swallowed fluid. About 30% have Down syndrome.

Why not the others

- **B:** Gastroschisis shows free bowel outside the abdomen.
- **C:** Oesophageal atresia shows a small or absent stomach.
- **D:** Pyloric stenosis develops after birth.
- **E:** Renal agenesis causes oligohydramnios, not a double bubble.

Key point: Offer karyotyping when duodenal atresia is found.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 65 · Fetal Anomalies · **Hard** · C2

At 20 weeks, the scan shows no amniotic fluid, no fetal kidneys and an empty fetal bladder on repeated views.

What is the most likely outcome?

A. Normal outcome after birth
B. Polyhydramnios later
C. Pulmonary hypoplasia, usually lethal (Potter sequence)
D. Spontaneous resolution
E. Treatable by fetal surgery

Answer: C. Pulmonary hypoplasia, usually lethal (Potter sequence)

Bilateral renal agenesis causes anhydramnios because fetal urine forms most amniotic fluid after 16 weeks. Without fluid, the lungs do not develop (pulmonary hypoplasia) and Potter facies and limb deformities occur. It is lethal.

Why not the others

- **A:** The outcome is fatal.
- **B:** Fluid will not increase.
- **D:** It does not resolve.
- **E:** There is no effective fetal treatment.

Key point: After 16 weeks, amniotic fluid is mainly fetal urine.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 66 · Fetal Anomalies · **Moderate** · C2

A 30-year-old woman at 20 weeks has a scan showing the fetal stomach and bowel in the left chest, with the heart pushed to the right.

What is the most likely diagnosis?

A. Congenital cystic adenomatoid malformation
B. Congenital diaphragmatic hernia
C. Dextrocardia only
D. Pleural effusion
E. Tetralogy of Fallot

Answer: B. Congenital diaphragmatic hernia

Congenital diaphragmatic hernia (usually left-sided) allows abdominal organs into the chest, displacing the heart and causing pulmonary hypoplasia. The lung-to-head ratio predicts survival. Delivery should be in a centre with neonatal surgery.

Why not the others

- **A:** CCAM is a lung lesion, not abdominal organs in the chest.
- **C:** Dextrocardia alone does not involve the stomach in the chest.
- **D:** Effusion is fluid.
- **E:** Tetralogy is a heart defect.

Key point: Fetoscopic tracheal occlusion may improve outcome in severe cases.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 67 · Fetal Anomalies · **Hard** · C2

A 12-week scan shows a large septated fluid-filled swelling at the back of the fetal neck and generalised skin oedema.

Which chromosomal abnormality is most strongly associated with cystic hygroma?

A. Fragile X syndrome
B. Klinefelter syndrome
C. Triple X syndrome
D. Trisomy 21 only
E. Turner syndrome (45,X)

Answer: E. Turner syndrome (45,X)

Septated cystic hygroma is strongly associated with Turner syndrome, as well as trisomies 21 and 18. It indicates abnormal lymphatic development. Karyotyping and detailed assessment are offered.

Why not the others

- **A:** Fragile X does not cause hygroma.
- **B:** Klinefelter syndrome is usually normal on scan.
- **C:** Triple X is usually normal on scan.
- **D:** Trisomy 21 is associated, but Turner is the classic association.

Key point: Cystic hygroma with hydrops has a poor prognosis.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 68 · Fetal Anomalies · **Hard** · C3

A 28-year-old woman's combined test was low chance. Nuchal translucency was 4.2 mm, and invasive testing showed a normal karyotype and microarray.

Which further investigation is most important?

A. Fetal echocardiography
B. Maternal thyroid function
C. Repeat combined test
D. TORCH serology only
E. Umbilical artery Doppler at 12 weeks

Answer: A. Fetal echocardiography

An increased nuchal translucency with a normal karyotype is associated with structural abnormalities, especially congenital heart disease, and genetic syndromes. Detailed anomaly scanning and fetal echocardiography are recommended.

Why not the others

- **B:** Thyroid function is not relevant.
- **C:** Repeating the combined test adds nothing.
- **D:** Infection is not the main concern.
- **E:** Doppler at 12 weeks is not useful here.

Key point: An NT of 3.5 mm or more warrants specialist assessment.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 69 · Genetics · **Moderate** · C3

A couple who are first cousins have a child with an autosomal recessive metabolic disorder. They are planning another pregnancy.

What is the risk that their next child will be affected?

A. 1 in 2 (50%)
B. 1 in 4 (25%)
C. 1 in 8
D. 1 in 100
E. Almost zero

Answer: B. 1 in 4 (25%)

Both parents are carriers. Each pregnancy has a 25% chance of an affected child, 50% chance of a carrier and 25% chance of an unaffected non-carrier. Consanguinity, common in Pakistan, increases recessive disorders. Prenatal diagnosis or PGT can be offered.

Why not the others

- **A:** 50% applies to autosomal dominant conditions.
- **C:** 1 in 8 is not correct for two carriers.
- **D:** 1 in 100 underestimates the risk.
- **E:** The risk is substantial.

Key point: Genetic counselling is valuable for consanguineous couples with an affected child.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 70 · Genetics · **Moderate** · C3

A woman whose brother has Duchenne muscular dystrophy is found to be a carrier. She is pregnant with a boy.

What is the chance that her son will be affected?

A. 0%
B. 25%
C. 50%
D. 75%
E. 100%

Answer: C. 50%

Duchenne muscular dystrophy is X-linked recessive. A carrier mother passes the affected X to half of her sons (who will be affected) and half of her daughters (who will be carriers).

Why not the others

- **A:** Sons can be affected.
- **B:** 25% is the risk for any child of either sex being an affected son.
- **D:** 75% is not correct.
- **E:** Not every son is affected.

Key point: Prenatal diagnosis can be done by CVS.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 71 · Haemoglobinopathy · **Moderate** · C3

A 24-year-old woman at 9 weeks has a low MCV with normal ferritin. Haemoglobin electrophoresis shows raised HbA2, consistent with beta-thalassaemia trait.

What is the most important next step?

A. Give iron injections
B. Reassure; no further action
C. Start chelation
D. Termination of pregnancy
E. Test her partner for haemoglobinopathy as soon as possible

Answer: E. Test her partner for haemoglobinopathy as soon as possible

If the mother is a beta-thalassaemia carrier, her partner should be tested urgently. If both are carriers, the fetus has a 25% risk of beta-thalassaemia major, and prenatal diagnosis by CVS can be offered.

Why not the others

- **A:** She is not iron deficient.
- **B:** Partner testing is essential.
- **C:** Chelation is for iron overload in thalassaemia major.
- **D:** There is no indication without fetal diagnosis.

Key point: Early booking allows time for partner testing and CVS.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 72 · Screening Principles · **Moderate** · C2

A woman is told her combined test result is "lower chance" (1 in 5,000). Her baby is born with Down syndrome.

What best explains this outcome?

A. A low-chance result means the condition is impossible
B. Screening tests do not detect all affected pregnancies; they give a probability, not a diagnosis
C. The laboratory always made an error
D. The test was diagnostic
E. The ultrasound caused Down syndrome

Answer: B. Screening tests do not detect all affected pregnancies; they give a probability, not a diagnosis

Screening tests have a detection rate below 100% (about 85–90% for the combined test) and give a chance, not a certainty. Some affected pregnancies have low-chance results (false negatives). This must be explained during counselling.

Why not the others

- **A:** Low chance is not zero chance.
- **C:** Errors are possible but not the usual explanation.
- **D:** Screening is not diagnostic.
- **E:** Ultrasound does not cause chromosomal conditions.

Key point: Informed consent before screening must cover false negatives and false positives.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 73 · Maternal Age · **Easy** · C2

A 42-year-old woman asks how her age affects the risk of Down syndrome.

How does maternal age affect the risk of trisomy 21?

A. Risk depends only on paternal age
B. Risk falls with age
C. Risk is highest under 20
D. Risk is the same at all ages
E. Risk rises with maternal age, especially after 35

Answer: E. Risk rises with maternal age, especially after 35

The risk of trisomy 21 rises with maternal age because of more meiotic non-disjunction in older eggs: about 1 in 1,500 at 20, 1 in 350 at 35 and 1 in 100 at 40. Most babies with Down syndrome are still born to younger women because they have more babies.

Why not the others

- **A:** Maternal age is the main factor.
- **B:** Risk rises with age.
- **C:** Risk is lowest in young women.
- **D:** Age has a strong effect.

Key point: Screening is offered to all women regardless of age.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 74 · Soft Markers · **Hard** · C3

At the 20-week scan, the fetal bowel appears as bright as bone (echogenic bowel). Growth and other anatomy are normal.

Which investigations are most appropriate?

A. Cystic fibrosis carrier testing of parents, CMV/toxoplasma serology and consideration of karyotype
B. Immediate delivery
C. Maternal thyroid tests only
D. No investigation
E. Termination of pregnancy

Answer: A. Cystic fibrosis carrier testing of parents, CMV/toxoplasma serology and consideration of karyotype

Echogenic bowel is associated with cystic fibrosis, congenital infection (CMV, toxoplasma), aneuploidy, intra-amniotic bleeding and growth restriction. Parental CF carrier testing, infection serology and growth scans are recommended; karyotyping can be discussed.

Why not the others

- **B:** Delivery is not indicated.
- **C:** Thyroid tests are not relevant.
- **D:** Investigation is needed.
- **E:** Most cases have a normal outcome.

Key point: Follow growth with serial scans.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 75 · Cardiac Anomalies · **Moderate** · C2

A 30-year-old woman with poorly controlled type 1 diabetes at conception (HbA1c 10%) asks which fetal anomaly she is at highest risk of.

Which anomalies are most associated with pre-existing diabetes?

A. Cleft lip only
B. Congenital heart and neural tube defects (and caudal regression)
C. Down syndrome
D. Gastroschisis
E. Turner syndrome

Answer: B. Congenital heart and neural tube defects (and caudal regression)

Poor glycaemic control around conception increases major anomalies, especially congenital heart disease, neural tube defects and caudal regression syndrome. Detailed anomaly scanning and fetal echocardiography are recommended.

Why not the others

- **A:** Cleft lip is less specifically associated.
- **C:** Diabetes does not cause chromosomal abnormalities.
- **D:** Gastroschisis is linked to young maternal age.
- **E:** Turner syndrome is chromosomal.

Key point: Good control before conception lowers anomaly risk.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis; Diabetes in pregnancy

MCQ 76 · Chromosomal Abnormalities · **Moderate** · C2

A 20-week scan shows a fetus with clenched hands with overlapping fingers, rocker-bottom feet, a strawberry-shaped skull, a ventricular septal defect and growth restriction.

What is the most likely chromosomal abnormality?

A. Triploidy
B. Trisomy 13 (Patau)
C. Trisomy 18 (Edwards)
D. Trisomy 21 (Down)
E. Turner syndrome

Answer: C. Trisomy 18 (Edwards)

Trisomy 18 is associated with clenched hands with overlapping fingers, rocker-bottom feet, strawberry skull, choroid plexus cysts, heart defects, exomphalos and early growth restriction. Most affected babies die in the first year.

Why not the others

- **A:** Triploidy shows severe early growth restriction and a large cystic placenta.
- **B:** Trisomy 13 shows holoprosencephaly, cleft lip and palate and polydactyly.
- **D:** Trisomy 21 shows increased nuchal fold, duodenal atresia and AVSD.
- **E:** Turner shows cystic hygroma and hydrops.

Key point: In trisomy 18 both hCG and PAPP-A are low.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 77 · Chromosomal Abnormalities · **Moderate** · C2

A 20-week scan shows fused cerebral ventricles (holoprosencephaly), a midline cleft lip and palate, and extra fingers on both hands.

What is the most likely diagnosis?

A. DiGeorge syndrome
B. Trisomy 13 (Patau)
C. Trisomy 18 (Edwards)
D. Trisomy 21 (Down)
E. Turner syndrome

Answer: B. Trisomy 13 (Patau)

Trisomy 13 typically shows holoprosencephaly, midline facial clefts, polydactyly, cardiac defects and exomphalos. It has a very poor prognosis.

Why not the others

- **A:** DiGeorge causes conotruncal heart defects and thymic hypoplasia.
- **C:** Trisomy 18 shows clenched hands and rocker-bottom feet.
- **D:** Trisomy 21 has different features.
- **E:** Turner shows hygroma and coarctation.

Key point: Holoprosencephaly + polydactyly + cleft = think trisomy 13.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 78 · Chromosomal Abnormalities · **Hard** · C2

At 18 weeks, a scan shows severe asymmetrical fetal growth restriction with a large head relative to the body, and a large placenta with multiple cystic spaces. The mother has early-onset severe pre-eclampsia.

What is the most likely fetal karyotype?

A. 45,X
B. 46,XX
C. 47,XX,+21
D. 47,XXY
E. 69,XXX (triploidy)

Answer: E. 69,XXX (triploidy)

Triploidy (69 chromosomes) with an extra paternal set causes a partial mole with a large cystic placenta, early severe growth restriction and early-onset pre-eclampsia. It is lethal.

Why not the others

- **A:** Turner shows hygroma and hydrops.
- **B:** A normal karyotype does not explain this picture.
- **C:** Trisomy 21 does not cause this pattern.
- **D:** Klinefelter is usually normal on scan.

Key point: Early-onset pre-eclampsia before 20 weeks suggests molar or triploid pregnancy.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 79 · Genetic Testing · **Hard** · C3

A 20-week scan shows multiple structural anomalies (cardiac and renal). QF-PCR for common trisomies is normal.

Which genetic test should be done next on the amniotic fluid sample?

A. Chromosomal microarray
B. FISH for X chromosome only
C. No further testing
D. Repeat QF-PCR
E. Serum AFP

Answer: A. Chromosomal microarray

Chromosomal microarray detects small deletions and duplications (copy number variants) not seen on standard karyotype. It is recommended when structural anomalies are found and rapid aneuploidy testing is normal. Exome sequencing may follow.

Why not the others

- **B:** FISH for X alone is too limited.
- **C:** Further testing may find the cause.
- **D:** Repeating gives the same result.
- **E:** AFP is a screening test.

Key point: Microarray may find variants of uncertain significance; counsel beforehand.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 80 · Fetal Anomalies · **Moderate** · C2

At 18 weeks, a scan shows absent skull vault and cerebral hemispheres above the orbits ("frog-like" appearance). There is polyhydramnios later.

What is the diagnosis?

A. Anencephaly
B. Encephalocele
C. Hydrocephalus
D. Microcephaly
E. Spina bifida occulta

Answer: A. Anencephaly

Anencephaly is absence of the skull vault and cerebral hemispheres. It is lethal and is usually detected at the 12-week or 20-week scan. Polyhydramnios occurs because swallowing is impaired.

Why not the others

- **B:** Encephalocele is herniation through a skull defect.
- **C:** Hydrocephalus shows enlarged ventricles with a normal skull.
- **D:** Microcephaly shows a small but present skull.
- **E:** Spina bifida occulta is usually not seen.

Key point: Recurrence risk after one NTD is about 2–5%; use 5 mg folic acid.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 81 · Fetal Anomalies · **Moderate** · C3

A 20-week scan shows the lateral cerebral ventricles measuring 12 mm (mild ventriculomegaly). No other abnormality is seen.

What is the most appropriate management?

A. Immediate delivery
B. Karyotype or microarray, infection screen, follow-up scans, and consider fetal MRI
C. No further action
D. Shunt insertion in utero
E. Termination is required

Answer: B. Karyotype or microarray, infection screen, follow-up scans, and consider fetal MRI

Ventricles of 10–15 mm are mild ventriculomegaly. Many outcomes are normal, but it may be associated with chromosomal abnormalities, infection (CMV, toxoplasma) and other brain anomalies. Investigations and follow-up scans guide counselling.

Why not the others

- **A:** Delivery is not indicated.
- **C:** Assessment is needed.
- **D:** In-utero shunting is not standard.
- **E:** Most isolated mild cases have good outcomes.

Key point: Isolated mild ventriculomegaly has a good prognosis in most cases.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 82 · Fetal Anomalies · **Hard** · C2

At 32 weeks, a woman has polyhydramnios. The fetal stomach bubble cannot be seen on repeated scans.

What is the most likely fetal abnormality?

A. Duodenal atresia
B. Gastroschisis
C. Oesophageal atresia (often with tracheo-oesophageal fistula)
D. Pyloric stenosis
E. Renal agenesis

Answer: C. Oesophageal atresia (often with tracheo-oesophageal fistula)

Oesophageal atresia prevents swallowed fluid reaching the stomach, giving polyhydramnios with a small or absent stomach. It may be part of VACTERL association or associated with trisomy 18.

Why not the others

- **A:** Duodenal atresia shows a double bubble.
- **B:** Gastroschisis shows bowel outside.
- **D:** Pyloric stenosis presents after birth.
- **E:** Renal agenesis causes anhydramnios.

Key point: A nasogastric tube that cannot be passed at birth confirms oesophageal atresia.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 83 · Soft Markers · **Moderate** · C3

A 26-year-old woman had a low-chance combined test. At 20 weeks, the scan shows a single echogenic focus in the left ventricle of the heart. Cardiac anatomy is normal.

What is the most appropriate management?

A. Amniocentesis for all women
B. Echocardiogram every week
C. Reassure; an isolated echogenic intracardiac focus in a low-chance woman needs no further action
D. Repeat combined test
E. Termination of pregnancy

Answer: C. Reassure; an isolated echogenic intracardiac focus in a low-chance woman needs no further action

An echogenic intracardiac focus is a common soft marker (seen in about 3–5% of normal fetuses). If isolated in a woman with a low-chance screening result, it does not change her risk significantly and needs no further testing.

Why not the others

- **A:** Invasive testing is not indicated.
- **B:** Weekly echo is unnecessary.
- **D:** The combined test cannot be repeated at 20 weeks.
- **E:** There is no indication.

Key point: Soft markers matter more when several are present or screening was not done.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 84 · Soft Markers · **Moderate** · C3

At the 20-week scan, the umbilical cord is found to have only two vessels (one artery and one vein). No other anomaly is seen.

What is the most appropriate management?

A. Amniocentesis in all cases
B. Caesarean section at 37 weeks
C. Check fetal kidneys and heart carefully, and arrange growth scans
D. No further action at all
E. Termination of pregnancy

Answer: C. Check fetal kidneys and heart carefully, and arrange growth scans

A single umbilical artery is found in about 1% of pregnancies. It is associated with renal and cardiac anomalies and growth restriction. If isolated, the prognosis is good, but kidneys and heart should be checked and growth monitored.

Why not the others

- **A:** Invasive testing is not routinely needed if isolated.
- **B:** Mode of delivery is not affected.
- **D:** Some assessment is needed.
- **E:** There is no indication.

Key point: Most fetuses with an isolated single umbilical artery are normal.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 85 · Fetal Hydrops · **Hard** · C2

A 24-week scan shows fetal ascites, pleural effusions and skin oedema. The mother is RhD-positive with no red cell antibodies. She had a rash and joint pains 4 weeks ago, after her child had a "slapped cheek" illness.

What is the most likely cause of the hydrops?

A. Cytomegalovirus
B. Parvovirus B19 causing fetal anaemia
C. Rhesus disease
D. Rubella
E. Toxoplasmosis

Answer: B. Parvovirus B19 causing fetal anaemia

Parvovirus B19 infects red cell precursors, causing fetal anaemia and non-immune hydrops, especially before 20 weeks. Middle cerebral artery Doppler shows raised peak systolic velocity. Intrauterine transfusion can be lifesaving.

Why not the others

- **A:** CMV causes growth restriction and brain changes, less commonly hydrops.
- **C:** She has no red cell antibodies.
- **D:** Rubella causes congenital rubella syndrome.
- **E:** Toxoplasmosis causes brain calcification.

Key point: Non-immune hydrops causes include infection, cardiac, chromosomal, twin-twin transfusion and anaemia.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis; Infections in pregnancy

MCQ 86 · Invasive Testing · **Hard** · C3

A 32-year-old woman living with HIV has a high-chance screening result for trisomy 21 and wants amniocentesis. Her viral load is detectable.

What is the most appropriate advice?

A. Amniocentesis carries no transmission risk
B. CVS is safer than amniocentesis
C. Invasive testing is absolutely contraindicated for life
D. Offer cfDNA screening and, if invasive testing is needed, delay until viral load is undetectable on treatment
E. Proceed immediately without any changes

Answer: D. Offer cfDNA screening and, if invasive testing is needed, delay until viral load is undetectable on treatment

Invasive procedures can transmit HIV to the fetus, especially with a detectable viral load. Non-invasive cfDNA screening is preferred. If invasive testing is needed, it should ideally be done when the viral load is suppressed on antiretroviral therapy.

Why not the others

- **A:** There is a transmission risk.
- **B:** CVS is not safer for transmission.
- **C:** It is not absolutely contraindicated.
- **E:** Precautions are needed.

Key point: Similar caution applies to hepatitis B and C.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis; Infections in pregnancy

MCQ 87 · Invasive Testing · **Easy** · C3

A 30-year-old RhD-negative woman has amniocentesis at 16 weeks. She has no anti-D antibodies.

What should be given after the procedure?

A. Anti-D immunoglobulin
B. Antibiotics
C. Folic acid
D. Iron
E. Steroids

Answer: A. Anti-D immunoglobulin

Invasive procedures can cause fetomaternal haemorrhage. RhD-negative women without antibodies should receive anti-D immunoglobulin within 72 hours to prevent sensitisation.

Why not the others

- **B:** Antibiotics are not routinely needed.
- **C:** Folic acid is not related.
- **D:** Iron is not related.
- **E:** Steroids are for fetal lung maturity.

Key point: Other sensitising events include bleeding after 12 weeks, ECV and abdominal trauma.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis; Rhesus disease

MCQ 88 · Haemoglobinopathy · **Hard** · C3

Both partners are carriers of HbS (sickle cell trait). The woman is 10 weeks pregnant.

What should be offered?

A. Iron supplements
B. No further action because trait is harmless
C. Prenatal diagnosis by CVS, with counselling about a 25% risk of sickle cell disease
D. Repeat electrophoresis at 28 weeks
E. Termination without testing

Answer: C. Prenatal diagnosis by CVS, with counselling about a 25% risk of sickle cell disease

When both parents carry HbS, each pregnancy has a 25% risk of sickle cell disease (HbSS). Couples should be counselled and offered prenatal diagnosis by CVS early in pregnancy.

Why not the others

- **A:** Iron does not address the genetic risk.
- **B:** The fetus may have sickle cell disease.
- **D:** Repeat testing adds nothing.
- **E:** Decisions should follow diagnosis and counselling.

Key point: Screening by 10 weeks allows time for CVS.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 89 · Cystic Fibrosis · **Moderate** · C3

A woman whose sister has cystic fibrosis is a known carrier. Her husband tests negative for common CFTR mutations.

What is the most accurate statement about the risk to her baby?

A. Every child will be a carrier
B. The baby has a 25% risk
C. The baby has a 50% risk
D. The risk is low but not zero, because the screen does not detect all mutations
E. There is no risk at all

Answer: D. The risk is low but not zero, because the screen does not detect all mutations

Carrier screening detects most but not all CFTR mutations, so a negative test lowers the partner's carrier risk but does not remove it. The fetal risk is therefore low but not zero.

Why not the others

- **A:** Each child has a 50% chance of being a carrier from her.
- **B:** 25% applies only if both are confirmed carriers.
- **C:** 50% is not correct for a recessive condition.
- **E:** A small residual risk remains.

Key point: Echogenic bowel may raise suspicion of CF in the fetus.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 90 · Counselling · **Easy** · C3

A couple are told that their fetus has trisomy 21 confirmed by amniocentesis. They ask the doctor what they should do.

What is the most appropriate approach to counselling?

A. Advise continuing the pregnancy
B. Advise termination
C. Give non-directive counselling with accurate information and support for whichever choice they make
D. Refuse to discuss options
E. Tell them to decide within one hour

Answer: C. Give non-directive counselling with accurate information and support for whichever choice they make

Counselling after prenatal diagnosis should be non-directive: provide balanced information about the condition, options (continuing, palliative or supportive care, or termination where legal), and support their decision. Contact with support organisations may help.

Why not the others

- **A:** Directive advice is inappropriate.
- **B:** Directive advice is inappropriate.
- **D:** They are entitled to information.
- **E:** They need time.

Key point: Respect the couple's values and beliefs.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 91 · Fetal Anomalies · **Easy** · C2

A 20-week scan shows a defect in the upper lip extending into the nostril on the left side. The palate cannot be fully seen.

What is the most appropriate next step?

A. Immediate delivery
B. No action until birth
C. Refer to fetal medicine and cleft team for counselling and planning
D. Termination is required
E. Weekly scans

Answer: C. Refer to fetal medicine and cleft team for counselling and planning

Cleft lip with or without palate is common and usually isolated, with good surgical outcomes. Referral to fetal medicine and the cleft team allows assessment for associated anomalies and counselling about feeding and surgery.

Why not the others

- **A:** Delivery is not indicated.
- **B:** Planning helps the family prepare.
- **D:** Isolated cleft has a good outcome.
- **E:** Weekly scans are unnecessary.

Key point: Lip repair is usually at 3 months and palate at 6–12 months.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 92 · Fetal Anomalies · **Moderate** · C2

A 20-week scan shows both fetal feet turned inwards and downwards persistently. Everything else is normal.

What is the most likely diagnosis and prognosis?

A. Arthrogryposis with lethal outcome
B. Isolated talipes equinovarus, usually treatable after birth
C. Spina bifida in all cases
D. Thanatophoric dysplasia
E. Trisomy 18 in all cases

Answer: B. Isolated talipes equinovarus, usually treatable after birth

Isolated talipes (club foot) is common and usually has a good outcome with Ponseti casting after birth. Associated anomalies such as spina bifida or neuromuscular problems should be excluded.

Why not the others

- **A:** Arthrogryposis affects multiple joints.
- **C:** Spina bifida must be excluded but is not present in all cases.
- **D:** Thanatophoric dysplasia has short limbs and a small chest.
- **E:** Trisomy 18 has other features.

Key point: Check the spine carefully when talipes is seen.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 93 · Fetal Anomalies · **Hard** · C2

A 20-week scan shows very short, bowed long bones, a narrow bell-shaped chest and a large head with frontal bossing.

What is the most likely diagnosis?

A. Achondroplasia with normal survival
B. Constitutional short stature
C. Osteogenesis imperfecta type I
D. Spina bifida
E. Thanatophoric dysplasia

Answer: E. Thanatophoric dysplasia

Thanatophoric dysplasia is the commonest lethal skeletal dysplasia, with severe micromelia, bowed femurs, a narrow chest causing pulmonary hypoplasia and a large head. It is caused by FGFR3 mutations.

Why not the others

- **A:** Achondroplasia usually shows milder shortening appearing later in pregnancy.
- **B:** Constitutional short stature is not detectable at 20 weeks.
- **C:** OI type I is mild; lethal OI type II shows fractures.
- **D:** Spina bifida has spinal defects.

Key point: A narrow chest predicts lethal pulmonary hypoplasia.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 94 · Fetal Therapy · **Hard** · C3

A 23-week scan shows an isolated open lumbar spina bifida with a normal karyotype. The couple want to continue the pregnancy and ask about treatment before birth.

Which fetal therapy may improve outcomes?

A. Fetal blood transfusion
B. In-utero (open or fetoscopic) surgical repair of the spinal defect in specialist centres
C. Laser ablation of placental vessels
D. Maternal steroids
E. Shunting of the fetal bladder

Answer: B. In-utero (open or fetoscopic) surgical repair of the spinal defect in specialist centres

Prenatal repair of open spina bifida before 26 weeks in selected cases (MOMS trial) reduces the need for shunting and improves motor function, but increases risks of preterm birth and uterine dehiscence. It is done in specialist centres.

Why not the others

- **A:** Transfusion treats fetal anaemia.
- **C:** Laser treats twin-twin transfusion syndrome.
- **D:** Steroids do not treat spina bifida.
- **E:** Bladder shunts treat lower urinary tract obstruction.

Key point: Future pregnancies after open fetal surgery need caesarean delivery.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 95 · Screening in Twins · **Moderate** · C2

A 30-year-old woman with a dichorionic twin pregnancy at 12 weeks asks about screening for Down syndrome.

Which screening method is used in twins?

A. Combined test (nuchal translucency for each twin with serum markers)
B. No screening is possible in twins
C. Quadruple test is preferred
D. Serum markers alone
E. Third-trimester ultrasound only

Answer: A. Combined test (nuchal translucency for each twin with serum markers)

In twins, the combined test is used, with nuchal translucency measured for each fetus and serum markers combined to calculate a risk for each twin (or per pregnancy for monochorionic twins). The quadruple test is not recommended.

Why not the others

- **B:** Screening is possible.
- **C:** The quadruple test is less accurate in twins.
- **D:** Serum markers alone cannot assign risk to each fetus.
- **E:** Third-trimester scans are not for aneuploidy screening.

Key point: Chorionicity must be determined first.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis; Multiple pregnancy

MCQ 96 · Fetal Anomalies · **Moderate** · C2

A 20-week scan in a male fetus shows a dilated bladder with a "keyhole" appearance, bilateral hydronephrosis and reduced amniotic fluid.

What is the most likely diagnosis?

A. Bilateral renal agenesis
B. Multicystic dysplastic kidney
C. Posterior urethral valves (lower urinary tract obstruction)
D. Prune belly only
E. Ureteropelvic junction obstruction

Answer: C. Posterior urethral valves (lower urinary tract obstruction)

Posterior urethral valves in a male fetus obstruct the urethra, causing a dilated bladder with a keyhole sign, bilateral hydronephrosis and oligohydramnios, risking pulmonary hypoplasia and renal damage. Vesicoamniotic shunting may be considered in selected cases.

Why not the others

- **A:** Renal agenesis has no kidneys or bladder.
- **B:** MCDK is usually unilateral with a normal bladder.
- **D:** Prune belly may coexist but valves explain the keyhole sign.
- **E:** UPJ obstruction causes renal pelvis dilatation without a large bladder.

Key point: Oligohydramnios with bladder obstruction predicts poor lung development.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 97 · Fetal Imaging · **Moderate** · C2

A 26-week scan suggests agenesis of the corpus callosum, but views are limited by maternal obesity.

Which imaging gives better detail of fetal brain anatomy?

A. CT scan
B. Fetal MRI
C. PET scan
D. Plain X-ray
E. Repeat abdominal X-ray

Answer: B. Fetal MRI

Fetal MRI gives detailed images of brain anatomy without ionising radiation and is used when ultrasound is limited or to assess brain anomalies in detail.

Why not the others

- **A:** CT uses radiation and is not used for this.
- **C:** PET is not used.
- **D:** X-ray does not show soft tissue.
- **E:** X-ray does not show the brain.

Key point: Fetal MRI is usually done after 20 weeks.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 98 · Fetal Anomalies · **Easy** · C2

A 20-week scan shows a large solid and cystic mass arising from the fetal sacrum and coccyx.

What is the most likely diagnosis?

A. Myelomeningocele
B. Neuroblastoma
C. Sacrococcygeal teratoma
D. Spina bifida occulta
E. Wilms tumour

Answer: C. Sacrococcygeal teratoma

Sacrococcygeal teratoma is the commonest fetal tumour, arising from the coccyx. Large vascular tumours can cause high-output heart failure and hydrops. Most are benign and removed after birth.

Why not the others

- **A:** Myelomeningocele arises from the spine with neural tissue and the lemon/banana signs.
- **B:** Neuroblastoma arises in the adrenal.
- **D:** Spina bifida occulta is usually not visible.
- **E:** Wilms tumour is renal.

Key point: Monitor for hydrops and polyhydramnios.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 99 · Screening Principles · **Easy** · C2

A 25-year-old woman asks why she is being offered screening rather than a test that gives a definite answer.

What is the main difference between a screening test and a diagnostic test?

A. Diagnostic tests are always non-invasive
B. Screening identifies those at higher chance; diagnostic tests confirm or exclude the condition
C. Screening is more accurate
D. Screening tests are only done after birth
E. There is no difference

Answer: B. Screening identifies those at higher chance; diagnostic tests confirm or exclude the condition

Screening tests (combined test, cfDNA) identify women at higher chance of a condition, without risk to the pregnancy. Diagnostic tests (CVS, amniocentesis) confirm or exclude it but carry a small risk of miscarriage.

Why not the others

- **A:** Most diagnostic tests in pregnancy are invasive.
- **C:** Diagnostic tests are more accurate.
- **D:** Screening is done antenatally.
- **E:** There is an important difference.

Key point: Screening is always optional; women can decline.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

MCQ 100 · Genetic Testing · **Easy** · C2

A 38-year-old woman has amniocentesis after a high-chance result. She is very anxious and asks how soon she will know whether the baby has Down syndrome.

How long does rapid aneuploidy testing (QF-PCR) usually take?

A. 2–3 days
B. 2 weeks
C. 4 weeks
D. After the baby is born
E. Same hour

Answer: A. 2–3 days

Quantitative fluorescent PCR (QF-PCR) gives rapid results for trisomies 21, 18 and 13 (and sex chromosomes) usually within 2–3 working days. Full karyotype or microarray takes about 2 weeks.

Why not the others

- **B:** Two weeks is the time for full karyotype or microarray.
- **C:** Four weeks is too long.
- **D:** Results are available during pregnancy.
- **E:** It is not instant.

Key point: Rapid results reduce anxiety and allow timely decisions.

Reference: Obstetrics by Ten Teachers — Prenatal diagnosis

CHAPTER 3

Fetal Growth and Wellbeing

MCQ 101 · Definitions · **Easy** · C2

A 30-year-old woman at 32 weeks has an ultrasound showing an estimated fetal weight on the 6th centile. Umbilical artery Doppler is normal.

How is a small-for-gestational-age (SGA) fetus defined?

A. Abdominal circumference or estimated fetal weight below the 10th centile
B. Birth weight under 2.5 kg at any gestation
C. Estimated fetal weight below the 50th centile
D. Fundal height above dates
E. Head circumference above the 90th centile

Answer: A. Abdominal circumference or estimated fetal weight below the 10th centile

SGA is an estimated fetal weight or abdominal circumference below the 10th centile. Severe SGA is below the 3rd centile. Not all SGA fetuses are growth restricted; some are constitutionally small.

Why not the others

- **B:** Low birthweight (under 2.5 kg) is a different definition.
- **C:** The 50th centile is average.
- **D:** Fundal height above dates suggests a large baby.
- **E:** Large head size is not SGA.

Key point: Fetal growth restriction (FGR) means failure to reach growth potential, usually from placental insufficiency.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 102 · Fetal Growth Restriction · **Moderate** · C2

A 34-year-old smoker with chronic hypertension has serial scans. The abdominal circumference has fallen from the 50th to the 5th centile, while the head circumference remains on the 40th centile.

What pattern of growth restriction is this, and what is the usual cause?

A. Asymmetrical growth restriction, usually from placental insufficiency
B. Constitutionally small fetus
C. Macrosomia from diabetes
D. Symmetrical growth restriction, usually from chromosomal abnormality
E. Wrong dates

Answer: A. Asymmetrical growth restriction, usually from placental insufficiency

In placental insufficiency, the fetus redirects blood to the brain ("brain sparing"), so head growth is preserved while the abdomen (liver glycogen) falls behind: asymmetrical growth restriction. Symmetrical restriction suggests an early insult such as chromosomal abnormality or infection.

Why not the others

- **B:** A constitutionally small fetus grows along a low centile.
- **C:** Macrosomia is large.
- **D:** Symmetrical restriction affects all measurements.
- **E:** Dates were confirmed by early scans.

Key point: A falling growth trajectory is more important than a single small measurement.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 103 · Fetal Growth Restriction · **Easy** · C2

A 27-year-old woman has a small-for-gestational-age fetus at 34 weeks.

Which maternal factor is the commonest preventable cause of fetal growth restriction?

A. Advanced age
B. Blood group O
C. Cigarette smoking
D. Height over 170 cm
E. Previous normal birth

Answer: C. Cigarette smoking

Smoking reduces birth weight by about 200–300 g on average, through vasoconstriction and carbon monoxide. Other causes include pre-eclampsia, chronic hypertension, renal disease, infection, chromosomal abnormalities and substance misuse.

Why not the others

- **A:** Age over 40 is a risk factor but not preventable.
- **B:** Blood group is not relevant.
- **D:** Tall women tend to have bigger babies.
- **E:** A previous normal birth is not a risk factor.

Key point: Stopping smoking at any stage of pregnancy improves fetal growth.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 104 · Doppler · **Moderate** · C2

A 32-week growth-restricted fetus has umbilical artery Doppler showing absent end-diastolic flow.

What does absent end-diastolic flow in the umbilical artery indicate?

A. Fetal anaemia
B. High placental resistance from placental insufficiency
C. Normal finding at 32 weeks
D. Polyhydramnios
E. Twin-twin transfusion

Answer: B. High placental resistance from placental insufficiency

Normally, diastolic flow in the umbilical artery increases through pregnancy as placental resistance falls. Raised resistance from placental insufficiency reduces diastolic flow; absent or reversed end-diastolic flow indicates severe compromise and a high risk of stillbirth.

Why not the others

- **A:** Anaemia is assessed by MCA peak systolic velocity.
- **C:** Diastolic flow should be present.
- **D:** Polyhydramnios is unrelated.
- **E:** TTTS has its own staging.

Key point: Reversed end-diastolic flow is even more serious than absent flow.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 105 · Doppler · **Hard** · C3

A 31-week fetus with growth restriction has reversed end-diastolic flow in the umbilical artery. Ductus venosus Doppler shows absent a-wave and computerised CTG short-term variation is reduced.

What is the most appropriate management?

A. Bed rest and repeat scan in 2 weeks
B. Corticosteroids, magnesium sulfate and delivery by caesarean section
C. Induction of labour at 37 weeks
D. Low-dose aspirin only
E. Repeat Doppler next week

Answer: B. Corticosteroids, magnesium sulfate and delivery by caesarean section

Reversed umbilical artery flow, abnormal ductus venosus and reduced CTG variability indicate severe fetal compromise. Delivery is indicated after corticosteroids (for lung maturity) and magnesium sulfate (for neuroprotection under 32 weeks), usually by caesarean section.

Why not the others

- **A:** Waiting risks stillbirth.
- **C:** Waiting to 37 weeks is unsafe.
- **D:** Aspirin does not treat established FGR.
- **E:** Waiting a week risks stillbirth.

Key point: Ductus venosus changes are late signs of fetal decompensation.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 106 · Doppler · **Hard** · C2

A 37-week SGA fetus has a normal umbilical artery Doppler but a low middle cerebral artery pulsatility index (cerebroplacental ratio is low).

What does this finding indicate?

A. Fetal anaemia

B. Fetal brain sparing (redistribution of blood to the brain), suggesting late-onset FGR

C. Normal growth

D. Polyhydramnios

E. Twin pregnancy

Answer: B. Fetal brain sparing (redistribution of blood to the brain), suggesting late-onset FGR

In late-onset FGR, the umbilical artery may be normal but cerebral vasodilatation (low MCA PI and low cerebroplacental ratio) shows redistribution to the brain. This is associated with poorer outcomes and supports delivery at term.

Why not the others

- **A:** Anaemia raises MCA peak systolic velocity.
- **C:** This is not normal.
- **D:** Polyhydramnios is unrelated.
- **E:** Twins are not relevant.

Key point: Late FGR often has a normal umbilical artery Doppler.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 107 · Management of FGR · **Moderate** · C3

A 36-week SGA fetus (EFW on the 5th centile) has a normal umbilical artery Doppler, normal liquor and normal CTG.

What is the most appropriate plan for delivery?

A. Deliver by caesarean today

B. Immediate induction at 36 weeks

C. Monitor with fortnightly Doppler and offer delivery by 37 weeks

D. No monitoring needed

E. Wait until 42 weeks

Answer: C. Monitor with fortnightly Doppler and offer delivery by 37 weeks

An SGA fetus with normal umbilical artery Doppler should be monitored (Doppler at least fortnightly) and delivery offered at 37 weeks. Induction of labour is reasonable with continuous monitoring in labour.

Why not the others

- **A:** Emergency caesarean is not indicated.
- **B:** Early delivery is not needed with normal Doppler.
- **D:** Monitoring is needed.
- **E:** Waiting to 42 weeks increases stillbirth risk.

Key point: Abnormal Doppler shortens the time to delivery.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; RCOG Green-top 31

MCQ 108 · Antenatal Corticosteroids · **Moderate** · C2

A 30-week growth-restricted fetus is likely to need delivery within the next few days.

What is the main benefit of giving the mother corticosteroids before preterm delivery?

A. Increase fetal growth
B. Prevent pre-eclampsia
C. Reduce neonatal respiratory distress syndrome, intraventricular haemorrhage and death
D. Speed up labour
E. Treat maternal infection

Answer: C. Reduce neonatal respiratory distress syndrome, intraventricular haemorrhage and death

Antenatal corticosteroids (betamethasone or dexamethasone, two doses 12–24 hours apart) accelerate fetal lung maturation and reduce respiratory distress syndrome, intraventricular haemorrhage, necrotising enterocolitis and neonatal death. Benefit is greatest when delivery occurs 24 hours to 7 days after the first dose.

Why not the others

- **A:** Steroids do not increase growth.
- **B:** They do not prevent pre-eclampsia.
- **D:** They do not affect labour.
- **E:** They do not treat infection.

Key point: Steroids can cause transient maternal hyperglycaemia; monitor in diabetes.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; Preterm labour

MCQ 109 · Magnesium Neuroprotection · **Moderate** · C2

A 29-week woman is about to have a caesarean section for severe fetal growth restriction.

Why is magnesium sulfate given before preterm delivery under 30 weeks?

A. To lower maternal blood pressure
B. To prevent maternal seizures only
C. To reduce the risk of cerebral palsy in the baby
D. To relax the uterus
E. To treat fetal anaemia

Answer: C. To reduce the risk of cerebral palsy in the baby

Magnesium sulfate given before preterm birth (recommended under 30 weeks, considered up to 34 weeks) reduces the risk of cerebral palsy in the baby (neuroprotection).

Why not the others

- **A:** It is not used for blood pressure control.
- **B:** Seizure prevention applies in pre-eclampsia; here it is for neuroprotection.
- **D:** It is not an effective tocolytic.
- **E:** It does not treat anaemia.

Key point: Monitor reflexes, respiratory rate and urine output during magnesium infusion.

Reference: Obstetrics by Ten Teachers — Preterm labour; Fetal growth and wellbeing

MCQ 110 · Amniotic Fluid · **Easy** · C2

An ultrasound at 34 weeks reports a deepest vertical pool of amniotic fluid of 1.5 cm.

What does this finding indicate?

A. Normal liquor volume
B. Oligohydramnios
C. Polyhydramnios
D. Twin pregnancy
E. Wrong dates

Answer: B. Oligohydramnios

Oligohydramnios is a deepest vertical pool under 2 cm or an amniotic fluid index under 5 cm. Causes include ruptured membranes, placental insufficiency with FGR, fetal renal anomalies and post-term pregnancy.

Why not the others

- **A:** Normal deepest pool is 2–8 cm.
- **C:** Polyhydramnios is a pool over 8 cm or AFI over 25 cm.
- **D:** Liquor volume does not indicate twins.
- **E:** Dates are not assessed this way.

Key point: Oligohydramnios with FGR suggests placental insufficiency.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 111 · Amniotic Fluid · **Moderate** · C2

A 30-year-old woman at 32 weeks has a tense, large-for-dates uterus. Ultrasound shows an amniotic fluid index of 32 cm. Fetal anatomy looks normal.

What is the most common identifiable maternal cause of polyhydramnios?

A. Chronic hypertension
B. Diabetes mellitus
C. Hyperthyroidism
D. Iron deficiency
E. Smoking

Answer: B. Diabetes mellitus

Polyhydramnios (AFI over 25 cm or deepest pool over 8 cm) is often idiopathic. Maternal diabetes is the commonest identifiable maternal cause (fetal polyuria). Fetal causes include gut atresia, neuromuscular conditions and twin-twin transfusion.

Why not the others

- **A:** Hypertension is linked to oligohydramnios via FGR.
- **C:** Hyperthyroidism is not a common cause.
- **D:** Anaemia is not a cause.
- **E:** Smoking is linked to FGR and oligohydramnios.

Key point: Do an oral glucose tolerance test in unexplained polyhydramnios.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 112 · Amniotic Fluid · **Hard** · C3

A 28-year-old woman at 33 weeks has severe polyhydramnios with breathlessness and abdominal discomfort. The fetus has oesophageal atresia.

Which complications is she at increased risk of?

A. Fetal growth restriction and oligohydramnios
B. Post-term pregnancy
C. Preterm labour, malpresentation, cord prolapse and postpartum haemorrhage
D. Reduced risk of placental abruption
E. Small-for-dates uterus

Answer: C. Preterm labour, malpresentation, cord prolapse and postpartum haemorrhage

Polyhydramnios overdistends the uterus, increasing preterm labour, unstable lie and malpresentation, cord prolapse when membranes rupture, placental abruption after sudden decompression, and postpartum haemorrhage from uterine atony.

Why not the others

- **A:** These are linked to oligohydramnios.
- **B:** Preterm birth, not post-term, is more likely.
- **D:** Abruption risk increases with sudden decompression.
- **E:** The uterus is large for dates.

Key point: Controlled amnioreduction or indomethacin may be used for severe symptoms.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 113 · Reduced Fetal Movements · **Easy** · C3

A 26-year-old woman at 34 weeks reports that her baby has moved less than usual since yesterday. She has no other symptoms.

What is the most appropriate first step?

A. Advise her to count kicks at home for a week
B. Auscultate the fetal heart and perform a CTG the same day
C. Immediate caesarean section
D. Reassure by phone without assessment
E. Wait until her next routine appointment

Answer: B. Auscultate the fetal heart and perform a CTG the same day

Reduced fetal movements after 28 weeks can precede stillbirth. Women should be assessed promptly: confirm fetal heartbeat and perform a CTG. An ultrasound for growth and liquor is arranged if there are risk factors or concerns.

Why not the others

- **A:** Kick charts are not recommended.
- **C:** Caesarean is not indicated without findings.
- **D:** She must be seen.
- **E:** Delay can be fatal.

Key point: Women should be told to report reduced movements immediately and not wait.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 114 · Reduced Fetal Movements · **Moderate** · C3

A 31-year-old woman at 36 weeks has her second presentation with reduced fetal movements this week. CTG is normal.

What is the most appropriate management?

A. Advise that recurrent reduced movements are normal
B. Caesarean section today
C. Discharge without further tests
D. Repeat CTG in 1 month
E. Ultrasound for fetal growth, liquor and Doppler, and consider delivery

Answer: E. Ultrasound for fetal growth, liquor and Doppler, and consider delivery

Recurrent reduced fetal movements are associated with adverse outcomes. An ultrasound scan for growth, liquor volume and Doppler is recommended, with discussion of induction of labour depending on findings.

Why not the others

- **A:** Recurrent RFM is a warning sign.
- **B:** Caesarean is not indicated without findings.
- **C:** Further assessment is needed.
- **D:** One month is too long.

Key point: Do not rely on a normal CTG alone for recurrent RFM.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 115 · Antenatal CTG · **Moderate** · C2

A CTG at 36 weeks shows a baseline fetal heart rate of 140/min, variability of 10 bpm and two accelerations of more than 15 bpm in 20 minutes, with no decelerations.

How should this CTG be classified?

A. Abnormal
B. Normal (reactive)
C. Pathological
D. Sinusoidal
E. Suspicious

Answer: B. Normal (reactive)

A normal antenatal CTG has a baseline of 110–160/min, variability of 5–25 bpm, accelerations and no decelerations. Accelerations are a sign of a healthy, non-hypoxic fetus.

Why not the others

- **A:** All features are normal.
- **C:** There are no pathological features.
- **D:** A sinusoidal pattern is a smooth wave suggesting anaemia.
- **E:** No feature is suspicious.

Key point: Computerised CTG (Dawes–Redman) measures short-term variation antenatally.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 116 · Biophysical Profile · **Moderate** · C2

A biophysical profile is performed on a 35-week fetus with growth restriction.

Which components make up the biophysical profile?

A. Biparietal diameter, femur length and head circumference
B. CTG, fetal breathing, fetal movements, fetal tone and amniotic fluid volume
C. Maternal BP, urine protein and platelets
D. Placental grading only
E. Umbilical artery Doppler only

Answer: B. CTG, fetal breathing, fetal movements, fetal tone and amniotic fluid volume

The biophysical profile scores five components (each 0 or 2): non-stress test (CTG), fetal breathing movements, gross body movements, fetal tone and amniotic fluid volume. A score of 8–10 is reassuring.

Why not the others

- **A:** These are biometry measurements.
- **C:** These assess pre-eclampsia.
- **D:** Placental grading is not part of it.
- **E:** Doppler is a separate test.

Key point: Doppler is now more commonly used than the BPP for FGR.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 117 · Large for Gestational Age · **Moderate** · C2

A 33-year-old woman with gestational diabetes has a scan at 36 weeks showing an estimated fetal weight above the 97th centile with an abdominal circumference much larger than the head.

Which complication at delivery is this fetus most at risk of?

A. Breech presentation
B. Cord prolapse
C. Placenta praevia
D. Shoulder dystocia
E. Small baby syndrome

Answer: D. Shoulder dystocia

Macrosomia, particularly in diabetes where the trunk and shoulders grow disproportionately, increases the risk of shoulder dystocia and brachial plexus injury, as well as prolonged labour and postpartum haemorrhage.

Why not the others

- **A:** Macrosomia does not cause breech.
- **B:** Cord prolapse is linked to malpresentation and polyhydramnios.
- **C:** Placenta praevia is unrelated.
- **E:** The baby is large.

Key point: Babies of diabetic mothers also risk neonatal hypoglycaemia.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; Diabetes in pregnancy

MCQ 118 · Stillbirth · **Moderate** · C3

A 29-year-old woman at 37 weeks reports no fetal movements for 2 days. Ultrasound confirms intrauterine fetal death. She is well, BP normal and there are no signs of infection or bleeding.

What is the recommended management?

A. Caesarean section immediately in all cases

B. Discharge for 6 weeks and wait

C. Discuss options; recommend induction of labour (mifepristone then misoprostol), with investigations to find the cause

D. Induce only after 4 weeks

E. Wait for spontaneous labour without discussion

Answer: C. Discuss options; recommend induction of labour (mifepristone then misoprostol), with investigations to find the cause

After stillbirth, vaginal birth by induction (mifepristone followed by misoprostol) is usually recommended. Caesarean is reserved for specific indications. Investigations (maternal bloods, Kleihauer, infection screen, placental histology, and post-mortem with consent) help find the cause.

Why not the others

- **A:** Caesarean carries risks and is not routinely needed.
- **B:** Prolonged retention risks infection and coagulopathy.
- **D:** Delay risks complications.
- **E:** Discussion and support are needed.

Key point: Offer lactation suppression with cabergoline and bereavement support.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; Stillbirth

MCQ 119 · Stillbirth · **Hard** · C2

A 33-year-old woman has a stillbirth at 36 weeks. She had a minor fall a week ago but no bleeding. She is RhD-negative.

Which test is important to detect fetomaternal haemorrhage and guide anti-D dosing?

A. Coombs test of the baby

B. Kleihauer–Betke test

C. Liver function

D. Serum ferritin

E. Urine culture

Answer: B. Kleihauer–Betke test

The Kleihauer test detects fetal red cells in maternal blood, indicating fetomaternal haemorrhage, which can cause stillbirth. In RhD-negative women it guides the dose of anti-D needed.

Why not the others

- **A:** A direct Coombs test on the baby detects antibody-coated red cells.
- **C:** Liver tests check for cholestasis or pre-eclampsia.
- **D:** Ferritin assesses iron stores.
- **E:** Urine culture checks for infection.

Key point: Do the Kleihauer test before delivery if possible.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; Stillbirth

MCQ 120 · Stillbirth · **Easy** · C2

A 30-year-old woman is counselled after a stillbirth. She asks what factors increase stillbirth risk in future pregnancies.

Which factor most increases the risk of stillbirth?

A. Breastfeeding a previous baby
B. Female fetus
C. Fetal growth restriction (especially undetected)
D. Normal BMI
E. Sleeping on her left side

Answer: C. Fetal growth restriction (especially undetected)

Fetal growth restriction, particularly when not detected antenatally, is the largest identifiable risk factor for stillbirth. Others include smoking, obesity, advanced maternal age, pre-existing diabetes and hypertension, and going to sleep on the back after 28 weeks.

Why not the others

- **A:** Breastfeeding does not increase risk.
- **B:** Fetal sex has little effect.
- **D:** Normal BMI is lower risk.
- **E:** Left-side sleeping is the recommended position.

Key point: Advise sleeping on the side, not the back, after 28 weeks.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; Stillbirth

MCQ 121 · Post-term Pregnancy · **Easy** · C3

A 28-year-old woman with an uncomplicated pregnancy, dated by early scan, is at 41 weeks.

What is the recommended management?

A. Caesarean section
B. Offer induction of labour (with membrane sweep beforehand)
C. Wait for spontaneous labour with no monitoring
D. Wait until 44 weeks
E. Weekly CTG only until 43 weeks

Answer: B. Offer induction of labour (with membrane sweep beforehand)

The risk of stillbirth rises after 41 weeks. Induction of labour is offered between 41+0 and 42+0 weeks, with a membrane sweep offered beforehand. Women who decline should be offered increased monitoring (CTG and ultrasound for liquor).

Why not the others

- **A:** Caesarean is not routinely indicated.
- **C:** Monitoring is needed if she declines induction.
- **D:** Waiting to 44 weeks is unsafe.
- **E:** Monitoring without discussing induction is not recommended.

Key point: A membrane sweep increases the chance of spontaneous labour.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; Induction of labour

MCQ 122 · Prevention of FGR · **Moderate** · C3

A 32-year-old woman's first baby had severe early-onset FGR at 30 weeks due to placental insufficiency. She is now 10 weeks pregnant.

Which measures are most appropriate in this pregnancy?

A. Bed rest from 20 weeks
B. High-protein diet only
C. Low-dose aspirin from 12 weeks and serial growth scans with uterine artery Doppler
D. No extra care
E. Progesterone injections

Answer: C. Low-dose aspirin from 12 weeks and serial growth scans with uterine artery Doppler

Women with previous placental-mediated FGR have a high recurrence risk. Low-dose aspirin from 12 weeks reduces risk, and uterine artery Doppler at 20–24 weeks with serial growth scans allows early detection.

Why not the others

- **A:** Bed rest does not improve growth.
- **B:** Diet supplements have no proven effect.
- **D:** She is high risk.
- **E:** Progesterone does not prevent FGR.

Key point: Low PAPP-A is another indication for serial scans.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 123 · Fetal Heart Rate · **Easy** · C2

A midwife auscultates the fetal heart at an antenatal visit at 30 weeks.

What is the normal fetal heart rate range?

A. 60–90/min
B. 90–110/min
C. 110–160/min
D. 160–200/min
E. 200–240/min

Answer: C. 110–160/min

The normal baseline fetal heart rate is 110–160 beats per minute. A baseline under 110 is bradycardia and over 160 is tachycardia (often due to maternal fever or infection).

Why not the others

- **A:** Severe bradycardia.
- **B:** Bradycardia.
- **D:** Tachycardia.
- **E:** Severe tachycardia or arrhythmia.

Key point: Preterm fetuses have higher baselines.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 124 · Customised Growth Charts · **Moderate** · C2

A midwife plots symphysis–fundal height on a chart adjusted for the mother's height, weight, parity and ethnicity.

What is the purpose of customised growth charts?

A. To calculate the due date
B. To diagnose diabetes
C. To improve detection of fetuses that are small for their individual growth potential
D. To measure amniotic fluid
E. To predict fetal sex

Answer: C. To improve detection of fetuses that are small for their individual growth potential

Customised charts adjust for maternal characteristics, improving detection of truly growth-restricted fetuses and reducing false alarms in constitutionally small mothers.

Why not the others

- **A:** Dates come from the dating scan.
- **B:** Diabetes is diagnosed by glucose tests.
- **D:** Liquor is measured by ultrasound.
- **E:** Sex is not predicted by growth charts.

Key point: Combining SFH charts with scans for high-risk women improves FGR detection.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 125 · Fetal Growth Restriction · **Hard** · C2

A 24-week fetus has an estimated fetal weight below the 3rd centile with symmetrical growth restriction, normal umbilical artery Doppler and echogenic bowel. The mother had a flu-like illness at 14 weeks.

Which cause should be investigated?

A. Congenital infection such as cytomegalovirus
B. Gestational diabetes
C. Maternal hyperthyroidism
D. Placental abruption
E. Post-term pregnancy

Answer: A. Congenital infection such as cytomegalovirus

Early symmetrical FGR with normal Doppler suggests a non-placental cause, such as congenital infection (especially CMV) or chromosomal abnormality. Maternal serology and amniocentesis for CMV PCR and karyotype are considered.

Why not the others

- **B:** Diabetes usually causes macrosomia.
- **C:** Hyperthyroidism is not the usual cause.
- **D:** Abruption causes acute compromise.
- **E:** It is mid-pregnancy.

Key point: Placental FGR usually shows abnormal Doppler; normal Doppler suggests another cause.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; Infections in pregnancy

MCQ 126 · Definitions · **Easy** · C2

A student asks how stillbirth is defined in the UK.

What is the UK definition of stillbirth?

A. A baby born dead after 12 weeks
B. A baby born dead after 20 weeks
C. A baby born with no signs of life at or after 24 completed weeks of pregnancy
D. A baby that dies in the first week of life
E. Any pregnancy loss

Answer: C. A baby born with no signs of life at or after 24 completed weeks of pregnancy

In the UK, stillbirth is a baby born with no signs of life at or after 24+0 weeks. Losses before 24 weeks are miscarriages. WHO uses 28 weeks for international comparisons.

Why not the others

- **A:** Losses at 12 weeks are miscarriages.
- **B:** Some countries use 20 or 22 weeks, but not the UK.
- **D:** That is an early neonatal death.
- **E:** Not all losses are stillbirths.

Key point: Perinatal mortality includes stillbirths and early neonatal deaths (first 7 days).

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; Stillbirth

MCQ 127 · Stillbirth · **Moderate** · C3

A 34-year-old woman has an unexplained stillbirth at 38 weeks. She wants to understand why it happened.

Which investigation gives the most information about the cause of stillbirth?

A. Full post-mortem examination with placental histology (with parental consent)
B. Maternal CA-125
C. Maternal ECG
D. Repeat ultrasound after delivery
E. Urine pregnancy test

Answer: A. Full post-mortem examination with placental histology (with parental consent)

A full post-mortem with placental histology identifies a cause or excludes others in many cases. Parents should be offered it sensitively; limited or non-invasive options exist if they decline full examination.

Why not the others

- **B:** CA-125 is not relevant.
- **C:** ECG is not relevant.
- **D:** Ultrasound after delivery adds little.
- **E:** A pregnancy test is not relevant.

Key point: Respect religious and cultural views about post-mortem.

Reference: Obstetrics by Ten Teachers — Stillbirth

MCQ 128 · Stillbirth · **Hard** · C2

A 32-year-old woman's fetus died 5 weeks ago, confirmed on scan, but she declined induction. She now has bruising and bleeding from the gums.

Which complication must be checked for?

A. Disseminated intravascular coagulation
B. Hyperthyroidism
C. Hypoglycaemia
D. Pre-eclampsia
E. Vitamin B12 deficiency

Answer: A. Disseminated intravascular coagulation

Retention of a dead fetus for more than about 4 weeks can cause disseminated intravascular coagulation, from release of thromboplastic substances. Clotting studies and fibrinogen should be checked, and delivery arranged.

Why not the others

- **B:** Hyperthyroidism does not cause bleeding.
- **C:** Hypoglycaemia does not cause bruising.
- **D:** Pre-eclampsia can cause low platelets but is less likely here.
- **E:** B12 deficiency does not cause this.

Key point: Placental abruption and infection also cause DIC in stillbirth.

Reference: Obstetrics by Ten Teachers — Stillbirth

MCQ 129 · Stillbirth · **Moderate** · C3

A 30-year-old woman whose previous baby was stillborn at 37 weeks from unexplained causes is now 12 weeks pregnant.

What is the most appropriate care in this pregnancy?

A. Caesarean at 32 weeks
B. Consultant-led care with serial growth scans and discussion of planned birth from 39 weeks or earlier
C. No extra care
D. Routine midwife care only
E. Weekly CTG from 12 weeks

Answer: B. Consultant-led care with serial growth scans and discussion of planned birth from 39 weeks or earlier

After a stillbirth, women should have consultant-led care, screening for risk factors (such as diabetes), serial growth scans, support for anxiety, and a discussion of timing of birth, often induction at 38–39 weeks.

Why not the others

- **A:** Very early caesarean causes prematurity.
- **C:** Extra care is needed.
- **D:** Specialist care is recommended.
- **E:** Weekly CTG from 12 weeks is meaningless.

Key point: Bereavement support should continue into the next pregnancy.

Reference: Obstetrics by Ten Teachers — Stillbirth

MCQ 130 · Uterine Artery Doppler · **Moderate** · C2

A 33-year-old woman at high risk of pre-eclampsia has a uterine artery Doppler at 22 weeks showing high resistance with bilateral early diastolic notching.

What does this finding predict?

A. Fetal anaemia
B. Higher risk of pre-eclampsia and FGR from impaired placentation
C. Macrosomia
D. Normal pregnancy
E. Polyhydramnios

Answer: B. Higher risk of pre-eclampsia and FGR from impaired placentation

Persistent high resistance and notching in the uterine arteries at 20–24 weeks reflect incomplete trophoblast invasion of the spiral arteries. This predicts early-onset pre-eclampsia and FGR, and leads to closer surveillance.

Why not the others

- **A:** Anaemia is assessed by MCA Doppler.
- **C:** Macrosomia is not predicted.
- **D:** It is an abnormal finding.
- **E:** Polyhydramnios is not predicted.

Key point: Serial growth scans are arranged when uterine artery Doppler is abnormal.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 131 · Placental Markers · **Hard** · C2

A 31-year-old woman's combined test shows a PAPP-A of 0.3 multiples of the median. Her chance of trisomy is low.

What is the clinical significance of a low PAPP-A?

A. Higher risk of fetal macrosomia
B. Higher risk of placental dysfunction (FGR, pre-eclampsia, stillbirth)
C. It confirms Down syndrome
D. Lower risk of preterm birth
E. No significance

Answer: B. Higher risk of placental dysfunction (FGR, pre-eclampsia, stillbirth)

A low PAPP-A (under 0.4 MoM) reflects reduced placental function and is associated with FGR, pre-eclampsia and stillbirth. Serial growth scans from 28 weeks and consideration of aspirin are recommended.

Why not the others

- **A:** Low PAPP-A is linked to small babies.
- **C:** Her trisomy chance is low.
- **D:** Preterm birth risk is higher.
- **E:** It has significance.

Key point: Placental growth factor (PlGF) is another marker of placental function.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 132 · Ultrasound Accuracy · **Moderate** · C2

A 29-year-old woman has a third-trimester scan showing an estimated fetal weight of 4.2 kg. She asks how accurate this is.

What is the typical margin of error for third-trimester ultrasound estimated fetal weight?

A. About 1%
B. About 10–15% either way
C. About 30%
D. About 50%
E. Exactly accurate

Answer: B. About 10–15% either way

Ultrasound estimated fetal weight has an error of about 10–15% in the third trimester, and accuracy is lower in large babies and obese women. Decisions should not rely on a single estimate.

Why not the others

- **A:** It is not that precise.
- **C:** 30% overstates the error.
- **D:** 50% overstates the error.
- **E:** It is not exact.

Key point: Serial measurements showing a trend are more useful than one value.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 133 · Large for Gestational Age · **Hard** · C3

A 34-year-old woman with type 1 diabetes has a fetus with an estimated weight of 4.6 kg at 38 weeks.

What is the most appropriate mode of delivery to discuss?

A. Breech extraction
B. Elective caesarean section
C. External cephalic version
D. Vaginal birth at 42 weeks
E. Ventouse at 8 cm

Answer: B. Elective caesarean section

In women with diabetes, an estimated fetal weight over about 4.5 kg is associated with a high risk of shoulder dystocia and brachial plexus injury. Elective caesarean section should be discussed and offered.

Why not the others

- **A:** Breech extraction is not relevant.
- **C:** ECV is for breech.
- **D:** Waiting increases size and stillbirth risk.
- **E:** Instrumental delivery before full dilatation is not done.

Key point: Women with diabetes are usually offered birth at 37–38+6 weeks.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; Fetal growth and wellbeing

MCQ 134 · Large for Gestational Age · **Moderate** · C3

A 30-year-old woman without diabetes has a scan at 38 weeks showing an estimated fetal weight of 4.1 kg. Her glucose tolerance test was normal.

What is the most appropriate management?

A. Caesarean section for all babies over 4 kg

B. Discuss options including expectant management or induction of labour; caesarean is not routinely indicated

C. Immediate delivery

D. Restrict her diet

E. Start insulin

Answer: B. Discuss options including expectant management or induction of labour; caesarean is not routinely indicated

Suspected macrosomia in non-diabetic women is not an indication for routine caesarean section. Options include expectant management or induction, after discussing the small increase in shoulder dystocia risk.

Why not the others

- **A:** Caesarean for all babies over 4 kg is not recommended.
- **C:** Immediate delivery is not indicated.
- **D:** Dieting at term does not help.
- **E:** She does not have diabetes.

Key point: Elective caesarean is considered at estimated weight over 5 kg without diabetes.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 135 · Post-term Pregnancy · **Moderate** · C2

A woman at 42+2 weeks declined induction. In labour, there is thick meconium-stained liquor.

Which neonatal complication is particularly associated with post-term pregnancy and meconium?

A. Hyaline membrane disease

B. Meconium aspiration syndrome

C. Necrotising enterocolitis

D. Physiological jaundice only

E. Retinopathy of prematurity

Answer: B. Meconium aspiration syndrome

Post-term pregnancy increases stillbirth, meconium passage and meconium aspiration syndrome, oligohydramnios, macrosomia and birth injury. Meconium aspiration can cause severe respiratory distress.

Why not the others

- **A:** Hyaline membrane disease affects preterm babies.
- **C:** NEC mainly affects preterm babies.
- **D:** Jaundice is not specific.
- **E:** Retinopathy affects preterm babies.

Key point: Continuous fetal monitoring is advised when meconium is present.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 136 · Oligohydramnios · **Moderate** · C3

A 30-year-old woman at 40+3 weeks has an ultrasound showing a deepest pool of 1.5 cm. The fetus is well grown and CTG is normal. Membranes are intact.

What is the most appropriate management?

A. Amnioinfusion at home
B. Encourage fluids and review in 2 weeks
C. Offer induction of labour
D. Reassure and wait until 42 weeks
E. Weekly scans until 43 weeks

Answer: C. Offer induction of labour

Oligohydramnios at or after term may indicate declining placental function and is associated with fetal compromise. Induction of labour is usually offered.

Why not the others

- **A:** Amnioinfusion is not a home treatment.
- **B:** Waiting 2 weeks is unsafe.
- **D:** Waiting is unsafe.
- **E:** Waiting is unsafe.

Key point: Always check for ruptured membranes when liquor is reduced.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 137 · Fetal Growth Restriction · **Hard** · C3

A 27-week fetus has severe FGR with absent end-diastolic flow but a normal ductus venosus and normal computerised CTG. Estimated weight is 650 g.

What is the most appropriate management?

A. Deliver immediately by caesarean
B. Give corticosteroids and monitor closely with frequent Doppler and computerised CTG, aiming to prolong pregnancy safely
C. Induction of labour now
D. No monitoring
E. Termination is required

Answer: B. Give corticosteroids and monitor closely with frequent Doppler and computerised CTG, aiming to prolong pregnancy safely

At very early gestations, each extra day in utero improves survival. With absent end-diastolic flow but normal ductus venosus and CTG, steroids are given and the fetus monitored intensively (TRUFFLE approach), delivering when ductus venosus or CTG becomes abnormal or by about 32 weeks.

Why not the others

- **A:** Very early delivery without signs of decompensation increases prematurity risks.
- **C:** Labour is poorly tolerated by a compromised preterm fetus.
- **D:** Close monitoring is essential.
- **E:** Management is individualised with the parents.

Key point: Delivery decisions at the limit of viability need neonatal team input.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 138 · Doppler · **Moderate** · C2

A student asks what the umbilical artery pulsatility index measures.

What does a raised umbilical artery pulsatility index reflect?

A. Fetal heart rate
B. Increased downstream resistance in the placenta
C. Maternal blood pressure
D. Placental position
E. Volume of amniotic fluid

Answer: B. Increased downstream resistance in the placenta

The pulsatility index compares systolic and diastolic flow. A raised PI in the umbilical artery means reduced diastolic flow from increased resistance in the placental vascular bed, as seen in placental insufficiency.

Why not the others

- **A:** Heart rate is measured on CTG.
- **C:** Maternal BP is measured with a cuff.
- **D:** Position is seen on scan.
- **E:** Liquor is measured separately.

Key point: PI falls normally as pregnancy advances.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 139 · Fetal Movements · **Easy** · C2

A 25-year-old woman at 38 weeks has been told that babies move less near term because there is less room.

What is the correct advice about fetal movements near term?

A. Movements normally stop in the last week
B. Movements should continue until labour; any reduction should be reported
C. Reduced movements are expected after 36 weeks
D. She should only worry if no movements for 3 days
E. She should use a home Doppler to check

Answer: B. Movements should continue until labour; any reduction should be reported

Fetal movements do not normally reduce towards term, although their character may change. Any reduction should be reported immediately. Home Doppler devices can give false reassurance.

Why not the others

- **A:** Movements continue until labour.
- **C:** Reduction is not normal.
- **D:** Waiting 3 days is dangerous.
- **E:** Home Dopplers are not recommended.

Key point: Women know their baby's pattern best.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 140 · Sleep Position · **Easy** · C3

A 30-year-old woman at 30 weeks asks about the safest way to go to sleep.

What is the recommended advice?

A. Any position is equally safe
B. Go to sleep on her side, not on her back, from 28 weeks
C. Sleep on her back only
D. Sleep on her front
E. Sleep sitting up

Answer: B. Go to sleep on her side, not on her back, from 28 weeks

Going to sleep on the back after 28 weeks is associated with a higher risk of stillbirth, probably from caval compression reducing uterine blood flow. Women are advised to go to sleep on their side (left or right).

Why not the others

- **A:** Supine sleep carries extra risk.
- **C:** Supine sleep carries extra risk.
- **D:** Lying prone is uncomfortable and not advised.
- **E:** Sitting is not necessary.

Key point: Waking on the back is common; she should simply turn to her side.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing; Stillbirth

MCQ 141 · Fetal Growth Restriction · **Moderate** · C2

A 30-year-old woman with a 33-week fetus with FGR asks how it may affect her baby long term.

Which long-term risk is linked to fetal growth restriction?

A. Higher risk of adult cardiovascular disease and type 2 diabetes
B. Lower risk of all diseases
C. No long-term effects
D. Protection from obesity
E. Taller adult height

Answer: A. Higher risk of adult cardiovascular disease and type 2 diabetes

The "developmental origins of health and disease" (Barker hypothesis) links fetal growth restriction to higher risk of hypertension, coronary heart disease and type 2 diabetes in adult life, and to neurodevelopmental problems.

Why not the others

- **B:** Risks increase, not decrease.
- **C:** There are long-term effects.
- **D:** Risk of metabolic syndrome increases.
- **E:** Growth-restricted babies may remain shorter.

Key point: Neonatal problems include hypoglycaemia, hypothermia and polycythaemia.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 142 · Fetal Growth Restriction · **Moderate** · C3

A 26-year-old woman with a 34-week FGR fetus has an umbilical artery Doppler with raised PI but positive end-diastolic flow. CTG is normal.

What is the most appropriate management?

A. Caesarean today

B. Discharge with routine care

C. Increase surveillance (Doppler twice weekly) and plan delivery by 37 weeks, giving steroids if delivery before 35 weeks

D. No further scans

E. Stop all monitoring

Answer: C. Increase surveillance (Doppler twice weekly) and plan delivery by 37 weeks, giving steroids if delivery before 35 weeks

Raised PI with positive end-diastolic flow is less severe than absent or reversed flow. Surveillance is increased and delivery planned by 37 weeks, or earlier if Doppler worsens.

Why not the others

- **A:** Immediate delivery is not needed with positive flow and normal CTG.
- **B:** Increased surveillance is needed.
- **D:** Scans are needed.
- **E:** Monitoring is needed.

Key point: Delivery timing in FGR depends on gestation and Doppler severity.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 143 · Neonatal Problems · **Moderate** · C2

A baby with severe growth restriction is born at 37 weeks weighing 2.0 kg.

Which early neonatal problem is common in growth-restricted babies?

A. Hyperglycaemia

B. Hypoglycaemia

C. Hypothermia is never seen

D. Macrosomia

E. Polyhydramnios

Answer: B. Hypoglycaemia

Growth-restricted babies have low glycogen and fat stores, so they are prone to hypoglycaemia and hypothermia. Polycythaemia and jaundice are also common. Early feeding and glucose monitoring are needed.

Why not the others

- **A:** Hyperglycaemia is uncommon.
- **C:** Hypothermia is common.
- **D:** The baby is small.
- **E:** Polyhydramnios is a pregnancy finding.

Key point: Feed early and keep warm.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 144 · Fetal Growth Restriction · **Hard** · C3

A 33-year-old woman at 32 weeks has FGR with umbilical artery absent end-diastolic flow. She asks about mode of delivery.

What is the most appropriate mode of delivery?

A. Caesarean section
B. External cephalic version first
C. Induction of labour with prostaglandins
D. Spontaneous labour at term
E. Vacuum-assisted vaginal birth

Answer: A. Caesarean section

A fetus with absent or reversed end-diastolic flow is unlikely to tolerate labour, so caesarean section is usually recommended. When end-diastolic flow is present, induction with continuous monitoring may be considered.

Why not the others

- **B:** ECV is for breech presentation.
- **C:** Labour risks hypoxia in this fetus.
- **D:** Waiting to term is unsafe.
- **E:** Instrumental birth requires labour.

Key point: Discuss with neonatologists before preterm delivery.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 145 · Stillbirth · **Moderate** · C3

A woman has a stillbirth at 35 weeks. During her pregnancy she complained of severe itching of her palms and soles, but bile acids were never checked.

Which condition should be investigated as a possible cause?

A. Acute fatty liver
B. Gestational diabetes
C. Hyperemesis gravidarum
D. Intrahepatic cholestasis of pregnancy
E. Pemphigoid gestationis

Answer: D. Intrahepatic cholestasis of pregnancy

Intrahepatic cholestasis of pregnancy causes itching of palms and soles and raised bile acids. Very high bile acids (100 µmol/L or more) are associated with an increased risk of stillbirth.

Why not the others

- **A:** AFLP causes vomiting and liver failure.
- **B:** GDM does not cause itching.
- **C:** Hyperemesis is early pregnancy vomiting.
- **E:** Pemphigoid causes a blistering rash.

Key point: Check bile acids in any pregnant woman with itching without a rash.

Reference: Obstetrics by Ten Teachers — Stillbirth; Medical disorders in pregnancy

MCQ 146 · Fetal Growth Restriction · **Easy** · C2

A 25-year-old woman with no risk factors is having routine care.

From what gestation is symphysis–fundal height measured at each antenatal visit?

A. 10 weeks
B. 16 weeks
C. 24 weeks
D. 34 weeks
E. 40 weeks

Answer: C. 24 weeks

SFH is measured at each appointment from 24 weeks and plotted on a growth chart to screen for SGA and LGA fetuses.

Why not the others

- **A:** The uterus is not palpable at 10 weeks.
- **B:** SFH is not reliable before 24 weeks.
- **D:** Too late to start.
- **E:** Too late to start.

Key point: Use a non-elastic tape measure, starting from the fundus.

Reference: Obstetrics by Ten Teachers — Antenatal care; Fetal growth and wellbeing

MCQ 147 · Small Fetus · **Moderate** · C2

A 30-year-old small woman (height 150 cm, weight 45 kg) has a fetus on the 8th centile on a standard chart, growing steadily along that centile, with normal Doppler and liquor.

What is the most likely explanation?

A. Constitutionally small but healthy fetus
B. Fetal anaemia
C. Placental abruption
D. Severe FGR needing immediate delivery
E. Wrong dates

Answer: A. Constitutionally small but healthy fetus

A fetus growing steadily along a low centile with normal Doppler and liquor, in a small mother, is likely constitutionally small. Customised charts help distinguish this from FGR. Monitoring continues.

Why not the others

- **B:** Anaemia does not cause this.
- **C:** Abruption causes acute problems.
- **D:** Normal Doppler and steady growth argue against severe FGR.
- **E:** Dates were confirmed early.

Key point: About half of SGA fetuses are constitutionally small and healthy.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 148 · Intrauterine Fetal Death · **Moderate** · C3

A 28-year-old woman has an intrauterine fetal death at 34 weeks. She is shocked and asks for a caesarean section immediately.

What is the most appropriate response?

A. Agree to caesarean immediately

B. Explain that vaginal birth is usually safer, discuss options and allow time, while checking she is medically well

C. Insist on vaginal birth without discussion

D. Send her home and do nothing

E. Tell her caesarean is impossible

Answer: B. Explain that vaginal birth is usually safer, discuss options and allow time, while checking she is medically well

Unless there is a medical indication, vaginal birth is recommended after stillbirth because it avoids surgical risks and scarring for future pregnancies. Women need time and sensitive discussion; many go home and return for induction within 24–48 hours if medically well.

Why not the others

- **A:** Caesarean carries unnecessary risk without an indication.
- **C:** Her views must be heard.
- **D:** Follow-up and plans are needed.
- **E:** Caesarean is possible but not usually advised.

Key point: Check BP, clotting and infection markers before she goes home.

Reference: Obstetrics by Ten Teachers — Stillbirth

MCQ 149 · Placental Abnormalities · **Moderate** · C2

The placenta of a growth-restricted baby shows multiple infarcts and small, poorly vascularised villi on histology.

What does this indicate?

A. Chorioamnionitis

B. Maternal vascular malperfusion of the placenta

C. Normal placenta

D. Placenta accreta

E. Twin placenta

Answer: B. Maternal vascular malperfusion of the placenta

Infarcts and distal villous hypoplasia indicate maternal vascular malperfusion, the typical placental lesion in pre-eclampsia and FGR, reflecting poor spiral artery remodelling.

Why not the others

- **A:** Chorioamnionitis shows inflammatory cells.
- **C:** These are abnormal findings.
- **D:** Accreta is abnormal invasion into the myometrium.
- **E:** Twin placentas are not suggested.

Key point: Placental histology helps explain stillbirth and FGR.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

MCQ 150 · Antenatal CTG · **Hard** · C2

An antenatal CTG at 34 weeks in a woman with reduced movements shows a smooth, regular, wave-like pattern with an amplitude of 5–15 bpm at about 3 cycles per minute, persisting for over 30 minutes, with no accelerations.

What does this pattern suggest?

A. Fetal sleep
B. Maternal tachycardia
C. Normal reactive trace
D. Severe fetal anaemia or hypoxia
E. Twin pregnancy

Answer: D. Severe fetal anaemia or hypoxia

A sinusoidal pattern is a regular, smooth, sine-wave-like oscillation that lasts more than 30 minutes. It is associated with severe fetal anaemia (such as from fetomaternal haemorrhage, rhesus disease or vasa praevia) or hypoxia, and needs urgent assessment.

Why not the others

- **A:** Sleep causes reduced variability but not a sinusoidal pattern.
- **B:** Maternal tachycardia does not cause this.
- **C:** It is not normal.
- **E:** Twins are not indicated.

Key point: Consider a Kleihauer test and MCA Doppler.

Reference: Obstetrics by Ten Teachers — Fetal growth and wellbeing

CHAPTER 4

Hypertensive Disorders of Pregnancy

MCQ 151 · Classification · **Easy** · C2

A 28-year-old primigravida at 32 weeks has a BP of 146/94 mmHg on two occasions 4 hours apart. Her booking BP at 10 weeks was 112/70. Urine protein:creatinine ratio is 12 mg/mmol. Blood tests are normal.

What is the diagnosis?

A. Chronic hypertension
B. Eclampsia
C. Gestational hypertension
D. HELLP syndrome
E. Pre-eclampsia

Answer: C. Gestational hypertension

Gestational hypertension is new hypertension (≥140/90 mmHg) after 20 weeks without significant proteinuria (uPCR under 30 mg/mmol) or other features of pre-eclampsia. About a quarter progress to pre-eclampsia, so monitoring continues.

Why not the others

- **A:** Chronic hypertension is present before 20 weeks.
- **B:** Eclampsia involves seizures.
- **D:** HELLP has haemolysis, raised liver enzymes and low platelets.
- **E:** There is no significant proteinuria or organ involvement.

Key point: Monitor BP and urine at least weekly in gestational hypertension.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; NICE NG133

MCQ 152 · Classification · **Easy** · C2

A 33-year-old woman at 34 weeks has a BP of 152/98 mmHg. Urine protein:creatinine ratio is 85 mg/mmol. Her BP was normal at booking.

What is the diagnosis?

A. Chronic hypertension
B. Gestational hypertension
C. Normal pregnancy
D. Pre-eclampsia
E. White coat hypertension

Answer: D. Pre-eclampsia

Pre-eclampsia is new hypertension after 20 weeks with significant proteinuria (uPCR 30 mg/mmol or more) or other maternal organ dysfunction (renal, liver, neurological, haematological) or uteroplacental dysfunction (FGR).

Why not the others

- **A:** BP was normal at booking.
- **B:** Proteinuria makes it pre-eclampsia.
- **C:** This is not normal.
- **E:** Proteinuria indicates real disease.

Key point: Pre-eclampsia can occur without proteinuria if other organ features are present.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 153 · Classification · **Moderate** · C2

A 36-year-old woman at 10 weeks has a BP of 150/96 mmHg on repeated readings. She has no proteinuria.

What is the diagnosis?

A. Chronic (pre-existing) hypertension
B. Gestational hypertension
C. HELLP syndrome
D. Physiological change of pregnancy
E. Pre-eclampsia

Answer: A. Chronic (pre-existing) hypertension

Hypertension before 20 weeks (or known before pregnancy) is chronic hypertension. BP normally falls in the first and second trimesters, so a high reading at 10 weeks indicates pre-existing disease. She is at higher risk of superimposed pre-eclampsia.

Why not the others

- **B:** Gestational hypertension arises after 20 weeks.
- **C:** HELLP occurs later with lab abnormalities.
- **D:** BP falls, not rises, in early pregnancy.
- **E:** Pre-eclampsia arises after 20 weeks.

Key point: Look for secondary causes in young women with hypertension.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 154 · Pathophysiology · **Moderate** · C2

A student asks what causes pre-eclampsia.

What is the key underlying abnormality in pre-eclampsia?

A. Excess maternal iron
B. Fetal anaemia
C. Hyperthyroidism
D. Inadequate trophoblast invasion of the spiral arteries, causing placental ischaemia and endothelial dysfunction
E. Viral infection of the placenta

Answer: D. Inadequate trophoblast invasion of the spiral arteries, causing placental ischaemia and endothelial dysfunction

In pre-eclampsia, trophoblast fails to remodel the maternal spiral arteries into low-resistance vessels. The ischaemic placenta releases anti-angiogenic factors (such as sFlt-1) and reduces placental growth factor (PlGF), causing widespread maternal endothelial dysfunction.

Why not the others

- **A:** Iron is not involved.
- **B:** Fetal anaemia is not the cause.
- **C:** Thyroid disease is not the cause.
- **E:** Infection is not the cause.

Key point: Delivery of the placenta is the only cure.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 155 · Investigation · **Moderate** · C3

A 30-year-old woman at 30 weeks has a BP of 142/90 mmHg and mild headache. Proteinuria is borderline. The team is unsure whether she has pre-eclampsia.

Which blood test helps to rule out pre-eclampsia in the next 1–2 weeks?

A. Alpha-fetoprotein
B. CA-125
C. Placental growth factor (PlGF)-based testing
D. Serum ferritin
E. Thyroid function

Answer: C. Placental growth factor (PlGF)-based testing

PlGF-based testing (PlGF alone or sFlt-1:PlGF ratio) between 20 and 35 weeks (36+6 for some tests) has a high negative predictive value for pre-eclampsia needing delivery within 1–2 weeks. Low PlGF supports the diagnosis.

Why not the others

- **A:** AFP is for neural tube defects.
- **B:** CA-125 is not relevant.
- **D:** Ferritin assesses iron.
- **E:** Thyroid tests are not relevant.

Key point: PlGF testing reduces unnecessary admissions and speeds diagnosis.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; NICE DG49

MCQ 156 · Risk Factors · **Easy** · C2

A 25-year-old woman at booking asks about her risk of pre-eclampsia.

Which is a high-risk factor for pre-eclampsia?

A. Being a non-smoker
B. Previous hypertensive disease in pregnancy
C. Previous uncomplicated pregnancy with the same partner
D. Second pregnancy
E. Young age (20–30)

Answer: B. Previous hypertensive disease in pregnancy

High-risk factors include previous hypertensive disease in pregnancy, chronic kidney disease, autoimmune disease (SLE, antiphospholipid syndrome), diabetes and chronic hypertension. One high-risk factor is an indication for aspirin.

Why not the others

- **A:** Smoking paradoxically lowers pre-eclampsia risk, but non-smoking is not a risk factor.
- **C:** A previous normal pregnancy is protective.
- **D:** First pregnancy is a risk factor.
- **E:** Age 40 or over is a risk factor.

Key point: Moderate risk factors: first pregnancy, age 40+, BMI 35+, family history, interval over 10 years, multiple pregnancy.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 157 · Antihypertensive Treatment · **Easy** · C3

A 30-year-old woman at 32 weeks has pre-eclampsia with BP 154/100 mmHg. She has no asthma.

What is the first-line oral antihypertensive?

A. Bendroflumethiazide
B. Enalapril
C. Labetalol
D. Losartan
E. Propranolol

Answer: C. Labetalol

Labetalol (an alpha and beta blocker) is first-line in pregnancy. Nifedipine is an alternative, especially in women with asthma, and methyldopa is another option. The target is about 135/85 mmHg.

Why not the others

- **A:** Diuretics reduce plasma volume and are avoided.
- **B:** ACE inhibitors are contraindicated antenatally.
- **D:** ARBs are contraindicated antenatally.
- **E:** Propranolol is not first line and may cause growth restriction.

Key point: Avoid labetalol in women with asthma; use nifedipine.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; NICE NG133

MCQ 158 · Antihypertensive Treatment · **Moderate** · C3

A 29-year-old woman with asthma has gestational hypertension at 30 weeks with BP 150/100 mmHg.

Which antihypertensive is most appropriate?

A. Atenolol
B. Enalapril
C. Labetalol
D. Modified-release nifedipine
E. Spironolactone

Answer: D. Modified-release nifedipine

Labetalol is a beta blocker and can trigger bronchospasm in asthma. Modified-release nifedipine is the preferred alternative. Methyldopa can also be used.

Why not the others

- **A:** Atenolol is a beta blocker linked to growth restriction.
- **B:** ACE inhibitors are contraindicated in pregnancy.
- **C:** Labetalol may worsen asthma.
- **E:** Spironolactone is not used in pregnancy.

Key point: Nifedipine may cause headache and flushing.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 159 · Antihypertensive Treatment · **Moderate** · C2

A 32-year-old woman with chronic hypertension asks about her BP target during pregnancy.

What BP target is recommended for women on antihypertensive treatment in pregnancy?

A. Below 110/60 mmHg
B. About 135/85 mmHg
C. About 150/100 mmHg
D. About 160/110 mmHg
E. No target; treat only symptoms

Answer: B. About 135/85 mmHg

NICE recommends treating BP of 140/90 or higher, with a target of 135/85 mmHg. Over-lowering BP may reduce placental perfusion.

Why not the others

- **A:** Too low; risks placental underperfusion.
- **C:** Too high.
- **D:** This is severe hypertension.
- **E:** BP itself should be treated.

Key point: Tight control (CHIPS trial) reduces severe hypertension without harming the fetus.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; NICE NG133

MCQ 160 · Severe Hypertension · **Moderate** · C3

A 31-year-old woman at 35 weeks has a BP of 172/114 mmHg confirmed on repeat. She has headache. Urine protein is 3+.

What is the most appropriate immediate management?

A. Bed rest without drugs

B. Oral methyldopa and recheck in a week

C. Rapid BP control with oral nifedipine, IV labetalol or IV hydralazine, and magnesium sulfate

D. Sublingual nifedipine capsule bitten

E. Wait for 24-hour urine collection

Answer: C. Rapid BP control with oral nifedipine, IV labetalol or IV hydralazine, and magnesium sulfate

Severe hypertension (160/110 or higher) needs urgent treatment within an hour to reduce the risk of stroke. Options are oral immediate-release nifedipine, IV labetalol or IV hydralazine. Magnesium sulfate is given for severe pre-eclampsia.

Why not the others

- **A:** Severe hypertension needs drugs.
- **B:** Methyldopa is too slow.
- **D:** Bitten sublingual nifedipine can drop BP too fast.
- **E:** Treatment must not wait for tests.

Key point: Stroke is a leading cause of death in pre-eclampsia.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 161 · Magnesium Sulfate · **Easy** · C2

A 26-year-old woman with severe pre-eclampsia is being prepared for delivery.

What is the main purpose of magnesium sulfate in severe pre-eclampsia?

A. Induce labour

B. Lower BP as the main treatment

C. Prevent and treat eclamptic seizures

D. Prevent postpartum haemorrhage

E. Treat fetal anaemia

Answer: C. Prevent and treat eclamptic seizures

Magnesium sulfate is the drug of choice to prevent and treat eclamptic seizures. It halves the risk of eclampsia (Magpie trial). It is not used mainly as an antihypertensive.

Why not the others

- **A:** It does not induce labour.
- **B:** It has only a minor effect on BP.
- **D:** It may slightly increase PPH by relaxing the uterus.
- **E:** It does not treat fetal anaemia.

Key point: Continue magnesium for 24 hours after delivery or the last seizure.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 162 · Magnesium Sulfate · **Moderate** · C2

A woman with severe pre-eclampsia is starting magnesium sulfate.

What is the standard Collaborative (Pritchard/Zuspan) loading and maintenance regimen used in the UK?

A. 1 g IV loading then 4 g/hour
B. 10 g IM only
C. 4 g IV over 5–15 minutes, then 1 g/hour for 24 hours
D. 4 g orally daily
E. No loading dose

Answer: C. 4 g IV over 5–15 minutes, then 1 g/hour for 24 hours

The UK (Zuspan) regimen is a 4 g IV loading dose over 5–15 minutes, followed by an infusion of 1 g/hour for 24 hours. A further 2–4 g bolus is given for recurrent seizures.

Why not the others

- **A:** These doses are reversed and dangerous.
- **B:** IM regimens (Pritchard) combine IV and IM doses.
- **D:** Magnesium sulfate is not given orally for this.
- **E:** A loading dose is needed.

Key point: Reduce the dose in renal impairment and monitor closely.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 163 · Magnesium Toxicity · **Moderate** · C3

A woman on magnesium sulfate infusion for severe pre-eclampsia has absent patellar reflexes, a respiratory rate of 9/min and drowsiness. Urine output has fallen to 15 mL/h.

What is the most appropriate immediate action?

A. Continue the infusion and recheck in 4 hours
B. Give calcium gluconate 10 mL of 10% IV and stop the infusion
C. Give furosemide only
D. Increase the magnesium dose
E. Start IV labetalol

Answer: B. Give calcium gluconate 10 mL of 10% IV and stop the infusion

Loss of reflexes and respiratory depression indicate magnesium toxicity, worsened by reduced urine output. Stop the infusion and give 10 mL of 10% calcium gluconate IV over 10 minutes, with airway support.

Why not the others

- **A:** Continuing risks respiratory arrest.
- **C:** Furosemide alone is not the antidote.
- **D:** Increasing the dose is dangerous.
- **E:** Labetalol does not treat toxicity.

Key point: Monitor reflexes, respiratory rate, oxygen saturation and urine output hourly.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 164 · Eclampsia · **Easy** · C3

A 19-year-old primigravida at 36 weeks with headache has a generalised tonic-clonic seizure on the ward. BP afterwards is 168/112 mmHg.

What is the most appropriate first step?

A. Call for help, secure the airway, place her in left lateral position and give magnesium sulfate
B. Emergency caesarean during the seizure
C. Give diazepam as first line
D. Insert a urinary catheter
E. Perform a CT brain first

Answer: A. Call for help, secure the airway, place her in left lateral position and give magnesium sulfate

Eclampsia is managed with ABC (call for help, airway, oxygen, left lateral position to avoid caval compression) and magnesium sulfate as the anticonvulsant. BP is controlled and delivery planned once she is stable.

Why not the others

- **B:** Delivery should not occur during a seizure; stabilise the mother first.
- **C:** Magnesium is more effective than diazepam.
- **D:** Catheterisation is later.
- **E:** Imaging is not the first step.

Key point: Stabilise the mother before delivering the baby.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 165 · Eclampsia · **Moderate** · C2

A 24-year-old woman delivered 5 days ago after an uncomplicated pregnancy with normal BP. She now has severe headache and visual disturbance, then has a seizure. BP is 160/105 mmHg.

What is the most likely diagnosis?

A. Epilepsy
B. Hypoglycaemia
C. Migraine
D. Postpartum eclampsia
E. Vasovagal syncope

Answer: D. Postpartum eclampsia

Eclampsia can occur up to 4 weeks after delivery, even without previous hypertension. Hypertension with headache and seizure postpartum is eclampsia until proved otherwise and is treated with magnesium sulfate. Imaging may be needed to exclude other causes such as cerebral venous thrombosis.

Why not the others

- **A:** There is no history of epilepsy.
- **B:** Check glucose, but hypertension points to eclampsia.
- **C:** Migraine does not usually cause seizures with hypertension.
- **E:** Syncope does not cause hypertension.

Key point: About 40% of eclamptic seizures occur postpartum.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 166 · HELLP Syndrome · **Moderate** · C2

A 32-year-old woman at 33 weeks has right upper quadrant pain, nausea and malaise. BP is 148/96 mmHg. Haemoglobin 98 g/L, platelets 62 × 10^9/L, ALT 285 U/L, LDH 900 U/L, and the blood film shows fragmented red cells.

What is the most likely diagnosis?

A. Acute fatty liver of pregnancy
B. Gallstones
C. HELLP syndrome
D. Hepatitis A
E. Intrahepatic cholestasis

Answer: C. HELLP syndrome

HELLP syndrome is Haemolysis (fragmented cells, raised LDH), Elevated Liver enzymes and Low Platelets, a severe form of pre-eclampsia. It causes epigastric or right upper quadrant pain and needs delivery after stabilisation.

Why not the others

- **A:** AFLP has hypoglycaemia, coagulopathy and renal failure.
- **B:** Gallstones do not cause haemolysis and low platelets.
- **D:** Hepatitis does not cause haemolysis and hypertension.
- **E:** Cholestasis causes itch with raised bile acids.

Key point: HELLP can occur without severe hypertension.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 167 · Timing of Delivery · **Moderate** · C3

A 29-year-old woman has pre-eclampsia at 37+2 weeks. BP is controlled at 140/90 mmHg and blood tests are normal.

What is the recommended management?

A. Caesarean section immediately
B. Continue to 40 weeks
C. Deliver after 2 weeks of observation
D. Discharge home without follow-up
E. Plan delivery within 24–48 hours

Answer: E. Plan delivery within 24–48 hours

For women with pre-eclampsia at 37 weeks or more, delivery within 24–48 hours is recommended (HYPITAT trial). Mode of delivery depends on obstetric factors; induction is often possible.

Why not the others

- **A:** Caesarean is not automatically needed.
- **B:** Continuing increases maternal risk.
- **C:** Delay increases risk.
- **D:** She needs delivery.

Key point: Before 34 weeks, expectant management is preferred if mother and fetus are stable.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; NICE NG133

MCQ 168 · Timing of Delivery · **Hard** · C3

A 28-year-old woman has pre-eclampsia at 31 weeks. BP is controlled on labetalol, platelets and liver tests are normal, and the fetus is well grown with normal Doppler.

What is the most appropriate management?

A. Corticosteroids, close inpatient monitoring and expectant management, delivering if severe features develop
B. Delivery by caesarean today
C. Discharge home with routine care
D. Immediate induction
E. Stop antihypertensives

Answer: A. Corticosteroids, close inpatient monitoring and expectant management, delivering if severe features develop

Before 34 weeks, if the mother and fetus are stable, expectant management with close monitoring improves neonatal outcomes. Steroids are given. Delivery is indicated for uncontrolled BP, worsening bloods, neurological signs, eclampsia, HELLP, abruption, pulmonary oedema or fetal compromise.

Why not the others

- **B:** Delivery at 31 weeks without indication increases prematurity risks.
- **C:** She needs inpatient monitoring.
- **D:** Induction is not indicated now.
- **E:** BP must be controlled.

Key point: Indications for delivery are often maternal, not fetal.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 169 · Complications · **Moderate** · C3

A 30-year-old woman with severe pre-eclampsia after delivery becomes breathless with a respiratory rate of 30/min, SpO2 89% and bilateral crackles. She has had 3 litres of IV fluid in 12 hours.

What is the most likely diagnosis?

A. Amniotic fluid embolism
B. Asthma
C. Pneumonia
D. Pulmonary embolism
E. Pulmonary oedema from fluid overload

Answer: E. Pulmonary oedema from fluid overload

Women with pre-eclampsia have leaky capillaries and low oncotic pressure, so they easily develop pulmonary oedema. Fluids are restricted (usually about 80 mL/hour total). Treatment is oxygen, sitting up and furosemide.

Why not the others

- **A:** AFE presents with sudden collapse and coagulopathy, usually during labour.
- **B:** Asthma causes wheeze, not crackles.
- **C:** Pneumonia has fever and consolidation.
- **D:** PE has clear lungs typically.

Key point: Restrict fluids in pre-eclampsia, even when urine output is low.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 170 · Complications · **Moderate** · C2

A 33-year-old woman with pre-eclampsia at 34 weeks suddenly develops severe constant abdominal pain, a tense tender uterus and dark vaginal bleeding. The fetal heart rate is 90/min.

What is the most likely diagnosis?

A. Labour only
B. Placenta praevia
C. Placental abruption
D. Uterine rupture
E. Vasa praevia

Answer: C. Placental abruption

Pre-eclampsia is a major risk factor for placental abruption. Constant pain, a tender woody-hard uterus, dark bleeding (which may be concealed) and fetal compromise are typical. Emergency delivery and resuscitation are needed.

Why not the others

- **A:** Labour does not cause a woody uterus and constant pain.
- **B:** Placenta praevia causes painless bright red bleeding.
- **D:** Rupture usually occurs in labour with a scarred uterus.
- **E:** Vasa praevia bleeds at membrane rupture.

Key point: Watch for DIC in abruption.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; Antepartum haemorrhage

MCQ 171 · Postnatal Care · **Moderate** · C3

A 30-year-old woman had pre-eclampsia and delivered 3 days ago. She is breastfeeding. Her BP is 152/98 mmHg on labetalol.

Which antihypertensive is suitable postnatally while breastfeeding?

A. Enalapril
B. Losartan
C. Methyldopa long term
D. No treatment is needed
E. Spironolactone

Answer: A. Enalapril

Enalapril is suitable postnatally and compatible with breastfeeding. Nifedipine or amlodipine are alternatives (preferred in women of Black African or Caribbean origin), and labetalol can continue. Methyldopa should be stopped within 2 days of birth because of the risk of depression.

Why not the others

- **B:** ARBs have less data in breastfeeding.
- **C:** Methyldopa is linked to postnatal depression.
- **D:** BP needs treatment.
- **E:** Spironolactone is not first line.

Key point: BP often peaks 3–5 days after delivery.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; NICE NG133

MCQ 172 · Long-term Risks · **Moderate** · C2

A 32-year-old woman had severe pre-eclampsia in her first pregnancy. She asks about her future health.

Which long-term risk is increased after pre-eclampsia?

A. Breast cancer
B. Cardiovascular disease and chronic hypertension
C. Endometrial cancer
D. Osteoporosis
E. Thyroid cancer

Answer: B. Cardiovascular disease and chronic hypertension

Women who have had pre-eclampsia have about double the lifetime risk of cardiovascular disease and stroke, and a higher risk of chronic hypertension and kidney disease. Lifestyle advice and regular BP checks are recommended.

Why not the others

- **A:** Breast cancer is not increased.
- **C:** Endometrial cancer is not linked.
- **D:** Osteoporosis is not linked.
- **E:** Thyroid cancer is not linked.

Key point: Recurrence in the next pregnancy is about 1 in 6 (higher if early-onset).

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 173 · Chronic Hypertension · **Hard** · C2

A 26-year-old woman at 12 weeks has severe hypertension (172/108 mmHg), episodic headaches, palpitations and sweating. Her BP fluctuates widely.

Which condition must be excluded before labour or surgery?

A. Coarctation of the aorta only
B. Cushing's syndrome
C. Hyperaldosteronism
D. Phaeochromocytoma
E. Renal artery stenosis

Answer: D. Phaeochromocytoma

Phaeochromocytoma is rare but extremely dangerous in pregnancy, with high maternal and fetal mortality if unrecognised (labour, anaesthesia or drugs can trigger a crisis). Plasma or urine metanephrines should be checked. Alpha-blockade is started before beta-blockade.

Why not the others

- **A:** Coarctation causes upper-limb hypertension and radio-femoral delay.
- **B:** Cushing's causes other features.
- **C:** Hyperaldosteronism causes hypokalaemia.
- **E:** Renal artery stenosis does not cause paroxysms.

Key point: Never give beta blockers alone in suspected phaeochromocytoma.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 174 · Labour Management · **Moderate** · C3

A woman with severe pre-eclampsia is in labour. After delivery of the baby, the midwife asks which drug to use for the third stage.

Which uterotonic should be avoided?

A. Carbetocin
B. Ergometrine (including Syntometrine)
C. Misoprostol
D. Oxytocin
E. Tranexamic acid

Answer: B. Ergometrine (including Syntometrine)

Ergometrine causes vasoconstriction and can cause severe hypertension, stroke or eclampsia in women with hypertension. Oxytocin alone (or carbetocin) is used for the third stage.

Why not the others

- **A:** Carbetocin is acceptable.
- **C:** Misoprostol is acceptable.
- **D:** Oxytocin is the drug of choice.
- **E:** Tranexamic acid is not a uterotonic.

Key point: Syntometrine contains ergometrine.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 175 · Prevention · **Moderate** · C3

A 34-year-old woman has chronic hypertension and is 9 weeks pregnant.

Which preventive measure for pre-eclampsia should be started?

A. Antioxidant vitamins
B. Aspirin 75–150 mg daily from 12 weeks
C. Bed rest
D. Fish oil
E. Salt restriction

Answer: B. Aspirin 75–150 mg daily from 12 weeks

Chronic hypertension is a high-risk factor for pre-eclampsia. Low-dose aspirin from 12 weeks until birth reduces the risk. Calcium supplementation helps if dietary calcium is low.

Why not the others

- **A:** Vitamins C and E do not help.
- **C:** Bed rest does not prevent pre-eclampsia.
- **D:** Fish oil has no proven benefit.
- **E:** Salt restriction is not recommended.

Key point: Aspirin is most effective if started before 16 weeks.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 176 · Proteinuria · **Easy** · C3

A 27-year-old woman at 30 weeks has a BP of 144/92 mmHg. Urine dipstick shows 1+ protein.

How should proteinuria be quantified?

A. 24-hour collection only after delivery

B. Ignore 1+ protein

C. Repeat dipstick in 4 weeks

D. Serum albumin

E. Urine protein:creatinine ratio (significant if 30 mg/mmol or more)

Answer: E. Urine protein:creatinine ratio (significant if 30 mg/mmol or more)

Dipstick proteinuria of 1+ or more in a hypertensive woman should be quantified with a urine protein:creatinine ratio (30 mg/mmol or more is significant) or albumin:creatinine ratio (8 mg/mmol or more). 24-hour collections are no longer needed.

Why not the others

- **A:** Quantification is needed now, not after delivery.
- **B:** It may indicate pre-eclampsia.
- **C:** Waiting risks missing disease.
- **D:** Serum albumin does not quantify urine protein.

Key point: Dipsticks have many false positives and negatives.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; NICE NG133

MCQ 177 · BP Measurement · **Easy** · C2

A midwife is measuring BP in an obese woman at 28 weeks with a manual sphygmomanometer.

Which technique is correct?

A. Measure only after exercise

B. Use a cuff of appropriate size, with the woman seated, and record diastolic at Korotkoff phase V (disappearance)

C. Use a small cuff to get a lower reading

D. Use phase I for diastolic

E. Use the leg

Answer: B. Use a cuff of appropriate size, with the woman seated, and record diastolic at Korotkoff phase V (disappearance)

BP should be measured with the woman seated or semi-recumbent, using a cuff of the right size for her arm (a small cuff overestimates BP). Diastolic BP is recorded at Korotkoff V, the disappearance of sounds.

Why not the others

- **A:** Rest before measurement.
- **C:** A small cuff gives falsely high readings.
- **D:** Phase I is systolic.
- **E:** The arm is used.

Key point: Automated devices may underestimate BP in pre-eclampsia; check with a validated device.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 178 · Chronic Hypertension · **Moderate** · C3

A 35-year-old woman on ramipril and amlodipine for hypertension plans to conceive in the next few months.

What is the most appropriate pre-conception advice?

A. Continue ramipril throughout pregnancy

B. Stop all antihypertensives before conception

C. Switch ramipril to labetalol (keeping or adjusting amlodipine), or stop ramipril within 2 working days of a positive test

D. Take a diuretic instead

E. Use losartan instead

Answer: C. Switch ramipril to labetalol (keeping or adjusting amlodipine), or stop ramipril within 2 working days of a positive test

ACE inhibitors and ARBs are associated with fetal renal damage, especially later in pregnancy. Women planning pregnancy should switch to safer drugs or stop them within 2 working days of finding they are pregnant. Labetalol, nifedipine or amlodipine are suitable.

Why not the others

- **A:** ACE inhibitors are unsafe in pregnancy.
- **B:** Uncontrolled BP is harmful.
- **D:** Diuretics are avoided.
- **E:** ARBs have the same risks.

Key point: Also start aspirin from 12 weeks.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 179 · Chronic Hypertension · **Moderate** · C2

A 33-year-old woman with chronic hypertension is 24 weeks pregnant. Her BP is well controlled on labetalol.

Which additional fetal surveillance is recommended?

A. Amniocentesis

B. Daily CTG from 24 weeks

C. No surveillance

D. Serial ultrasound for fetal growth, liquor and umbilical artery Doppler from 28–30 weeks

E. Weekly MRI

Answer: D. Serial ultrasound for fetal growth, liquor and umbilical artery Doppler from 28–30 weeks

Chronic hypertension increases the risk of FGR and superimposed pre-eclampsia. Serial growth scans with liquor and umbilical artery Doppler are recommended from 28–30 weeks.

Why not the others

- **A:** Amniocentesis is not indicated.
- **B:** Daily CTG is unnecessary.
- **C:** Surveillance is needed.
- **E:** MRI is not used for this.

Key point: Offer birth from 37 weeks if BP is controlled.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 180 · Clinical Features · **Moderate** · C2

A 30-year-old woman at 35 weeks with pre-eclampsia is assessed for severity.

Which finding suggests severe pre-eclampsia and imminent eclampsia?

A. Ankle oedema only
B. Normal reflexes
C. Physiological heartburn
D. Platelets 280 × 10^9/L
E. Severe headache, visual disturbance and more than 3 beats of clonus

Answer: E. Severe headache, visual disturbance and more than 3 beats of clonus

Features of severe disease include severe headache, visual disturbance (flashing lights, blurring), epigastric pain, vomiting, hyperreflexia with clonus, papilloedema, reduced platelets, rising creatinine and raised liver enzymes.

Why not the others

- **A:** Ankle oedema is common in normal pregnancy.
- **B:** Normal reflexes are reassuring.
- **C:** Heartburn is common, though epigastric pain with high BP is concerning.
- **D:** A normal platelet count is reassuring.

Key point: Epigastric pain in pre-eclampsia suggests liver involvement.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 181 · Complications · **Hard** · C2

A 31-year-old woman with severe pre-eclampsia develops sudden severe epigastric and right shoulder pain, then becomes hypotensive and shocked. Her abdomen is distended.

What is the most likely complication?

A. Acute cholecystitis
B. Acute pancreatitis
C. Myocardial infarction
D. Pulmonary embolism
E. Subcapsular liver haematoma with rupture

Answer: E. Subcapsular liver haematoma with rupture

Liver haematoma and rupture is a rare but life-threatening complication of severe pre-eclampsia and HELLP, presenting with epigastric or right shoulder pain and shock from intraperitoneal bleeding. It needs resuscitation, imaging and surgery or embolisation.

Why not the others

- **A:** Cholecystitis does not usually cause shock this quickly.
- **B:** Pancreatitis is less likely.
- **C:** MI is uncommon and does not cause a distended abdomen.
- **D:** PE does not cause abdominal distension.

Key point: Avoid palpating the liver vigorously in HELLP.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 182 · Complications · **Hard** · C2

A 28-year-old woman with severe pre-eclampsia has sudden cortical blindness, headache and confusion. MRI shows bilateral parieto-occipital white matter oedema.

What is the most likely diagnosis?

A. Cerebral venous sinus thrombosis
B. Migraine
C. Multiple sclerosis
D. Pituitary apoplexy
E. Posterior reversible encephalopathy syndrome (PRES)

Answer: E. Posterior reversible encephalopathy syndrome (PRES)

PRES is vasogenic brain oedema, mainly in the parieto-occipital regions, linked to severe hypertension and endothelial dysfunction in pre-eclampsia. It causes headache, visual loss and seizures, and usually resolves with BP control and magnesium.

Why not the others

- **A:** CVST shows venous thrombosis on imaging.
- **B:** Migraine does not cause these MRI changes.
- **C:** MS has a different pattern.
- **D:** Pituitary apoplexy shows pituitary haemorrhage.

Key point: Most cases of PRES resolve fully.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 183 · Fluid Management · **Moderate** · C3

A 26-year-old woman with severe pre-eclampsia on magnesium sulfate has a urine output of 25 mL/h for 3 hours. Her chest is clear and creatinine is normal.

What is the most appropriate fluid management?

A. Albumin infusion
B. Diuretics routinely
C. Give 2 litres of fluid rapidly
D. Restrict total fluids to about 80 mL/h and monitor closely
E. Stop all fluids

Answer: D. Restrict total fluids to about 80 mL/h and monitor closely

Oliguria is common in pre-eclampsia and usually resolves after delivery. Fluid boluses risk pulmonary oedema, so total fluids are restricted (about 80 mL/hour) unless there is ongoing blood loss.

Why not the others

- **A:** Albumin is not routinely used.
- **B:** Diuretics are used only for pulmonary oedema.
- **C:** Rapid fluid risks pulmonary oedema.
- **E:** Some fluid is needed.

Key point: Check renal function and watch for magnesium accumulation if oliguric.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 184 · Anaesthesia · **Moderate** · C2

A 30-year-old woman with HELLP syndrome needs a caesarean section. Her platelet count is 58 × 10^9/L.

What is the appropriate anaesthetic consideration?

A. Any anaesthetic is safe
B. Epidural is safe at any platelet count
C. General anaesthesia should never be used
D. Platelets of 1 × 10^9/L are acceptable
E. Spinal or epidural is usually avoided below about 75–80 × 10^9/L because of the risk of spinal haematoma

Answer: E. Spinal or epidural is usually avoided below about 75–80 × 10^9/L because of the risk of spinal haematoma

Regional anaesthesia is usually considered safe with platelets above about 75–80 × 10^9/L. Below this, general anaesthesia may be needed, with care to control the hypertensive response to intubation. Platelet transfusion is given before caesarean if very low (under about 50).

Why not the others

- **A:** Choices depend on clotting.
- **B:** Low platelets increase spinal haematoma risk.
- **C:** GA may be needed.
- **D:** That is far too low.

Key point: Control BP before intubation to avoid a hypertensive surge and stroke.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 185 · Eclampsia · **Moderate** · C3

A woman with eclampsia has a second seizure while on the magnesium sulfate maintenance infusion.

What is the most appropriate action?

A. Give a further 2–4 g magnesium sulfate IV bolus
B. Give phenytoin as first line
C. Stop magnesium
D. Switch to oral diazepam
E. Wait and observe

Answer: A. Give a further 2–4 g magnesium sulfate IV bolus

Recurrent seizures on magnesium are treated with a further 2 g (or 4 g if weight over 70 kg) IV bolus of magnesium sulfate over 5–10 minutes. If seizures continue, other anticonvulsants and anaesthetic help are needed, and imaging considered.

Why not the others

- **B:** Phenytoin is less effective than magnesium.
- **C:** Stopping removes protection.
- **D:** Oral drugs are not appropriate during a seizure.
- **E:** Treatment is needed.

Key point: Check magnesium levels if seizures recur or toxicity is suspected.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 186 · Differential Diagnosis · **Hard** · C2

A 33-year-old woman at 36 weeks has nausea, vomiting, abdominal pain and jaundice. BP is 138/88 mmHg. Glucose is 2.6 mmol/L, INR 2.1, creatinine 180 µmol/L, ALT 400 U/L and uric acid is very high.

What is the most likely diagnosis?

A. Acute fatty liver of pregnancy
B. Gallstones
C. HELLP syndrome
D. Hepatitis E
E. Intrahepatic cholestasis

Answer: A. Acute fatty liver of pregnancy

Acute fatty liver of pregnancy causes liver failure with hypoglycaemia, coagulopathy, renal impairment, jaundice and very high uric acid, often with only mild hypertension. Urgent delivery and supportive care are needed.

Why not the others

- **B:** Gallstones do not cause liver failure.
- **C:** HELLP rarely causes hypoglycaemia and marked coagulopathy.
- **D:** Hepatitis E causes severe hepatitis but not this typical metabolic picture.
- **E:** Cholestasis causes itch without liver failure.

Key point: Hypoglycaemia and coagulopathy point to AFLP rather than HELLP.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 187 · Molar Pregnancy · **Hard** · C2

A 22-year-old woman at 16 weeks has a BP of 158/104 mmHg and proteinuria. Her uterus is large for dates and hCG is very high.

What is the most likely underlying cause of early-onset pre-eclampsia?

A. Chronic hypertension only
B. Hydatidiform mole
C. Normal singleton pregnancy
D. Renal artery stenosis
E. Urinary tract infection

Answer: B. Hydatidiform mole

Pre-eclampsia before 20 weeks is unusual and suggests a molar pregnancy (or triploidy, multiple pregnancy, or antiphospholipid syndrome). Ultrasound is needed.

Why not the others

- **A:** Chronic hypertension does not cause high hCG and a large uterus.
- **C:** Normal pregnancies rarely have pre-eclampsia before 20 weeks.
- **D:** Renal artery stenosis does not explain hCG.
- **E:** UTI does not cause this.

Key point: Pre-eclampsia before 20 weeks = think mole.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; Gestational trophoblastic disease

MCQ 188 · Postnatal Care · **Easy** · C3

A 30-year-old woman with gestational hypertension delivered yesterday. Her BP is now 130/80 mmHg on labetalol.

What is the most appropriate postnatal plan?

A. Check BP once at 6 months
B. Continue labetalol forever
C. No BP checks needed
D. Reduce and stop treatment as BP falls, with regular BP checks and review at 6–8 weeks
E. Stop all monitoring at discharge

Answer: D. Reduce and stop treatment as BP falls, with regular BP checks and review at 6–8 weeks

BP is checked regularly after delivery and treatment reduced as BP falls, usually stopping within weeks. A medical review at 6–8 weeks checks BP and urine and discusses future risk.

Why not the others

- **A:** Checks are needed much sooner.
- **B:** Most women do not need long-term treatment.
- **C:** BP can rise after birth.
- **E:** Follow-up is needed.

Key point: Persistent hypertension or proteinuria at 6–8 weeks needs further assessment.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 189 · Drugs · **Moderate** · C2

A 34-year-old woman took losartan until 24 weeks because she did not know it was unsafe.

Which fetal complication is associated with ACE inhibitors or ARBs in the second and third trimesters?

A. Fetal macrosomia
B. Fetal renal failure with oligohydramnios
C. Fetal tachycardia
D. Neural tube defects
E. Polyhydramnios

Answer: B. Fetal renal failure with oligohydramnios

ACE inhibitors and ARBs in later pregnancy impair fetal renal function, causing oligohydramnios, limb contractures, pulmonary hypoplasia, skull ossification defects and neonatal renal failure.

Why not the others

- **A:** They do not cause macrosomia.
- **C:** Tachycardia is not typical.
- **D:** NTDs are linked to antiepileptics.
- **E:** They cause oligohydramnios, not polyhydramnios.

Key point: Stop ACE inhibitors and ARBs as soon as pregnancy is confirmed.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 190 · Drugs · **Moderate** · C2

A 28-year-old woman has been on methyldopa during pregnancy. She has just delivered and is breastfeeding.

Why should methyldopa be stopped soon after birth?

A. It causes hypoglycaemia in the baby
B. It increases the risk of postnatal depression
C. It is unsafe in breastfeeding
D. It raises BP after birth
E. It stops milk production

Answer: B. It increases the risk of postnatal depression

Methyldopa can cause low mood and depression. Because the postnatal period carries a high risk of depression, it should be stopped within 2 days of birth and replaced with another drug if needed.

Why not the others

- **A:** It does not cause neonatal hypoglycaemia.
- **C:** It is compatible with breastfeeding, but depression is the concern.
- **D:** It lowers BP.
- **E:** It does not stop milk.

Key point: Methyldopa also causes sedation and liver enzyme rises.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 191 · Admission Criteria · **Moderate** · C3

A 30-year-old woman at 33 weeks has a BP of 150/95 mmHg and a protein:creatinine ratio of 60 mg/mmol. She feels well. Blood tests are normal and the fetus is well.

What is the most appropriate management?

A. Admit, start treatment and monitor BP and bloods, with fetal assessment
B. Deliver today by caesarean
C. Discharge with no treatment
D. Review in 4 weeks
E. Start ACE inhibitor at home

Answer: A. Admit, start treatment and monitor BP and bloods, with fetal assessment

Women with pre-eclampsia are usually admitted for assessment and monitoring, at least initially, with BP treatment, regular bloods (FBC, renal and liver function) and fetal assessment. Some stable women may later be managed as outpatients in specialist units.

Why not the others

- **B:** Delivery at 33 weeks is not indicated if stable.
- **C:** She needs treatment and monitoring.
- **D:** Too long; pre-eclampsia can progress rapidly.
- **E:** ACE inhibitors are contraindicated.

Key point: Check bloods at least twice weekly in pre-eclampsia.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; NICE NG133

MCQ 192 · White Coat Hypertension · **Moderate** · C3

A 31-year-old woman at 14 weeks has a clinic BP of 148/94 mmHg, but her home BP readings with a validated device average 118/76 mmHg.

What is the most likely diagnosis and approach?

A. Chronic hypertension needing two drugs
B. Gestational hypertension
C. Pre-eclampsia
D. Severe hypertension needing admission
E. White coat hypertension; monitor with home or ambulatory BP

Answer: E. White coat hypertension; monitor with home or ambulatory BP

White coat hypertension is high clinic BP with normal home or ambulatory BP. It is confirmed by ambulatory or home monitoring and is managed by monitoring rather than treatment, as some women develop true hypertension.

Why not the others

- **A:** Home readings are normal.
- **B:** Gestational hypertension occurs after 20 weeks.
- **C:** There is no pre-eclampsia.
- **D:** BP is not severe.

Key point: About a quarter of women with clinic hypertension early in pregnancy have white coat hypertension.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 193 · Recurrence · **Moderate** · C2

A 29-year-old woman had pre-eclampsia requiring delivery at 30 weeks. She asks about the next pregnancy.

What is the approximate risk of pre-eclampsia recurring when the first episode required delivery before 34 weeks?

A. Almost zero
B. About 1 in 4
C. About 1 in 50
D. About 1 in 100
E. Certain to recur

Answer: B. About 1 in 4

Recurrence risk of pre-eclampsia is about 1 in 6 overall, rising to about 1 in 4 if the previous episode needed delivery before 34 weeks, and about 1 in 2 if before 28 weeks. Aspirin and close monitoring are recommended.

Why not the others

- **A:** The risk is significant.
- **C:** Too low.
- **D:** Too low.
- **E:** It is not certain.

Key point: Gestational hypertension risk in a future pregnancy is up to 1 in 2.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; NICE NG133

MCQ 194 · Calcium · **Moderate** · C2

A 26-year-old woman in a rural area with a low dietary calcium intake is at moderate risk of pre-eclampsia.

Which supplement may reduce pre-eclampsia risk in women with low calcium intake?

A. Calcium supplementation
B. Iron
C. Vitamin A
D. Vitamin C
E. Zinc

Answer: A. Calcium supplementation

WHO recommends calcium supplementation (1.5–2 g elemental calcium daily) in populations with low dietary calcium to reduce the risk of pre-eclampsia, in addition to aspirin for high-risk women.

Why not the others

- **B:** Iron does not prevent pre-eclampsia.
- **C:** Vitamin A does not prevent pre-eclampsia.
- **D:** Vitamin C does not help.
- **E:** Zinc has no proven effect.

Key point: Separate calcium and iron tablets by a few hours.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 195 · Multiple Pregnancy · **Easy** · C2

A 30-year-old woman with a twin pregnancy asks whether twins affect her BP.

How does twin pregnancy affect the risk of pre-eclampsia?

A. It has no effect
B. It increases the risk
C. It only affects BP after birth
D. It prevents pre-eclampsia
E. It reduces the risk by half

Answer: B. It increases the risk

Multiple pregnancy increases placental mass and is a moderate risk factor for pre-eclampsia, which tends to develop earlier and be more severe.

Why not the others

- **A:** Twins increase the risk.
- **C:** Risk applies during pregnancy.
- **D:** Twins do not prevent it.
- **E:** Risk increases.

Key point: Twin pregnancy plus another moderate factor is an indication for aspirin.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy; Multiple pregnancy

MCQ 196 · Severe Hypertension · **Hard** · C3

A 34-year-old woman with severe pre-eclampsia receives IV labetalol, but her BP remains 168/112 mmHg after three doses. She has had asthma in the past but is not wheezy.

What is the most appropriate next drug?

A. Bendroflumethiazide
B. Enalapril IV
C. IV hydralazine or oral nifedipine
D. IV morphine
E. Oral methyldopa

Answer: C. IV hydralazine or oral nifedipine

If BP is not controlled with labetalol, IV hydralazine or oral immediate-release nifedipine is added. A colloid preload of up to 500 mL may be given before hydralazine to avoid sudden hypotension, with careful fluid balance.

Why not the others

- **A:** Diuretics are not used.
- **B:** ACE inhibitors are contraindicated antenatally.
- **D:** Morphine does not treat hypertension.
- **E:** Methyldopa acts too slowly.

Key point: Aim to lower BP to under 150/100 mmHg, gradually.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 197 · Pathophysiology · **Hard** · C2

In pre-eclampsia, the ratio of soluble fms-like tyrosine kinase-1 (sFlt-1) to placental growth factor (PlGF) is high.

What does a high sFlt-1:PlGF ratio reflect?

A. Fetal anaemia
B. Imbalance of anti-angiogenic and pro-angiogenic factors from a stressed placenta
C. Increased maternal immunity
D. Normal pregnancy
E. Overactive thyroid

Answer: B. Imbalance of anti-angiogenic and pro-angiogenic factors from a stressed placenta

sFlt-1 is an anti-angiogenic factor that binds PlGF and VEGF, preventing their action on maternal endothelium. A high ratio reflects placental dysfunction and is used to support diagnosis and predict short-term risk.

Why not the others

- **A:** Anaemia is not reflected.
- **C:** Immunity is not measured.
- **D:** The ratio is abnormal.
- **E:** Thyroid function is not measured.

Key point: A low ratio has a high negative predictive value for pre-eclampsia within 1 week.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 198 · Eclampsia Prevention · **Moderate** · C2

In a low-resource hospital, a woman with severe pre-eclampsia needs magnesium sulfate but there is no infusion pump.

Which regimen can be used?

A. Diazepam infusion only
B. Intramuscular Pritchard regimen (IV and IM loading, then IM doses every 4 hours)
C. No magnesium
D. Oral magnesium
E. Phenytoin only

Answer: B. Intramuscular Pritchard regimen (IV and IM loading, then IM doses every 4 hours)

The Pritchard regimen gives 4 g IV plus 10 g IM (5 g in each buttock), then 5 g IM every 4 hours, and does not need infusion pumps. It is widely used in low-resource settings.

Why not the others

- **A:** Diazepam is less effective.
- **C:** Magnesium is essential.
- **D:** Oral magnesium is not effective here.
- **E:** Phenytoin is less effective.

Key point: Monitor reflexes and breathing before each IM dose.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 199 · Complications · **Moderate** · C2

A 32-year-old woman with severe pre-eclampsia has bleeding from cannula sites. Platelets are 45 × 10^9/L, fibrinogen 0.9 g/L and PT prolonged.

What complication has developed?

A. Disseminated intravascular coagulation
B. Haemophilia
C. Immune thrombocytopenia only
D. Vitamin K deficiency
E. Von Willebrand disease

Answer: A. Disseminated intravascular coagulation

Severe pre-eclampsia, HELLP and abruption can trigger DIC, with low platelets, low fibrinogen and prolonged clotting times. Treatment is delivery and replacement of blood products guided by haematology.

Why not the others

- **B:** Haemophilia is inherited and rare in women.
- **C:** ITP does not lower fibrinogen.
- **D:** Vitamin K deficiency does not lower platelets.
- **E:** VWD is inherited.

Key point: Low fibrinogen predicts severe bleeding.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

MCQ 200 · Long-term Risks · **Easy** · C3

A 35-year-old woman who had pre-eclampsia is seen at her 6–8-week postnatal check. BP is now normal and urine has no protein.

What advice is most appropriate?

A. Avoid future pregnancy completely

B. Have annual BP checks and adopt a healthy lifestyle, as her cardiovascular risk is higher

C. No further follow-up needed ever

D. She will certainly have pre-eclampsia again

E. Take aspirin daily for life

Answer: B. Have annual BP checks and adopt a healthy lifestyle, as her cardiovascular risk is higher

Pre-eclampsia increases long-term cardiovascular risk. Women should be advised about healthy weight, exercise, not smoking and annual BP checks. In future pregnancies, aspirin is advised from 12 weeks.

Why not the others

- **A:** Future pregnancy is possible with planning.
- **C:** Long-term follow-up helps.
- **D:** Recurrence is possible but not certain.
- **E:** Lifelong aspirin is not routinely recommended.

Key point: Inform her GP so long-term risk is recorded.

Reference: Obstetrics by Ten Teachers — Hypertensive disorders of pregnancy

CHAPTER 5

Diabetes and Endocrine Disorders

MCQ 201 · Gestational Diabetes Screening · **Easy** · C2

A 30-year-old woman of Pakistani origin with a BMI of 32 kg/m² is booked at 10 weeks. Her mother has type 2 diabetes.

When and how should she be screened for gestational diabetes?

A. 75 g oral glucose tolerance test at 24–28 weeks
B. Fasting glucose at booking only
C. HbA1c at 36 weeks
D. No screening is needed
E. Random glucose at 12 weeks

Answer: A. 75 g oral glucose tolerance test at 24–28 weeks

Women with risk factors (BMI over 30, previous baby 4.5 kg or more, previous GDM, first-degree relative with diabetes, or high-risk ethnic origin such as South Asian) should be offered a 75 g OGTT at 24–28 weeks. Women with previous GDM have an earlier OGTT or self-monitoring.

Why not the others

- **B:** A single fasting glucose misses many cases.
- **C:** HbA1c is not reliable for GDM diagnosis.
- **D:** She has several risk factors.
- **E:** A random glucose is not the screening test.

Key point: South Asian ethnicity is a strong risk factor.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 202 · Gestational Diabetes Diagnosis · **Moderate** · C2

A 32-year-old woman has a 75 g OGTT at 26 weeks. Fasting glucose is 5.8 mmol/L and 2-hour glucose is 7.2 mmol/L.

What does this result show (using NICE criteria)?

A. Gestational diabetes, based on the fasting value
B. Impaired glucose tolerance only
C. Normal result
D. Pre-existing type 1 diabetes
E. Type 2 diabetes confirmed

Answer: A. Gestational diabetes, based on the fasting value

NICE diagnoses GDM with a fasting glucose of 5.6 mmol/L or more, or a 2-hour glucose of 7.8 mmol/L or more. Her fasting value of 5.8 meets the criteria.

Why not the others

- **B:** Impaired glucose tolerance is not the diagnosis in pregnancy.
- **C:** The fasting value is raised.
- **D:** Type 1 diabetes presents differently.
- **E:** These values do not confirm type 2 diabetes.

Key point: Remember "5–6–7–8": fasting 5.6, 2-hour 7.8.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 203 · Gestational Diabetes Management · **Easy** · C3

A 29-year-old woman is diagnosed with gestational diabetes at 27 weeks. Fasting glucose was 6.0 mmol/L. There is no fetal macrosomia.

What is the first step in management?

A. Admit for IV insulin
B. Diet and exercise advice with self-monitoring of glucose
C. Glibenclamide immediately
D. Immediate delivery
E. Insulin at diagnosis in all women

Answer: B. Diet and exercise advice with self-monitoring of glucose

Most women with GDM and a fasting glucose under 7.0 mmol/L start with diet and exercise and capillary glucose monitoring. If targets are not met within 1–2 weeks, metformin is added, then insulin if needed.

Why not the others

- **A:** Admission is not needed.
- **C:** Glibenclamide is not first line.
- **D:** Delivery is not indicated.
- **E:** Insulin is first line only when fasting glucose is 7.0 or more, or with complications.

Key point: Targets: fasting under 5.3, 1-hour after meals under 7.8 mmol/L.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 204 · Gestational Diabetes Management · **Moderate** · C3

A 31-year-old woman diagnosed with GDM at 28 weeks has a fasting glucose of 7.4 mmol/L on the OGTT. Scan shows an abdominal circumference above the 95th centile.

What is the most appropriate treatment?

A. Diet alone for 4 weeks
B. Diet and exercise, then review in 2 weeks
C. Glibenclamide only
D. Metformin alone
E. Start insulin immediately (with or without metformin)

Answer: E. Start insulin immediately (with or without metformin)

Insulin should be offered immediately if fasting glucose at diagnosis is 7.0 mmol/L or more, or if it is 6.0–6.9 with complications such as macrosomia or polyhydramnios.

Why not the others

- **A:** Diet alone is not enough.
- **B:** Waiting is not appropriate.
- **C:** Glibenclamide is not first line.
- **D:** Metformin alone is not enough at this level.

Key point: Fetal macrosomia shows the need for tighter control.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 205 · Gestational Diabetes Management · **Moderate** · C2

A 30-year-old woman with GDM is started on metformin. She asks whether it is safe for her baby.

Which statement about metformin in pregnancy is correct?

A. It causes neural tube defects

B. It crosses the placenta but has not been shown to cause malformations; it is used for GDM and type 2 diabetes

C. It does not cross the placenta

D. It increases miscarriage

E. It must be stopped at 28 weeks

Answer: B. It crosses the placenta but has not been shown to cause malformations; it is used for GDM and type 2 diabetes

Metformin crosses the placenta, but large studies have not shown increased malformations. It is used in GDM and type 2 diabetes and reduces maternal weight gain. Gastrointestinal side effects are common.

Why not the others

- **A:** It does not cause NTDs.
- **C:** It does cross the placenta.
- **D:** It does not increase miscarriage.
- **E:** It can be continued until delivery.

Key point: Many women need insulin added to metformin.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 206 · Gestational Diabetes Delivery · **Moderate** · C3

A 32-year-old woman with diet-controlled GDM has good glucose control and a normally grown fetus at 39 weeks.

When should birth be offered at the latest?

A. 37 weeks

B. 38 weeks

C. 40+6 weeks

D. 42 weeks

E. No limit

Answer: C. 40+6 weeks

Women with uncomplicated GDM should give birth no later than 40+6 weeks, with induction or caesarean offered by then. Earlier birth is considered if there are complications or poor control.

Why not the others

- **A:** 37 weeks is for pre-existing diabetes with complications.
- **B:** 38 weeks is for pre-existing diabetes.
- **D:** Waiting to 42 weeks increases stillbirth risk.
- **E:** There is a limit.

Key point: Pre-existing diabetes: offer birth at 37+0 to 38+6 weeks.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 207 · Postnatal Care · **Moderate** · C3

A 30-year-old woman had GDM treated with insulin. She has just delivered a healthy baby.

What is the correct postnatal management?

A. Continue insulin at the same dose for 6 months
B. Do not test again
C. Recheck OGTT at 6 months only
D. Start metformin for life
E. Stop insulin and metformin, and check fasting glucose or HbA1c at 6–13 weeks

Answer: E. Stop insulin and metformin, and check fasting glucose or HbA1c at 6–13 weeks

GDM usually resolves after delivery, so glucose-lowering treatment stops. A fasting glucose (at 6–13 weeks) or HbA1c (after 13 weeks) checks for persistent diabetes. Women need annual HbA1c afterwards because their lifetime risk of type 2 diabetes is high.

Why not the others

- **A:** Insulin can cause hypoglycaemia after delivery.
- **B:** Follow-up is needed.
- **C:** The OGTT is not recommended at 6 months.
- **D:** Metformin for life is not indicated.

Key point: Check her glucose before discharge to detect undiagnosed diabetes.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 208 · Long-term Risk · **Easy** · C2

A 33-year-old woman who had GDM asks about her future health.

What is her main long-term risk?

A. Endometrial cancer
B. Hyperthyroidism
C. Lupus
D. Osteoporosis
E. Type 2 diabetes

Answer: E. Type 2 diabetes

Women who have had GDM have a high risk of type 2 diabetes (up to 50% within 10 years) and a high risk of GDM in future pregnancies (30–50%). Weight control and exercise reduce risk.

Why not the others

- **A:** Endometrial cancer is linked to obesity, but diabetes is the main risk.
- **B:** Hyperthyroidism is not linked.
- **C:** Lupus is not linked.
- **D:** Osteoporosis is not linked.

Key point: Annual HbA1c is recommended after GDM.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 209 · Pre-existing Diabetes · **Moderate** · C3

A 27-year-old woman with type 1 diabetes wants to become pregnant. Her HbA1c is 64 mmol/mol (8.0%).

What is the most appropriate pre-conception advice?

A. Aim for HbA1c under 48 mmol/mol (6.5%) if safe, take 5 mg folic acid, and delay conception until control improves

B. Conceive now; control does not matter

C. Stop insulin

D. Switch to oral tablets

E. Take 400 micrograms folic acid only

Answer: A. Aim for HbA1c under 48 mmol/mol (6.5%) if safe, take 5 mg folic acid, and delay conception until control improves

Good control before conception reduces miscarriage, malformations and stillbirth. NICE advises aiming for HbA1c under 48 mmol/mol without problematic hypoglycaemia, and avoiding pregnancy if HbA1c is over 86 mmol/mol. Folic acid 5 mg is taken until 12 weeks.

Why not the others

- **B:** Control is very important.
- **C:** Stopping insulin is dangerous.
- **D:** Type 1 diabetes needs insulin.
- **E:** A higher dose (5 mg) is needed.

Key point: Offer retinal and renal assessment before pregnancy.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 210 · Pre-existing Diabetes · **Moderate** · C3

A 34-year-old woman with type 2 diabetes takes metformin, gliclazide, atorvastatin and ramipril. She has a positive pregnancy test at 6 weeks.

Which drugs should be stopped?

A. All drugs including metformin

B. Atorvastatin and ramipril (and switch gliclazide to insulin)

C. Metformin only

D. None

E. Ramipril only

Answer: B. Atorvastatin and ramipril (and switch gliclazide to insulin)

Statins and ACE inhibitors should be stopped in pregnancy. Metformin can continue. Other oral agents such as gliclazide are usually switched to insulin. Folic acid 5 mg and aspirin from 12 weeks are started.

Why not the others

- **A:** Metformin can be continued.
- **C:** Metformin is safe.
- **D:** Some drugs must be stopped.
- **E:** Statins should also be stopped.

Key point: Women with type 2 diabetes need the same pre-pregnancy care as type 1.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 211 · Pre-existing Diabetes · **Moderate** · C2

A 26-year-old woman with type 1 diabetes for 15 years is 10 weeks pregnant.

How often should she have retinal screening during pregnancy?

A. At booking and at 28 weeks (and 16–20 weeks if retinopathy found)
B. Never in pregnancy
C. Only after delivery
D. Only if her vision changes
E. Weekly

Answer: A. At booking and at 28 weeks (and 16–20 weeks if retinopathy found)

Retinopathy can progress rapidly in pregnancy, especially with rapid improvement in glucose control. Retinal assessment is done at booking (or soon after) and at 28 weeks, and additionally at 16–20 weeks if retinopathy is present.

Why not the others

- **B:** Screening is needed.
- **C:** Waiting misses progression.
- **D:** Retinopathy can progress without symptoms.
- **E:** Weekly screening is unnecessary.

Key point: Diabetic retinopathy is not a contraindication to vaginal birth.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 212 · Pre-existing Diabetes · **Moderate** · C2

A 29-year-old woman with type 1 diabetes is 12 weeks pregnant. She has had two episodes of severe hypoglycaemia at night.

What is the most appropriate advice?

A. Discuss continuous glucose monitoring and ensure she and her partner have glucagon and know how to use it
B. Reduce all insulin by half permanently
C. Stop driving and do nothing else
D. Stop insulin at night
E. There is nothing to be done

Answer: A. Discuss continuous glucose monitoring and ensure she and her partner have glucagon and know how to use it

Hypoglycaemia is common in early pregnancy in type 1 diabetes. Women should be offered continuous glucose monitoring, given glucagon and taught (with their partner) how to use it, and advised about driving safety.

Why not the others

- **B:** Large blanket reductions may cause hyperglycaemia.
- **C:** Driving advice is part of it, but more is needed.
- **D:** Stopping insulin risks DKA.
- **E:** Action is needed.

Key point: Continuous glucose monitoring improves outcomes in type 1 diabetes in pregnancy.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 213 · Diabetic Ketoacidosis · **Hard** · C3

A 25-year-old woman with type 1 diabetes at 30 weeks has vomiting and abdominal pain. Glucose is 14 mmol/L, pH 7.18, bicarbonate 10 mmol/L and ketones 4.5 mmol/L. She received betamethasone yesterday.

What is the most appropriate management?

A. Discharge with oral fluids

B. Emergency caesarean section first

C. Immediate IV fluids, fixed-rate IV insulin, potassium replacement and close monitoring, treating the mother first

D. Insulin only after delivery

E. Wait until glucose rises above 20 mmol/L

Answer: C. Immediate IV fluids, fixed-rate IV insulin, potassium replacement and close monitoring, treating the mother first

DKA in pregnancy can occur at lower glucose levels and develops quickly; steroids can trigger it. It is treated with fluids, fixed-rate insulin, potassium and monitoring. Fetal heart abnormalities usually improve once the mother is treated; delivery is avoided until she is stable.

Why not the others

- **A:** DKA is a medical emergency.
- **B:** Delivering an acidotic mother is dangerous.
- **D:** Insulin is urgent.
- **E:** DKA can occur at near-normal glucose in pregnancy.

Key point: Corticosteroids for fetal lungs can worsen glucose control; increase insulin.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 214 · Pre-existing Diabetes · **Moderate** · C3

A 31-year-old woman with type 1 diabetes at 33 weeks is to receive antenatal corticosteroids for threatened preterm labour.

What adjustment is needed?

A. Additional insulin according to a protocol, with close glucose monitoring for 24–72 hours

B. Give glucose infusion

C. No change

D. Stop insulin

E. Withhold steroids in all diabetic women

Answer: A. Additional insulin according to a protocol, with close glucose monitoring for 24–72 hours

Corticosteroids cause marked hyperglycaemia for several days in women with diabetes. Insulin should be increased according to a protocol (often an IV insulin infusion) with close monitoring.

Why not the others

- **B:** Extra glucose worsens hyperglycaemia.
- **C:** Glucose will rise.
- **D:** Stopping insulin risks DKA.
- **E:** Steroids are still recommended.

Key point: Steroid-induced hyperglycaemia peaks about 12 hours after each dose.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 215 · Delivery · **Moderate** · C3

A 33-year-old woman with type 1 diabetes is at 37 weeks. The pregnancy is uncomplicated and the fetus is normally grown.

When should birth be offered?

A. At 34 weeks
B. At 40+6 weeks
C. At 42 weeks
D. Between 37+0 and 38+6 weeks
E. Only when labour starts naturally

Answer: D. Between 37+0 and 38+6 weeks

Women with pre-existing type 1 or type 2 diabetes should be offered birth between 37+0 and 38+6 weeks, earlier if there are maternal or fetal complications.

Why not the others

- **A:** 34 weeks causes avoidable prematurity.
- **B:** 40+6 is for uncomplicated GDM.
- **C:** 42 weeks increases stillbirth risk.
- **E:** A planned birth is recommended.

Key point: Diabetes alone is not an indication for caesarean section.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 216 · Intrapartum Care · **Moderate** · C3

A 30-year-old woman with type 1 diabetes is in established labour.

How should her glucose be managed?

A. Check glucose once a day
B. Give large boluses of insulin
C. Monitor capillary glucose hourly, aiming for 4–7 mmol/L, using IV insulin and dextrose if needed
D. No monitoring
E. Stop all insulin and give glucose freely

Answer: C. Monitor capillary glucose hourly, aiming for 4–7 mmol/L, using IV insulin and dextrose if needed

In labour, capillary glucose is checked hourly and kept at 4–7 mmol/L. Women with type 1 diabetes often need a variable-rate IV insulin infusion with dextrose. Maternal hyperglycaemia causes fetal hyperinsulinaemia and neonatal hypoglycaemia.

Why not the others

- **A:** Monitoring is too infrequent.
- **B:** Boluses risk hypoglycaemia.
- **D:** Monitoring is essential.
- **E:** Uncontrolled glucose harms the baby.

Key point: After delivery, insulin requirements drop sharply.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 217 · Postnatal Care · **Moderate** · C3

A 29-year-old woman with type 1 diabetes has just delivered. During pregnancy her insulin dose doubled.

What should happen to her insulin after delivery?

A. Continue the late-pregnancy dose
B. Double the dose again
C. Reduce immediately to her pre-pregnancy dose (or lower) with close monitoring
D. Stop insulin completely
E. Switch to metformin

Answer: C. Reduce immediately to her pre-pregnancy dose (or lower) with close monitoring

Insulin resistance disappears quickly after delivery of the placenta. Insulin should be reduced immediately to pre-pregnancy doses (or slightly lower if breastfeeding) to avoid hypoglycaemia.

Why not the others

- **A:** This causes hypoglycaemia.
- **B:** This causes severe hypoglycaemia.
- **D:** Type 1 diabetes always needs insulin.
- **E:** Metformin cannot replace insulin in type 1 diabetes.

Key point: Breastfeeding increases hypoglycaemia risk; eat before or during feeds.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 218 · Neonatal Complications · **Easy** · C2

A baby is born at 38 weeks to a mother with poorly controlled type 1 diabetes. The baby weighs 4.6 kg.

Which complication is the baby at particular risk of in the first hours?

A. Hyperglycaemia
B. Hypoglycaemia
C. Hypothermia only
D. Low red cell count
E. Overgrowth of the liver only

Answer: B. Hypoglycaemia

Fetal hyperinsulinaemia continues after birth when the maternal glucose supply stops, causing neonatal hypoglycaemia. The baby should be fed within 30 minutes and blood glucose checked at 2–4 hours. Other risks include respiratory distress, polycythaemia and jaundice.

Why not the others

- **A:** High insulin causes low glucose.
- **C:** Hypothermia can occur but hypoglycaemia is the main risk.
- **D:** Polycythaemia (high red cells) is common.
- **E:** Organomegaly may occur but hypoglycaemia is the key risk.

Key point: Early and frequent feeding reduces neonatal hypoglycaemia.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 219 · Pathophysiology · **Moderate** · C2

A student asks why babies of mothers with poorly controlled diabetes are large.

What is the mechanism of macrosomia in diabetic pregnancy?

A. Maternal glucose crosses the placenta, causing fetal hyperinsulinaemia, which acts as a growth hormone
B. Maternal insulin crosses the placenta
C. Overeating by the fetus
D. Placental insufficiency
E. Thyroid hormone excess

Answer: A. Maternal glucose crosses the placenta, causing fetal hyperinsulinaemia, which acts as a growth hormone

Glucose crosses the placenta, but maternal insulin does not. The fetal pancreas responds to high glucose by producing more insulin, which promotes growth of fat, liver and shoulders (Pedersen hypothesis).

Why not the others

- **B:** Insulin does not cross the placenta.
- **C:** This is not a mechanism.
- **D:** Placental insufficiency causes small babies.
- **E:** Thyroid hormone is not the cause.

Key point: The trunk grows more than the head, increasing shoulder dystocia risk.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 220 · Pre-existing Diabetes · **Hard** · C2

A 32-year-old woman with type 1 diabetes and an HbA1c of 95 mmol/mol at conception is at 20 weeks.

Which congenital anomaly is particularly associated with poorly controlled diabetes and should be looked for on the anomaly scan?

A. Caudal regression syndrome
B. Cleft lip
C. Down syndrome
D. Gastroschisis
E. Turner syndrome

Answer: A. Caudal regression syndrome

Poorly controlled diabetes at conception increases congenital anomalies, especially cardiac defects, neural tube defects and caudal regression syndrome (sacral agenesis), which is highly specific for diabetes. A detailed anomaly scan and fetal echocardiography are recommended.

Why not the others

- **B:** Cleft lip is less specifically associated.
- **C:** Diabetes does not cause aneuploidy.
- **D:** Gastroschisis is linked to young maternal age.
- **E:** Turner syndrome is chromosomal.

Key point: Anomaly risk rises steadily with HbA1c at conception.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 221 · Pre-existing Diabetes · **Moderate** · C2

A 30-year-old woman with type 1 diabetes and diabetic nephropathy (proteinuria 1 g/day) is 8 weeks pregnant.

Which pregnancy complication is she at particular risk of?

A. Hyperemesis
B. Oligohydramnios only
C. Placenta praevia
D. Post-term pregnancy
E. Pre-eclampsia

Answer: E. Pre-eclampsia

Diabetic nephropathy greatly increases the risk of pre-eclampsia, FGR and preterm birth. She needs aspirin from 12 weeks and close monitoring. Thromboprophylaxis is considered if proteinuria is heavy.

Why not the others

- **A:** Hyperemesis is not specifically linked.
- **B:** FGR may occur, but pre-eclampsia is the key risk.
- **C:** Praevia is not linked.
- **D:** Preterm birth, not post-term, is more likely.

Key point: Refer to a renal specialist if creatinine is raised.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 222 · Gestational Diabetes · **Moderate** · C3

A 34-year-old woman had GDM in her last pregnancy. She is now 10 weeks pregnant.

What is the recommended screening approach?

A. Early self-monitoring of glucose or an OGTT as soon as possible after booking, then OGTT at 24–28 weeks if normal
B. HbA1c at 36 weeks only
C. No screening; she will not get it again
D. OGTT only at 36 weeks
E. Urine glucose testing only

Answer: A. Early self-monitoring of glucose or an OGTT as soon as possible after booking, then OGTT at 24–28 weeks if normal

Women with previous GDM are offered early self-monitoring of capillary glucose or an OGTT soon after booking, with a further OGTT at 24–28 weeks if the first is normal. Recurrence is common.

Why not the others

- **B:** HbA1c late in pregnancy is not reliable.
- **C:** Recurrence is 30–50%.
- **D:** 36 weeks is too late.
- **E:** Glycosuria is common in normal pregnancy and unreliable.

Key point: Glycosuria in pregnancy is often due to increased GFR.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 223 · Glycosuria · **Easy** · C2

A 28-year-old woman at 24 weeks has 1+ glucose on urine dipstick at a routine visit. She has no risk factors for diabetes.

What is the most likely explanation?

A. Diabetes insipidus
B. Kidney disease
C. Physiological glycosuria from increased GFR and reduced tubular reabsorption
D. Type 1 diabetes
E. UTI

Answer: C. Physiological glycosuria from increased GFR and reduced tubular reabsorption

Glycosuria is common in normal pregnancy because GFR increases and tubular reabsorption of glucose is relatively reduced. Repeated glycosuria of 2+ or more on two occasions, or 1+ with risk factors, should prompt testing for GDM.

Why not the others

- **A:** Diabetes insipidus causes dilute urine without glucose.
- **B:** Kidney disease is not suggested.
- **D:** Type 1 diabetes is unlikely without symptoms.
- **E:** UTI does not cause glycosuria.

Key point: Glycosuria 2+ or more on one occasion, or 1+ on two occasions, needs further testing.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 224 · Gestational Diabetes · **Hard** · C3

A 29-year-old woman with GDM on metformin and insulin has a growth scan at 34 weeks showing an abdominal circumference on the 99th centile and polyhydramnios.

What is the most appropriate action?

A. Caesarean section at 34 weeks
B. No change
C. Review glucose control and intensify treatment, with planned birth discussed
D. Stop insulin
E. Switch to diet alone

Answer: C. Review glucose control and intensify treatment, with planned birth discussed

Accelerated fetal growth and polyhydramnios suggest suboptimal glucose control. Treatment should be intensified and the timing and mode of birth discussed, balancing risks of macrosomia and prematurity.

Why not the others

- **A:** Very early delivery is not routinely indicated.
- **B:** Action is needed.
- **D:** Stopping insulin worsens control.
- **E:** Diet alone is insufficient.

Key point: Fetal growth scans every 4 weeks from 28–36 weeks are advised in diabetes.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 225 · Pre-existing Diabetes · **Moderate** · C2

A 30-year-old woman with type 2 diabetes asks why she needs aspirin in pregnancy.

Why is low-dose aspirin recommended for women with pre-existing diabetes?

A. To lower glucose
B. To prevent miscarriage
C. To prevent neural tube defects
D. To reduce pre-eclampsia risk
E. To thin the blood for delivery

Answer: D. To reduce pre-eclampsia risk

Pre-existing diabetes is a high-risk factor for pre-eclampsia. Aspirin 75–150 mg daily from 12 weeks reduces this risk.

Why not the others

- **A:** Aspirin does not lower glucose.
- **B:** It is not given to prevent miscarriage in this context.
- **C:** Folic acid prevents NTDs.
- **E:** It is not given for delivery.

Key point: Aspirin is stopped around 36 weeks or continued until birth according to local practice.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; Hypertensive disorders of pregnancy

MCQ 226 · Hypothyroidism · **Easy** · C3

A 30-year-old woman on levothyroxine 100 micrograms daily for Hashimoto's thyroiditis has a positive pregnancy test at 5 weeks. Her last TSH was normal.

What is the most appropriate action?

A. Halve the dose
B. Increase the levothyroxine dose (by about 25–50 micrograms) and check TSH
C. No change and check after delivery
D. Stop levothyroxine
E. Switch to carbimazole

Answer: B. Increase the levothyroxine dose (by about 25–50 micrograms) and check TSH

Thyroxine requirements rise by 25–50% from early pregnancy because of increased thyroid-binding globulin and placental metabolism. The dose should be increased as soon as pregnancy is confirmed and TSH checked every 4–6 weeks, aiming for a trimester-specific target (often under 2.5 mU/L).

Why not the others

- **A:** Requirements rise, not fall.
- **C:** Untreated hypothyroidism harms fetal brain development.
- **D:** Stopping is dangerous.
- **E:** Carbimazole treats hyperthyroidism.

Key point: The fetus depends on maternal thyroxine until about 12 weeks.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 227 · Hypothyroidism · **Moderate** · C2

A 26-year-old woman has untreated overt hypothyroidism throughout pregnancy.

Which complication is associated with untreated maternal hypothyroidism?

A. Fetal macrosomia
B. Fetal thyrotoxicosis
C. Impaired neurodevelopment of the child, miscarriage and pre-eclampsia
D. Polyhydramnios only
E. Post-term pregnancy only

Answer: C. Impaired neurodevelopment of the child, miscarriage and pre-eclampsia

Untreated maternal hypothyroidism is associated with miscarriage, pre-eclampsia, preterm birth, low birth weight and impaired neurodevelopment of the child.

Why not the others

- **A:** Macrosomia is linked to diabetes.
- **B:** Fetal thyrotoxicosis is linked to Graves' antibodies.
- **D:** Polyhydramnios is not the main issue.
- **E:** Post-term pregnancy is not the main issue.

Key point: Iodine deficiency is the commonest cause of hypothyroidism worldwide.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 228 · Hyperthyroidism · **Moderate** · C3

A 28-year-old woman at 7 weeks has Graves' disease with tremor, weight loss and goitre. Free T4 is high and TSH receptor antibodies are positive.

Which antithyroid drug is preferred in the first trimester?

A. Carbimazole
B. Levothyroxine
C. Propylthiouracil
D. Radioactive iodine
E. Thyroidectomy immediately

Answer: C. Propylthiouracil

Propylthiouracil is preferred in the first trimester because carbimazole is linked to embryopathy (including aplasia cutis and choanal or oesophageal atresia). After the first trimester, many switch to carbimazole because PTU can cause liver failure.

Why not the others

- **A:** Carbimazole is avoided in the first trimester.
- **B:** Levothyroxine treats hypothyroidism.
- **D:** Radioiodine is contraindicated in pregnancy.
- **E:** Surgery is reserved for failed medical treatment, ideally in the second trimester.

Key point: Use the lowest dose that keeps free T4 at the upper end of normal.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 229 · Hyperthyroidism · **Hard** · C2

A 32-year-old woman had a thyroidectomy for Graves' disease 3 years ago and is now euthyroid on levothyroxine. At 30 weeks the fetal heart rate is 185/min and the scan shows a fetal goitre.

What is the most likely cause?

A. Excess maternal levothyroxine

B. Fetal thyrotoxicosis from maternal TSH receptor antibodies crossing the placenta

C. Maternal anaemia

D. Normal fetal heart rate

E. Placental abruption

Answer: B. Fetal thyrotoxicosis from maternal TSH receptor antibodies crossing the placenta

Women with current or past Graves' disease (even after surgery or radioiodine) can still have TSH receptor-stimulating antibodies. These cross the placenta and stimulate the fetal thyroid, causing fetal tachycardia, goitre and growth restriction. TRAb should be measured in pregnancy.

Why not the others

- **A:** Levothyroxine crosses the placenta poorly in physiological doses.
- **C:** Anaemia does not cause a fetal goitre.
- **D:** 185/min is tachycardia.
- **E:** Abruption does not cause a goitre.

Key point: The baby needs monitoring for neonatal thyrotoxicosis after birth.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 230 · Hyperthyroidism · **Moderate** · C2

A 25-year-old woman at 9 weeks has severe vomiting. Free T4 is mildly raised and TSH suppressed. TSH receptor antibodies are negative and there is no goitre.

What is the most likely diagnosis?

A. Graves' disease

B. Hashimoto's thyroiditis

C. Subacute thyroiditis

D. Thyroid storm

E. Transient gestational thyrotoxicosis

Answer: E. Transient gestational thyrotoxicosis

High hCG in early pregnancy, especially with hyperemesis, stimulates the TSH receptor, causing transient biochemical thyrotoxicosis. It settles by 18–20 weeks and does not need antithyroid drugs.

Why not the others

- **A:** Graves' has positive antibodies and often goitre or eye signs.
- **B:** Hashimoto's causes hypothyroidism.
- **C:** Subacute thyroiditis has a painful thyroid.
- **D:** Thyroid storm is a severe crisis.

Key point: Treat the vomiting, not the thyroid.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 231 · Postpartum Thyroiditis · **Moderate** · C2

A 29-year-old woman 3 months after delivery has palpitations, anxiety and weight loss. Free T4 is high and TSH suppressed. The thyroid is not tender, TRAb is negative and isotope uptake is low.

What is the most likely diagnosis?

A. Graves' disease
B. Postpartum thyroiditis
C. Sheehan syndrome
D. Struma ovarii
E. Toxic nodule

Answer: B. Postpartum thyroiditis

Postpartum thyroiditis is autoimmune (usually TPO antibody-positive) and occurs within a year of delivery. A thyrotoxic phase (low uptake, painless) is often followed by a hypothyroid phase. Beta blockers treat symptoms; antithyroid drugs are not used.

Why not the others

- **A:** Graves' has high uptake and positive TRAb.
- **C:** Sheehan's causes hypopituitarism.
- **D:** Struma ovarii is rare.
- **E:** A toxic nodule shows a hot nodule.

Key point: About a quarter develop permanent hypothyroidism; check TSH annually.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 232 · Thyroid Storm · **Hard** · C3

A 24-year-old woman with poorly controlled Graves' disease goes into labour. She develops a temperature of 40°C, heart rate 160/min in atrial fibrillation, agitation and vomiting.

What is the most appropriate management?

A. Antithyroid drug (PTU), beta blocker, steroids, iodine after PTU, cooling and supportive care in high dependency
B. Emergency caesarean before any treatment
C. Give levothyroxine
D. Paracetamol only
E. Wait for thyroid function results

Answer: A. Antithyroid drug (PTU), beta blocker, steroids, iodine after PTU, cooling and supportive care in high dependency

Thyroid storm is life-threatening. Management includes PTU (blocks synthesis and T4 to T3 conversion), beta blockers, corticosteroids, iodine (given after PTU), cooling, fluids and treatment of the trigger, in a critical care setting.

Why not the others

- **B:** Stabilise the mother first.
- **C:** Levothyroxine worsens it.
- **D:** Paracetamol alone is insufficient.
- **E:** Treatment must not wait.

Key point: Triggers include labour, infection, caesarean section and stopping drugs.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 233 · Hyperthyroidism · **Moderate** · C2

A 27-year-old woman with Graves' disease on carbimazole is breastfeeding.

What is the advice about antithyroid drugs and breastfeeding?

A. Antithyroid drugs at low to moderate doses are compatible with breastfeeding
B. Breastfeeding is always contraindicated
C. Radioactive iodine should be used instead
D. She must stop all treatment
E. Switch to levothyroxine

Answer: A. Antithyroid drugs at low to moderate doses are compatible with breastfeeding

Carbimazole and PTU at low to moderate doses pass into breast milk in small amounts and are compatible with breastfeeding. Taking the dose after a feed reduces exposure.

Why not the others

- **B:** Breastfeeding is possible.
- **C:** Radioiodine requires stopping breastfeeding.
- **D:** Stopping risks relapse.
- **E:** Levothyroxine treats hypothyroidism.

Key point: Check the baby's thyroid function if the mother is on high doses.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 234 · Adrenal Disease · **Hard** · C3

A 31-year-old woman with Addison's disease on hydrocortisone and fludrocortisone is in established labour.

What is the correct management of her steroids?

A. Double oral hydrocortisone only after delivery
B. Give parenteral hydrocortisone (e.g. 100 mg IM/IV, then infusion or 6-hourly) during labour
C. No change
D. Stop fludrocortisone and hydrocortisone
E. Switch to dexamethasone

Answer: B. Give parenteral hydrocortisone (e.g. 100 mg IM/IV, then infusion or 6-hourly) during labour

Women with adrenal insufficiency need stress-dose steroids in labour and for caesarean section to prevent an adrenal crisis. Parenteral hydrocortisone is given during labour and tapered back to the usual dose over 24–48 hours after delivery.

Why not the others

- **A:** Oral doses may not be absorbed in labour.
- **C:** Labour is a major stress.
- **D:** Stopping causes adrenal crisis.
- **E:** Dexamethasone lacks mineralocorticoid action and is not standard.

Key point: Hyperemesis can also precipitate adrenal crisis.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 235 · Prolactinoma · **Moderate** · C3

A 30-year-old woman with a known 12 mm macroprolactinoma becomes pregnant after cabergoline treatment.

What monitoring is needed during pregnancy?

A. Monthly serum prolactin
B. No monitoring
C. Regular visual field assessment, with MRI if symptoms develop
D. Routine CT head each trimester
E. Stop all follow-up

Answer: C. Regular visual field assessment, with MRI if symptoms develop

Macroadenomas can enlarge in pregnancy. Visual fields should be checked regularly (each trimester), with MRI without contrast if headaches or visual symptoms develop. Many continue cabergoline. Prolactin levels are not useful because they rise normally in pregnancy.

Why not the others

- **A:** Prolactin rises normally and is not useful.
- **B:** Monitoring is needed.
- **D:** CT uses radiation and is not routine.
- **E:** Follow-up is needed.

Key point: Microadenomas rarely enlarge significantly.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 236 · Metabolic Disorders · **Hard** · C3

A 25-year-old woman with phenylketonuria stopped her special diet as a teenager. She plans to conceive.

What is the most important advice?

A. Avoid only alcohol
B. No special measures are needed
C. Restart a strict low-phenylalanine diet before conception and maintain it throughout pregnancy
D. Start diet only after 20 weeks
E. Take high-protein supplements

Answer: C. Restart a strict low-phenylalanine diet before conception and maintain it throughout pregnancy

High maternal phenylalanine levels are teratogenic, causing microcephaly, learning disability and congenital heart disease in the baby (maternal PKU syndrome). A strict diet started before conception prevents this.

Why not the others

- **A:** Diet is essential.
- **B:** Special measures are essential.
- **D:** Organogenesis occurs in early pregnancy.
- **E:** High protein raises phenylalanine.

Key point: Plan pregnancy with a metabolic team.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 237 · Pre-existing Diabetes · **Moderate** · C2

A 28-year-old woman with type 1 diabetes asks about the glucose targets in pregnancy.

What are the NICE capillary glucose targets?

A. Fasting 8–12 mmol/L
B. Fasting under 10 mmol/L
C. Fasting under 3 mmol/L
D. Fasting under 5.3 mmol/L and 1-hour after meals under 7.8 mmol/L
E. No targets

Answer: D. Fasting under 5.3 mmol/L and 1-hour after meals under 7.8 mmol/L

NICE targets are fasting under 5.3 mmol/L, 1-hour after meals under 7.8 mmol/L or 2-hour under 6.4 mmol/L, while avoiding hypoglycaemia (keep above 4 mmol/L on insulin).

Why not the others

- **A:** Too high.
- **B:** Too high.
- **C:** Too low; dangerous hypoglycaemia.
- **E:** Targets guide treatment.

Key point: Women on insulin should keep glucose above 4 mmol/L.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 238 · Neonatal Complications · **Moderate** · C2

A baby born at 37 weeks to a mother with poorly controlled diabetes develops grunting and tachypnoea.

Why is respiratory distress more common in babies of diabetic mothers?

A. Fetal hyperinsulinaemia delays lung surfactant maturation
B. Infection is always present
C. Low birth weight
D. Maternal antibodies
E. Small heart

Answer: A. Fetal hyperinsulinaemia delays lung surfactant maturation

Fetal hyperinsulinaemia inhibits surfactant production, so lung maturation is delayed. Babies of diabetic mothers have more respiratory distress syndrome even near term, which is one reason elective birth before 37 weeks is avoided unless needed.

Why not the others

- **B:** Infection is not always present.
- **C:** These babies are often large.
- **D:** Antibodies are not the cause.
- **E:** Cardiac hypertrophy may occur, but surfactant deficiency causes RDS.

Key point: Hypertrophic cardiomyopathy may also occur in these babies.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 239 · Stillbirth · **Moderate** · C2

A 35-year-old woman with poorly controlled type 2 diabetes asks why her baby is at risk of stillbirth.

Which factor contributes to stillbirth in diabetic pregnancy?

A. Fetal hyperglycaemia and hyperinsulinaemia causing fetal acidosis and hypoxia
B. Low birth weight only
C. Maternal hypotension
D. Overuse of insulin by the mother
E. Twin pregnancy

Answer: A. Fetal hyperglycaemia and hyperinsulinaemia causing fetal acidosis and hypoxia

Poor glucose control causes fetal hyperinsulinaemia, increased fetal oxygen demand, polycythaemia and acidosis, increasing the risk of sudden stillbirth, particularly in late pregnancy. This is why birth is planned at 37–38+6 weeks.

Why not the others

- **B:** These babies are usually large.
- **C:** Hypotension is not the cause.
- **D:** Insulin use is necessary.
- **E:** Twins are not the cause.

Key point: Stillbirth risk in diabetes is several times higher than in women without diabetes.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 240 · Gestational Diabetes · **Easy** · C2

A 27-year-old woman with GDM asks whether she can breastfeed.

What is the advice about breastfeeding after GDM?

A. Breastfeeding is encouraged; it helps the baby's glucose and may lower her own risk of type 2 diabetes
B. Breastfeeding is not allowed
C. Breastfeeding raises her diabetes risk
D. Only after 6 months
E. She must use formula for the first week

Answer: A. Breastfeeding is encouraged; it helps the baby's glucose and may lower her own risk of type 2 diabetes

Breastfeeding is encouraged. Early feeding helps prevent neonatal hypoglycaemia, and breastfeeding is associated with a lower risk of type 2 diabetes in the mother.

Why not the others

- **B:** Breastfeeding is encouraged.
- **C:** It may lower risk.
- **D:** Breastfeeding should start straight away.
- **E:** Formula is not required.

Key point: Women with diabetes can express colostrum from 36 weeks for the baby.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 241 · Pre-existing Diabetes · **Hard** · C3

A 33-year-old woman with type 1 diabetes and proliferative retinopathy is 14 weeks pregnant. Her HbA1c has fallen rapidly from 80 to 50 mmol/mol in 2 months.

What is the most appropriate action?

A. Avoid any eye treatment in pregnancy
B. Caesarean section is mandatory at 32 weeks
C. Raise her glucose to slow change
D. Stop insulin
E. Urgent ophthalmology review; laser treatment can be given in pregnancy if needed

Answer: E. Urgent ophthalmology review; laser treatment can be given in pregnancy if needed

Rapid improvement in glucose control can worsen retinopathy. Proliferative retinopathy needs urgent ophthalmology review, and laser photocoagulation is safe in pregnancy. Retinopathy is not by itself an indication for caesarean section.

Why not the others

- **A:** Laser is safe in pregnancy.
- **B:** Retinopathy alone is not an indication for caesarean.
- **C:** Poor control harms the fetus.
- **D:** Stopping insulin is dangerous.

Key point: Retinopathy usually improves after pregnancy.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 242 · Gestational Diabetes · **Moderate** · C2

A 32-year-old woman with GDM controlled by diet asks about monitoring.

How should she monitor her glucose?

A. Capillary glucose fasting and 1 hour after each meal
B. HbA1c weekly
C. Only when she feels unwell
D. Random glucose at clinic visits only
E. Urine glucose testing

Answer: A. Capillary glucose fasting and 1 hour after each meal

Women with GDM on diet or metformin should test fasting and 1-hour post-meal capillary glucose daily. Those on insulin also test before meals and at bedtime.

Why not the others

- **B:** HbA1c changes slowly and is not used weekly.
- **C:** Regular monitoring is needed.
- **D:** Clinic checks alone are insufficient.
- **E:** Urine glucose is unreliable.

Key point: Bring her glucose diary to every clinic visit.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

MCQ 243 · Endocrine · **Hard** · C2

A 34-year-old woman at 36 weeks with acute fatty liver of pregnancy develops polyuria with very dilute urine and hypernatraemia.

What is the most likely cause of her polyuria?

A. Gestational diabetes
B. Hypercalcaemia
C. Primary polydipsia
D. Transient gestational diabetes insipidus from excess placental vasopressinase
E. Urinary tract infection

Answer: D. Transient gestational diabetes insipidus from excess placental vasopressinase

The placenta produces vasopressinase, which breaks down ADH. Liver dysfunction (as in AFLP or HELLP) reduces its clearance, causing transient diabetes insipidus. It responds to desmopressin, which is not broken down by vasopressinase.

Why not the others

- **A:** GDM causes glycosuria, not dilute urine with hypernatraemia.
- **B:** Hypercalcaemia is less likely.
- **C:** Primary polydipsia gives low sodium.
- **E:** UTI does not cause this.

Key point: Desmopressin is the treatment.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 244 · Hypothyroidism · **Moderate** · C3

A 29-year-old woman with hypothyroidism is taking levothyroxine and also iron and calcium supplements at the same time in the morning. Her TSH is rising.

What is the most likely reason?

A. Iron and calcium reduce levothyroxine absorption
B. Levothyroxine is not absorbed in pregnancy
C. Pregnancy lowers TSH
D. She has Graves' disease
E. The thyroid has recovered

Answer: A. Iron and calcium reduce levothyroxine absorption

Iron and calcium bind levothyroxine in the gut and reduce absorption. Levothyroxine should be taken on an empty stomach, at least 4 hours apart from iron or calcium.

Why not the others

- **B:** It is absorbed normally when taken correctly.
- **C:** Rising TSH means underactive thyroid.
- **D:** Graves' would suppress TSH.
- **E:** Thyroid recovery would lower TSH.

Key point: Check adherence and timing before increasing the dose.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 245 · Hypothyroidism · **Moderate** · C3

A 30-year-old woman at 10 weeks has a TSH of 5.2 mU/L with a normal free T4. TPO antibodies are positive.

What is the most appropriate management?

A. Antithyroid drugs
B. No action ever
C. Radioiodine
D. Thyroidectomy
E. Treat with levothyroxine and monitor TSH

Answer: E. Treat with levothyroxine and monitor TSH

Subclinical hypothyroidism with positive TPO antibodies in pregnancy is often treated with levothyroxine because it may be associated with miscarriage and adverse outcomes. Thresholds for treatment vary between guidelines.

Why not the others

- **A:** Antithyroid drugs treat hyperthyroidism.
- **B:** Treatment is commonly recommended.
- **C:** Radioiodine is contraindicated.
- **D:** Surgery is not indicated.

Key point: Women with TPO antibodies are at risk of postpartum thyroiditis.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 246 · Hyperthyroidism · **Moderate** · C2

A 26-year-old woman with Graves' disease took carbimazole in early pregnancy.

Which congenital abnormality is associated with carbimazole in the first trimester?

A. Aplasia cutis (scalp defects) and choanal or oesophageal atresia
B. Ebstein's anomaly
C. Neural tube defects
D. Phocomelia
E. Renal agenesis

Answer: A. Aplasia cutis (scalp defects) and choanal or oesophageal atresia

Carbimazole (and methimazole) in the first trimester is associated with carbimazole embryopathy: aplasia cutis, choanal and oesophageal atresia, and facial abnormalities.

Why not the others

- **B:** Ebstein's anomaly is linked to lithium.
- **C:** NTDs are linked to valproate.
- **D:** Phocomelia is linked to thalidomide.
- **E:** Renal effects are linked to ACE inhibitors.

Key point: Switch to PTU before conception if possible.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 247 · Calcium Disorders · **Hard** · C2

A 28-year-old woman at 20 weeks has recurrent kidney stones, abdominal pain and a calcium of 3.0 mmol/L with raised parathyroid hormone.

What is the most likely diagnosis and fetal risk?

A. Hypoparathyroidism; fetal hypercalcaemia
B. Normal pregnancy calcium
C. Primary hyperparathyroidism; neonatal hypocalcaemia and tetany
D. Sarcoidosis
E. Vitamin D deficiency

Answer: C. Primary hyperparathyroidism; neonatal hypocalcaemia and tetany

Primary hyperparathyroidism (usually a parathyroid adenoma) causes maternal hypercalcaemia. Calcium crosses the placenta, suppressing fetal parathyroid glands, so the baby may develop hypocalcaemia and tetany after birth. Surgery in the second trimester may be considered.

Why not the others

- **A:** PTH is raised, not low.
- **B:** Calcium is raised.
- **D:** Sarcoidosis has low PTH.
- **E:** Vitamin D deficiency causes low calcium.

Key point: Measure calcium in pregnant women with kidney stones.

Reference: Obstetrics by Ten Teachers — Endocrine disorders in pregnancy

MCQ 248 · Gestational Diabetes · **Moderate** · C2

A 31-year-old woman with GDM asks whether her baby will have diabetes.

What is the long-term risk for the child of a mother with GDM?

A. Certain to have type 1 diabetes
B. Higher risk of childhood obesity and type 2 diabetes later in life
C. Lower risk of obesity
D. No risk
E. Risk only of low blood pressure

Answer: B. Higher risk of childhood obesity and type 2 diabetes later in life

Exposure to maternal hyperglycaemia in utero is associated with higher risk of childhood obesity and type 2 diabetes in later life. Breastfeeding and healthy family lifestyle help.

Why not the others

- **A:** Type 1 diabetes is autoimmune and not caused by GDM.
- **C:** Risk of obesity rises.
- **D:** There is some long-term risk.
- **E:** BP is not the main concern.

Key point: Encourage healthy family lifestyle after GDM.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 249 · Pre-existing Diabetes · **Easy** · C2

A 26-year-old woman with type 1 diabetes plans pregnancy. She asks how her diabetes should be managed in the months before conception.

Which service should she attend?

A. A pre-conception diabetes clinic
B. Emergency department
C. No service is needed
D. Physiotherapy
E. Surgical clinic

Answer: A. A pre-conception diabetes clinic

Pre-conception care in a specialist diabetes clinic improves outcomes by optimising glucose control, reviewing medications, starting folic acid and screening for complications.

Why not the others

- **B:** Emergency care is not needed.
- **C:** Specialist input improves outcomes.
- **D:** Physiotherapy is not relevant.
- **E:** Surgery is not relevant.

Key point: Many pregnancies are unplanned; discuss contraception and planning at every visit.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy

MCQ 250 · Gestational Diabetes Management · **Moderate** · C3

A 30-year-old woman with GDM has been taking metformin but stops because of severe diarrhoea. Her fasting glucose remains 6.2 mmol/L despite diet.

What is the most appropriate treatment now?

A. Acarbose
B. Glibenclamide as first choice
C. Pioglitazone
D. SGLT2 inhibitor (such as empagliflozin)
E. Subcutaneous insulin

Answer: E. Subcutaneous insulin

If metformin is not tolerated or targets are not met, insulin is the recommended treatment. Glibenclamide may be considered only if metformin is unsuitable and insulin declined. SGLT2 inhibitors and pioglitazone are not used in pregnancy.

Why not the others

- **A:** Acarbose is not recommended in pregnancy.
- **B:** Glibenclamide is an alternative only if insulin is declined.
- **C:** Pioglitazone is not used in pregnancy.
- **D:** SGLT2 inhibitors are not used in pregnancy.

Key point: Insulin is safe and does not cross the placenta.

Reference: Obstetrics by Ten Teachers — Diabetes in pregnancy; NICE NG3

CHAPTER 6

Medical Disorders in Pregnancy

MCQ 251 · Venous Thromboembolism · **Easy** · C3

A 30-year-old woman at 28 weeks has pain and swelling of the left calf for 2 days. The left calf is 3 cm larger than the right. She is not breathless.

What is the most appropriate management?

A. D-dimer to decide
B. Discharge with aspirin
C. Start treatment-dose low molecular weight heparin and arrange compression duplex ultrasound
D. Wait for ultrasound before any treatment
E. Warfarin

Answer: C. Start treatment-dose low molecular weight heparin and arrange compression duplex ultrasound

Suspected DVT in pregnancy should be treated with LMWH while awaiting compression duplex ultrasound, unless contraindicated. DVT in pregnancy is commoner in the left leg (compression of the left iliac vein).

Why not the others

- **A:** D-dimer rises in normal pregnancy and is unhelpful.
- **B:** Aspirin does not treat DVT.
- **D:** Treatment should not be delayed.
- **E:** Warfarin is avoided in pregnancy.

Key point: If ultrasound is negative but suspicion high, continue LMWH and repeat at 3 and 7 days.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy; RCOG Green-top 37b

MCQ 252 · Venous Thromboembolism · **Moderate** · C3

A 33-year-old woman at 32 weeks has sudden pleuritic chest pain and breathlessness. Pulse 110/min, SpO2 93%. Chest X-ray and legs are normal.

What is the most appropriate next step?

A. Arrange CTPA or V/Q scan and start LMWH immediately
B. D-dimer only
C. Discharge if chest X-ray is normal
D. Give antibiotics
E. Thrombolysis immediately

Answer: A. Arrange CTPA or V/Q scan and start LMWH immediately

Suspected PE in pregnancy is treated with LMWH immediately while imaging is arranged. With a normal chest X-ray, a V/Q (perfusion) scan or CTPA is used, after discussing risks with the woman.

Why not the others

- **B:** D-dimer is not reliable in pregnancy.
- **C:** A normal chest X-ray does not exclude PE.
- **D:** There is no sign of infection.
- **E:** Thrombolysis is for massive PE with shock.

Key point: V/Q gives slightly more fetal radiation; CTPA gives more maternal breast radiation.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy; RCOG Green-top 37b

MCQ 253 · Venous Thromboembolism · **Moderate** · C3

A 29-year-old woman with a DVT at 30 weeks is being treated with LMWH. She asks how long treatment will last.

What is the recommended duration of anticoagulation?

A. 2 weeks
B. Until delivery only
C. Throughout pregnancy and for at least 6 weeks postnatally, with a total of at least 3 months
D. Lifelong
E. Only during labour

Answer: C. Throughout pregnancy and for at least 6 weeks postnatally, with a total of at least 3 months

Treatment of VTE in pregnancy continues for the rest of pregnancy and at least 6 weeks after birth, with a total duration of at least 3 months. Warfarin or LMWH can be used postnatally and both are compatible with breastfeeding.

Why not the others

- **A:** Too short.
- **B:** The postnatal period has the highest risk.
- **D:** Lifelong treatment is not routine.
- **E:** Too short.

Key point: DOACs are avoided in pregnancy and breastfeeding.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 254 · Venous Thromboembolism · **Moderate** · C3

A 31-year-old woman on treatment-dose LMWH (twice daily) for DVT goes into spontaneous labour. Her last dose was 6 hours ago. She requests an epidural.

What is the correct advice?

A. Epidural can be inserted now
B. Epidural should be delayed until at least 24 hours after the last treatment dose of LMWH
C. Give protamine and site the epidural
D. Reverse with vitamin K
E. Stop LMWH for 1 week first

Answer: B. Epidural should be delayed until at least 24 hours after the last treatment dose of LMWH

Regional anaesthesia should be delayed for at least 24 hours after a treatment dose of LMWH (12 hours after a prophylactic dose) to reduce the risk of spinal haematoma. Women are advised to stop injections when labour starts.

Why not the others

- **A:** Six hours is too soon.
- **C:** Protamine only partly reverses LMWH.
- **D:** Vitamin K reverses warfarin.
- **E:** One week is unnecessary.

Key point: Plan delivery with the anaesthetist for women on LMWH.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 255 · Thromboprophylaxis · **Moderate** · C3

A 36-year-old woman with a BMI of 38 kg/m² has an emergency caesarean section in labour.

What thromboprophylaxis is recommended?

A. Aspirin only
B. Compression stockings only
C. LMWH for at least 10 days after delivery
D. No prophylaxis
E. Warfarin for 1 week

Answer: C. LMWH for at least 10 days after delivery

Under RCOG risk scoring, caesarean section in labour scores 2 and a BMI of 30 or more scores 1, giving a total of 3 or more, so LMWH is recommended for at least 10 days after delivery. Six weeks is advised for higher-risk women, such as those with previous VTE.

Why not the others

- **A:** Aspirin is not adequate VTE prophylaxis.
- **B:** Stockings alone are not enough.
- **D:** She is at increased risk.
- **E:** Warfarin is not used for this.

Key point: Assess VTE risk at booking, on admission and after delivery.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy; RCOG Green-top 37a

MCQ 256 · Cardiac Disease · **Moderate** · C2

A 26-year-old woman from a rural area with previous rheumatic fever becomes breathless at 28 weeks, with a mid-diastolic murmur at the apex and atrial fibrillation.

Which valve lesion is the most likely and most dangerous in pregnancy?

A. Aortic regurgitation
B. Mitral regurgitation
C. Mitral stenosis
D. Pulmonary stenosis
E. Tricuspid regurgitation

Answer: C. Mitral stenosis

Rheumatic mitral stenosis is common in Pakistan. The rise in heart rate and blood volume in pregnancy shortens diastolic filling and raises left atrial pressure, causing pulmonary oedema and AF. Beta blockers, diuretics and anticoagulation help; balloon valvotomy may be needed.

Why not the others

- **A:** Regurgitant lesions are better tolerated.
- **B:** Regurgitant lesions are better tolerated.
- **D:** Pulmonary stenosis is usually well tolerated.
- **E:** Tricuspid regurgitation is usually well tolerated.

Key point: Stenotic lesions tolerate pregnancy worse than regurgitant lesions.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 257 · Cardiac Disease · **Hard** · C2

A 30-year-old woman develops breathlessness, orthopnoea and leg swelling 3 weeks after delivery. Echocardiography shows a dilated left ventricle with an ejection fraction of 30%. She had no previous heart disease.

What is the most likely diagnosis?

A. Mitral stenosis
B. Myocardial infarction
C. Peripartum cardiomyopathy
D. Pre-eclampsia
E. Pulmonary embolism

Answer: C. Peripartum cardiomyopathy

Peripartum cardiomyopathy is heart failure with reduced ejection fraction occurring from late pregnancy to 5 months after delivery, without another cause. Treatment includes heart failure drugs, anticoagulation if EF is very low, and sometimes bromocriptine. Recurrence risk in future pregnancy is high if function does not recover.

Why not the others

- **A:** Mitral stenosis would show a stenotic valve.
- **B:** MI shows regional wall changes and ECG changes.
- **D:** Pre-eclampsia can cause pulmonary oedema but not this cardiomyopathy picture.
- **E:** PE causes right heart strain.

Key point: Advise against future pregnancy if the ejection fraction does not recover.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 258 · Cardiac Disease · **Hard** · C3

A 27-year-old woman with idiopathic pulmonary arterial hypertension asks whether she can safely have a baby.

What is the most appropriate advice?

A. Only twin pregnancy is risky
B. Pregnancy carries a very high maternal mortality and is advised against; effective contraception is needed
C. Pregnancy improves pulmonary hypertension
D. Pregnancy is safe if she avoids exercise
E. Pregnancy is safe with a caesarean section

Answer: B. Pregnancy carries a very high maternal mortality and is advised against; effective contraception is needed

Pulmonary arterial hypertension carries a maternal mortality of up to 25–30% and is a WHO class IV condition in which pregnancy is contraindicated. If pregnancy occurs, termination is offered; if continued, care is in a specialist centre.

Why not the others

- **A:** Any pregnancy is high risk.
- **C:** Pregnancy worsens it.
- **D:** Rest does not remove the risk.
- **E:** Mode of delivery does not remove the risk.

Key point: Other WHO IV conditions include severe LV dysfunction and Marfan with aortic root over 45 mm.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 259 · Cardiac Disease · **Moderate** · C2

A 23-year-old woman at 24 weeks has a soft systolic murmur at the left sternal edge. She has no symptoms, normal pulse and no other signs.

What is the most likely explanation?

A. Aortic stenosis
B. Flow murmur due to increased cardiac output in pregnancy
C. Mitral stenosis
D. Patent ductus arteriosus
E. Ventricular septal defect

Answer: B. Flow murmur due to increased cardiac output in pregnancy

A soft ejection systolic flow murmur is heard in most pregnant women because of increased blood volume and cardiac output. Diastolic murmurs, loud murmurs or symptoms need echocardiography.

Why not the others

- **A:** Aortic stenosis gives a harsh murmur radiating to the carotids.
- **C:** Mitral stenosis gives a diastolic murmur.
- **D:** PDA gives a continuous murmur.
- **E:** VSD gives a harsh pansystolic murmur.

Key point: Any diastolic murmur in pregnancy is pathological.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 260 · Cardiac Disease · **Hard** · C2

A 35-year-old woman at 36 weeks has sudden severe chest pain radiating to the back. ECG shows anterior ST elevation. Coronary angiography shows a spontaneous dissection of the left anterior descending artery.

What is the most likely diagnosis?

A. Aortic dissection
B. Atherosclerotic myocardial infarction
C. Pericarditis
D. Pulmonary embolism
E. Spontaneous coronary artery dissection

Answer: E. Spontaneous coronary artery dissection

Spontaneous coronary artery dissection is the commonest cause of myocardial infarction in pregnancy and the postpartum period, linked to hormonal effects on the vessel wall. Management is individualised; many are treated conservatively.

Why not the others

- **A:** Aortic dissection affects the aorta.
- **B:** Atherosclerosis is less common in young pregnant women.
- **C:** Pericarditis has widespread ST changes.
- **D:** PE does not cause coronary dissection.

Key point: Chest pain in pregnancy needs proper assessment; cardiac disease is a leading cause of maternal death.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 261 · Epilepsy · **Moderate** · C3

A 28-year-old woman with epilepsy well controlled on lamotrigine is 20 weeks pregnant. She has had two seizures this month after 3 years without seizures.

What is the most likely reason?

A. Fetal movements

B. Lamotrigine levels fall in pregnancy because clearance increases

C. Normal pregnancy change; no action needed

D. Pregnancy cures epilepsy

E. The drug has become toxic

Answer: B. Lamotrigine levels fall in pregnancy because clearance increases

Lamotrigine clearance increases markedly in pregnancy, lowering levels and risking seizures. Levels should be monitored and the dose increased as needed, then reduced after delivery to avoid toxicity.

Why not the others

- **A:** Fetal movements do not cause seizures.
- **C:** Seizures need action.
- **D:** Pregnancy does not cure epilepsy.
- **E:** Levels fall rather than rise.

Key point: Sudden unexpected death in epilepsy (SUDEP) is a cause of maternal death.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 262 · Epilepsy · **Moderate** · C3

A 30-year-old woman with epilepsy on levetiracetam asks about breastfeeding and caring for her baby.

What is the most appropriate advice?

A. Bathe the baby alone in a full bath

B. Breastfeeding is encouraged; she should take safety precautions such as changing the baby on the floor and avoiding bathing the baby alone

C. Breastfeeding is not allowed

D. Stop medication after delivery

E. Use formula only

Answer: B. Breastfeeding is encouraged; she should take safety precautions such as changing the baby on the floor and avoiding bathing the baby alone

Most antiepileptic drugs are compatible with breastfeeding. Safety advice reduces risk to the baby if she has a seizure: change nappies on the floor, avoid bathing the baby alone, and use a pram rather than carrying the baby on stairs. Sleep deprivation should be minimised.

Why not the others

- **A:** Bathing alone is unsafe.
- **C:** Breastfeeding is encouraged.
- **D:** Stopping medication risks seizures.
- **E:** Formula is not required.

Key point: Sleep deprivation is a common seizure trigger after birth.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 263 · Asthma · **Easy** · C3

A 26-year-old woman with asthma is 8 weeks pregnant. She has stopped her inhaled steroid because she is worried about the baby.

What is the most appropriate advice?

A. Avoid salbutamol

B. Continue her usual asthma medication, including inhaled steroids

C. Oral steroids are contraindicated in pregnancy

D. Stop all inhalers

E. Use only home remedies

Answer: B. Continue her usual asthma medication, including inhaled steroids

Inhaled steroids and beta-agonists are safe in pregnancy. Poorly controlled asthma is a greater risk to the fetus (hypoxia, growth restriction) than the medications. Oral steroids can be used for exacerbations.

Why not the others

- **A:** Salbutamol is safe.
- **C:** Oral steroids can be used when needed.
- **D:** Stopping risks attacks.
- **E:** Effective treatment is needed.

Key point: Most women's asthma stays the same in pregnancy; about a third worsen.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 264 · Sickle Cell Disease · **Moderate** · C3

A 24-year-old woman with sickle cell disease (HbSS) is 10 weeks pregnant.

Which measures are recommended during her pregnancy?

A. Avoid all fluids

B. Folic acid 5 mg, low-dose aspirin from 12 weeks, LMWH thromboprophylaxis in admissions and from 28 weeks, and serial growth scans

C. Iron for all regardless of ferritin

D. No extra care

E. Stop penicillin prophylaxis

Answer: B. Folic acid 5 mg, low-dose aspirin from 12 weeks, LMWH thromboprophylaxis in admissions and from 28 weeks, and serial growth scans

Women with sickle cell disease have higher risks of crises, infection, VTE, pre-eclampsia and FGR. Care includes folic acid 5 mg, continuing penicillin prophylaxis, aspirin, thromboprophylaxis, avoiding dehydration and cold, and growth scans. Iron is given only if deficient.

Why not the others

- **A:** Dehydration triggers crises.
- **C:** Iron overload is a risk; give only if deficient.
- **D:** Extra care is essential.
- **E:** Penicillin prophylaxis protects against infection.

Key point: Hydroxycarbamide should be stopped before conception.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 265 · Thrombocytopenia · **Moderate** · C2

A 28-year-old woman at 34 weeks has a platelet count of 112 × 10^9/L on routine testing. She is well, BP is normal and previous counts before pregnancy were normal.

What is the most likely diagnosis?

A. Gestational thrombocytopenia
B. HELLP syndrome
C. Immune thrombocytopenic purpura
D. Leukaemia
E. Thrombotic thrombocytopenic purpura

Answer: A. Gestational thrombocytopenia

Gestational thrombocytopenia is the commonest cause of low platelets in pregnancy, affecting about 5–8% of women in late pregnancy. Platelets are usually over 70 × 10^9/L, there are no symptoms, and it resolves after delivery without fetal effects.

Why not the others

- **B:** HELLP has hypertension and abnormal liver tests.
- **C:** ITP usually starts earlier and counts are lower.
- **D:** Leukaemia has other abnormalities.
- **E:** TTP has haemolysis, neurological signs and renal impairment.

Key point: Check BP and liver tests to exclude pre-eclampsia.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 266 · Thrombocytopenia · **Hard** · C3

A 30-year-old woman with immune thrombocytopenia has a platelet count of 25 × 10^9/L at 36 weeks with some bruising.

What is the most appropriate treatment to raise her platelets before delivery?

A. Emergency splenectomy
B. No treatment
C. Oral corticosteroids or intravenous immunoglobulin
D. Platelet transfusion weekly
E. Warfarin

Answer: C. Oral corticosteroids or intravenous immunoglobulin

ITP in pregnancy is treated with corticosteroids or IV immunoglobulin when platelets are low near delivery or with bleeding. A count of over 50 is advised for delivery and over about 75–80 for regional anaesthesia. Antibodies can cross the placenta and lower the baby's platelets.

Why not the others

- **A:** Splenectomy is rarely needed in pregnancy.
- **B:** Treatment is needed before delivery.
- **D:** Transfused platelets are quickly destroyed in ITP.
- **E:** Warfarin would worsen bleeding.

Key point: Check the baby's platelet count after birth; avoid fetal scalp electrodes and ventouse.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 267 · Systemic Lupus Erythematosus · **Hard** · C2

A 29-year-old woman with SLE has anti-Ro antibodies. She is 18 weeks pregnant.

Which fetal complication is she at risk of?

A. Congenital heart block
B. Fetal macrosomia
C. Neural tube defects
D. Polyhydramnios
E. Trisomy 21

Answer: A. Congenital heart block

Anti-Ro and anti-La antibodies cross the placenta and can damage the fetal cardiac conduction system, causing congenital heart block (about 2% of pregnancies) and neonatal lupus rash. Fetal heart rate is monitored, especially between 16 and 26 weeks.

Why not the others

- **B:** Macrosomia is not linked.
- **C:** NTDs are not linked.
- **D:** Polyhydramnios is not the typical issue.
- **E:** SLE does not cause aneuploidy.

Key point: Continue hydroxychloroquine in pregnancy; it reduces flares and may reduce heart block.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 268 · Systemic Lupus Erythematosus · **Moderate** · C3

A 31-year-old woman with SLE controlled on hydroxychloroquine is planning pregnancy.

What is the most appropriate advice?

A. Conceive during a flare
B. Continue hydroxychloroquine and plan pregnancy when disease has been quiet for at least 6 months
C. No special care
D. Stop hydroxychloroquine before conceiving
E. Switch to methotrexate

Answer: B. Continue hydroxychloroquine and plan pregnancy when disease has been quiet for at least 6 months

Pregnancy outcomes are better when lupus has been inactive for 6 months before conception. Hydroxychloroquine should be continued because stopping increases flares. Methotrexate and mycophenolate are teratogenic and must be stopped before pregnancy.

Why not the others

- **A:** Flares increase complications.
- **C:** Specialist care is needed.
- **D:** Stopping causes flares.
- **E:** Methotrexate is teratogenic.

Key point: Lupus nephritis increases the risk of pre-eclampsia; aspirin is advised.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 269 · Liver Disease · **Easy** · C2

A 30-year-old woman at 32 weeks has intense itching of the palms and soles, worse at night. There is no rash. Serum bile acids are 45 µmol/L and ALT is mildly raised.

What is the most likely diagnosis?

A. Acute fatty liver of pregnancy
B. Atopic eruption of pregnancy
C. Intrahepatic cholestasis of pregnancy
D. Pemphigoid gestationis
E. Polymorphic eruption of pregnancy

Answer: C. Intrahepatic cholestasis of pregnancy

Intrahepatic cholestasis of pregnancy causes itching without a rash, especially of the palms and soles, with raised bile acids. It resolves after delivery. Stillbirth risk rises when bile acids are 100 µmol/L or more.

Why not the others

- **A:** AFLP causes vomiting and liver failure.
- **B:** Atopic eruption has eczematous rash.
- **D:** Pemphigoid has blisters.
- **E:** PEP has a rash in the striae.

Key point: Itching without a rash in pregnancy: check bile acids.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 270 · Liver Disease · **Moderate** · C3

A 28-year-old woman with intrahepatic cholestasis of pregnancy has peak bile acids of 120 µmol/L at 34 weeks.

What is the recommended timing of birth?

A. 35–36 weeks
B. 38–39 weeks
C. 40 weeks
D. After 42 weeks
E. Immediately at 34 weeks regardless

Answer: A. 35–36 weeks

RCOG 2022 guidance links stillbirth risk to bile acid levels. With peak bile acids of 100 µmol/L or more, planned birth at 35–36 weeks is recommended. For 40–99 µmol/L, birth at 38–39 weeks; for 19–39 µmol/L (without other risks), by 40 weeks.

Why not the others

- **B:** 38–39 weeks is for moderate levels.
- **C:** 40 weeks is for mild levels.
- **D:** Waiting increases stillbirth risk.
- **E:** Immediate delivery is not required without other indications.

Key point: Ursodeoxycholic acid may relieve itching but does not reduce stillbirth.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy; RCOG Green-top 43

MCQ 271 · Skin Disorders · **Moderate** · C2

A 26-year-old primigravida at 37 weeks has an itchy rash starting in the abdominal stretch marks, sparing the umbilicus, spreading to the thighs. Bile acids are normal.

What is the most likely diagnosis?

A. Intrahepatic cholestasis
B. Pemphigoid gestationis
C. Polymorphic eruption of pregnancy
D. Psoriasis
E. Scabies

Answer: C. Polymorphic eruption of pregnancy

Polymorphic eruption of pregnancy is a benign, itchy rash of urticarial papules and plaques that begins in the striae and spares the umbilicus, usually in first pregnancies in the third trimester. It has no fetal risk and is treated with emollients and topical steroids.

Why not the others

- **A:** Cholestasis has no primary rash.
- **B:** Pemphigoid involves the umbilicus and forms blisters.
- **D:** Psoriasis has scaly plaques.
- **E:** Scabies affects finger webs with burrows.

Key point: PEP is commoner in multiple pregnancy.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 272 · Skin Disorders · **Hard** · C2

A 30-year-old woman at 28 weeks has an intensely itchy rash that began around the umbilicus and has developed into tense blisters on the abdomen and limbs. Biopsy shows linear C3 deposits at the basement membrane.

What is the diagnosis?

A. Bullous impetigo
B. Pemphigoid gestationis
C. Pemphigus vulgaris
D. Polymorphic eruption of pregnancy
E. Varicella

Answer: B. Pemphigoid gestationis

Pemphigoid gestationis is a rare autoimmune blistering disorder starting around the umbilicus, with linear C3 at the basement membrane. It is associated with FGR and preterm birth, and treated with steroids. It may recur in later pregnancies.

Why not the others

- **A:** Impetigo is an infection with honey-coloured crusts.
- **C:** Pemphigus causes flaccid blisters with intercellular deposits.
- **D:** PEP spares the umbilicus and has no blisters.
- **E:** Varicella causes vesicles of different ages with fever.

Key point: The baby may have a transient blistering rash.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 273 · Renal Disease · **Moderate** · C3

A 24-year-old woman at 22 weeks has fever of 39°C, rigors, right loin pain and vomiting. Urine dipstick shows leucocytes and nitrites.

What is the most appropriate management?

A. Admit for IV antibiotics and fluids, with urine and blood cultures
B. Discharge with oral nitrofurantoin
C. No treatment unless culture positive
D. Oral trimethoprim at home for 3 days
E. Wait for ultrasound before treatment

Answer: A. Admit for IV antibiotics and fluids, with urine and blood cultures

Acute pyelonephritis in pregnancy needs admission for IV antibiotics (such as cefuroxime), fluids and monitoring, because it can lead to sepsis and preterm labour. Urine and blood cultures guide treatment.

Why not the others

- **B:** Oral treatment at home is inadequate for systemic illness.
- **C:** Treatment should not wait.
- **D:** Three days of trimethoprim is inadequate.
- **E:** Antibiotics should not be delayed.

Key point: Check urine for test of cure and consider prophylaxis if recurrent.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 274 · Psychiatric Disorders · **Moderate** · C2

A 29-year-old woman with bipolar disorder took lithium in early pregnancy.

Which fetal cardiac anomaly is associated with lithium?

A. Coarctation of the aorta
B. Ebstein's anomaly
C. Tetralogy of Fallot
D. Transposition of the great arteries
E. Ventricular septal defect only

Answer: B. Ebstein's anomaly

First-trimester lithium is associated with a small increased risk of Ebstein's anomaly (displaced tricuspid valve). Fetal echocardiography is offered. Lithium levels must be monitored closely in pregnancy and after delivery.

Why not the others

- **A:** Coarctation is linked to Turner syndrome.
- **C:** Tetralogy is not specifically linked.
- **D:** TGA is linked to diabetes.
- **E:** VSD is not the specific association.

Key point: Lithium toxicity can develop rapidly after delivery as clearance falls.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy; Mental health in pregnancy

MCQ 275 · Neurological Disease · **Hard** · C3

A 30-year-old woman with myasthenia gravis develops severe pre-eclampsia at 36 weeks.

Which drug should be avoided?

A. Labetalol
B. Magnesium sulfate
C. Nifedipine
D. Oxytocin
E. Pyridostigmine

Answer: B. Magnesium sulfate

Magnesium sulfate blocks neuromuscular transmission and can precipitate a myasthenic crisis. Alternative anticonvulsants are used. Myasthenia can also affect the baby (transient neonatal myasthenia).

Why not the others

- **A:** Labetalol can be used with care.
- **C:** Nifedipine can be used.
- **D:** Oxytocin is safe.
- **E:** Pyridostigmine is her treatment.

Key point: Aminoglycosides also worsen myasthenia.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 276 · Anaemia · **Moderate** · C3

A 27-year-old woman at 35 weeks has a haemoglobin of 84 g/L with ferritin of 5 µg/L. She has not tolerated two different oral iron preparations because of vomiting.

What is the most appropriate treatment?

A. Blood transfusion routinely
B. Folic acid alone
C. Intravenous iron
D. No treatment until after delivery
E. Vitamin B12 injections

Answer: C. Intravenous iron

Intravenous iron is recommended when oral iron is not tolerated or not effective, or when anaemia is diagnosed late in pregnancy and needs faster correction. It is given after the first trimester.

Why not the others

- **A:** Transfusion is reserved for severe symptomatic anaemia or bleeding.
- **B:** Folic acid does not treat iron deficiency.
- **D:** She needs reserves before delivery and possible blood loss.
- **E:** She has iron deficiency.

Key point: Correcting anaemia before birth reduces the need for transfusion after PPH.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 277 · Anaemia · **Moderate** · C2

A 24-year-old vegetarian woman at 30 weeks is tired. Haemoglobin is 92 g/L with an MCV of 112 fL. She has a sore tongue.

What is the most likely cause?

A. Anaemia of chronic disease

B. Folate or vitamin B12 deficiency

C. Iron deficiency

D. Physiological haemodilution

E. Thalassaemia trait

Answer: B. Folate or vitamin B12 deficiency

A high MCV with anaemia suggests megaloblastic anaemia from folate or vitamin B12 deficiency. Folate needs rise in pregnancy, and strict vegetarian diets may lack B12. Both levels should be checked before treatment.

Why not the others

- **A:** Chronic disease gives a normal or low MCV.
- **C:** Iron deficiency gives a low MCV.
- **D:** Haemodilution does not raise MCV.
- **E:** Thalassaemia gives a low MCV.

Key point: Do not give folic acid alone if B12 is low; it can worsen neurological damage.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 278 · Cardiac Disease · **Hard** · C3

A 29-year-old woman with a mechanical mitral valve wants to plan a pregnancy.

What is the most important counselling point?

A. Anticoagulation can be stopped in pregnancy

B. Mechanical valves pose no risk in pregnancy

C. Pregnancy carries a high risk of valve thrombosis and bleeding; anticoagulation must be planned with specialists

D. She must have the valve removed

E. Warfarin is completely safe throughout

Answer: C. Pregnancy carries a high risk of valve thrombosis and bleeding; anticoagulation must be planned with specialists

Mechanical valves are a high-risk condition in pregnancy because of valve thrombosis and the risks of anticoagulants (warfarin embryopathy, bleeding). Options include warfarin (if low dose), LMWH with anti-Xa monitoring, or a combination, managed by a specialist team.

Why not the others

- **A:** Stopping anticoagulation causes valve thrombosis.
- **B:** The risks are high.
- **D:** Removing the valve is not appropriate.
- **E:** Warfarin has fetal risks.

Key point: Anti-Xa levels guide LMWH dosing in women with mechanical valves.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 279 · Cardiac Disease · **Hard** · C3

A 28-year-old woman with Marfan syndrome has an aortic root diameter of 47 mm. She wants to become pregnant.

What is the most appropriate advice?

A. Pregnancy carries a high risk of aortic dissection; she should be advised against pregnancy until the aortic root is repaired

B. Pregnancy is safe with any aortic size

C. Pregnancy is safe with bed rest

D. Stop beta blockers before pregnancy

E. The baby has no risk of inheriting Marfan

Answer: A. Pregnancy carries a high risk of aortic dissection; she should be advised against pregnancy until the aortic root is repaired

In Marfan syndrome an aortic root over 45 mm carries a high risk of dissection in pregnancy. Prophylactic aortic surgery is recommended before pregnancy. Beta blockers continue. The child has a 50% chance of inheriting it (autosomal dominant).

Why not the others

- **B:** Size matters greatly.
- **C:** Bed rest does not prevent dissection.
- **D:** Beta blockers reduce aortic stress.
- **E:** Marfan is autosomal dominant.

Key point: Aortic dissection is a cause of maternal death.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 280 · Cardiac Disease · **Moderate** · C3

A 30-year-old woman with moderate mitral stenosis is in labour at term.

Which intrapartum management is most appropriate?

A. Avoid epidural

B. Early epidural, careful fluid balance, a shortened (assisted) second stage if needed, and oxytocin (not ergometrine)

C. Ergometrine for the third stage

D. Large rapid fluid boluses

E. Lie flat on her back

Answer: B. Early epidural, careful fluid balance, a shortened (assisted) second stage if needed, and oxytocin (not ergometrine)

Women with significant heart disease benefit from early epidural (reduces tachycardia from pain), careful fluid balance, avoiding prolonged pushing (assisted second stage), and oxytocin infusion rather than bolus ergometrine, which raises venous return and BP.

Why not the others

- **A:** Epidural reduces cardiac stress.
- **C:** Ergometrine increases afterload and preload.
- **D:** Fluid overload causes pulmonary oedema.
- **E:** Supine position reduces cardiac output.

Key point: The period just after delivery is risky because of autotransfusion from the uterus.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 281 · Cardiac Disease · **Moderate** · C2

A 25-year-old woman had a ventricular septal defect repaired in childhood. She asks about the risk to her baby.

What is the approximate risk of congenital heart disease in her child?

A. 0%

B. 1%

C. About 3–5% (higher than the general population)

D. 50%

E. 100%

Answer: C. About 3–5% (higher than the general population)

When a parent has congenital heart disease, the risk to the child is about 3–5% (higher if the mother is affected and for some lesions), compared with about 0.8% in the general population. Fetal echocardiography is offered.

Why not the others

- **A:** There is some risk.
- **B:** 1% is close to population risk.
- **D:** 50% applies to some single-gene disorders.
- **E:** Not every child is affected.

Key point: Offer fetal echocardiography at about 20–22 weeks.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 282 · Renal Disease · **Moderate** · C2

A 31-year-old woman with chronic kidney disease (creatinine 160 µmol/L) wants to become pregnant.

Which outcome is she at increased risk of?

A. Accelerated decline in kidney function, pre-eclampsia, FGR and preterm birth

B. Better kidney function

C. Macrosomia

D. No change

E. Post-term pregnancy

Answer: A. Accelerated decline in kidney function, pre-eclampsia, FGR and preterm birth

Moderate to severe CKD increases the risk of pre-eclampsia, FGR, preterm birth and permanent loss of kidney function. Pre-pregnancy counselling, aspirin, BP control and specialist renal and obstetric care are needed.

Why not the others

- **B:** Kidney function may worsen.
- **C:** FGR is more likely.
- **D:** Risks increase.
- **E:** Preterm birth is more likely.

Key point: Women with kidney transplants can have successful pregnancies with careful planning.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 283 · Neurological Disease · **Hard** · C2

A 26-year-old woman 10 days after delivery has a progressive severe headache, vomiting and then a seizure. BP is normal. MRI venography shows thrombosis of the superior sagittal sinus.

What is the diagnosis and treatment?

A. Cerebral venous sinus thrombosis; anticoagulation with LMWH
B. Eclampsia; magnesium only
C. Migraine; triptan
D. Post-dural puncture headache; blood patch
E. Subarachnoid haemorrhage; surgery

Answer: A. Cerebral venous sinus thrombosis; anticoagulation with LMWH

The postpartum period is prothrombotic. Cerebral venous sinus thrombosis presents with headache, seizures, focal signs or reduced consciousness, and is treated with anticoagulation even if there is haemorrhagic change.

Why not the others

- **B:** BP is normal and MRV shows thrombosis.
- **C:** Migraine does not show thrombosis.
- **D:** Post-dural headache is positional and does not cause seizures.
- **E:** SAH shows blood on imaging.

Key point: Headache red flags postpartum: thunderclap onset, seizures, focal signs, raised BP.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 284 · Neurological Disease · **Moderate** · C3

A 28-year-old woman with migraine is 16 weeks pregnant and has frequent attacks.

Which treatment is safe for acute migraine in pregnancy?

A. Ergotamine
B. Paracetamol (with an antiemetic if needed)
C. Sodium valproate
D. Topiramate
E. Warfarin

Answer: B. Paracetamol (with an antiemetic if needed)

Paracetamol is first-line for migraine in pregnancy, with metoclopramide for nausea. Sumatriptan may be used if needed. NSAIDs are avoided in the third trimester. Ergotamine, valproate and topiramate are contraindicated.

Why not the others

- **A:** Ergotamine causes uterine contraction and vasoconstriction.
- **C:** Valproate is teratogenic.
- **D:** Topiramate is teratogenic.
- **E:** Warfarin is not a migraine treatment.

Key point: Migraine often improves in the second and third trimesters.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 285 · Neurological Disease · **Moderate** · C2

A 32-year-old woman with relapsing-remitting multiple sclerosis asks how pregnancy will affect her disease.

What is the usual pattern of MS activity around pregnancy?

A. MS always worsens permanently
B. No change at all
C. Pregnancy cures MS
D. Relapses fall during pregnancy, especially the third trimester, and rise in the first 3 months after delivery
E. Relapses increase in pregnancy and fall postpartum

Answer: D. Relapses fall during pregnancy, especially the third trimester, and rise in the first 3 months after delivery

MS relapse rate falls during pregnancy, particularly in the third trimester, and rises in the first 3 months postpartum before returning to the pre-pregnancy rate. Pregnancy does not worsen long-term disability.

Why not the others

- **A:** Long-term disability is not worsened.
- **B:** There is a predictable change.
- **C:** Pregnancy does not cure MS.
- **E:** The opposite is true.

Key point: Many disease-modifying drugs must be stopped before conception.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 286 · Gastrointestinal Disease · **Moderate** · C3

A 27-year-old woman at 30 weeks has 24 hours of abdominal pain, now in the right flank and upper right abdomen, with fever and nausea. White count is raised. Ultrasound is unclear.

Which diagnosis must not be missed?

A. Acute appendicitis, displaced upwards by the uterus
B. Braxton Hicks contractions
C. Constipation
D. Normal round ligament pain
E. Pelvic girdle pain

Answer: A. Acute appendicitis, displaced upwards by the uterus

Appendicitis is the commonest non-obstetric surgical emergency in pregnancy. The growing uterus pushes the appendix upwards, so pain may be in the flank or right upper quadrant. Delay increases perforation and fetal loss. MRI helps diagnosis.

Why not the others

- **B:** Braxton Hicks do not cause fever.
- **C:** Constipation does not cause fever and raised white count.
- **D:** Round ligament pain does not cause fever.
- **E:** Pelvic girdle pain is musculoskeletal.

Key point: Perforated appendicitis carries a high fetal loss rate.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 287 · Gastrointestinal Disease · **Moderate** · C3

A 29-year-old woman with Crohn's disease in remission on azathioprine is planning pregnancy.

What is the most appropriate advice?

A. Conceive during a flare
B. Continue azathioprine; conceive when the disease is in remission
C. Stop all medication before conceiving
D. Switch to methotrexate
E. Take no folic acid

Answer: B. Continue azathioprine; conceive when the disease is in remission

Disease activity at conception and during pregnancy predicts outcomes. Azathioprine and most biologics are continued in pregnancy. Methotrexate is teratogenic and must be stopped at least 3–6 months before conception.

Why not the others

- **A:** Active disease worsens outcomes.
- **C:** Stopping causes flares.
- **D:** Methotrexate is teratogenic.
- **E:** Folic acid is needed, especially with sulfasalazine (5 mg).

Key point: Women with IBD and perianal disease may need caesarean section.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 288 · Substance Misuse · **Moderate** · C3

A 25-year-old woman who uses heroin is 14 weeks pregnant. She wants to stop using.

What is the most appropriate management?

A. Abrupt withdrawal without support
B. Refer to specialist services for opioid substitution therapy (methadone or buprenorphine)
C. Report to police only
D. Terminate the pregnancy
E. Use naloxone daily

Answer: B. Refer to specialist services for opioid substitution therapy (methadone or buprenorphine)

Opioid substitution with methadone or buprenorphine, with specialist support, is recommended. Abrupt withdrawal can cause fetal distress and relapse. The baby needs observation for neonatal abstinence syndrome.

Why not the others

- **A:** Abrupt withdrawal is dangerous.
- **C:** Healthcare and safeguarding, not punishment, is the approach.
- **D:** Termination is not required.
- **E:** Naloxone reverses overdose; daily use is not treatment.

Key point: Breastfeeding is encouraged on stable methadone if not using other drugs.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 289 · Psychiatric Disorders · **Moderate** · C3

A 30-year-old woman with moderate depression on sertraline is 8 weeks pregnant.

What is the most appropriate advice?

A. Continue sertraline if it is effective, after discussing risks and benefits
B. Stop sertraline immediately
C. Switch to lithium
D. Switch to paroxetine
E. Switch to valproate

Answer: A. Continue sertraline if it is effective, after discussing risks and benefits

Untreated depression has risks for mother and baby. Sertraline has a reassuring safety record. Continuing an effective antidepressant is usually advised. Babies may have transient neonatal adaptation symptoms; paroxetine is associated with cardiac defects.

Why not the others

- **B:** Abrupt stopping risks relapse and withdrawal.
- **C:** Lithium is not indicated.
- **D:** Paroxetine has a higher cardiac risk.
- **E:** Valproate is teratogenic and not an antidepressant.

Key point: Perinatal mental health problems are a leading cause of maternal death.

Reference: Obstetrics by Ten Teachers — Mental health in pregnancy

MCQ 290 · Haemoglobinopathy · **Hard** · C3

A 26-year-old woman with beta-thalassaemia major (transfusion-dependent) wants to become pregnant.

Which pre-pregnancy assessment is most important?

A. Cardiac assessment (including MRI T2*) and assessment of iron overload, endocrine and liver function
B. Dental check only
C. No assessment needed
D. Routine blood count only
E. Skin check

Answer: A. Cardiac assessment (including MRI T2*) and assessment of iron overload, endocrine and liver function

Iron overload from transfusions damages the heart, liver and endocrine glands. Cardiac MRI T2* assesses cardiac iron, and chelation should be optimised before pregnancy. Most chelators are stopped in pregnancy. Diabetes, thyroid function and bone health are also checked.

Why not the others

- **B:** Dental care is not the priority.
- **C:** Assessment is essential.
- **D:** A full blood count is not enough.
- **E:** Skin is not the concern.

Key point: Cardiac failure from iron overload is the main cause of death in thalassaemia.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 291 · Haematological Disorders · **Hard** · C2

A 30-year-old woman at 24 weeks has fever, confusion, anaemia with fragmented red cells on film, platelets 18 × 10^9/L, and normal clotting. ADAMTS13 activity is very low.

What is the most likely diagnosis?

A. Acute fatty liver
B. Disseminated intravascular coagulation
C. Gestational thrombocytopenia
D. HELLP syndrome
E. Thrombotic thrombocytopenic purpura

Answer: E. Thrombotic thrombocytopenic purpura

TTP causes microangiopathic haemolytic anaemia, severe thrombocytopenia, neurological symptoms, fever and renal impairment, with very low ADAMTS13 activity. Clotting is normal. Urgent plasma exchange is needed.

Why not the others

- **A:** AFLP causes liver failure and coagulopathy.
- **B:** DIC has abnormal clotting.
- **C:** Gestational thrombocytopenia is mild and asymptomatic.
- **D:** HELLP occurs later with hypertension and liver enzymes.

Key point: Platelet transfusion may worsen TTP; avoid unless life-threatening bleeding.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 292 · Antiphospholipid Syndrome · **Hard** · C3

A 33-year-old woman with antiphospholipid syndrome had a previous DVT and is on warfarin. She has a positive pregnancy test at 5 weeks.

What is the most appropriate management?

A. Aspirin alone
B. Continue warfarin throughout
C. No anticoagulation
D. Stop warfarin and start treatment-dose LMWH with low-dose aspirin
E. Switch to rivaroxaban

Answer: D. Stop warfarin and start treatment-dose LMWH with low-dose aspirin

Warfarin should be stopped before 6 weeks because of embryopathy. Women with APS and previous thrombosis need treatment-dose LMWH throughout pregnancy and postpartum, with low-dose aspirin.

Why not the others

- **A:** Aspirin alone is inadequate with previous thrombosis.
- **B:** Warfarin is teratogenic.
- **C:** She has a high thrombosis risk.
- **E:** DOACs are not used in pregnancy.

Key point: Switch from warfarin before 6 weeks of pregnancy.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 293 · Respiratory Disease · **Moderate** · C3

A 26-year-old woman with asthma at 30 weeks has an acute severe attack. Peak flow is 40% of best and SpO2 is 93%.

What is the most appropriate treatment?

A. Avoid oral steroids because of the baby

B. Delay treatment for fetal monitoring

C. Give only paracetamol

D. Give oxygen, nebulised salbutamol and ipratropium, and oral prednisolone (or IV hydrocortisone), as in non-pregnant patients

E. Immediate caesarean section

Answer: D. Give oxygen, nebulised salbutamol and ipratropium, and oral prednisolone (or IV hydrocortisone), as in non-pregnant patients

Acute asthma in pregnancy is treated the same as outside pregnancy, aiming for oxygen saturation of 94–98%. Maternal hypoxia harms the fetus more than the drugs.

Why not the others

- **A:** Steroids are safe and essential.
- **B:** Treatment must not be delayed.
- **C:** Paracetamol does not treat asthma.
- **E:** Delivery is not the treatment.

Key point: Women on long-term oral steroids need IV hydrocortisone in labour.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 294 · Sickle Cell Disease · **Moderate** · C3

A 23-year-old woman with sickle cell disease at 28 weeks has severe bone pain in her back and legs. She is not febrile.

What is the most appropriate initial management of this painful crisis?

A. Avoid opioids in pregnancy

B. Fluid restriction

C. Immediate delivery

D. Prompt analgesia (including opioids), hydration, oxygen if hypoxic, thromboprophylaxis and looking for a trigger

E. Use NSAIDs throughout the third trimester

Answer: D. Prompt analgesia (including opioids), hydration, oxygen if hypoxic, thromboprophylaxis and looking for a trigger

Painful crises are treated with rapid analgesia (opioids are appropriate), fluids, oxygen if needed, VTE prophylaxis and assessment for infection or other triggers. NSAIDs are avoided after 28 weeks.

Why not the others

- **A:** Opioids are appropriate.
- **B:** Dehydration worsens sickling.
- **C:** Delivery is not the treatment.
- **E:** NSAIDs are avoided after 28 weeks.

Key point: Watch for acute chest syndrome: chest pain, fever and new infiltrates.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 295 · Hyperemesis · **Moderate** · C3

A 26-year-old woman at 10 weeks has severe vomiting, ketonuria and 6% weight loss. She is admitted for IV fluids.

What additional treatment should all admitted women with hyperemesis receive?

A. Antibiotics
B. Iron infusion
C. Low molecular weight heparin thromboprophylaxis (unless contraindicated)
D. Termination of pregnancy
E. Warfarin

Answer: C. Low molecular weight heparin thromboprophylaxis (unless contraindicated)

Hyperemesis gravidarum with dehydration and immobility increases VTE risk. Women admitted should receive LMWH thromboprophylaxis unless contraindicated, along with antiemetics, fluids and thiamine.

Why not the others

- **A:** There is no infection.
- **B:** Iron does not help vomiting.
- **D:** Termination is rarely needed and is a personal decision.
- **E:** Warfarin is not used.

Key point: Continue prophylaxis until discharge.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 296 · Rheumatoid Arthritis · **Moderate** · C2

A 31-year-old woman with rheumatoid arthritis on methotrexate wants to conceive.

What is the most appropriate advice?

A. Continue methotrexate
B. Methotrexate improves fertility
C. No need to plan
D. Stop methotrexate at least 3 months before conception and switch to a pregnancy-compatible drug
E. Switch to leflunomide

Answer: D. Stop methotrexate at least 3 months before conception and switch to a pregnancy-compatible drug

Methotrexate is teratogenic and must be stopped at least 3 months before conception. Hydroxychloroquine, sulfasalazine and some biologics are compatible with pregnancy. RA often improves during pregnancy and flares after delivery.

Why not the others

- **A:** Methotrexate is teratogenic.
- **B:** It does not improve fertility.
- **C:** Planning is essential.
- **E:** Leflunomide is also teratogenic and needs washout.

Key point: Take high-dose folic acid while switching.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 297 · Venous Thromboembolism · **Easy** · C2

A 28-year-old woman asks why pregnant women are at higher risk of blood clots.

When is the risk of VTE highest?

A. First trimester only
B. In the postpartum period, especially the first week
C. Never in pregnancy
D. Only after menopause
E. Second trimester only

Answer: B. In the postpartum period, especially the first week

VTE risk increases throughout pregnancy but is highest in the first weeks after delivery, especially after caesarean section. Prophylaxis is targeted at high-risk periods.

Why not the others

- **A:** Risk is raised in all trimesters, highest postpartum.
- **C:** Pregnancy raises risk.
- **D:** Risk is raised in pregnancy.
- **E:** Risk is not limited to one trimester.

Key point: Encourage early mobilisation and hydration after birth.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

MCQ 298 · Hepatitis · **Hard** · C2

A 26-year-old woman in her third trimester in a region where hepatitis E is common develops jaundice, confusion and coagulopathy after a short illness with nausea.

Which infection is particularly dangerous in pregnancy, with high maternal mortality?

A. Hepatitis A
B. Hepatitis B
C. Hepatitis C
D. Hepatitis E
E. Infectious mononucleosis

Answer: D. Hepatitis E

Hepatitis E, spread by contaminated water, can cause fulminant hepatic failure in pregnant women, especially in the third trimester, with high maternal and fetal mortality. It is common in South Asia, including Pakistan.

Why not the others

- **A:** Hepatitis A is usually mild in pregnancy.
- **B:** Hepatitis B is a concern mainly for transmission.
- **C:** Hepatitis C rarely causes acute liver failure.
- **E:** EBV rarely causes liver failure.

Key point: Safe drinking water prevents hepatitis E.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy; Infections in pregnancy

MCQ 299 · Venous Thromboembolism · **Moderate** · C3

A 34-year-old woman had an unprovoked DVT 2 years ago, treated with warfarin which has now stopped. She is 7 weeks pregnant.

What thromboprophylaxis is recommended?

A. Aspirin only
B. LMWH from 28 weeks only
C. Postnatal prophylaxis only
D. Prophylactic LMWH throughout the antenatal period and for 6 weeks postnatally
E. Warfarin from booking

Answer: D. Prophylactic LMWH throughout the antenatal period and for 6 weeks postnatally

Women with a previous VTE (except a single one related to major surgery) are high risk and should have prophylactic LMWH from booking throughout pregnancy and for 6 weeks after delivery.

Why not the others

- **A:** Aspirin is not adequate VTE prophylaxis.
- **B:** Starting at 28 weeks is too late for her risk level.
- **C:** Antenatal prophylaxis is also needed.
- **E:** Warfarin is avoided antenatally.

Key point: Refer women with previous VTE to a specialist at booking.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy; RCOG Green-top 37a

MCQ 300 · Asthma · **Easy** · C2

A 26-year-old woman with well-controlled asthma finds out she is 7 weeks pregnant. She uses a beclometasone inhaler twice daily and salbutamol as needed. She is worried the medicines will harm the baby.

What is the most appropriate advice?

A. Change to oral montelukast only
B. Reduce the inhaled steroid to once weekly
C. Stop all inhalers until the second trimester
D. Stop the steroid inhaler and use salbutamol only
E. Use both inhalers as before

Answer: E. Use both inhalers as before

Inhaled beta-agonists and inhaled steroids are safe in pregnancy. Poorly controlled asthma is a bigger risk to the mother and baby than the medicines. She should keep using her usual treatment.

Why not the others

- **A:** Montelukast is not first line and should not replace an inhaled steroid that already works.
- **B:** Cutting the dose risks loss of control and severe attacks.
- **C:** Stopping treatment risks severe asthma and fetal hypoxia.
- **D:** Stopping the preventer leads to poor control.

Key point: Do not stop asthma medicines in pregnancy; poor control is the main danger.

Reference: Obstetrics by Ten Teachers — Medical disorders in pregnancy

CHAPTER 7

Infections in Pregnancy

MCQ 301 · Group B streptococcus · **Easy** · C2

A 29-year-old woman at 37 weeks had a vaginal swab for another reason, and it grew group B streptococcus (GBS). She is well and plans a vaginal birth.

What is the most appropriate management?

A. Caesarean section at 39 weeks
B. Intravenous benzylpenicillin in labour
C. Oral amoxicillin now for 7 days
D. Repeat swab every week until labour
E. Treat the baby with antibiotics at birth

Answer: B. Intravenous benzylpenicillin in labour

GBS carriage found in this pregnancy is managed with intrapartum antibiotic prophylaxis. Intravenous benzylpenicillin is given as soon as possible after labour starts and every 4 hours until birth. This lowers the risk of early-onset neonatal GBS disease.

Why not the others

- **A:** GBS is not an indication for caesarean section.
- **C:** Treatment before labour does not stop recolonisation and is not advised.
- **D:** Repeat swabs do not change management.
- **E:** A well baby does not need antibiotics if the mother had adequate prophylaxis.

Key point: GBS found in pregnancy means IV benzylpenicillin in labour, not antenatal treatment.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 302 · Group B streptococcus · **Moderate** · C2

A 31-year-old woman in labour at 39 weeks had a baby in her last pregnancy who developed early-onset GBS sepsis. She has a severe penicillin allergy with a history of anaphylaxis.

What is the most appropriate intrapartum antibiotic?

A. Amoxicillin
B. Benzylpenicillin
C. Cefuroxime
D. Clindamycin
E. Vancomycin

Answer: E. Vancomycin

In the UK (RCOG Green-top 36), for women with severe penicillin allergy, vancomycin is recommended for intrapartum GBS prophylaxis. Many GBS strains are resistant to clindamycin, so it is no longer the first choice.

Why not the others

- **A:** Amoxicillin is a penicillin and is contraindicated after anaphylaxis.
- **B:** Benzylpenicillin is contraindicated after anaphylaxis.
- **C:** Cephalosporins are avoided after penicillin anaphylaxis.
- **D:** Clindamycin resistance in GBS is common, so it is no longer advised.

Key point: Severe penicillin allergy plus GBS: vancomycin in labour.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 303 · Group B streptococcus · **Moderate** · C3

A 27-year-old woman at 35 weeks has a urine culture that grows group B streptococcus at more than 10^5 cfu/mL. She has no symptoms.

What is the most appropriate management?

A. Give intravenous antibiotics in labour only
B. No action unless symptoms develop
C. Repeat urine culture in 4 weeks
D. Treat now only
E. Treat now, and give intravenous antibiotics in labour

Answer: E. Treat now, and give intravenous antibiotics in labour

GBS bacteriuria is treated at the time as for any bacteriuria in pregnancy. It is also a marker of heavy colonisation, so intrapartum antibiotic prophylaxis is still needed.

Why not the others

- **A:** The bacteriuria itself needs treating now.
- **B:** Asymptomatic bacteriuria in pregnancy must be treated.
- **C:** Waiting risks pyelonephritis.
- **D:** Treatment now does not remove the need for prophylaxis in labour.

Key point: GBS bacteriuria: treat now and give IAP in labour.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 304 · Group B streptococcus · **Hard** · C3

A 30-year-old woman with known GBS carriage is booked for a planned caesarean section at 39 weeks for breech presentation. Membranes are intact and she is not in labour.

What is the most appropriate advice about GBS prophylaxis?

A. Benzylpenicillin for 4 hours before surgery
B. Delay surgery until a negative swab
C. Intravenous antibiotics are not needed for GBS
D. Oral penicillin for 5 days before surgery
E. Vancomycin at skin incision

Answer: C. Intravenous antibiotics are not needed for GBS

With planned caesarean section before labour and with intact membranes, the risk of GBS transmission is very low. GBS prophylaxis is not needed, though she will still get routine antibiotics for the caesarean.

Why not the others

- **A:** Benzylpenicillin is used for labour, not a pre-labour caesarean with intact membranes.
- **B:** Swab results do not change the plan.
- **D:** Antenatal oral treatment does not help.
- **E:** Vancomycin is for penicillin allergy in labour.

Key point: Pre-labour CS with intact membranes: no GBS prophylaxis needed.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 305 · HIV · **Easy** · C2

A 25-year-old woman books at 10 weeks. She declines the HIV test, saying she is at low risk.

What is the most appropriate action?

A. Accept her decision and never offer again
B. Explain the benefits and offer the test again at about 20 weeks
C. Refer her to the safeguarding team
D. Tell her the test is compulsory
E. Test her blood anyway

Answer: B. Explain the benefits and offer the test again at about 20 weeks

HIV screening is offered to all pregnant women as an opt-out test. If declined, the reasons should be explored, and the test should be offered again, usually at about 20 weeks. Treatment can almost remove transmission to the baby.

Why not the others

- **A:** Guidelines say to re-offer the test.
- **C:** Declining a test is not a safeguarding issue.
- **D:** The test is voluntary.
- **E:** Testing without consent is not allowed.

Key point: Declined screening tests should be re-offered at about 20 weeks.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 306 · HIV · **Moderate** · C2

A 32-year-old woman with HIV is on combination antiretroviral therapy. At 36 weeks her viral load is below 50 copies/mL. There are no obstetric complications.

What is the recommended mode of delivery?

A. Caesarean section at 38 weeks
B. Caesarean section at 39 weeks with intravenous zidovudine
C. Induction of labour at 37 weeks
D. Instrumental delivery in the second stage
E. Planned vaginal birth

Answer: E. Planned vaginal birth

BHIVA advises planned vaginal birth when the viral load is below 50 copies/mL at 36 weeks. Transmission risk with an undetectable viral load is very low and caesarean adds no benefit.

Why not the others

- **A:** Caesarean is for a viral load above 400 copies/mL or for obstetric reasons.
- **B:** IV zidovudine is for a high or unknown viral load.
- **C:** Early induction is not needed for HIV.
- **D:** Routine instrumental delivery is not advised.

Key point: HIV with VL <50 at 36 weeks: plan vaginal birth.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 307 · HIV · **Hard** · C3

A 28-year-old woman with HIV started treatment late in pregnancy. At 36 weeks her viral load is 1200 copies/mL.

What is the most appropriate mode of delivery?

A. Caesarean section at 38 weeks
B. Induction of labour at 38 weeks
C. Planned vaginal birth at term
D. Spontaneous labour with fetal scalp electrode
E. Vaginal birth with artificial rupture of membranes

Answer: A. Caesarean section at 38 weeks

BHIVA advises planned caesarean section if the viral load is above 400 copies/mL at 36 weeks. When it is done to prevent transmission, it is planned at 38–39 weeks. Intravenous zidovudine is also given.

Why not the others

- **B:** Vaginal birth is not advised with a viral load above 400.
- **C:** This increases transmission risk.
- **D:** Scalp electrodes are avoided in HIV.
- **E:** Early amniotomy adds risk with a detectable viral load.

Key point: HIV with VL >400 at 36 weeks: caesarean section with IV zidovudine.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 308 · HIV · **Moderate** · C3

A woman with HIV and an undetectable viral load has just had a healthy baby. She asks how to feed her baby in the UK.

What is the recommended advice?

A. Breastfeed for 6 months
B. Donor milk from a milk bank only
C. Expressed breast milk only
D. Formula feeding
E. Mixed breast and formula feeding

Answer: D. Formula feeding

In the UK, where safe formula is available, BHIVA advises formula feeding to remove the risk of transmission through breast milk. Women with an undetectable viral load who choose to breastfeed can be supported with close monitoring.

Why not the others

- **A:** Breastfeeding carries a small risk and is not the default advice.
- **B:** Donor milk is not the routine plan.
- **C:** Expressed milk still carries the virus.
- **E:** Mixed feeding has the highest transmission risk.

Key point: In the UK the standard advice for HIV is formula feeding.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 309 · Hepatitis B · **Moderate** · C2

A 30-year-old woman is HBsAg positive at booking. Her HBeAg is negative and her viral load is low.

What is the most appropriate plan for the baby?

A. Hepatitis B immunoglobulin only
B. Hepatitis B vaccine at 1 year
C. Hepatitis B vaccine at birth and at the routine schedule
D. Hepatitis B vaccine plus immunoglobulin at birth
E. No action because HBeAg is negative

Answer: C. Hepatitis B vaccine at birth and at the routine schedule

All babies of HBsAg-positive mothers get hepatitis B vaccine within 24 hours of birth, followed by further doses. Immunoglobulin is added when the mother is high risk, such as HBeAg positive or with a high viral load.

Why not the others

- **A:** Immunoglobulin alone gives no lasting protection.
- **B:** The first dose must be within 24 hours.
- **D:** Immunoglobulin is for high-infectivity mothers only.
- **E:** All babies of carriers need vaccination.

Key point: Every baby of an HBsAg-positive mother needs vaccine at birth.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 310 · Hepatitis B · **Hard** · C3

A 26-year-old woman is HBsAg and HBeAg positive with a viral load above 200,000 IU/mL at 24 weeks.

What is the most appropriate antenatal management to reduce transmission?

A. Caesarean section at 38 weeks
B. Immunoglobulin to the mother monthly
C. Interferon injections
D. Lamivudine after delivery only
E. Tenofovir from the third trimester

Answer: E. Tenofovir from the third trimester

A high hepatitis B viral load is the main cause of failed neonatal immunisation. Tenofovir from about 28–32 weeks lowers the viral load and reduces transmission. The baby also gets vaccine plus immunoglobulin.

Why not the others

- **A:** Caesarean section does not reduce hepatitis B transmission.
- **B:** Maternal immunoglobulin is not effective.
- **C:** Interferon is contraindicated in pregnancy.
- **D:** Treatment after birth is too late to lower risk at delivery.

Key point: Hepatitis B with high viral load: tenofovir in the third trimester.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 311 · Hepatitis C · **Moderate** · C2

A 33-year-old woman with a past history of injecting drug use has a positive hepatitis C antibody and a positive HCV RNA test in pregnancy.

What is the most appropriate advice?

A. Avoid breastfeeding
B. Caesarean section is required
C. Direct-acting antivirals now
D. Fetal blood sampling is acceptable in labour
E. Vaginal birth and breastfeeding are both fine

Answer: E. Vaginal birth and breastfeeding are both fine

Vertical transmission of hepatitis C is about 5%. Caesarean section does not reduce it, and breastfeeding is allowed unless nipples are cracked or bleeding. Antiviral treatment is usually given after pregnancy.

Why not the others

- **A:** Breastfeeding does not transmit HCV unless nipples bleed.
- **B:** Caesarean section does not reduce transmission.
- **C:** Direct-acting antivirals are usually given after delivery.
- **D:** Invasive fetal procedures should be avoided.

Key point: Hepatitis C: vaginal birth and breastfeeding are fine; treat after birth.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 312 · Syphilis · **Easy** · C2

A 24-year-old woman has a positive syphilis screening test at booking. Confirmatory tests show early syphilis. She is not allergic to penicillin.

What is the treatment of choice?

A. Azithromycin
B. Benzathine penicillin
C. Ceftriaxone
D. Doxycycline
E. Erythromycin

Answer: B. Benzathine penicillin

Intramuscular benzathine penicillin is the treatment of choice for syphilis in pregnancy. It treats the mother and the fetus and prevents congenital syphilis.

Why not the others

- **A:** Azithromycin resistance is common.
- **C:** Ceftriaxone is a second-line choice.
- **D:** Doxycycline is contraindicated in pregnancy.
- **E:** Erythromycin does not cross the placenta well enough to treat the fetus.

Key point: Syphilis in pregnancy: benzathine penicillin.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 313 · Syphilis · **Hard** · C3

A 27-year-old woman with secondary syphilis gets her first injection of benzathine penicillin at 24 weeks. Six hours later she has fever, myalgia and uterine tightenings.

What is the most likely cause?

A. Anaphylaxis
B. Chorioamnionitis
C. Jarisch-Herxheimer reaction
D. Pyelonephritis
E. Serum sickness

Answer: C. Jarisch-Herxheimer reaction

The Jarisch-Herxheimer reaction is a fever reaction within 24 hours of treating syphilis, from release of treponemal products. In pregnancy it can cause contractions and fetal distress, so fetal monitoring is advised. It is treated with antipyretics.

Why not the others

- **A:** Anaphylaxis occurs within minutes with hypotension and wheeze.
- **B:** There is no rupture of membranes or tenderness to suggest this.
- **D:** There are no urinary symptoms.
- **E:** Serum sickness appears days to weeks later.

Key point: Fever within hours of syphilis treatment is the Jarisch-Herxheimer reaction.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 314 · Rubella · **Moderate** · C2

A 23-year-old woman is 9 weeks pregnant. A child at her nursery had rubella. She develops a fine rash and enlarged posterior cervical lymph nodes. Rubella IgM is positive.

What is the risk to the fetus at this stage?

A. About 1%
B. About 20%
C. About 5%
D. About 50%
E. Up to 90%

Answer: E. Up to 90%

Rubella in the first 12 weeks causes congenital defects in up to 90% of cases. The classic triad is cataracts, deafness and heart defects. The risk falls sharply after 16 weeks.

Why not the others

- **A:** This underestimates the risk.
- **B:** This is nearer the risk at 13–16 weeks.
- **C:** This underestimates the risk.
- **D:** This underestimates the first-trimester risk.

Key point: First-trimester rubella carries up to a 90% risk of congenital rubella syndrome.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 315 · Rubella · **Easy** · C2

A 28-year-old woman delivered a healthy baby yesterday. Her antenatal blood tests showed she is not immune to rubella.

What is the most appropriate action?

A. Give MMR vaccine after delivery
B. Give rubella immunoglobulin
C. No action is needed
D. Repeat serology in 6 months
E. Vaccinate only before her next pregnancy

Answer: A. Give MMR vaccine after delivery

Women who are not immune to rubella should be offered MMR vaccine after delivery. MMR is a live vaccine, so it cannot be given in pregnancy. It is safe with breastfeeding. Pregnancy should be avoided for 1 month after it.

Why not the others

- **B:** Immunoglobulin does not give lasting immunity.
- **C:** She should be protected for future pregnancies.
- **D:** Repeating serology does not protect her.
- **E:** After delivery is the ideal time to vaccinate.

Key point: Rubella non-immune: MMR after delivery, never during pregnancy.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 316 · CMV · **Moderate** · C3

A 29-year-old nursery worker at 18 weeks had a flu-like illness. CMV IgM is positive and CMV IgG avidity is low. The anomaly scan is normal.

What is the most appropriate next step to find out if the fetus is infected?

A. Amniocentesis for CMV PCR after 21 weeks and 6 weeks after infection
B. Chorionic villus sampling now
C. Cord blood sampling now
D. Maternal CMV viral load
E. Repeat ultrasound only at 32 weeks

Answer: A. Amniocentesis for CMV PCR after 21 weeks and 6 weeks after infection

Low IgG avidity suggests recent primary CMV infection. Fetal infection is diagnosed by CMV PCR on amniotic fluid. It is most reliable after 21 weeks and at least 6 weeks after maternal infection, because the fetus must pass the virus in urine.

Why not the others

- **B:** CVS is not used to diagnose fetal CMV.
- **C:** Cordocentesis has more risk and is not first line.
- **D:** Maternal viral load does not show fetal infection.
- **E:** Waiting misses the chance to counsel early.

Key point: Fetal CMV: amniotic fluid PCR after 21 weeks and 6 weeks after infection.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 317 · CMV · **Easy** · C2

A newborn has microcephaly, periventricular calcification and a failed hearing screen. The mother had a mild febrile illness in early pregnancy.

What is the most likely congenital infection?

A. Cytomegalovirus
B. Herpes simplex virus
C. Parvovirus B19
D. Rubella
E. Toxoplasmosis

Answer: A. Cytomegalovirus

CMV is the most common congenital infection. Typical features are microcephaly, periventricular calcification and sensorineural hearing loss. It is the leading infectious cause of congenital deafness.

Why not the others

- **B:** Congenital HSV is rare and causes skin, eye and CNS lesions.
- **C:** Parvovirus causes anaemia and hydrops, not calcification.
- **D:** Rubella causes cataracts, heart defects and deafness, without periventricular calcification.
- **E:** Toxoplasmosis causes diffuse calcification, hydrocephalus and chorioretinitis.

Key point: Periventricular calcification and deafness point to CMV.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 318 · Toxoplasmosis · **Moderate** · C2

A 25-year-old woman at 14 weeks has seroconversion for toxoplasma after eating undercooked meat. Amniocentesis is planned later.

What drug should be started now to reduce transmission to the fetus?

A. Clindamycin
B. Co-trimoxazole
C. Pyrimethamine
D. Spiramycin
E. Sulfadiazine

Answer: D. Spiramycin

Spiramycin is given after acute maternal toxoplasmosis to reduce the risk of transmission across the placenta. If fetal infection is confirmed, pyrimethamine, sulfadiazine and folinic acid are used.

Why not the others

- **A:** Clindamycin is not used for prevention here.
- **B:** Co-trimoxazole is not standard.
- **C:** Pyrimethamine is for confirmed fetal infection and is avoided in early pregnancy.
- **E:** Sulfadiazine is combined with pyrimethamine for confirmed fetal infection.

Key point: Maternal toxoplasmosis: spiramycin to reduce transmission.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 319 · Toxoplasmosis · **Easy** · C1

A 22-year-old woman at 8 weeks asks how she can avoid toxoplasmosis in pregnancy.

Which advice is most appropriate?

A. Avoid all dairy products
B. Avoid cooked chicken
C. Avoid shellfish only
D. Stop drinking tap water
E. Wear gloves for gardening and cleaning cat litter

Answer: E. Wear gloves for gardening and cleaning cat litter

Toxoplasma is caught from cat faeces, soil and undercooked meat. Advice includes wearing gloves for gardening and cat litter, washing hands, washing vegetables and cooking meat well.

Why not the others

- **A:** Dairy is not a source of toxoplasma (unpasteurised milk is a listeria risk).
- **B:** Cooked meat is safe.
- **C:** Shellfish is not the main source.
- **D:** Tap water in the UK is not a major source.

Key point: Toxoplasma prevention: gloves, hand washing and well-cooked meat.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 320 · Varicella · **Moderate** · C2

A 30-year-old woman at 16 weeks had face-to-face contact with a child with chickenpox 3 days ago. She is not sure if she had chickenpox. Her VZV IgG is negative.

What is the most appropriate management?

A. Aciclovir from day 7 to day 14 after exposure
B. Immediate varicella vaccine
C. No action unless a rash appears
D. Termination of pregnancy
E. Varicella-zoster immunoglobulin today

Answer: A. Aciclovir from day 7 to day 14 after exposure

Current UK guidance (UKHSA, RCOG) advises oral aciclovir from day 7 to day 14 after exposure for susceptible pregnant women. This has replaced VZIG as first-line post-exposure prophylaxis.

Why not the others

- **B:** Varicella vaccine is live and contraindicated in pregnancy.
- **C:** Prophylaxis reduces the risk of severe illness.
- **D:** The fetal risk is small and this is not indicated.
- **E:** VZIG is now reserved for women who cannot take aciclovir.

Key point: Non-immune chickenpox contact in pregnancy: oral aciclovir on days 7–14.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 321 · Varicella · **Hard** · C3

A 27-year-old woman at 30 weeks develops chickenpox. On day 2 of the rash she is breathless, with a cough and oxygen saturation of 91% on air. Chest X-ray shows diffuse nodular shadowing.

What is the most appropriate management?

A. Admit for intravenous aciclovir
B. Deliver by caesarean section now
C. Give varicella immunoglobulin
D. Oral aciclovir at home
E. Oral amoxicillin and review in 48 hours

Answer: A. Admit for intravenous aciclovir

Varicella pneumonia is a serious complication in pregnancy and can cause death. It needs hospital admission, intravenous aciclovir and input from a multidisciplinary team.

Why not the others

- **B:** Delivery during viraemia increases risk for mother and baby.
- **C:** Immunoglobulin has no role once disease is present.
- **D:** Pneumonia with hypoxia needs IV treatment in hospital.
- **E:** This is viral pneumonia and needs antiviral treatment.

Key point: Varicella pneumonia in pregnancy: admit for IV aciclovir.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 322 · Varicella · **Hard** · C3

A 31-year-old woman develops a chickenpox rash 3 days before delivering at term.

What is the main risk to the baby?

A. Congenital cataracts
B. Fetal varicella syndrome
C. Hydrops fetalis
D. Hypoplastic limbs
E. Severe neonatal varicella

Answer: E. Severe neonatal varicella

If the mother gets the rash from 5 days before to 2 days after birth, the baby gets virus without maternal antibody. This can cause severe neonatal varicella. The baby should get VZIG and be watched closely.

Why not the others

- **A:** Cataracts are linked to rubella.
- **B:** Fetal varicella syndrome follows infection before 28 weeks.
- **C:** Hydrops is linked to parvovirus.
- **D:** Limb hypoplasia is part of fetal varicella syndrome from early infection.

Key point: Maternal chickenpox near delivery risks severe neonatal varicella.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 323 · Parvovirus B19 · **Moderate** · C2

A 28-year-old primary school teacher at 18 weeks has a positive parvovirus B19 IgM after a slapped-cheek outbreak at school.

What is the most appropriate fetal monitoring?

A. Amniocentesis for karyotype
B. Fetal blood sampling now
C. Growth scans every 4 weeks
D. Middle cerebral artery Doppler every 1–2 weeks
E. No monitoring is needed

Answer: D. Middle cerebral artery Doppler every 1–2 weeks

Parvovirus causes fetal anaemia and hydrops. Middle cerebral artery peak systolic velocity is monitored every 1–2 weeks for up to 12 weeks after infection. A raised value suggests anaemia and the need for intrauterine transfusion.

Why not the others

- **A:** Parvovirus does not cause chromosomal problems.
- **B:** Fetal blood sampling is for when anaemia is suspected.
- **C:** Growth scans do not detect anaemia.
- **E:** Monitoring is needed because of the risk of hydrops.

Key point: Parvovirus in pregnancy: serial MCA Doppler for fetal anaemia.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 324 · Parvovirus B19 · **Hard** · C3

At 22 weeks, a fetus whose mother had parvovirus 4 weeks ago has ascites, a pericardial effusion and an MCA peak systolic velocity of 1.8 multiples of the median.

What is the most appropriate management?

A. Deliver by caesarean section
B. Give maternal IV immunoglobulin
C. Intrauterine blood transfusion
D. Repeat scan in 4 weeks
E. Start maternal aciclovir

Answer: C. Intrauterine blood transfusion

This fetus has hydrops from severe anaemia due to parvovirus. Intrauterine transfusion of red cells improves survival. Most cases resolve once the infection clears.

Why not the others

- **A:** At 22 weeks the baby is too premature to deliver.
- **B:** IV immunoglobulin is not a proven treatment.
- **D:** Waiting risks fetal death.
- **E:** Aciclovir does not treat parvovirus.

Key point: Parvovirus hydrops with high MCA velocity: intrauterine transfusion.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 325 · Listeria · **Moderate** · C2

A 32-year-old woman at 30 weeks has fever, myalgia and diarrhoea after eating soft unpasteurised cheese. Blood cultures grow Gram-positive rods.

What is the most appropriate antibiotic?

A. Amoxicillin
B. Cefotaxime
C. Ciprofloxacin
D. Metronidazole
E. Nitrofurantoin

Answer: A. Amoxicillin

Listeria monocytogenes is a Gram-positive rod and causes a flu-like illness. It can cause miscarriage, preterm labour and neonatal sepsis. High-dose amoxicillin (or ampicillin), often with gentamicin, is the treatment.

Why not the others

- **B:** Listeria is naturally resistant to cephalosporins.
- **C:** Ciprofloxacin is not first line and is avoided in pregnancy.
- **D:** Metronidazole does not cover listeria.
- **E:** Nitrofurantoin is only for urinary infections.

Key point: Listeria is resistant to cephalosporins; treat with amoxicillin.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 326 · Herpes simplex · **Moderate** · C3

A 26-year-old woman at 36 weeks has her first episode of genital herpes, with painful vulval ulcers. She has never had cold sores and HSV type-specific antibodies are negative.

What is the recommended mode of delivery?

A. Caesarean section
B. Induction of labour at 37 weeks
C. Instrumental delivery to shorten labour
D. Vaginal birth with aciclovir from 36 weeks
E. Vaginal birth with fetal scalp electrode

Answer: A. Caesarean section

A primary HSV episode in the third trimester, especially within 6 weeks of birth, carries a high risk of neonatal herpes (up to 41%) because there is no maternal antibody. Caesarean section is recommended.

Why not the others

- **B:** Induction does not reduce viral shedding.
- **C:** Instrumental delivery does not reduce risk.
- **D:** This is advice for recurrent herpes, not a primary episode near term.
- **E:** Scalp electrodes are avoided.

Key point: Primary genital herpes in the third trimester: caesarean section.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 327 · Herpes simplex · **Moderate** · C2

A 30-year-old woman has a history of recurrent genital herpes for 5 years. She is 35 weeks pregnant and has no lesions at present.

What is the most appropriate management?

A. Caesarean section at 39 weeks
B. HSV IgM test weekly
C. No treatment and avoid labour
D. Oral aciclovir from 36 weeks and plan vaginal birth
E. Swab the vulva weekly from 36 weeks

Answer: D. Oral aciclovir from 36 weeks and plan vaginal birth

With recurrent herpes, the baby gets maternal antibody and the risk of neonatal herpes is very low. Daily suppressive aciclovir from 36 weeks reduces lesions at term. Vaginal birth is appropriate.

Why not the others

- **A:** Caesarean is not advised for recurrent herpes without lesions.
- **B:** Serology does not guide delivery.
- **C:** Avoiding labour is not needed.
- **E:** Weekly swabs do not predict shedding at birth.

Key point: Recurrent genital herpes: aciclovir from 36 weeks and vaginal birth.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 328 · Malaria · **Hard** · C3

A 27-year-old woman at 26 weeks has just returned from Nigeria. She has fever and headache. The blood film shows Plasmodium falciparum with 3% parasitaemia. She is alert and eating.

What is the most appropriate treatment?

A. Chloroquine
B. Doxycycline
C. Intravenous artesunate
D. Oral artemether-lumefantrine
E. Primaquine

Answer: C. Intravenous artesunate

Pregnant women with falciparum malaria are at high risk of severe disease, and UK guidance advises admission. Parasitaemia of 2% or more in pregnancy is often treated as severe; intravenous artesunate is first line for severe or complicated malaria in all trimesters.

Why not the others

- **A:** Falciparum is widely chloroquine resistant.
- **B:** Doxycycline is contraindicated in pregnancy.
- **D:** Oral treatment is for uncomplicated malaria with low parasitaemia.
- **E:** Primaquine is contraindicated in pregnancy and is for vivax relapse.

Key point: Severe or high-parasitaemia falciparum malaria in pregnancy: IV artesunate.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 329 · Malaria · **Easy** · C1

A 29-year-old woman at 12 weeks plans to travel to a malaria area in sub-Saharan Africa to visit family.

What is the best advice?

A. Chloroquine is the best prophylaxis
B. Doxycycline is the best prophylaxis
C. Malaria is milder in pregnancy
D. Mosquito nets are not needed
E. Travel should be avoided if possible

Answer: E. Travel should be avoided if possible

Malaria in pregnancy is more severe and causes miscarriage, stillbirth and maternal death. Pregnant women should avoid travel to malarial areas. If travel cannot be avoided, mefloquine and strict bite prevention are advised.

Why not the others

- **A:** Chloroquine resistance is common in Africa.
- **B:** Doxycycline is contraindicated in pregnancy.
- **C:** Malaria is more severe in pregnancy.
- **D:** Bed nets are essential.

Key point: Pregnant women should avoid travel to malarial areas.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 330 · Tuberculosis · **Moderate** · C2

A 28-year-old woman at 20 weeks has a 6-week cough, night sweats and weight loss. Sputum is positive for acid-fast bacilli. The organism is fully sensitive.

What is the most appropriate treatment?

A. Defer treatment until after delivery
B. Isoniazid alone for 9 months
C. Rifampicin, isoniazid and streptomycin
D. Rifampicin, isoniazid, pyrazinamide and ethambutol
E. Treat only if the baby is infected

Answer: D. Rifampicin, isoniazid, pyrazinamide and ethambutol

Standard first-line TB drugs are safe in pregnancy. Untreated TB is far more dangerous. Pyridoxine is added with isoniazid, and vitamin K is given to the baby because of rifampicin.

Why not the others

- **A:** Delay risks maternal and neonatal harm.
- **B:** Single-drug therapy is for latent TB only.
- **C:** Streptomycin causes fetal ototoxicity.
- **E:** Maternal disease must be treated.

Key point: Standard quadruple TB therapy is safe in pregnancy; avoid streptomycin.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 331 · Maternal sepsis · **Moderate** · C3

A 30-year-old woman 3 days after caesarean section has a temperature of 38.9 °C, heart rate 125/min, BP 88/50 mmHg and respiratory rate 26/min. She is confused.

What is the most important immediate action?

A. Arrange a CT of the abdomen
B. Await blood culture results before antibiotics
C. Give oral antibiotics and review in 24 hours
D. Take bloods and start IV broad-spectrum antibiotics within 1 hour
E. Wound swab and wait for the result

Answer: D. Take bloods and start IV broad-spectrum antibiotics within 1 hour

This is maternal sepsis with shock. The Sepsis Six should be done within 1 hour: oxygen, blood cultures, IV antibiotics, IV fluids, lactate and urine output. Delay in antibiotics raises mortality.

Why not the others

- **A:** Imaging may come later but must not delay treatment.
- **B:** Antibiotics should not wait for culture results.
- **C:** Oral antibiotics are not enough in septic shock.
- **E:** Waiting for the swab delays treatment.

Key point: Maternal sepsis: Sepsis Six with IV antibiotics within 1 hour.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 332 · Maternal sepsis · **Hard** · C3

A 25-year-old woman 2 days after a vaginal birth has severe abdominal pain out of proportion to the findings, a temperature of 39.5 °C, diarrhoea and a rapid fall in blood pressure. Her son had a sore throat last week.

Which organism is most likely?

A. Escherichia coli
B. Group A streptococcus
C. Group B streptococcus
D. Listeria monocytogenes
E. Staphylococcus epidermidis

Answer: B. Group A streptococcus

Group A streptococcus (Streptococcus pyogenes) causes rapid, severe puerperal sepsis and toxic shock. Contact with children with sore throats is a clue. It needs early IV antibiotics, often with clindamycin to block toxins.

Why not the others

- **A:** E. coli is common but less linked to throat contacts and toxic shock.
- **C:** GBS is mostly a neonatal pathogen.
- **D:** Listeria causes a flu-like illness in pregnancy.
- **E:** S. epidermidis is a skin contaminant.

Key point: Rapid puerperal sepsis after a child's sore throat suggests group A strep.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 333 · Chorioamnionitis · **Moderate** · C2

A 24-year-old woman at 32 weeks had ruptured membranes 4 days ago. She now has a temperature of 38.4 °C, uterine tenderness, offensive vaginal discharge and fetal tachycardia.

What is the most appropriate management?

A. Continue expectant management with oral erythromycin
B. Give IV broad-spectrum antibiotics and plan delivery
C. Give steroids and wait 48 hours before delivery
D. Repeat bloods in 24 hours
E. Start tocolysis to delay delivery

Answer: B. Give IV broad-spectrum antibiotics and plan delivery

These features show chorioamnionitis. Management is IV broad-spectrum antibiotics and delivery, whatever the gestation. Steroids can be given but must not delay delivery.

Why not the others

- **A:** Expectant care is stopped once infection is present.
- **C:** Delaying delivery risks maternal and fetal sepsis.
- **D:** Waiting worsens the outcome.
- **E:** Tocolysis is contraindicated with infection.

Key point: Chorioamnionitis: IV antibiotics and delivery.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 334 · Urinary tract infection · **Easy** · C2

A 26-year-old woman at 14 weeks has a routine urine culture that grows E. coli at more than 10^5 cfu/mL. She has no symptoms.

What is the most appropriate management?

A. No treatment as she has no symptoms
B. Repeat culture at 28 weeks
C. Treat only if she gets symptoms
D. Treat with an antibiotic according to sensitivities
E. Use cranberry juice only

Answer: D. Treat with an antibiotic according to sensitivities

Asymptomatic bacteriuria in pregnancy should be treated. Untreated, up to 30% develop pyelonephritis, and it is linked to preterm birth. A test of cure is advised afterwards.

Why not the others

- **A:** Bacteriuria needs treatment in pregnancy.
- **B:** This delays treatment.
- **C:** This risks pyelonephritis.
- **E:** Cranberry is not a treatment.

Key point: Treat asymptomatic bacteriuria in pregnancy.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 335 · Urinary tract infection · **Moderate** · C3

A 23-year-old woman at 38 weeks has dysuria and frequency. She has no fever or loin pain. The urine dip is positive for nitrites.

Which antibiotic should be avoided at this stage of pregnancy?

A. Amoxicillin
B. Cefalexin
C. Co-amoxiclav
D. Nitrofurantoin
E. Pivmecillinam

Answer: D. Nitrofurantoin

Nitrofurantoin should be avoided at term because it can cause neonatal haemolysis, especially with G6PD deficiency. Cefalexin or amoxicillin (if sensitive) are suitable at term.

Why not the others

- **A:** Amoxicillin is safe if the organism is sensitive.
- **B:** Cefalexin is safe at term.
- **C:** Co-amoxiclav is usually safe for UTI.
- **E:** Pivmecillinam can be used.

Key point: Avoid nitrofurantoin at term because of neonatal haemolysis.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 336 · Pyelonephritis · **Easy** · C2

A 22-year-old woman at 24 weeks has fever of 39 °C, right loin pain, rigors and vomiting.

What is the most appropriate management?

A. Admit for IV antibiotics
B. Oral nitrofurantoin at home
C. Oral trimethoprim at home
D. Paracetamol and fluids only
E. Renal ultrasound before antibiotics

Answer: A. Admit for IV antibiotics

Acute pyelonephritis in pregnancy needs admission for IV antibiotics and fluids. It can lead to sepsis, ARDS and preterm labour.

Why not the others

- **B:** Nitrofurantoin does not reach renal tissue.
- **C:** Oral treatment at home is not enough when she is vomiting with rigors.
- **D:** Antibiotics are needed.
- **E:** Imaging must not delay antibiotics.

Key point: Pyelonephritis in pregnancy: admit for IV antibiotics.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 337 · Bacterial vaginosis · **Easy** · C2

A 28-year-old woman at 20 weeks has thin, grey vaginal discharge with a fishy smell. Vaginal pH is 5.0 and clue cells are seen on microscopy.

What is the most appropriate treatment?

A. Clotrimazole pessary
B. Doxycycline
C. Fluconazole orally
D. Metronidazole
E. No treatment in pregnancy

Answer: D. Metronidazole

Symptomatic bacterial vaginosis in pregnancy is treated with metronidazole (oral or vaginal gel) or clindamycin cream. Metronidazole is safe in pregnancy; high single doses are avoided.

Why not the others

- **A:** Clotrimazole treats candida.
- **B:** Doxycycline is contraindicated in pregnancy.
- **C:** Fluconazole treats candida and is avoided in pregnancy.
- **E:** Symptomatic BV should be treated.

Key point: Symptomatic BV in pregnancy: metronidazole.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 338 · Candida · **Easy** · C2

A 27-year-old woman at 26 weeks has vulval itch and thick white discharge. Vaginal pH is 4.2.

What is the most appropriate treatment?

A. Clotrimazole pessary
B. Metronidazole
C. Oral fluconazole
D. Oral itraconazole
E. Topical steroid only

Answer: A. Clotrimazole pessary

Vulvovaginal candidiasis is common in pregnancy. Topical imidazoles such as clotrimazole are used, often for 7 days. Oral antifungals are avoided in pregnancy.

Why not the others

- **B:** Metronidazole treats BV and trichomonas.
- **C:** Oral fluconazole is avoided in pregnancy.
- **D:** Oral itraconazole is avoided in pregnancy.
- **E:** Steroids do not treat infection.

Key point: Thrush in pregnancy: topical imidazole, no oral azoles.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 339 · Chlamydia · **Moderate** · C2

A 19-year-old woman at 10 weeks has a positive chlamydia NAAT test. She has no allergies.

What is the most appropriate treatment?

A. Azithromycin
B. Ceftriaxone single dose
C. Doxycycline for 7 days
D. Metronidazole for 7 days
E. Ofloxacin for 7 days

Answer: A. Azithromycin

Doxycycline and quinolones are contraindicated in pregnancy. BASHH advises azithromycin (or erythromycin or amoxicillin) for chlamydia in pregnancy. A test of cure is needed and partners must be treated.

Why not the others

- **B:** Ceftriaxone treats gonorrhoea.
- **C:** Doxycycline is contraindicated in pregnancy.
- **D:** Metronidazole does not treat chlamydia.
- **E:** Ofloxacin is avoided in pregnancy.

Key point: Chlamydia in pregnancy: azithromycin, then test of cure.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 340 · Gonorrhoea · **Moderate** · C2

A baby develops purulent eye discharge with lid swelling on day 2 of life.

What is the most likely cause?

A. Chemical conjunctivitis
B. Chlamydia trachomatis
C. Herpes simplex virus
D. Neisseria gonorrhoeae
E. Staphylococcus aureus

Answer: D. Neisseria gonorrhoeae

Gonococcal ophthalmia neonatorum usually starts within 2–5 days of birth with heavy purulent discharge. It can damage the cornea quickly and needs urgent IV ceftriaxone for the baby.

Why not the others

- **A:** Chemical conjunctivitis occurs within 24 hours and is mild.
- **B:** Chlamydial conjunctivitis starts later, at 5–14 days.
- **C:** HSV eye disease usually appears later with vesicles.
- **E:** Staph infection is usually milder.

Key point: Severe purulent conjunctivitis at day 2–5 suggests gonorrhoea.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 341 · COVID-19 · **Moderate** · C2

A 30-year-old woman at 16 weeks asks whether she should have the COVID-19 vaccine.

What is the most appropriate advice?

A. Avoid vaccination until after breastfeeding
B. Vaccinate only if she has diabetes
C. Vaccinate only in the first trimester
D. Vaccination is recommended in pregnancy
E. Vaccine is contraindicated in pregnancy

Answer: D. Vaccination is recommended in pregnancy

COVID-19 vaccination is recommended in pregnancy. Pregnant women with COVID-19 have higher risks of severe illness and preterm birth, and vaccines are safe for the baby.

Why not the others

- **A:** Vaccination is safe in breastfeeding too.
- **B:** It is recommended for all pregnant women.
- **C:** It can be given at any stage.
- **E:** It is not contraindicated.

Key point: COVID-19 vaccine is recommended in pregnancy.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 342 · Influenza · **Easy** · C1

A 25-year-old woman at 12 weeks attends in October. She asks if the flu vaccine is safe in pregnancy.

What is the most appropriate advice?

A. Give the inactivated flu vaccine now
B. Give the live nasal flu vaccine
C. Vaccinate only after delivery
D. Vaccinate only in the third trimester
E. Vaccination is not needed in pregnancy

Answer: A. Give the inactivated flu vaccine now

Inactivated flu vaccine is recommended at any stage of pregnancy during flu season. It protects the mother from severe illness and gives the baby antibodies for the first months.

Why not the others

- **B:** The live nasal vaccine is contraindicated in pregnancy.
- **C:** Waiting leaves her unprotected during pregnancy.
- **D:** It can be given in any trimester.
- **E:** Pregnant women are at higher risk from flu.

Key point: Inactivated flu vaccine at any stage of pregnancy.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 343 · Pertussis · **Moderate** · C1

A 27-year-old woman at 18 weeks asks about the whooping cough vaccine.

When is the pertussis vaccine ideally given?

A. At booking only
B. Between 16 and 32 weeks
C. In the first trimester only
D. Only after delivery
E. Only if she has not been vaccinated as a child

Answer: B. Between 16 and 32 weeks

The UK programme offers pertussis vaccine from 16 weeks, ideally by 32 weeks, so antibodies can pass to the baby before birth. It protects the newborn before their own vaccines start.

Why not the others

- **A:** Booking is usually too early.
- **C:** It is given after 16 weeks.
- **D:** After delivery does not protect the newborn as well.
- **E:** Every pregnancy needs a dose.

Key point: Pertussis vaccine in every pregnancy from 16 weeks.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 344 · Zika · **Hard** · C3

A 29-year-old woman at 22 weeks returned from a Zika-affected area 3 weeks ago. She had a rash and conjunctivitis. Her ultrasound now shows a head circumference below the 3rd centile.

What is the most likely cause?

A. Congenital CMV
B. Congenital rubella
C. Congenital toxoplasmosis
D. Congenital varicella
E. Congenital Zika syndrome

Answer: E. Congenital Zika syndrome

Zika virus is spread by mosquitoes and sexually. Maternal infection can cause severe microcephaly, brain calcification and eye problems. Travel history with rash and conjunctivitis is the clue.

Why not the others

- **A:** CMV can cause microcephaly, but this history points to Zika.
- **B:** Rubella mainly causes cataracts, deafness and heart defects.
- **C:** Toxoplasmosis is linked to cats and undercooked meat.
- **D:** Varicella causes skin scarring and limb problems.

Key point: Rash and conjunctivitis after travel plus microcephaly suggests Zika.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 345 · Hepatitis E · **Hard** · C3

A 25-year-old woman at 32 weeks returns from South Asia with jaundice, vomiting and confusion. ALT is 2000 IU/L and INR is 2.5.

Which infection carries a particularly high maternal mortality in pregnancy?

A. Hepatitis A
B. Hepatitis B
C. Hepatitis C
D. Hepatitis D
E. Hepatitis E

Answer: E. Hepatitis E

Hepatitis E, spread by contaminated water, can cause fulminant liver failure in the third trimester with maternal mortality up to 20–25%. The other hepatitis viruses do not carry this specific pregnancy risk.

Why not the others

- **A:** Hepatitis A is usually mild in pregnancy.
- **B:** Acute hepatitis B is not usually fulminant in pregnancy.
- **C:** Hepatitis C is usually silent.
- **D:** Hepatitis D only occurs with hepatitis B.

Key point: Hepatitis E in the third trimester can cause fulminant liver failure.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 346 · Trichomonas · **Moderate** · C2

A 22-year-old woman at 18 weeks has frothy green-yellow discharge and vulval soreness. A strawberry cervix is seen.

What is the most appropriate treatment?

A. Clindamycin cream
B. Clotrimazole pessary
C. Doxycycline
D. Fluconazole
E. Metronidazole

Answer: E. Metronidazole

Trichomonas vaginalis is treated with metronidazole, usually 400–500 mg twice daily for 7 days in pregnancy. Partners need treatment too.

Why not the others

- **A:** Clindamycin cream does not treat trichomonas.
- **B:** Clotrimazole treats candida.
- **C:** Doxycycline is contraindicated in pregnancy.
- **D:** Fluconazole treats candida.

Key point: Trichomonas: metronidazole for patient and partner.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 347 · Genital warts · **Moderate** · C2

A 24-year-old woman at 28 weeks has multiple genital warts that have grown during pregnancy.

Which treatment should be avoided in pregnancy?

A. Cryotherapy
B. Excision
C. Laser ablation
D. Podophyllotoxin
E. Trichloroacetic acid

Answer: D. Podophyllotoxin

Podophyllotoxin is an antimitotic agent and is contraindicated in pregnancy. Cryotherapy, trichloroacetic acid, excision or laser are safe options. Warts often shrink after delivery.

Why not the others

- **A:** Cryotherapy is safe.
- **B:** Excision is safe.
- **C:** Laser is safe.
- **E:** Trichloroacetic acid is safe.

Key point: Avoid podophyllotoxin and imiquimod in pregnancy.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 348 · Measles · **Hard** · C3

A 27-year-old woman at 20 weeks had close contact with a child with measles 2 days ago. She has no record of MMR vaccination and her measles IgG is negative.

What is the most appropriate management?

A. Give human normal immunoglobulin
B. Give MMR vaccine now
C. Oral aciclovir
D. Reassure as measles does not affect pregnancy
E. Termination of pregnancy

Answer: A. Give human normal immunoglobulin

Measles in pregnancy raises the risk of miscarriage, preterm birth and severe maternal illness. Susceptible pregnant contacts should get human normal immunoglobulin within 6 days of exposure.

Why not the others

- **B:** MMR is a live vaccine and is contraindicated.
- **C:** Aciclovir does not treat measles.
- **D:** Measles does cause harm in pregnancy.
- **E:** Measles is not teratogenic; this is not indicated.

Key point: Susceptible pregnant measles contact: human normal immunoglobulin within 6 days.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 349 · Group B streptococcus · **Hard** · C3

A 29-year-old woman with no known GBS status goes into spontaneous labour at 34 weeks with intact membranes. She is afebrile.

What is the most appropriate antibiotic plan?

A. Antibiotics only if membranes rupture
B. IV benzylpenicillin in labour
C. No antibiotics as she is afebrile
D. Oral amoxicillin in labour
E. Wait for a GBS swab result before deciding

Answer: B. IV benzylpenicillin in labour

RCOG advises intrapartum antibiotic prophylaxis for all women in confirmed preterm labour, because preterm babies are at higher risk of early-onset GBS disease.

Why not the others

- **A:** Antibiotics are advised in preterm labour regardless.
- **C:** Prophylaxis is not based on fever alone.
- **D:** Oral antibiotics do not give adequate levels.
- **E:** Waiting delays prophylaxis.

Key point: Preterm labour: offer IV benzylpenicillin for GBS prophylaxis.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

MCQ 350 · Maternal sepsis · **Easy** · C2

A 31-year-old woman 5 days after caesarean section has a red, hot, tender wound with purulent discharge. She is well, with normal observations.

What is the most likely organism?

A. Bacteroides fragilis
B. Candida albicans
C. Escherichia coli
D. Pseudomonas aeruginosa
E. Staphylococcus aureus

Answer: E. Staphylococcus aureus

Staphylococcus aureus is the most common cause of caesarean wound infection. A swab is taken, and flucloxacillin is often used if she is well.

Why not the others

- **A:** Bacteroides can occur in deeper infections but is less common.
- **B:** Candida is not a common wound pathogen.
- **C:** E. coli is more common in urinary or uterine infection.
- **D:** Pseudomonas is uncommon in this setting.

Key point: Most caesarean wound infections are caused by Staph aureus.

Reference: Obstetrics by Ten Teachers — Infections in pregnancy

CHAPTER 8

Multiple Pregnancy

MCQ 351 · Chorionicity · **Easy** · C2

A 29-year-old woman has a scan at 12 weeks that shows a twin pregnancy. There is a thick membrane that meets the placenta in a triangular shape.

What is the chorionicity?

A. Cannot be told on ultrasound
B. Conjoined twins
C. Dichorionic diamniotic
D. Monochorionic diamniotic
E. Monochorionic monoamniotic

Answer: C. Dichorionic diamniotic

The lambda (twin-peak) sign is a triangle of placental tissue between the membranes. It shows dichorionic twins. Chorionicity is best judged at 11–14 weeks.

Why not the others

- **A:** It is best seen in the first trimester.
- **B:** Conjoined twins have no dividing membrane.
- **D:** Monochorionic twins show a thin T sign.
- **E:** Monoamniotic twins have no membrane.

Key point: Lambda sign means dichorionic; T sign means monochorionic.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 352 · Chorionicity · **Easy** · C2

An ultrasound at 12 weeks of a twin pregnancy shows a thin membrane joining the placenta at a right angle.

What does this sign show?

A. Dichorionic diamniotic twins
B. Dizygotic twins
C. Monochorionic diamniotic twins
D. Monochorionic monoamniotic twins
E. Vanishing twin

Answer: C. Monochorionic diamniotic twins

The T sign, a thin membrane meeting the placenta at a right angle, shows monochorionic diamniotic twins. They share one placenta, which brings risks such as TTTS.

Why not the others

- **A:** Dichorionic twins show the lambda sign.
- **B:** Zygosity cannot be seen on scan; dizygotic twins are always dichorionic.
- **D:** Monoamniotic twins have no membrane.
- **E:** Vanishing twin is loss of one embryo.

Key point: T sign = monochorionic diamniotic.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 353 · Zygosity · **Moderate** · C1

A medical student asks about the timing of embryo splitting in monozygotic twins.

Splitting between days 4 and 8 after fertilisation gives which type of twins?

A. Conjoined
B. Dichorionic diamniotic
C. Dizygotic
D. Monochorionic diamniotic
E. Monochorionic monoamniotic

Answer: D. Monochorionic diamniotic

Monozygotic twinning depends on when the embryo splits: before day 4 gives DCDA; days 4–8 gives MCDA (the most common); days 8–12 gives MCMA; after day 12 gives conjoined twins.

Why not the others

- **A:** Conjoined twins split after day 12.
- **B:** DCDA monozygotic twins split before day 4.
- **C:** Dizygotic twins come from two eggs.
- **E:** MCMA twins split at days 8–12.

Key point: Later split = more shared structures (DCDA → MCDA → MCMA → conjoined).

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 354 · Zygosity · **Easy** · C1

A 36-year-old woman of West African origin has had IVF and has a family history of twins on her mother's side.

Which type of twinning is most affected by these risk factors?

A. Conjoined twinning
B. Dizygotic twinning
C. Monoamniotic twinning
D. Monozygotic twinning
E. Twin reversed arterial perfusion

Answer: B. Dizygotic twinning

Dizygotic twinning rises with maternal age, African origin, maternal family history, higher parity and assisted conception. Monozygotic twinning is fairly constant at about 1 in 250.

Why not the others

- **A:** Conjoined twins are rare and not linked to these factors.
- **C:** Monoamniotic twins are monozygotic.
- **D:** Monozygotic rates are fairly constant (though slightly increased with IVF).
- **E:** TRAP is a rare complication of monochorionic twins.

Key point: Race, age, family history and fertility treatment raise dizygotic twinning.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 355 · Antenatal care · **Moderate** · C2

A 30-year-old woman has uncomplicated monochorionic diamniotic twins at 14 weeks.

How often should she have ultrasound scans from 16 weeks?

A. Every 1 week
B. Every 2 weeks
C. Every 4 weeks
D. Every 6 weeks
E. Only at 20 and 32 weeks

Answer: B. Every 2 weeks

NICE advises scans every 2 weeks from 16 weeks in monochorionic twins to look for TTTS, selective growth restriction and TAPS. Dichorionic twins have scans every 4 weeks from 20 weeks.

Why not the others

- **A:** Weekly scans are not routine.
- **C:** Every 4 weeks is for dichorionic twins.
- **D:** This is too infrequent to detect TTTS.
- **E:** This is too infrequent.

Key point: MC twins: scan every 2 weeks from 16 weeks; DC twins: every 4 weeks from 20 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 356 · Antenatal care · **Moderate** · C2

A 32-year-old woman with dichorionic twins is 12 weeks pregnant. Her BP is normal.

Which complication is she at higher risk of than a woman with a singleton pregnancy?

A. Cholestasis only
B. Placenta accreta only
C. Post-term pregnancy
D. Pre-eclampsia
E. Small baby syndrome only in the first trimester

Answer: D. Pre-eclampsia

Twin pregnancy raises the risk of pre-eclampsia, anaemia, gestational diabetes, preterm birth and PPH. NICE advises aspirin 150 mg from 12 weeks if she has one more moderate risk factor; twins count as a moderate risk factor.

Why not the others

- **A:** Cholestasis is also more common but not the main risk here.
- **B:** Accreta is linked to previous caesarean section.
- **C:** Twins tend to deliver early.
- **E:** This is not a recognised complication.

Key point: Twins increase the risk of pre-eclampsia, anaemia, GDM and PPH.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 357 · Antenatal care · **Easy** · C2

A 28-year-old woman has a twin pregnancy at 20 weeks. Her haemoglobin is 104 g/L.

Why is anaemia more common in twin pregnancy?

A. Decreased iron absorption
B. Greater plasma volume expansion and iron demand
C. Increased destruction of red cells
D. Less erythropoietin
E. Lower folate intake only

Answer: B. Greater plasma volume expansion and iron demand

Plasma volume expands more in twin pregnancy, causing more haemodilution. Iron and folate demands are also higher. NICE advises a full blood count at 20–24 weeks in twins.

Why not the others

- **A:** Iron absorption actually increases in pregnancy.
- **C:** Haemolysis is not the cause.
- **D:** Erythropoietin rises in pregnancy.
- **E:** Folate demand is a factor, but not the main one.

Key point: Twins: greater haemodilution and iron demand; check FBC at 20–24 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 358 · Twin-to-twin transfusion · **Moderate** · C3

A woman with MCDA twins at 20 weeks has a scan showing one twin with a deepest vertical pool of 10 cm and a large bladder. The other twin has a pool of 1 cm and the bladder is not seen.

What is the most likely diagnosis?

A. Ruptured membranes in one sac
B. Selective fetal growth restriction
C. Twin anaemia-polycythaemia sequence
D. Twin reversed arterial perfusion
E. Twin-to-twin transfusion syndrome

Answer: E. Twin-to-twin transfusion syndrome

TTTS is caused by unbalanced vascular connections in a shared placenta. The recipient has polyhydramnios (DVP ≥8 cm) and a large bladder; the donor has oligohydramnios (DVP ≤2 cm) and may appear 'stuck'.

Why not the others

- **A:** This would not cause polyhydramnios in the other sac.
- **B:** sFGR shows a weight difference, not this fluid pattern.
- **C:** TAPS shows MCA Doppler differences with normal fluid.
- **D:** TRAP has an acardiac twin.

Key point: TTTS: oligo-polyhydramnios sequence in MC twins.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 359 · Twin-to-twin transfusion · **Hard** · C3

At 19 weeks, MCDA twins have stage II TTTS: the donor bladder is not seen and the recipient has polyhydramnios.

What is the treatment of choice?

A. Amnioreduction every week
B. Deliver by caesarean section
C. Fetoscopic laser ablation of placental anastomoses
D. Indomethacin to the mother
E. Selective termination of the recipient

Answer: C. Fetoscopic laser ablation of placental anastomoses

Fetoscopic laser ablation of the connecting vessels is the treatment of choice for stage II–IV TTTS between 16 and 26 weeks. It improves survival and neurological outcome compared with amnioreduction.

Why not the others

- **A:** Amnioreduction is less effective than laser.
- **B:** The twins are previable.
- **D:** Indomethacin is not a treatment for TTTS.
- **E:** Selective reduction is a last resort, not first choice.

Key point: TTTS stage II or above at 16–26 weeks: fetoscopic laser.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 360 · Twin-to-twin transfusion · **Hard** · C1

A trainee is studying Quintero staging of TTTS.

What defines stage III?

A. Absent donor bladder only
B. Critically abnormal Doppler in either twin
C. Death of one or both twins
D. Hydrops in either twin
E. Oligo-polyhydramnios with visible donor bladder

Answer: B. Critically abnormal Doppler in either twin

Quintero staging: I – fluid discordance with visible donor bladder; II – donor bladder not seen; III – critically abnormal Dopplers (absent/reversed umbilical artery flow, reversed ductus venosus a-wave, pulsatile umbilical vein); IV – hydrops; V – death of one or both.

Why not the others

- **A:** This is stage II.
- **C:** This is stage V.
- **D:** This is stage IV.
- **E:** This is stage I.

Key point: Quintero: I fluid, II bladder, III Dopplers, IV hydrops, V death.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 361 · Twin anaemia-polycythaemia · **Hard** · C3

A woman with MCDA twins had laser treatment for TTTS 3 weeks ago. Now one twin has an MCA peak systolic velocity of 1.6 MoM and the other has 0.7 MoM. Amniotic fluid is normal in both sacs.

What is the most likely diagnosis?

A. Parvovirus infection
B. Recurrent TTTS
C. Selective growth restriction
D. Twin anaemia-polycythaemia sequence
E. Twin reversed arterial perfusion

Answer: D. Twin anaemia-polycythaemia sequence

TAPS is caused by tiny residual connections that allow slow blood transfer. One twin becomes anaemic (high MCA velocity) and the other polycythaemic (low MCA velocity), with normal fluid. It can follow incomplete laser treatment.

Why not the others

- **A:** Parvovirus would not cause polycythaemia in the co-twin.
- **B:** TTTS shows fluid discordance.
- **C:** sFGR shows weight discordance.
- **E:** TRAP has an acardiac twin.

Key point: TAPS: MCA Doppler discordance with normal fluid, often after laser.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 362 · Selective growth restriction · **Moderate** · C2

Dichorionic twins at 28 weeks have estimated weights of 1250 g and 900 g.

What is the weight discordance and is it significant?

A. 14%, not significant
B. 18%, not significant
C. 28%, significant
D. 38%, significant
E. 48%, significant

Answer: C. 28%, significant

Discordance = (larger − smaller) ÷ larger × 100 = (1250 − 900) ÷ 1250 × 100 = 28%. A difference of 25% or more is significant and needs referral to fetal medicine.

Why not the others

- **A:** This is a wrong calculation.
- **B:** This is a wrong calculation.
- **D:** This is a wrong calculation.
- **E:** This is a wrong calculation.

Key point: Twin weight discordance ≥25% needs fetal medicine review.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 363 · Selective growth restriction · **Hard** · C3

MCDA twins at 24 weeks: one twin is below the 3rd centile with intermittent absent end-diastolic flow in the umbilical artery. The other twin is normal.

Why is death of one twin especially dangerous in monochorionic twins?

A. Rhesus sensitisation occurs
B. The dead twin causes immediate preterm labour
C. The mother develops DIC in most cases
D. The surviving twin always dies within 24 hours
E. The surviving twin can lose blood through placental connections

Answer: E. The surviving twin can lose blood through placental connections

In monochorionic twins, when one twin dies, the survivor can bleed into the dead twin's low-pressure circulation through shared vessels. This causes acute hypotension, brain damage (about 26%) or death (about 15%).

Why not the others

- **A:** Rhesus sensitisation is not caused this way.
- **B:** Preterm labour can occur but is not the main danger.
- **C:** Maternal DIC is rare.
- **D:** Survival is usual, though with risk.

Key point: Single twin death in MC twins risks death or brain injury in the survivor.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 364 · Single fetal death · **Hard** · C3

A woman with MCDA twins at 28 weeks has a scan that shows one twin has died. The other twin has normal Dopplers and CTG.

What is the most appropriate management?

A. Deliver both twins by caesarean section today
B. Induction of labour today
C. Manage expectantly with fetal medicine surveillance
D. Selective termination of the survivor
E. Weekly maternal clotting only

Answer: C. Manage expectantly with fetal medicine surveillance

Any damage to the survivor happens at the time of death, so immediate delivery does not prevent it. Expectant management with fetal medicine input, MCA Dopplers and an MRI of the fetal brain about 4 weeks later is advised.

Why not the others

- **A:** Immediate delivery adds prematurity without benefit.
- **B:** Delivery at 28 weeks is not indicated.
- **D:** This is not appropriate.
- **E:** Maternal DIC is rare and is not the main concern.

Key point: Single twin death: expectant care and fetal brain MRI after 4 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 365 · Monoamniotic twins · **Hard** · C3

A woman has monochorionic monoamniotic twins at 20 weeks.

What is the recommended timing and mode of delivery?

A. Caesarean section at 32 to 33+6 weeks
B. Caesarean section at 37 weeks
C. Induction of labour at 36 weeks
D. Spontaneous labour at term
E. Vaginal birth at 34 weeks

Answer: A. Caesarean section at 32 to 33+6 weeks

Monoamniotic twins have a high risk of cord entanglement and sudden death. NICE advises caesarean section at 32+0 to 33+6 weeks after steroids.

Why not the others

- **B:** This is too late given the risk of cord accidents.
- **C:** Vaginal birth is not advised due to cord entanglement.
- **D:** Waiting for spontaneous labour risks fetal death.
- **E:** Vaginal birth is not advised.

Key point: MCMA twins: caesarean at 32 to 33+6 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 366 · Timing of delivery · **Moderate** · C2

A woman with uncomplicated dichorionic diamniotic twins is 34 weeks pregnant.

When does NICE recommend planned birth?

A. 34 weeks
B. 36 weeks
C. 37 weeks
D. 39 weeks
E. 40 weeks

Answer: C. 37 weeks

NICE advises planned birth at 37 weeks for uncomplicated DCDA twins. Continuing past this increases stillbirth risk.

Why not the others

- **A:** This is too early without a complication.
- **B:** 36 weeks is for MCDA twins.
- **D:** This is later than recommended.
- **E:** This is too late.

Key point: DCDA twins: 37 weeks; MCDA: 36 weeks; MCMA: 32–33+6 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 367 · Timing of delivery · **Moderate** · C2

A woman with uncomplicated monochorionic diamniotic twins is 33 weeks pregnant.

When does NICE recommend planned birth?

A. 32 weeks
B. 34 weeks
C. 36 weeks
D. 38 weeks
E. 40 weeks

Answer: C. 36 weeks

NICE advises planned birth at 36 weeks for uncomplicated MCDA twins, after considering steroids. Stillbirth risk rises after this.

Why not the others

- **A:** 32 weeks is for MCMA twins.
- **B:** This is too early without a complication.
- **D:** This is too late.
- **E:** This is too late.

Key point: MCDA twins: planned birth at 36 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 368 · Timing of delivery · **Hard** · C2

A woman with uncomplicated trichorionic triamniotic triplets is 30 weeks pregnant.

When does NICE recommend planned birth?

A. 30 weeks
B. 32 weeks
C. 35 weeks
D. 37 weeks
E. 38 weeks

Answer: C. 35 weeks

NICE advises planned birth at 35 weeks for uncomplicated trichorionic triamniotic triplets, and at 32 to 33+6 weeks for MC or shared-amnion triplets.

Why not the others

- **A:** This is too early.
- **B:** This is for triplets sharing a chorion or amnion.
- **D:** This is for DCDA twins.
- **E:** This is too late.

Key point: TCTA triplets: planned birth at 35 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 369 · Mode of delivery · **Moderate** · C2

A woman with DCDA twins at 37 weeks has twin 1 cephalic and twin 2 breech. There are no other complications.

What is the most appropriate advice about mode of delivery?

A. Caesarean section is required
B. External version of twin 2 now
C. Planned vaginal birth is reasonable
D. Twin 2 must be delivered by caesarean after twin 1
E. Vaginal birth only if twin 2 is cephalic

Answer: C. Planned vaginal birth is reasonable

When the first twin is cephalic, planned vaginal birth is as safe as planned caesarean, whatever the presentation of the second twin. The Twin Birth Study supports this.

Why not the others

- **A:** Caesarean is not required when twin 1 is cephalic.
- **B:** ECV of twin 2 is not done before labour.
- **D:** Twin 2 can usually be delivered vaginally.
- **E:** The second twin's presentation does not decide this.

Key point: If twin 1 is cephalic, vaginal birth is reasonable.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 370 · Mode of delivery · **Easy** · C2

A woman with DCDA twins at 37 weeks has twin 1 breech and twin 2 cephalic.

What is the most appropriate mode of delivery?

A. Caesarean section
B. Induction of labour
C. Instrumental delivery
D. Spontaneous vaginal birth
E. Vaginal breech birth

Answer: A. Caesarean section

When the first twin is not cephalic, planned caesarean section is advised. Breech-cephalic twins also carry a small risk of locked twins.

Why not the others

- **B:** Vaginal birth is not advised with twin 1 breech.
- **C:** Instrumental delivery is not a plan for breech.
- **D:** Not advised with twin 1 breech.
- **E:** Not advised for twins.

Key point: First twin non-cephalic: caesarean section.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 371 · Delivery of second twin · **Moderate** · C3

Twin 1 has just been born vaginally. Twin 2 is in a longitudinal lie with cephalic presentation, membranes intact. Contractions have slowed.

What is the most appropriate next step?

A. Caesarean section for twin 2

B. Give oxytocin infusion and rupture membranes when the head is in the pelvis

C. Give syntometrine immediately

D. Internal podalic version straight away

E. Wait 2 hours without intervention

Answer: B. Give oxytocin infusion and rupture membranes when the head is in the pelvis

After twin 1, the lie of twin 2 is checked. If longitudinal, oxytocin can restart contractions, and membranes are ruptured once the presenting part is engaged. The aim is to deliver twin 2 within about 30 minutes, with continuous monitoring.

Why not the others

- **A:** Caesarean is not needed when vaginal birth is likely.
- **C:** Uterotonic drugs for the third stage are given only after both twins are born.
- **D:** Version is for a transverse lie.
- **E:** Long delays increase acidosis risk for twin 2.

Key point: Second twin longitudinal: oxytocin, then ARM once engaged.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 372 · Delivery of second twin · **Hard** · C3

After vaginal birth of twin 1, twin 2 is in a transverse lie with intact membranes. The CTG is normal.

What is the most appropriate management?

A. Await spontaneous version

B. External cephalic version or internal podalic version

C. Oxytocin infusion and rupture of membranes now

D. Syntometrine and controlled cord traction

E. Vacuum extraction

Answer: B. External cephalic version or internal podalic version

A transverse second twin can be turned by external cephalic version or, with intact membranes, internal podalic version and breech extraction. Rupturing membranes with a transverse lie risks cord prolapse.

Why not the others

- **A:** Waiting may lead to a closing cervix.
- **C:** ARM with a transverse lie risks cord prolapse.
- **D:** Uterotonics are only given after both twins.
- **E:** Vacuum is not used for a transverse lie.

Key point: Transverse second twin: ECV or internal podalic version.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 373 · Delivery of second twin · **Moderate** · C2

A woman with twins is planning a vaginal birth.

Which intrapartum measure is recommended?

A. Avoid continuous CTG
B. Delay cord clamping of twin 1 for 3 minutes routinely
C. Epidural analgesia is advised
D. Give oxytocin after twin 1 to prevent PPH
E. Physiological third stage

Answer: C. Epidural analgesia is advised

An epidural is advised because it allows quick manipulation or operative delivery of twin 2. Continuous monitoring of both twins and an active third stage are recommended.

Why not the others

- **A:** Continuous monitoring of both twins is advised.
- **B:** This is not a routine twin recommendation.
- **D:** Uterotonics are given after both twins are born.
- **E:** Active management is advised because of high PPH risk.

Key point: Twin labour: epidural, continuous CTG, active third stage.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 374 · Locked twins · **Hard** · C2

A woman with twins in labour has twin 1 breech and twin 2 cephalic. During the delivery, the chin of twin 1 hooks against the chin of twin 2.

What is this complication called?

A. Conjoined twins
B. Interlocking twins
C. Shoulder dystocia
D. Twin reversed arterial perfusion
E. Vanishing twin

Answer: B. Interlocking twins

Interlocking (locked) twins is a rare complication with breech/cephalic twins. The chins lock together. It is one reason that a non-cephalic first twin is delivered by caesarean.

Why not the others

- **A:** Conjoined twins are physically joined.
- **C:** Shoulder dystocia is impaction of the anterior shoulder.
- **D:** TRAP involves an acardiac twin.
- **E:** Vanishing twin is early loss of one twin.

Key point: Locked twins: twin 1 breech, twin 2 cephalic.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 375 · TRAP sequence · **Hard** · C3

A scan of monochorionic twins shows one normal fetus and one without a heart or head structure, which is still growing. Flow in its umbilical artery is reversed.

What is the most likely diagnosis?

A. Conjoined twins
B. Fetus in fetu
C. Selective growth restriction
D. Twin anaemia-polycythaemia sequence
E. Twin reversed arterial perfusion sequence

Answer: E. Twin reversed arterial perfusion sequence

In TRAP sequence, the 'pump' twin perfuses an acardiac twin via an artery-to-artery connection with reversed flow. The pump twin can develop heart failure. Treatment is ablation of the cord of the acardiac twin.

Why not the others

- **A:** Conjoined twins are joined.
- **B:** Fetus in fetu is a mass within a baby.
- **C:** sFGR has two normal fetuses.
- **D:** TAPS shows Hb differences.

Key point: An acardiac twin with reversed flow is TRAP; the pump twin risks heart failure.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 376 · Screening in twins · **Moderate** · C3

A 35-year-old woman with DCDA twins at 12 weeks wants screening for Down syndrome.

Which method is used in twins?

A. Combined test with a risk for each fetus
B. Quadruple test only
C. Screening is not possible in twins
D. Serum PAPP-A alone
E. Triple test

Answer: A. Combined test with a risk for each fetus

In twins, the combined test (nuchal translucency with serum markers) is used. In DC twins, a risk is given for each fetus. In MC twins, a risk is given for the pregnancy. The quadruple test is not recommended in twins.

Why not the others

- **B:** The quadruple test is not advised in twins.
- **C:** Screening is available.
- **D:** PAPP-A alone is not a screening test.
- **E:** The triple test is outdated.

Key point: Twins: combined test; risk per fetus in DC, per pregnancy in MC.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 377 · Preterm birth in twins · **Moderate** · C2

A woman with DCDA twins at 22 weeks asks how to prevent preterm birth. Her cervical length is normal.

What is the most appropriate advice?

A. Bed rest in hospital from 28 weeks
B. Cervical cerclage
C. No routine preventive treatment is advised
D. Prophylactic oral tocolytics
E. Routine progesterone pessaries

Answer: C. No routine preventive treatment is advised

NICE says bed rest, cerclage, progesterone and oral tocolytics should not be used routinely to prevent preterm birth in twins. None have shown benefit.

Why not the others

- **A:** Bed rest does not help and increases VTE risk.
- **B:** Cerclage is not advised routinely in twins.
- **D:** Oral tocolytics do not help.
- **E:** Progesterone does not reduce preterm birth in unselected twins.

Key point: No routine treatment prevents preterm birth in twins.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 378 · Vanishing twin · **Easy** · C2

A 30-year-old woman had an IVF pregnancy with two sacs at 7 weeks. At 12 weeks only one live fetus is seen, with a small empty sac nearby. She had light bleeding at 9 weeks.

What is the most likely explanation?

A. Ectopic pregnancy
B. Hydatidiform mole
C. Placental abruption
D. Subchorionic haematoma only
E. Vanishing twin

Answer: E. Vanishing twin

Vanishing twin is early loss of one twin, often in the first trimester. It is usually reabsorbed with a good outcome for the survivor. It can affect serum screening results.

Why not the others

- **A:** There is an intrauterine pregnancy.
- **B:** Molar change is not described.
- **C:** Abruption is a later complication.
- **D:** An empty second sac shows a lost twin.

Key point: Early loss of one of twins with a normal survivor is a vanishing twin.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 379 · Postpartum haemorrhage · **Easy** · C2

A woman has just delivered twins vaginally.

Why is she at higher risk of postpartum haemorrhage?

A. Cervical tear in all cases
B. Coagulopathy from twin pregnancy
C. Overdistended uterus with poor contraction
D. Retained placenta always occurs
E. Uterine inversion is common

Answer: C. Overdistended uterus with poor contraction

The uterus is overdistended in twin pregnancy and the placental site is larger. Uterine atony is the main cause of PPH, so active management of the third stage and an oxytocin infusion are advised.

Why not the others

- **A:** Tears are not universal.
- **B:** Coagulopathy is not routine in twins.
- **D:** Retained placenta is not universal.
- **E:** Inversion is rare.

Key point: Twins raise PPH risk mainly from uterine atony.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 380 · Chorionicity · **Moderate** · C2

A woman with twins at 20 weeks booked late and no early scan was done. The twins are different sexes.

What is the chorionicity?

A. Cannot be told
B. Conjoined
C. Dichorionic
D. Monochorionic diamniotic
E. Monochorionic monoamniotic

Answer: C. Dichorionic

Twins of different sex must be dizygotic, and dizygotic twins are always dichorionic. In later pregnancy, separate placentas and different sexes help confirm dichorionicity.

Why not the others

- **A:** Different sex confirms dichorionicity.
- **B:** Conjoined twins are always the same sex.
- **D:** MC twins are monozygotic, so same sex.
- **E:** MCMA twins are monozygotic, so same sex.

Key point: Different-sex twins are always dichorionic.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 381 · Monochorionic twins · **Moderate** · C2

A medical student asks which twin complication is unique to monochorionic twins.

Which complication only occurs in monochorionic twins?

A. Gestational diabetes
B. Pre-eclampsia
C. Preterm birth
D. Selective growth restriction
E. Twin-to-twin transfusion syndrome

Answer: E. Twin-to-twin transfusion syndrome

TTTS needs a shared placenta with vascular connections, so it only occurs in monochorionic twins, in about 10–15%. Growth restriction, pre-eclampsia and preterm birth occur in both types.

Why not the others

- **A:** GDM is a maternal complication of any twins.
- **B:** Pre-eclampsia occurs in any twins.
- **C:** Preterm birth occurs in any twins.
- **D:** Growth restriction can occur in DC twins too.

Key point: TTTS, TAPS and TRAP occur only in monochorionic twins.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 382 · Labelling twins · **Easy** · C1

A sonographer finds DCDA twins at 12 weeks.

What should be done to help track each twin in later scans?

A. Label them by fetal sex only
B. Label them by placental site and lie, and document it clearly
C. Label them by size only
D. No labelling is needed
E. Repeat chorionicity scan monthly

Answer: B. Label them by placental site and lie, and document it clearly

NICE advises labelling twins clearly, for example by left/right or upper/lower position and placental site, so each fetus can be followed reliably for screening and growth.

Why not the others

- **A:** Sex is not known at 12 weeks and may be the same.
- **C:** Size can change.
- **D:** Labelling is required.
- **E:** Chorionicity is decided once, in the first trimester.

Key point: Label each twin clearly at the first scan.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 383 · Conjoined twins · **Moderate** · C1

A scan at 12 weeks shows monochorionic monoamniotic twins whose bodies are joined at the chest and share a heart.

When does embryo splitting occur for conjoined twins?

A. Before day 4
B. Days 4–8
C. Days 8–12
D. After day 12
E. Before fertilisation

Answer: D. After day 12

Conjoined twins result from incomplete splitting after day 12 of fertilisation. Thoracopagus (joined at the chest) is the most common type.

Why not the others

- **A:** This gives DCDA twins.
- **B:** This gives MCDA twins.
- **C:** This gives MCMA twins.
- **E:** Monozygotic twins split after fertilisation.

Key point: Splitting after day 12 gives conjoined twins.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 384 · Growth monitoring · **Moderate** · C2

A woman has DCDA twins at 24 weeks with normal growth so far.

How should fetal growth be monitored?

A. Symphysis-fundal height only
B. Ultrasound every 2 weeks
C. Ultrasound every 4 weeks
D. Ultrasound only at 36 weeks
E. Weekly CTG

Answer: C. Ultrasound every 4 weeks

Fundal height is not useful in twins. Uncomplicated DCDA twins have ultrasound growth scans every 4 weeks from 20 weeks, measuring weight discordance.

Why not the others

- **A:** Fundal height cannot measure two babies.
- **B:** Every 2 weeks is for MC twins.
- **D:** This is too infrequent.
- **E:** CTG does not measure growth.

Key point: Fundal height is unhelpful in twins; use serial scans.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 385 · Hyperemesis · **Easy** · C2

A 27-year-old woman at 9 weeks has severe nausea and vomiting. Her scan shows twins.

Why is nausea and vomiting often worse in twin pregnancy?

A. Higher hCG levels
B. Increased progesterone receptor
C. Larger stomach volume
D. Lower oestrogen
E. Thyroid failure

Answer: A. Higher hCG levels

hCG levels are higher in twin and molar pregnancy. High hCG is linked to more severe nausea and vomiting and hyperemesis gravidarum.

Why not the others

- **B:** This is not the cause.
- **C:** Stomach volume is not the cause.
- **D:** Oestrogen is higher, not lower.
- **E:** High hCG can cause transient hyperthyroidism, not failure.

Key point: Higher hCG in twins worsens nausea and vomiting.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 386 · Selective reduction · **Hard** · C3

A woman with DCDA twins at 13 weeks has one twin with anencephaly and one normal twin.

What is the most appropriate method if she chooses selective termination?

A. Intracardiac potassium chloride in the affected twin
B. Laser ablation of placental vessels
C. Mifepristone and misoprostol
D. Radiofrequency ablation of the cord
E. Surgical evacuation

Answer: A. Intracardiac potassium chloride in the affected twin

In dichorionic twins, there are no shared vessels, so intracardiac potassium chloride into the affected twin is safe. In monochorionic twins, cord occlusion is needed because potassium chloride would pass to the other twin.

Why not the others

- **B:** Laser is used for TTTS.
- **C:** This would end the whole pregnancy.
- **D:** Cord occlusion methods are used in MC twins.
- **E:** This would end the whole pregnancy.

Key point: Selective reduction: KCl in DC twins, cord occlusion in MC twins.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 387 · Selective reduction · **Hard** · C3

A woman with MCDA twins at 18 weeks has one twin with severe growth restriction and absent end-diastolic flow. After counselling she chooses selective reduction.

What is the most appropriate method?

A. Amnioreduction
B. Bipolar cord occlusion
C. Intracardiac potassium chloride
D. Laser ablation of placental vessels only
E. Oral mifepristone

Answer: B. Bipolar cord occlusion

In monochorionic twins, selective reduction must stop blood flow between the twins. Bipolar cord coagulation or radiofrequency ablation is used. Potassium chloride would cross shared vessels and harm the other twin.

Why not the others

- **A:** Amnioreduction does not reduce a twin.
- **C:** KCl would cross to the co-twin.
- **D:** Laser is mainly for TTTS.
- **E:** Mifepristone would end the whole pregnancy.

Key point: In MC twins use cord occlusion, never KCl.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 388 · Triplets · **Moderate** · C2

A woman has a triplet pregnancy after IVF.

Which outcome is most significantly increased compared with twins?

A. Gestational diabetes
B. Post-term pregnancy
C. Preterm birth
D. Rhesus disease
E. Uterine rupture

Answer: C. Preterm birth

Preterm birth is the main cause of poor outcome in triplets; about 75% deliver before 35 weeks. Women may be offered multifetal pregnancy reduction.

Why not the others

- **A:** GDM is somewhat raised, but less important.
- **B:** Triplets rarely reach term.
- **D:** Rhesus risk is not increased.
- **E:** Rupture is not increased.

Key point: Preterm birth is the main risk in triplets.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 389 · Monochorionic twins · **Hard** · C3

A woman with MCDA twins at 22 weeks has a deepest pool of 9 cm in one sac and 3 cm in the other. Both bladders are seen. Dopplers are normal.

What is the most appropriate action?

A. Deliver now
B. Fetoscopic laser now
C. More frequent scans to monitor
D. Reassure, no change
E. Selective reduction

Answer: C. More frequent scans to monitor

TTTS needs both a recipient pool of 8 cm or more and a donor pool of 2 cm or less. Here the donor sac is 3 cm, so the criteria are not met. This fluid difference needs closer surveillance.

Why not the others

- **A:** The twins are previable.
- **B:** Laser is for confirmed TTTS stage II or above.
- **D:** The fluid difference needs closer checks.
- **E:** There is no indication.

Key point: TTTS criteria: recipient DVP ≥8 cm and donor DVP ≤2 cm.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 390 · Placenta · **Easy** · C1

A student asks why monochorionic twins have more complications than dichorionic twins.

What is the main reason?

A. Higher maternal age
B. Larger placental size
C. Monozygosity causes genetic disease
D. Shared placental circulation
E. Thicker dividing membranes

Answer: D. Shared placental circulation

Monochorionic twins share one placenta with vascular connections, leading to TTTS, TAPS, sFGR and risk to the co-twin if one dies.

Why not the others

- **A:** Maternal age is not the cause.
- **B:** Placental size is not the key factor.
- **C:** Monozygosity does not cause disease.
- **E:** MC twins have thinner membranes.

Key point: Shared placental circulation drives MC twin complications.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 391 · Delivery · **Moderate** · C3

After the birth of twin 1, the CTG of twin 2 shows a prolonged bradycardia of 70 bpm for 4 minutes. The head is high and the cervix is now 8 cm.

What is the most appropriate management?

A. Caesarean section for twin 2
B. Continue observation for 30 minutes
C. Forceps delivery at a high station
D. Increase oxytocin infusion
E. Syntometrine for the mother

Answer: A. Caesarean section for twin 2

If twin 2 shows fetal compromise and is not suitable for quick vaginal birth (high head, cervix not fully dilated), emergency caesarean section is needed.

Why not the others

- **B:** Delay risks hypoxia.
- **C:** High forceps are not done.
- **D:** Increasing oxytocin worsens hypoxia.
- **E:** This is only after both twins are delivered.

Key point: Compromised second twin with high head and partly closing cervix: caesarean.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 392 · Antenatal care · **Moderate** · C2

A woman with DCDA twins is 15 weeks pregnant. She has no other risk factors.

What is the advice about aspirin?

A. Aspirin 150 mg from 12 weeks
B. Aspirin 75 mg after 20 weeks
C. Aspirin is contraindicated in twins
D. Aspirin only after delivery
E. Aspirin only if BP is raised

Answer: A. Aspirin 150 mg from 12 weeks

Multiple pregnancy is a moderate risk factor for pre-eclampsia. NICE advises 75–150 mg aspirin from 12 weeks if there are two or more moderate risk factors. Many units offer aspirin to all twin pregnancies. 150 mg is now commonly used.

Why not the others

- **B:** Aspirin should start by 16 weeks.
- **C:** Aspirin is not contraindicated.
- **D:** It is for prevention in pregnancy.
- **E:** It is for prevention, not treatment.

Key point: Twins are a risk factor for pre-eclampsia; aspirin from 12 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 393 · Monochorionic twins · **Hard** · C2

A woman with MCDA twins at 16 weeks asks why she must have scans so often.

Which complication is the main reason for starting scans at 16 weeks?

A. Breech presentation
B. Placenta praevia
C. Pre-eclampsia
D. Twin-to-twin transfusion syndrome
E. Vasa praevia

Answer: D. Twin-to-twin transfusion syndrome

TTTS usually starts between 16 and 26 weeks. Scans every 2 weeks measure fluid and bladders to detect it early, when laser treatment can help.

Why not the others

- **A:** Presentation is checked near term.
- **B:** Praevia is assessed at 20 and 32 weeks.
- **C:** BP and urine checks screen for this.
- **E:** Vasa praevia is not the reason for frequent scans.

Key point: TTTS mostly develops at 16–26 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 394 · Twin labour · **Easy** · C1

A woman with twins is in labour.

What is the recommended fetal monitoring?

A. Continuous monitoring of both twins
B. Intermittent auscultation of twin 1 only
C. Monitor only twin 2
D. No monitoring after twin 1 is born
E. Ultrasound every 30 minutes

Answer: A. Continuous monitoring of both twins

Both twins should be monitored continuously in labour. A fetal scalp electrode on twin 1 and an abdominal transducer for twin 2 can ensure both hearts are recorded separately.

Why not the others

- **B:** Twin 2 also needs monitoring.
- **C:** Twin 1 also needs monitoring.
- **D:** Twin 2 needs monitoring after twin 1 is born.
- **E:** Ultrasound is used to check the lie and heart rate, but not as routine monitoring.

Key point: Monitor both twins continuously in labour.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 395 · Delivery of second twin · **Moderate** · C2

A woman delivered twin 1 vaginally 10 minutes ago. She asks how long it is safe to wait for twin 2.

What is the usual aim for the time between twins?

A. Within 30 minutes
B. Within 1 hour
C. Within 2 hours
D. Within 4 hours
E. There is no limit

Answer: A. Within 30 minutes

The aim is to deliver twin 2 within about 30 minutes, as acidosis increases with longer intervals. Longer intervals are allowed if the CTG is normal, but care must be close.

Why not the others

- **B:** Longer waits increase acidosis risk.
- **C:** This is too long.
- **D:** This is too long.
- **E:** There is a rising risk with time.

Key point: Aim to deliver the second twin within about 30 minutes.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 396 · Twin labour · **Hard** · C3

A woman with DCDA twins at 35 weeks is in labour. Twin 1 is cephalic. Twin 2 is estimated to be 30% larger than twin 1 and is breech.

What is the most appropriate management?

A. Await vaginal birth with an experienced team
B. Caesarean section for both twins
C. Give a tocolytic
D. Instrumental delivery of twin 1
E. Turn twin 2 by ECV now

Answer: B. Caesarean section for both twins

Many guidelines advise caesarean if twin 2 is substantially larger (e.g. more than 20–25%) and non-cephalic, due to the risk of head entrapment and difficult breech extraction.

Why not the others

- **A:** A much larger breech second twin raises risk.
- **C:** Tocolysis is not appropriate.
- **D:** Twin 1 does not need assisted delivery.
- **E:** ECV of twin 2 is not done before twin 1 is born.

Key point: Much larger non-cephalic twin 2: consider caesarean.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 397 · Multiple pregnancy · **Easy** · C1

A woman asks about the main cause of perinatal death in twins.

What is it?

A. Birth trauma
B. Congenital anomaly
C. Infection
D. Maternal diabetes
E. Preterm birth

Answer: E. Preterm birth

Preterm birth is the main cause of death and disability in twins. About 60% of twins are born before 37 weeks.

Why not the others

- **A:** Birth trauma is a smaller risk.
- **B:** Anomalies are more common, but not the main cause.
- **C:** Infection is a smaller risk.
- **D:** GDM is not a major cause.

Key point: Prematurity is the main cause of perinatal loss in twins.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 398 · Monoamniotic twins · **Moderate** · C3

A woman has MCMA twins at 26 weeks. The scan shows the cords are entangled.

What is the most appropriate plan?

A. Caesarean section at 32 to 33+6 weeks with close monitoring
B. Deliver now by caesarean section
C. Induction of labour at 36 weeks
D. Laser of the cords
E. No change; cord entanglement is harmless

Answer: A. Caesarean section at 32 to 33+6 weeks with close monitoring

Cord entanglement is almost universal in MCMA twins. Close fetal surveillance with planned caesarean at 32 to 33+6 weeks is advised. Immediate delivery at 26 weeks is not needed unless there is compromise.

Why not the others

- **B:** Entanglement alone does not need delivery at 26 weeks.
- **C:** Vaginal birth is not advised.
- **D:** Laser is not used for entanglement.
- **E:** Entanglement is a cause of sudden death.

Key point: MCMA twins: cord entanglement is expected; deliver at 32–33+6 weeks.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 399 · Single fetal death · **Moderate** · C2

A woman with DCDA twins at 26 weeks has a scan that shows one twin has died. The other is growing normally.

What is the risk to the surviving twin compared with monochorionic twins?

A. It always dies
B. Lower risk because there are no shared vessels
C. Same risk as monochorionic twins
D. The survivor must be delivered now
E. There is no risk at all

Answer: B. Lower risk because there are no shared vessels

In DC twins, the main risk to the survivor is preterm birth, as there are no shared vessels. Expectant care with growth scans is usual.

Why not the others

- **A:** The survivor usually does well.
- **C:** Risk is much lower than in MC twins.
- **D:** Immediate delivery adds prematurity.
- **E:** Preterm labour risk still exists.

Key point: Single twin death in DC twins: lower risk; mainly preterm birth.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

MCQ 400 · Twin pregnancy · **Moderate** · C2

A woman with DCDA twins at 32 weeks has a twin with an estimated weight below the 10th centile, but the discordance is 15% and Dopplers are normal.

What is the most appropriate management?

A. Caesarean section now
B. Deliver at 34 weeks
C. Increase scans and continue to planned birth
D. Induction now
E. Reassure and stop growth scans

Answer: C. Increase scans and continue to planned birth

A twin below the 10th centile with discordance under 25% and normal Dopplers needs closer surveillance. Delivery is planned based on Dopplers, growth and gestation.

Why not the others

- **A:** There is no indication.
- **B:** Not indicated with normal Dopplers.
- **D:** Not indicated.
- **E:** Surveillance should increase, not stop.

Key point: Small twin with normal Dopplers: increase surveillance.

Reference: Obstetrics by Ten Teachers — Multiple pregnancy

CHAPTER 9

Antepartum Haemorrhage

MCQ 401 · Placenta praevia · **Easy** · C2

A 32-year-old woman at 33 weeks has sudden painless bright red vaginal bleeding of about 200 mL. The uterus is soft and not tender. The fetus is in a transverse lie and the CTG is normal.

What is the most likely diagnosis?

A. Cervical ectropion
B. Placenta praevia
C. Placental abruption
D. Uterine rupture
E. Vasa praevia

Answer: B. Placenta praevia

Painless bright red bleeding with a soft uterus and a malpresentation is classic for placenta praevia. The low placenta prevents the presenting part from entering the pelvis.

Why not the others

- **A:** Ectropion usually gives light spotting after sex.
- **C:** Abruption is painful with a tender, tense uterus.
- **D:** Rupture causes pain and collapse, usually in labour.
- **E:** Vasa praevia bleeds at membrane rupture with fetal distress.

Key point: Painless bleeding, soft uterus, malpresentation: placenta praevia.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 402 · Placenta praevia · **Easy** · C2

A 28-year-old woman at 34 weeks presents with painless vaginal bleeding. The placental site is not known.

Which examination must be avoided until placenta praevia is excluded?

A. Abdominal palpation
B. Blood pressure measurement
C. CTG
D. Digital vaginal examination
E. Ultrasound scan

Answer: D. Digital vaginal examination

A digital vaginal examination can cause massive bleeding if the placenta is low. A speculum exam is safe, but digital exam must wait until the placental site is known.

Why not the others

- **A:** Abdominal palpation is safe.
- **B:** BP must be checked.
- **C:** CTG is safe and needed.
- **E:** Ultrasound is how praevia is diagnosed.

Key point: No digital vaginal exam until placenta praevia is excluded.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 403 · Placenta praevia · **Moderate** · C2

A 26-year-old woman has a routine anomaly scan at 20 weeks that shows the placenta reaching the internal os. She has had no bleeding.

What is the most appropriate next step?

A. Admit until delivery
B. Caesarean section booked at 37 weeks now
C. No further action as it always moves
D. Repeat scan at 40 weeks
E. Repeat transvaginal scan at 32 weeks

Answer: E. Repeat transvaginal scan at 32 weeks

Most low placentas at 20 weeks move up as the lower segment forms. RCOG advises a repeat scan at 32 weeks, ideally transvaginal, to confirm the diagnosis. If still low, another scan at 36 weeks helps plan delivery.

Why not the others

- **A:** Admission is not needed without bleeding.
- **B:** Delivery plans wait for the 32-week scan.
- **C:** Not all placentas move up.
- **D:** This is too late to plan.

Key point: Low placenta at 20 weeks: rescan transvaginally at 32 weeks.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 404 · Placenta praevia · **Moderate** · C2

A woman worried about the transvaginal scan at 32 weeks asks if it is safe with a low placenta.

What is the best advice?

A. It can only be done under anaesthesia
B. It is contraindicated
C. It is safe and more accurate than an abdominal scan
D. It should be done only after 36 weeks
E. Only an MRI is safe

Answer: C. It is safe and more accurate than an abdominal scan

Transvaginal ultrasound is safe in placenta praevia and gives a more accurate measure of the distance from the placental edge to the internal os.

Why not the others

- **A:** No anaesthesia is needed.
- **B:** It is not contraindicated.
- **D:** It is used at 32 weeks.
- **E:** MRI is for suspected accreta, not to find the placenta.

Key point: TVS is safe and more accurate in suspected praevia.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 405 · Placenta praevia · **Moderate** · C3

A 30-year-old woman has an uncomplicated placenta praevia confirmed at 32 and 36 weeks. She has had no bleeding.

When should delivery be planned?

A. 34 to 35+6 weeks
B. 36 to 37+6 weeks
C. 38 to 39 weeks
D. 40 weeks
E. Await spontaneous labour

Answer: B. 36 to 37+6 weeks

RCOG advises planned caesarean between 36+0 and 37+6 weeks for uncomplicated placenta praevia. With bleeding or other risk factors, 34+0 to 35+6 weeks is considered.

Why not the others

- **A:** This is for women with bleeding or risk factors.
- **C:** This raises the risk of bleeding in labour.
- **D:** Labour must be avoided.
- **E:** Labour with praevia can cause severe bleeding.

Key point: Uncomplicated praevia: planned CS at 36 to 37+6 weeks.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 406 · Placenta praevia · **Moderate** · C3

At 36 weeks, a scan shows the placental edge is 25 mm from the internal os. The head is cephalic.

What is the most appropriate mode of delivery?

A. Caesarean section at 36 weeks
B. Caesarean section at 39 weeks
C. Classical caesarean section
D. Elective caesarean hysterectomy
E. Plan for vaginal birth

Answer: E. Plan for vaginal birth

If the placental edge is more than 20 mm from the internal os in the third trimester, a vaginal birth is reasonable. A low-lying placenta within 20 mm usually needs a caesarean.

Why not the others

- **A:** Not needed with an edge more than 20 mm from the os.
- **B:** Not needed.
- **C:** A classical incision is not needed.
- **D:** There is no suggestion of accreta.

Key point: Placental edge >20 mm from the os: vaginal birth is possible.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 407 · Placenta accreta spectrum · **Hard** · C3

A 34-year-old woman has had two caesarean sections. A scan at 32 weeks shows an anterior placenta praevia over the scar, with loss of the clear zone and many lacunae.

What is the most likely diagnosis?

A. Circumvallate placenta
B. Placenta accreta spectrum
C. Placental abruption
D. Succenturiate lobe
E. Vasa praevia

Answer: B. Placenta accreta spectrum

Previous caesarean section with an anterior praevia is the main risk factor for placenta accreta spectrum. Loss of the clear zone and lacunae are typical ultrasound signs. Delivery is planned in a specialist centre.

Why not the others

- **A:** Circumvallate placenta has a rolled edge.
- **C:** Abruption is separation of the placenta.
- **D:** A succenturiate lobe is an extra lobe.
- **E:** Vasa praevia involves fetal vessels over the os.

Key point: Praevia over a caesarean scar: suspect accreta spectrum.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 408 · Placenta accreta spectrum · **Hard** · C3

A woman with suspected placenta percreta at 34 weeks is being counselled.

Where and when should delivery be planned?

A. At 35 to 36+6 weeks in a specialist centre with a multidisciplinary team
B. At 39 weeks in the local unit
C. At 40 weeks by induction
D. In a midwife-led unit
E. Whenever labour starts

Answer: A. At 35 to 36+6 weeks in a specialist centre with a multidisciplinary team

RCOG advises planned delivery at 35+0 to 36+6 weeks in a specialist centre with experienced surgeons, anaesthetists, blood bank and interventional radiology. Caesarean hysterectomy is often required.

Why not the others

- **B:** This is too late and in the wrong setting.
- **C:** Labour must be avoided.
- **D:** This is unsafe.
- **E:** Emergency delivery increases risk.

Key point: Accreta spectrum: planned CS at 35–36+6 weeks in a specialist centre.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 409 · Placental abruption · **Easy** · C2

A 30-year-old woman at 35 weeks has sudden severe abdominal pain and a small amount of dark vaginal bleeding. The uterus is hard and very tender. The CTG shows late decelerations.

What is the most likely diagnosis?

A. Labour
B. Placenta praevia
C. Placental abruption
D. Red degeneration of fibroid
E. Vasa praevia

Answer: C. Placental abruption

Placental abruption causes pain, a tense 'woody' uterus and fetal distress. Bleeding may be small or hidden (concealed), so blood loss can be underestimated.

Why not the others

- **A:** Normal labour has painful contractions with relaxation in between.
- **B:** Praevia causes painless bleeding.
- **D:** Red degeneration gives localised pain over a fibroid without fetal distress.
- **E:** Vasa praevia bleeds at membrane rupture.

Key point: Pain, woody hard uterus and fetal distress: abruption.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 410 · Placental abruption · **Easy** · C1

A medical student is learning about risk factors for placental abruption.

Which is the strongest risk factor?

A. Cocaine use
B. Nulliparity
C. Placenta praevia
D. Previous abruption
E. Vegetarian diet

Answer: D. Previous abruption

Previous abruption carries a recurrence risk of about 10%. Other risk factors include pre-eclampsia, smoking, cocaine, trauma and PPROM.

Why not the others

- **A:** Cocaine is a risk factor but less strong.
- **B:** Multiparity is more linked.
- **C:** Praevia is a separate condition.
- **E:** Diet is not a risk factor.

Key point: Previous abruption is the strongest predictor of recurrence.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 411 · Placental abruption · **Hard** · C3

A 29-year-old woman at 37 weeks has severe abdominal pain. The uterus is woody hard. There is no fetal heart on ultrasound. She has heavy vaginal bleeding. BP 100/60 mmHg, pulse 120/min.

What complication must be checked for urgently?

A. Amniotic fluid embolism
B. Disseminated intravascular coagulation
C. Hyperkalaemia
D. Hypoglycaemia
E. Uterine inversion

Answer: B. Disseminated intravascular coagulation

Severe abruption with fetal death is strongly linked to DIC, as thromboplastins are released from the placenta. Clotting, fibrinogen and platelets must be checked, and blood products given. Delivery is usually vaginal if she is stable.

Why not the others

- **A:** AFE is a different condition.
- **C:** Hyperkalaemia is not a typical problem.
- **D:** Hypoglycaemia is not the main concern.
- **E:** Inversion is a third-stage complication.

Key point: Abruption with fetal death: look for DIC.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 412 · Placental abruption · **Hard** · C3

A woman with severe abruption at 38 weeks has an intrauterine fetal death. She is stable after resuscitation and clotting is being corrected.

What is the usual preferred mode of delivery?

A. Classical caesarean section
B. Emergency caesarean section
C. Hysterectomy
D. Vaginal birth with amniotomy
E. Wait 2 weeks for spontaneous labour

Answer: D. Vaginal birth with amniotomy

After fetal death from abruption, vaginal birth is preferred if the mother is stable. Amniotomy speeds labour. Caesarean section is for maternal reasons, such as uncontrollable bleeding.

Why not the others

- **A:** A classical incision is not needed.
- **B:** Surgery adds risk with coagulopathy.
- **C:** Hysterectomy is not first line.
- **E:** Waiting raises DIC risk.

Key point: Abruption with fetal death: vaginal birth if the mother is stable.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 413 · Placental abruption · **Hard** · C2

At caesarean section for severe abruption, the uterus looks bruised and purple, with blood in the myometrium.

What is this called?

A. Couvelaire uterus
B. Hydatidiform mole
C. Placenta increta
D. Uterine inversion
E. Uterine rupture

Answer: A. Couvelaire uterus

A Couvelaire uterus results from blood tracking into the myometrium in severe abruption. It may contract poorly and raise PPH risk, but it is not by itself a reason for hysterectomy.

Why not the others

- **B:** A mole is a gestational trophoblastic disease.
- **C:** Increta is abnormal placental invasion.
- **D:** Inversion is turning inside out.
- **E:** Rupture is a tear in the uterine wall.

Key point: Blood within the myometrium after abruption: Couvelaire uterus.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 414 · Placental abruption · **Moderate** · C2

A 25-year-old woman at 30 weeks was in a car crash with a seatbelt injury. She now has mild abdominal pain and tightenings. CTG shows frequent tightenings.

What is the most appropriate management?

A. CTG monitoring for at least 4 hours
B. Discharge after reassurance
C. Give oxytocin
D. Pelvic X-ray
E. Ultrasound only

Answer: A. CTG monitoring for at least 4 hours

After trauma, abruption can be concealed. Continuous CTG for at least 2–4 hours is advised. Frequent contractions are a warning sign. Anti-D is needed if she is RhD negative.

Why not the others

- **B:** Concealed abruption can present late.
- **C:** Oxytocin is wrong here.
- **D:** X-ray does not detect abruption.
- **E:** Ultrasound often misses abruption.

Key point: Trauma in pregnancy: CTG for at least 2–4 hours.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 415 · Placental abruption · **Moderate** · C3

A woman at 35 weeks presents with abdominal pain and bleeding. Ultrasound of the placenta is normal.

What is true about ultrasound diagnosis of abruption?

A. A normal scan does not rule out abruption
B. It always shows a retroplacental clot
C. It is more accurate than clinical diagnosis
D. It is the gold standard
E. Normal Dopplers exclude it

Answer: A. A normal scan does not rule out abruption

Abruption is a clinical diagnosis. Ultrasound misses most cases, so a normal scan does not exclude it. Management depends on the clinical picture.

Why not the others

- **B:** Clots are often not seen.
- **C:** Clinical signs are more reliable.
- **D:** There is no imaging gold standard.
- **E:** Dopplers do not exclude abruption.

Key point: Abruption is a clinical diagnosis; a normal scan does not exclude it.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 416 · Vasa praevia · **Hard** · C3

A 30-year-old woman in labour at 39 weeks has spontaneous rupture of membranes with fresh bleeding. The CTG immediately shows fetal bradycardia. She is well.

What is the most likely diagnosis?

A. Cervical tear
B. Placenta praevia
C. Placental abruption
D. Uterine rupture
E. Vasa praevia

Answer: E. Vasa praevia

Vasa praevia is fetal vessels over the cervix. When the membranes rupture, the vessels can tear and the fetus bleeds quickly. The mother is well, but the fetus becomes distressed. This needs an immediate caesarean section.

Why not the others

- **A:** A cervical tear would not cause sudden fetal distress.
- **B:** Praevia causes maternal bleeding without sudden distress at ROM.
- **C:** Abruption causes pain.
- **D:** Rupture causes pain and maternal collapse.

Key point: Bleeding at ROM with fetal bradycardia: vasa praevia.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 417 · Vasa praevia · **Hard** · C3

A 32-year-old IVF pregnancy has a velamentous cord insertion. At 32 weeks, transvaginal colour Doppler shows a fetal vessel over the internal os.

What is the recommended management?

A. Amniotomy in early labour
B. Induction of labour at 39 weeks
C. Planned caesarean section at 34 to 36+6 weeks
D. Planned vaginal birth
E. Spontaneous labour at term

Answer: C. Planned caesarean section at 34 to 36+6 weeks

RCOG advises planned caesarean before labour, usually between 34+0 and 36+6 weeks, for confirmed vasa praevia. Steroids are offered, and admission from 30–32 weeks may be considered.

Why not the others

- **A:** Amniotomy may tear the vessels.
- **B:** Labour risks fetal bleeding.
- **D:** Vaginal birth is unsafe.
- **E:** Labour must be avoided.

Key point: Vasa praevia: planned CS at 34 to 36+6 weeks.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 418 · Vasa praevia · **Moderate** · C1

A student asks which factor increases the risk of vasa praevia.

Which is a risk factor?

A. Fundal placenta
B. Male fetus
C. Previous caesarean
D. Velamentous cord insertion
E. Young maternal age

Answer: D. Velamentous cord insertion

Risk factors are velamentous cord insertion, a low-lying placenta (or one that moved up), bilobed or succenturiate lobes, IVF and multiple pregnancy.

Why not the others

- **A:** A low placenta, not fundal, is the risk.
- **B:** Fetal sex is not a risk.
- **C:** Previous CS is linked to accreta.
- **E:** Age is not a key risk.

Key point: Velamentous insertion and bilobed placenta raise vasa praevia risk.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 419 · Uterine rupture · **Hard** · C3

A 31-year-old woman with one previous caesarean section is in labour at 40 weeks. She has sudden severe abdominal pain, vaginal bleeding and loss of contractions. The fetal head is no longer palpable vaginally. The CTG shows bradycardia.

What is the most likely diagnosis?

A. Amniotic fluid embolism
B. Placental abruption
C. Uterine inversion
D. Uterine rupture
E. Vasa praevia

Answer: D. Uterine rupture

Uterine rupture in VBAC presents with fetal distress (the most common sign), pain, bleeding, loss of contractions and loss of station. It needs an immediate laparotomy.

Why not the others

- **A:** AFE causes collapse and DIC.
- **B:** Abruption does not cause loss of station.
- **C:** Inversion occurs after birth.
- **E:** Vasa praevia does not cause pain or loss of station.

Key point: VBAC with pain, bradycardia and loss of station: uterine rupture.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 420 · Local causes · **Easy** · C2

A 27-year-old woman at 28 weeks has light bleeding after intercourse. Placenta is fundal. Speculum examination shows a red area around the os that bleeds on touch. Her smear is up to date and normal.

What is the most likely cause?

A. Cervical cancer
B. Cervical ectropion
C. Placenta praevia
D. Placental abruption
E. Vasa praevia

Answer: B. Cervical ectropion

Cervical ectropion is common in pregnancy due to high oestrogen. It often bleeds after sex. With a normal smear and normal placental site, reassurance is appropriate.

Why not the others

- **A:** Smear is normal and the appearance is benign.
- **C:** The placenta is fundal.
- **D:** There is no pain or tenderness.
- **E:** Vasa praevia is not linked to postcoital bleeding.

Key point: Postcoital spotting with normal placenta: often ectropion.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 421 · Anti-D · **Moderate** · C2

A 25-year-old RhD-negative woman at 30 weeks has an antepartum haemorrhage. The bleeding stops.

What is the most appropriate step about anti-D?

A. Give anti-D and do a Kleihauer test
B. Give anti-D only after delivery
C. Give anti-D only if bleeding recurs
D. No anti-D is needed after 28 weeks
E. Routine prophylaxis covers it

Answer: A. Give anti-D and do a Kleihauer test

Any APH after 20 weeks in an RhD-negative woman needs at least 500 IU anti-D within 72 hours, plus a Kleihauer test to measure fetal cells in her blood. Extra anti-D is given if needed.

Why not the others

- **B:** It must be given within 72 hours.
- **C:** It must be given for each event.
- **D:** It is needed at all gestations after 12 weeks.
- **E:** Routine prophylaxis does not cover events.

Key point: RhD-negative APH after 20 weeks: anti-D plus Kleihauer.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 422 · APH management · **Moderate** · C3

A 29-year-old woman at 32 weeks has an APH of 300 mL from a known placenta praevia. Bleeding has settled. She is stable and the CTG is normal.

What is the most appropriate next step?

A. Corticosteroids and admit for observation
B. Deliver by caesarean today
C. Discharge home
D. Give tranexamic acid and discharge
E. Start tocolytics routinely

Answer: A. Corticosteroids and admit for observation

After APH from praevia at 32 weeks with stable mother and baby, she should be admitted, given steroids for fetal lungs, and have blood cross-matched. Discharge is decided after bleeding stops for a period.

Why not the others

- **B:** Delivery is not needed if stable.
- **C:** Discharge is too soon.
- **D:** She needs admission.
- **E:** Tocolysis is not routine.

Key point: Praevia bleed at 32 weeks when stable: admit and give steroids.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 423 · APH definitions · **Easy** · C1

A medical student is learning about bleeding in pregnancy.

What is the RCOG definition of antepartum haemorrhage?

A. Any bleeding in pregnancy
B. Bleeding after 12 weeks
C. Bleeding after 20 weeks
D. Bleeding after 24 weeks and before birth
E. Bleeding after delivery

Answer: D. Bleeding after 24 weeks and before birth

RCOG defines APH as bleeding from or into the genital tract from 24 weeks until the birth of the baby.

Why not the others

- **A:** Earlier bleeding is miscarriage or other.
- **B:** This is not the definition.
- **C:** This is not the RCOG definition.
- **E:** This is PPH.

Key point: APH = bleeding from 24 weeks until birth.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 424 · APH definitions · **Moderate** · C1

A woman at 30 weeks had bleeding of 200 mL that has stopped. She is stable.

How is this APH classified?

A. Major haemorrhage
B. Massive haemorrhage
C. Minor haemorrhage
D. Moderate haemorrhage
E. Spotting

Answer: A. Major haemorrhage

RCOG classification: spotting – stains; minor – less than 50 mL that has settled; major – 50–1000 mL without shock; massive – more than 1000 mL and/or shock.

Why not the others

- **B:** Massive is more than 1000 mL or shock.
- **C:** Minor is less than 50 mL.
- **D:** The RCOG system does not use a moderate category.
- **E:** Spotting is just staining.

Key point: APH: minor <50 mL, major 50–1000 mL, massive >1000 mL or shock.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 425 · Massive haemorrhage · **Hard** · C3

A woman at 34 weeks with abruption has lost 2000 mL. BP 80/40 mmHg, pulse 140/min. Group-specific blood is not yet ready.

What is the most appropriate blood product right now?

A. Albumin
B. Cryoprecipitate alone
C. Group O RhD-negative blood
D. Platelets alone
E. Wait for fully cross-matched blood

Answer: C. Group O RhD-negative blood

In life-threatening bleeding, group O RhD-negative blood (or emergency stock) is given until group-specific blood is ready. The massive haemorrhage protocol should be activated.

Why not the others

- **A:** Albumin does not carry oxygen.
- **B:** Cryoprecipitate is given guided by fibrinogen.
- **D:** Platelets alone do not restore oxygen-carrying capacity.
- **E:** Waiting is unsafe.

Key point: Massive haemorrhage: O-negative blood while awaiting group-specific.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 426 · Placenta praevia · **Easy** · C1

A medical student asks about risk factors for placenta praevia.

Which is a recognised risk factor?

A. Low parity
B. Previous caesarean section
C. Primigravida under 20
D. Single pregnancy
E. Tall stature

Answer: B. Previous caesarean section

Risk factors for praevia include previous caesarean section, previous praevia, multiparity, older age, smoking, multiple pregnancy and assisted conception.

Why not the others

- **A:** Higher parity, not low, raises risk.
- **C:** Young first pregnancies are lower risk.
- **D:** Multiple pregnancy raises risk.
- **E:** Height is not a risk factor.

Key point: Previous caesarean section raises the risk of praevia and accreta.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 427 · Placenta praevia · **Moderate** · C2

A woman with known major placenta praevia at 34 weeks asks about staying at home.

Which factor is most important when deciding about home care?

A. Close to hospital with an adult at home and quick transport
B. Having a scan every week
C. Her age
D. Her blood group
E. Parity only

Answer: A. Close to hospital with an adult at home and quick transport

RCOG advises that women with praevia and no bleeding can be cared for at home if they live close to the hospital, have someone with them, and can get to hospital quickly if bleeding occurs.

Why not the others

- **B:** Weekly scans are not needed.
- **C:** Age alone does not decide this.
- **D:** Blood group does not decide this.
- **E:** Parity alone does not decide this.

Key point: Home care in praevia needs proximity, support and transport.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 428 · Placenta praevia · **Moderate** · C2

A woman with an anterior placenta praevia is having a planned caesarean section at 37 weeks.

Who should be present at the operation?

A. A consultant obstetrician and anaesthetist
B. A junior doctor only
C. A midwife only
D. A neonatal nurse only
E. Anyone on call

Answer: A. A consultant obstetrician and anaesthetist

RCOG advises a consultant obstetrician and consultant anaesthetist be present for caesarean with placenta praevia, especially anterior or with suspected accreta, due to the risk of major bleeding.

Why not the others

- **B:** This is unsafe given bleeding risk.
- **C:** A midwife alone cannot perform surgery.
- **D:** A neonatal nurse is not enough.
- **E:** Senior presence is needed.

Key point: Praevia CS: consultant obstetrician and anaesthetist present.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 429 · Placenta praevia · **Hard** · C3

During caesarean section for placenta praevia, the placenta separates but the lower segment continues to bleed heavily despite oxytocin and ergometrine.

Why does the lower segment bleed more in praevia?

A. It contracts poorly compared with the upper segment
B. It has a larger blood supply from the ovarian artery
C. Oxytocin receptors are higher in the lower segment
D. The placenta is always accreta
E. The upper segment cannot contract

Answer: A. It contracts poorly compared with the upper segment

The lower uterine segment has less muscle and contracts poorly, so the placental bed keeps bleeding. Measures such as balloon tamponade, sutures or uterine artery ligation may be needed.

Why not the others

- **B:** This is not the reason.
- **C:** Receptors are fewer in the lower segment.
- **D:** Accreta is a separate problem.
- **E:** The upper segment contracts well.

Key point: The lower segment contracts poorly, so praevia bleeds after delivery.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 430 · Placenta accreta spectrum · **Moderate** · C2

A woman with two previous caesarean sections has an anterior low-lying placenta at 20 weeks.

What is the most appropriate next step?

A. Caesarean hysterectomy at 30 weeks
B. No further scans
C. Repeat scan at 40 weeks
D. Specialist scan to look for accreta signs
E. Termination of pregnancy

Answer: D. Specialist scan to look for accreta signs

A low placenta with previous caesarean section is a high risk for placenta accreta spectrum. RCOG advises specialist ultrasound by an experienced operator. MRI can be added if needed.

Why not the others

- **A:** This is too early and premature.
- **B:** Further imaging is needed.
- **C:** This is too late.
- **E:** Not indicated.

Key point: Low placenta plus previous CS: specialist scan for accreta.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 431 · Placenta accreta spectrum · **Moderate** · C1

A student asks about the grades of abnormal placental invasion.

Placenta increta invades into which layer?

A. Bladder
B. Decidua only
C. Myometrium
D. Serosa
E. Through the serosa into nearby organs

Answer: C. Myometrium

Accreta: villi attach to the myometrium; increta: villi invade into the myometrium; percreta: villi go through the serosa and may invade organs like the bladder.

Why not the others

- **A:** Bladder invasion is percreta.
- **B:** Normal placentation is within decidua.
- **D:** Reaching serosa is percreta.
- **E:** Beyond serosa is percreta.

Key point: Accreta attaches, increta invades myometrium, percreta goes through.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 432 · Placenta accreta spectrum · **Hard** · C3

At planned caesarean, an anterior placenta percreta is confirmed with bladder involvement. The baby is delivered through a fundal incision.

What is the usual next step?

A. Give oxytocin and wait for separation
B. Leave the placenta in place and close, or proceed to hysterectomy
C. Manual removal of the placenta
D. Remove the placenta by cutting it out of the bladder
E. Use controlled cord traction

Answer: B. Leave the placenta in place and close, or proceed to hysterectomy

In percreta, attempting to remove the placenta can cause massive bleeding. Options are hysterectomy with the placenta in place, or leaving it in place (conservative management) in selected cases.

Why not the others

- **A:** The placenta will not separate.
- **C:** This risks massive haemorrhage.
- **D:** This risks massive bleeding and bladder injury.
- **E:** This risks massive bleeding.

Key point: Do not try to remove a percreta; hysterectomy or leave in situ.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 433 · Placental abruption · **Moderate** · C2

A 33-year-old woman at 38 weeks has mild abruption with a small bleed. The CTG is normal.

What is the most appropriate management?

A. Caesarean section immediately
B. Discharge with follow-up
C. Induction of labour
D. Tocolysis
E. Wait until 41 weeks

Answer: C. Induction of labour

At term, even mild abruption is an indication for delivery, usually by induction if the fetus is not compromised. Caesarean is for fetal distress.

Why not the others

- **A:** Caesarean is not needed with a normal CTG.
- **B:** At term, delivery is safer.
- **D:** Tocolysis is contraindicated.
- **E:** Waiting risks a further bleed.

Key point: Abruption at term: deliver, usually by induction.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 434 · Placental abruption · **Moderate** · C3

A 30-year-old woman at 32 weeks has a mild abruption. Bleeding has stopped. CTG is normal.

What is the most appropriate management?

A. Caesarean section today
B. Discharge without follow-up
C. Induction of labour today
D. Steroids and admission for monitoring
E. Tocolysis with nifedipine

Answer: D. Steroids and admission for monitoring

Preterm abruption with stable mother and fetus can be managed conservatively with steroids, monitoring and growth scans. Delivery is planned if the condition changes.

Why not the others

- **A:** Not needed if stable.
- **B:** Close follow-up is needed.
- **C:** Delivery is not needed now.
- **E:** Tocolysis is avoided.

Key point: Preterm mild abruption: steroids and observe.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 435 · Placental abruption · **Hard** · C3

A 36-year-old woman with abruption is being monitored after delivery. Her urine output is 15 mL/hour over 4 hours.

Which complication is most likely?

A. Acute kidney injury
B. Bladder injury
C. Diabetes insipidus
D. Fluid overload
E. Urinary retention

Answer: A. Acute kidney injury

Severe abruption can cause acute kidney injury from hypovolaemia and DIC. Fluid balance, renal function and careful resuscitation are needed.

Why not the others

- **B:** There was no surgery.
- **C:** DI causes high urine output.
- **D:** Low urine suggests poor perfusion.
- **E:** Retention should be excluded but AKI is the concern.

Key point: Abruption can cause AKI from hypovolaemia.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 436 · Placental abruption · **Hard** · C2

A woman who smokes 20 cigarettes a day has a pregnancy complicated by abruption at 34 weeks.

Which other outcome is linked to abruption?

A. Fetal growth restriction
B. Fetal macrosomia
C. Polyhydramnios
D. Post-term delivery
E. Twin pregnancy

Answer: A. Fetal growth restriction

Abruption shares causes with placental insufficiency, and FGR is often found. Stillbirth, prematurity and neurodevelopmental problems are also linked.

Why not the others

- **B:** Macrosomia is not linked.
- **C:** Polyhydramnios is a risk factor via sudden decompression, not a result.
- **D:** Abruption causes preterm delivery.
- **E:** Twins are a risk factor, not an outcome.

Key point: Abruption is linked to FGR and placental dysfunction.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 437 · Placental abruption · **Moderate** · C2

A woman with polyhydramnios has artificial rupture of membranes. Shortly after, she has pain and bleeding.

What is the most likely cause?

A. Cord prolapse
B. Placenta praevia
C. Placental abruption
D. Uterine inversion
E. Vasa praevia

Answer: C. Placental abruption

Sudden decompression of the uterus after rupture of membranes with polyhydramnios can shear the placenta off, causing abruption. Controlled amniotomy is advised.

Why not the others

- **A:** Cord prolapse causes fetal distress without pain.
- **B:** Praevia is painless.
- **D:** Inversion occurs after birth.
- **E:** Vasa praevia does not cause pain.

Key point: Sudden decompression of polyhydramnios can cause abruption.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 438 · Uterine rupture · **Moderate** · C2

A woman with one previous lower segment caesarean asks about her risk of uterine rupture if she tries for vaginal birth.

What is the approximate risk?

A. 1 in 20
B. 1 in 50
C. 1 in 200
D. 1 in 2000
E. 1 in 20,000

Answer: C. 1 in 200

The risk of uterine rupture in planned VBAC after one previous lower segment caesarean is about 0.5% (1 in 200). It is higher with induction or augmentation.

Why not the others

- **A:** Too high.
- **B:** Too high.
- **D:** Too low.
- **E:** Too low.

Key point: VBAC rupture risk is about 1 in 200.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 439 · Unexplained APH · **Moderate** · C2

A 28-year-old woman at 32 weeks had a minor bleed. The placenta is not low. Speculum examination is normal and the CTG is normal.

What is the most appropriate follow-up?

A. Caesarean at 34 weeks
B. Deliver now
C. Discharge with no change in care
D. Serial growth scans
E. Weekly CTGs until delivery

Answer: D. Serial growth scans

Unexplained APH is linked to FGR, preterm birth and stillbirth. RCOG advises the woman to be managed as high risk, with serial growth scans.

Why not the others

- **A:** Not indicated.
- **B:** Not needed.
- **C:** She needs closer follow-up.
- **E:** Weekly CTGs have no proven benefit.

Key point: Unexplained APH: high-risk care with serial growth scans.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 440 · Massive haemorrhage · **Hard** · C3

A woman with massive obstetric haemorrhage has a fibrinogen of 1.5 g/L.

What should be given?

A. Albumin
B. Cryoprecipitate or fibrinogen concentrate
C. Desmopressin
D. Platelets only
E. Vitamin K

Answer: B. Cryoprecipitate or fibrinogen concentrate

In obstetric haemorrhage, a fibrinogen below 2 g/L is linked to severe bleeding. Cryoprecipitate or fibrinogen concentrate should be given.

Why not the others

- **A:** Albumin does not correct clotting.
- **C:** Desmopressin is for vWD and some platelet problems.
- **D:** Platelets do not correct fibrinogen.
- **E:** Vitamin K is for warfarin or deficiency.

Key point: Obstetric bleeding: keep fibrinogen above 2 g/L.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 441 · Massive haemorrhage · **Moderate** · C2

A woman with major APH is being resuscitated.

Which drug reduces bleeding and death in obstetric haemorrhage?

A. Aspirin
B. Heparin
C. Tranexamic acid
D. Vitamin C
E. Warfarin

Answer: C. Tranexamic acid

Tranexamic acid (1 g IV) is an antifibrinolytic that reduces death from bleeding in PPH (WOMAN trial). It is used in major obstetric haemorrhage.

Why not the others

- **A:** Aspirin increases bleeding.
- **B:** Heparin is an anticoagulant.
- **D:** Vitamin C has no role.
- **E:** Warfarin is an anticoagulant.

Key point: Give tranexamic acid early in obstetric haemorrhage.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 442 · Jehovah's Witness · **Hard** · C3

A Jehovah's Witness at 30 weeks has a known placenta praevia. She refuses blood transfusion and has an advance directive.

What is the most appropriate plan?

A. Give blood if she becomes unconscious
B. Plan delivery with cell salvage after discussing her wishes and optimise Hb
C. Refuse to care for her
D. Transfer care to a midwife
E. Transfuse her baby without consent

Answer: B. Plan delivery with cell salvage after discussing her wishes and optimise Hb

A competent adult's refusal of blood must be respected. Plan with senior team input: optimise haemoglobin with iron, discuss acceptable products such as cell salvage, and plan delivery with a consultant team.

Why not the others

- **A:** A valid advance directive must be respected.
- **C:** Care must not be refused.
- **D:** Senior care is needed.
- **E:** The baby is not yet born; this is not relevant now.

Key point: Respect refusal of blood; optimise Hb and plan cell salvage.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 443 · Local causes · **Moderate** · C2

A 35-year-old woman at 26 weeks has recurrent light bleeding. Her smear history is overdue. Speculum examination shows an irregular, friable lesion on the cervix.

What is the most appropriate next step?

A. Colposcopy and biopsy
B. Cone biopsy only after delivery
C. Reassure and review after birth
D. Repeat smear after delivery
E. Treat as ectropion

Answer: A. Colposcopy and biopsy

A suspicious cervical lesion in pregnancy needs colposcopy and biopsy to exclude cancer. Cervical cancer can present with APH.

Why not the others

- **B:** Diagnosis should not wait.
- **C:** Reassurance is unsafe.
- **D:** This delays diagnosis.
- **E:** It may not be ectropion.

Key point: Suspicious cervix in pregnancy: colposcopy and biopsy.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 444 · Placenta praevia · **Hard** · C3

A woman with a major placenta praevia at 34 weeks has heavy bleeding of 1500 mL. Her BP is 85/50 mmHg and the CTG shows decelerations.

What is the most appropriate management?

A. Admit and give steroids, then wait 48 hours
B. Emergency caesarean section after resuscitation
C. Induction of labour
D. Tocolysis to delay delivery
E. Transfer to another hospital first

Answer: B. Emergency caesarean section after resuscitation

Massive bleeding from praevia with maternal instability and fetal distress needs immediate resuscitation and emergency caesarean section by a senior team.

Why not the others

- **A:** Waiting is unsafe.
- **C:** Vaginal birth is contraindicated.
- **D:** Tocolysis is contraindicated.
- **E:** Transfer is unsafe.

Key point: Massive praevia bleed with instability: emergency caesarean.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 445 · Placenta praevia · **Easy** · C2

A woman at 30 weeks with placenta praevia asks what she should avoid.

Which advice is appropriate?

A. Avoid all walking
B. Avoid eating red meat
C. Avoid sexual intercourse
D. Avoid showers
E. Avoid sleeping on her back only

Answer: C. Avoid sexual intercourse

Women with praevia are usually advised to avoid penetrative sex, as it may cause bleeding. They should seek help with any bleeding or contractions.

Why not the others

- **A:** Normal activity is fine.
- **B:** Diet is not related.
- **D:** Showers are fine.
- **E:** This is general stillbirth advice, not praevia-specific.

Key point: Avoid sex with placenta praevia.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 446 · Vasa praevia · **Moderate** · C2

A woman with vasa praevia at 31 weeks asks if she can stay at home.

What is the usual advice?

A. Admission from about 30–32 weeks is considered
B. Home until labour starts
C. Only admission at 39 weeks
D. Only CTG is needed
E. Vaginal birth is safe

Answer: A. Admission from about 30–32 weeks is considered

Admission from 30–32 weeks may be offered to allow quick access to caesarean if membranes rupture or labour starts, though this is decided case by case.

Why not the others

- **B:** Labour can tear the vessels.
- **C:** Too late.
- **D:** CTG alone does not prevent bleeding.
- **E:** Vaginal birth is unsafe.

Key point: Vasa praevia: consider admission from 30–32 weeks.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 447 · Anti-D · **Moderate** · C2

An RhD-negative woman at 34 weeks has an abruption and the Kleihauer test shows a feto-maternal haemorrhage of 8 mL.

What is the correct action?

A. 500 IU anti-D only
B. Additional anti-D based on the size of the bleed
C. Give blood
D. No anti-D needed
E. Repeat test in 4 weeks

Answer: B. Additional anti-D based on the size of the bleed

500 IU anti-D covers up to 4 mL of fetal red cells. Larger bleeds need more anti-D (125 IU per mL of fetal red cells) and a repeat Kleihauer test.

Why not the others

- **A:** 500 IU only covers 4 mL.
- **C:** Blood is not indicated for this.
- **D:** Anti-D is needed.
- **E:** Waiting risks sensitisation.

Key point: FMH over 4 mL needs extra anti-D based on the Kleihauer.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 448 · Placenta accreta spectrum · **Hard** · C3

A woman with suspected placenta accreta is having a planned caesarean section.

Which measure is most useful in reducing blood loss?

A. Avoid regional anaesthesia
B. Avoid the use of cell salvage
C. Interventional radiology with balloon catheters if available
D. Remove the placenta first
E. Use only general anaesthesia

Answer: C. Interventional radiology with balloon catheters if available

Interventional radiology with internal iliac balloon catheters can reduce bleeding in accreta, though evidence varies. Cell salvage and senior-led surgery are also used.

Why not the others

- **A:** Regional anaesthesia is often used.
- **B:** Cell salvage should be used.
- **D:** Removing the placenta causes bleeding.
- **E:** Regional anaesthesia is often used.

Key point: Accreta: plan with IR, cell salvage and senior surgeons.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 449 · APH · **Easy** · C2

A 30-year-old woman at 36 weeks presents with mucus streaked with a small amount of blood. She has irregular tightenings. The CTG is normal.

What is the most likely cause?

A. Cervical cancer
B. Placenta praevia
C. Placental abruption
D. Show
E. Vasa praevia

Answer: D. Show

A 'show' is the mucus plug coming away from the cervix as it softens or begins to dilate. It is streaked with blood and is normal near labour.

Why not the others

- **A:** Cancer is unlikely in this setting.
- **B:** Praevia causes fresh blood.
- **C:** Abruption causes pain and a tender uterus.
- **E:** Vasa praevia causes bleeding with membrane rupture and fetal distress.

Key point: Blood-stained mucus near term is a show.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

MCQ 450 · Placental abruption · **Hard** · C3

A woman at 30 weeks uses cocaine. She presents with sudden abdominal pain, BP 160/100 mmHg, and dark bleeding.

What is the most likely cause of her bleeding?

A. Ectopic pregnancy
B. Placenta praevia
C. Placental abruption
D. Uterine fibroids
E. Vasa praevia

Answer: C. Placental abruption

Cocaine causes vasoconstriction and hypertension, which can cause abruption. Pain and dark bleeding support this.

Why not the others

- **A:** Ectopic is not at 30 weeks.
- **B:** Praevia is painless.
- **D:** Fibroids do not cause this picture.
- **E:** Vasa praevia is linked to ROM.

Key point: Cocaine use is a risk factor for abruption.

Reference: Obstetrics by Ten Teachers — Antepartum haemorrhage

CHAPTER 10

Preterm Labour and PPROM

MCQ 451 · Definitions · **Easy** · C1

A medical student is learning about preterm birth.

What is the definition of preterm birth?

A. Birth before 24 weeks
B. Birth before 28 weeks
C. Birth before 34 weeks
D. Birth before 37 completed weeks
E. Birth before 40 weeks

Answer: D. Birth before 37 completed weeks

Preterm birth is birth before 37+0 weeks. It is subdivided into extremely preterm (<28 weeks), very preterm (28–31+6) and moderate to late preterm (32–36+6).

Why not the others

- **A:** 24 weeks is the usual limit of viability in the UK.
- **B:** This is extremely preterm.
- **C:** This is not the definition.
- **E:** 40 weeks is the due date.

Key point: Preterm = before 37 completed weeks.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 452 · Risk factors · **Easy** · C1

A 28-year-old woman at booking had a spontaneous preterm birth at 30 weeks in her last pregnancy.

Which is the strongest predictor of preterm birth?

A. Being a vegetarian
B. Low BMI only
C. Maternal age 25
D. Previous spontaneous preterm birth
E. Short stature

Answer: D. Previous spontaneous preterm birth

Previous spontaneous preterm birth is the strongest risk factor. Others include previous cervical surgery, short cervix, multiple pregnancy, infection and smoking.

Why not the others

- **A:** Not a risk factor.
- **B:** Low BMI is a weaker risk factor.
- **C:** Age 25 is not a risk.
- **E:** Short stature is not a strong predictor.

Key point: Previous spontaneous preterm birth is the strongest predictor.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 453 · Prediction · **Moderate** · C2

A woman at 30 weeks has contractions. Her cervical length on transvaginal scan is 12 mm.

What does NICE advise based on this cervical length?

A. Diagnose preterm labour and offer treatment
B. Discharge without follow-up
C. Measure fetal fibronectin only
D. Repeat scan in 2 weeks
E. Start cerclage

Answer: A. Diagnose preterm labour and offer treatment

NICE advises that at 30 weeks or more, a cervical length of 15 mm or less on TVS supports a diagnosis of preterm labour. She should be offered treatment such as steroids and, if appropriate, tocolysis.

Why not the others

- **B:** She should not be discharged without assessment.
- **C:** Fibronectin is an alternative if TVS is not available.
- **D:** Waiting delays treatment.
- **E:** Cerclage is not done in active labour.

Key point: Use TVS cervical length (≤15 mm) to diagnose preterm labour from 30 weeks.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 454 · Prediction · **Moderate** · C2

A woman at 31 weeks has contractions. TVS shows a cervical length of 25 mm.

What is the most appropriate action?

A. Admit and give steroids and magnesium
B. Explain preterm labour is unlikely and consider other causes
C. Insert cerclage
D. Start nifedipine
E. Start oxytocin

Answer: B. Explain preterm labour is unlikely and consider other causes

NICE says that if the cervical length is more than 15 mm at 30 weeks or more, preterm labour is unlikely. Other causes for symptoms should be considered.

Why not the others

- **A:** Not needed with a long cervix.
- **C:** Cerclage is not appropriate.
- **D:** Tocolysis is not needed.
- **E:** Oxytocin causes contractions.

Key point: Cervical length >15 mm: preterm labour unlikely.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 455 · Prediction · **Moderate** · C3

A woman at 32 weeks has tightenings. TVS is not available. A fetal fibronectin test is negative (below 50 ng/mL).

What does this result mean?

A. Delivery is likely in 24 hours
B. Delivery is likely in 48 hours
C. Preterm labour is unlikely
D. She must stay in hospital until 37 weeks
E. Steroids are needed

Answer: C. Preterm labour is unlikely

Fetal fibronectin has a high negative predictive value. A negative test means delivery within 7–14 days is unlikely. A positive test supports preterm labour.

Why not the others

- **A:** A negative test predicts the opposite.
- **B:** A negative test predicts the opposite.
- **D:** Not needed with a negative test.
- **E:** Steroids are not needed.

Key point: Negative fetal fibronectin: preterm birth within 1–2 weeks is unlikely.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 456 · Corticosteroids · **Easy** · C2

A woman at 29 weeks is in established preterm labour.

Which drug is given to improve neonatal lung maturity?

A. Antenatal betamethasone or dexamethasone
B. Indomethacin
C. Magnesium sulfate
D. Nifedipine
E. Oxytocin

Answer: A. Antenatal betamethasone or dexamethasone

Antenatal corticosteroids (two doses 12–24 hours apart) reduce respiratory distress syndrome, IVH and neonatal death. NICE offers them between 24 and 33+6 weeks.

Why not the others

- **B:** Indomethacin is a tocolytic.
- **C:** MgSO4 is for neuroprotection.
- **D:** Nifedipine is a tocolytic.
- **E:** Oxytocin causes contractions.

Key point: Steroids reduce RDS, IVH and neonatal death.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 457 · Corticosteroids · **Moderate** · C2

A woman at 30 weeks in preterm labour asks about steroids.

When do steroids have the greatest effect?

A. After 7 days only
B. At 4 hours
C. Between 24 hours and 7 days after the first dose
D. Immediately
E. Only if birth is after 37 weeks

Answer: C. Between 24 hours and 7 days after the first dose

The greatest benefit is when birth occurs between 24 hours and 7 days after the first dose. Some benefit is still seen if birth is earlier.

Why not the others

- **A:** Benefit falls after 7 days.
- **B:** Little benefit this early.
- **D:** There is a delay before full effect.
- **E:** Steroids are for preterm birth.

Key point: Steroids work best for birth 24 hours to 7 days after the first dose.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 458 · Corticosteroids · **Hard** · C3

A woman with type 1 diabetes at 32 weeks is given betamethasone for threatened preterm labour.

What is the most important extra precaution?

A. Avoid insulin for 2 days
B. Give potassium
C. Monitor blood glucose closely and increase insulin
D. Stop all food
E. Stop metformin

Answer: C. Monitor blood glucose closely and increase insulin

Steroids cause hyperglycaemia for several days. Diabetic women need close glucose monitoring and extra insulin, often with a sliding scale.

Why not the others

- **A:** Insulin needs increase.
- **B:** Potassium is not needed.
- **D:** Not appropriate.
- **E:** She has type 1 diabetes.

Key point: Steroids raise glucose; monitor and give extra insulin in diabetes.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 459 · Magnesium sulfate · **Moderate** · C2

A woman at 28 weeks is in established preterm labour and birth is expected within 24 hours.

Why is magnesium sulfate given?

A. To prevent eclampsia
B. To reduce PPH
C. To reduce the risk of cerebral palsy in the baby
D. To speed up labour
E. To stop contractions

Answer: C. To reduce the risk of cerebral palsy in the baby

NICE advises magnesium sulfate for neuroprotection between 24 and 29+6 weeks (and consider at 30–33+6 weeks) when birth is expected within 24 hours. It reduces cerebral palsy.

Why not the others

- **A:** There is no pre-eclampsia.
- **B:** It does not reduce PPH.
- **D:** It does not speed labour.
- **E:** It is not used for tocolysis in the UK.

Key point: Magnesium sulfate for fetal neuroprotection before 30 weeks.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 460 · Magnesium sulfate · **Hard** · C3

A woman on magnesium sulfate for neuroprotection has absent knee reflexes and a respiratory rate of 10/min.

What is the most appropriate action?

A. Continue the infusion and recheck in 4 hours
B. Give calcium gluconate and stop the infusion
C. Give more magnesium
D. Give naloxone
E. Increase the IV fluids

Answer: B. Give calcium gluconate and stop the infusion

Loss of reflexes and slow breathing show magnesium toxicity. Stop the infusion and give 10 mL of 10% calcium gluconate IV.

Why not the others

- **A:** Toxicity needs immediate treatment.
- **C:** This worsens toxicity.
- **D:** Naloxone reverses opioids.
- **E:** Fluids do not treat toxicity.

Key point: Magnesium toxicity: stop infusion, give calcium gluconate.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 461 · Tocolysis · **Moderate** · C2

A woman at 29 weeks in suspected preterm labour has intact membranes and no signs of infection.

Which tocolytic does NICE recommend first?

A. Atosiban
B. Indomethacin
C. Magnesium sulfate
D. Nifedipine
E. Terbutaline

Answer: D. Nifedipine

NICE suggests nifedipine as first-line tocolysis between 24 and 33+6 weeks. Atosiban is used if nifedipine is contraindicated. The main aim is to allow steroids and transfer.

Why not the others

- **A:** Atosiban is second line.
- **B:** Indomethacin is not first line in the UK.
- **C:** MgSO4 is not used for tocolysis in the UK.
- **E:** Betamimetics are not advised due to side effects.

Key point: Nifedipine is first-line tocolysis in the UK.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 462 · Tocolysis · **Moderate** · C3

A woman at 30 weeks in preterm labour has a temperature of 38.5 °C, uterine tenderness and offensive discharge.

Why is tocolysis contraindicated?

A. Infection makes delivery the safest option
B. Nifedipine causes fever
C. She is too far on
D. Steroids are not possible
E. Tocolysis works better with infection

Answer: A. Infection makes delivery the safest option

Chorioamnionitis is a contraindication to tocolysis. Delaying delivery worsens maternal and fetal sepsis. Antibiotics and delivery are needed.

Why not the others

- **B:** Not the reason.
- **C:** 30 weeks is within the tocolysis window.
- **D:** Steroids can still be given.
- **E:** This is wrong.

Key point: Do not use tocolysis with chorioamnionitis.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 463 · Tocolysis · **Hard** · C3

A woman at 27 weeks is in preterm labour. She has had a recent abruption with ongoing bleeding.

Which is a contraindication to tocolysis?

A. Abruption
B. Breech presentation
C. Intact membranes
D. Multiple pregnancy
E. Previous preterm birth

Answer: A. Abruption

Contraindications to tocolysis include abruption, infection, fetal death, lethal anomaly, fetal distress and severe pre-eclampsia.

Why not the others

- **B:** Breech is not a contraindication.
- **C:** Intact membranes are not a contraindication.
- **D:** Twins are not a contraindication.
- **E:** Not a contraindication.

Key point: Abruption is a contraindication to tocolysis.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 464 · Cerclage · **Moderate** · C2

A woman had two second-trimester losses with painless cervical dilation. She is now 12 weeks pregnant.

What is the most appropriate management?

A. Elective cerclage at 12–14 weeks
B. Emergency cerclage at 30 weeks
C. No intervention
D. Progesterone alone
E. Wait for labour

Answer: A. Elective cerclage at 12–14 weeks

A history-indicated cerclage is offered to women with three or more previous preterm births or second-trimester losses, or as here a history suggesting cervical weakness. It is usually placed at 12–14 weeks.

Why not the others

- **B:** Emergency cerclage is for a dilated cervix before 28 weeks.
- **C:** She needs prevention.
- **D:** Progesterone is an option but cerclage is better here.
- **E:** This risks another loss.

Key point: History-indicated cerclage is placed at 12–14 weeks.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 465 · Cerclage · **Moderate** · C3

A woman with a previous preterm birth at 26 weeks has a cervical length of 22 mm at 18 weeks.

What does NICE advise?

A. Bed rest
B. Cerclage or vaginal progesterone
C. Cervical pessary only
D. Immediate delivery
E. No action

Answer: B. Cerclage or vaginal progesterone

NICE: offer either prophylactic vaginal progesterone or cerclage to women with a history of preterm birth or mid-trimester loss and a cervical length of 25 mm or less at 16–24 weeks.

Why not the others

- **A:** Bed rest does not help.
- **C:** Not first-line in NICE.
- **D:** Not indicated.
- **E:** She needs prevention.

Key point: Previous PTB plus short cervix: progesterone or cerclage.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 466 · Cerclage · **Hard** · C3

A woman with a cerclage is now 37 weeks pregnant.

When is a transvaginal cerclage usually removed?

A. At 32 weeks
B. At 36–37 weeks
C. At 40 weeks
D. At caesarean section only
E. Never removed

Answer: B. At 36–37 weeks

A transvaginal cerclage is removed at 36–37 weeks or earlier if labour starts. An abdominal cerclage needs caesarean delivery.

Why not the others

- **A:** Too early.
- **C:** Too late.
- **D:** Only abdominal cerclage stays.
- **E:** Vaginal cerclage must be removed.

Key point: Remove transvaginal cerclage at 36–37 weeks.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 467 · Cerclage · **Hard** · C3

A woman with a cervical suture at 30 weeks starts regular painful contractions.

What is the most appropriate action?

A. Continue with the stitch in place
B. Give oxytocin
C. Insert a second stitch
D. Perform a caesarean section
E. Remove the stitch

Answer: E. Remove the stitch

If labour starts with a cerclage in place, it should be removed to prevent cervical tearing or uterine rupture.

Why not the others

- **A:** Labour against a stitch risks tears.
- **B:** Oxytocin is not appropriate.
- **C:** Not appropriate in labour.
- **D:** Not needed for this.

Key point: Remove the stitch if labour starts.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 468 · Progesterone · **Moderate** · C2

A woman with no history of preterm birth has a cervical length of 18 mm at 20 weeks.

What does NICE recommend?

A. Bed rest
B. Cerclage only
C. No action
D. Vaginal progesterone
E. Weekly fibronectin

Answer: D. Vaginal progesterone

NICE advises vaginal progesterone for women with no history of preterm birth and a cervical length of 25 mm or less at 16–24 weeks.

Why not the others

- **A:** Not effective.
- **B:** Cerclage is for those with a history.
- **C:** Treatment helps.
- **E:** Not a treatment.

Key point: Short cervix without history: vaginal progesterone.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 469 · Cerclage · **Hard** · C2

A woman at 22 weeks has painless dilation with the cervix 2 cm open and membranes visible but not bulging. There are no contractions or infection.

What may be offered?

A. Emergency (rescue) cerclage
B. Induction of labour
C. Oxytocin
D. Progesterone only
E. Steroids only

Answer: A. Emergency (rescue) cerclage

A rescue cerclage may be offered between 16 and 27+6 weeks to women with a dilated cervix and exposed but unruptured membranes, without infection or contractions.

Why not the others

- **B:** Not appropriate.
- **C:** Not appropriate.
- **D:** Not enough.
- **E:** Steroids are given at viability; not enough alone.

Key point: Rescue cerclage for dilated cervix without labour or infection.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 470 · Mode of delivery · **Moderate** · C2

A woman at 27 weeks is in preterm labour with a breech baby.

What does NICE advise about mode of delivery?

A. Caesarean must be done
B. Consider caesarean section after discussion
C. Forceps delivery
D. Vacuum extraction
E. Vaginal birth only

Answer: B. Consider caesarean section after discussion

NICE advises discussing the risks and benefits and considering caesarean section for breech presentation between 26 and 36+6 weeks in preterm labour.

Why not the others

- **A:** It is not mandatory.
- **C:** Forceps are not used for breech.
- **D:** Vacuum is not used before 34 weeks.
- **E:** Caesarean should be considered.

Key point: Preterm breech 26–36+6 weeks: consider caesarean.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 471 · Instrumental delivery · **Hard** · C2

A woman at 32 weeks is in the second stage of labour and needs assisted delivery.

Which instrument should be avoided?

A. Forceps
B. Kielland forceps for rotation only
C. Neville-Barnes forceps
D. Vacuum extractor
E. Wrigley's forceps

Answer: D. Vacuum extractor

Vacuum extraction is not used before 34 weeks due to the risk of cephalohaematoma, subgaleal haemorrhage and intracranial bleeding. Forceps can be used.

Why not the others

- **A:** Forceps can be used.
- **B:** Can be used with experience.
- **C:** Can be used.
- **E:** Can be used.

Key point: Avoid ventouse before 34 weeks.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 472 · Cord clamping · **Moderate** · C2

A preterm baby is born at 28 weeks and is breathing well.

When should the cord be clamped?

A. After at least 60 seconds
B. Immediately
C. Only after the placenta is delivered
D. Within 10 seconds
E. Within 30 seconds

Answer: A. After at least 60 seconds

NICE advises waiting at least 60 seconds before clamping the cord in preterm babies who do not need resuscitation. Delayed clamping reduces IVH and the need for transfusion.

Why not the others

- **B:** Immediate clamping is not advised.
- **C:** This is not standard.
- **D:** Too soon.
- **E:** Too soon.

Key point: Preterm babies: delay cord clamping at least 60 seconds.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 473 · Neonatal outcomes · **Easy** · C1

A medical student asks about the most common problem in very preterm babies.

Which is most common?

A. Down syndrome
B. Hypoglycaemia only
C. Jaundice only
D. Respiratory distress syndrome
E. Shoulder dystocia

Answer: D. Respiratory distress syndrome

RDS from surfactant deficiency is the most common serious problem in very preterm babies. Others include IVH, NEC, sepsis and retinopathy.

Why not the others

- **A:** Not related to prematurity.
- **B:** Not the most common serious problem.
- **C:** Common but not the main serious problem.
- **E:** Not related.

Key point: RDS is the main complication of prematurity.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 474 · Prevention · **Easy** · C1

A 25-year-old woman at booking smokes 15 cigarettes a day.

What is the most important advice to reduce preterm birth risk?

A. Avoid exercise
B. Change her diet only
C. Rest in bed
D. Stop smoking
E. Take vitamins only

Answer: D. Stop smoking

Smoking increases the risk of preterm birth, FGR and stillbirth. Smoking cessation support should be given.

Why not the others

- **A:** Exercise is healthy.
- **B:** Diet helps but is less key.
- **C:** Bed rest is harmful.
- **E:** Vitamins alone are not enough.

Key point: Stopping smoking reduces preterm birth.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 475 · Prevention · **Moderate** · C2

A woman had a large LLETZ for CIN3 two years ago. She is now 12 weeks pregnant.

What is the most appropriate antenatal plan?

A. Cerclage at 12 weeks
B. Monitor cervical length by TVS in the second trimester
C. No change in care
D. Progesterone from booking
E. Weekly speculum exam

Answer: B. Monitor cervical length by TVS in the second trimester

Previous cervical surgery increases preterm birth risk. Women are offered serial TVS cervical length checks from 16–24 weeks.

Why not the others

- **A:** Not indicated without other findings.
- **C:** She needs surveillance.
- **D:** Only if the cervix becomes short.
- **E:** Not useful.

Key point: After cervical surgery: TVS cervical length checks.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 476 · PPROM diagnosis · **Easy** · C2

A 27-year-old woman at 31 weeks reports a sudden gush of clear fluid from the vagina. She has no contractions.

What is the best first step to confirm rupture of membranes?

A. Amniocentesis
B. Digital vaginal examination
C. Nitrazine test only
D. Sterile speculum examination to look for pooling
E. Ultrasound for fluid volume only

Answer: D. Sterile speculum examination to look for pooling

A sterile speculum exam to see pooling of amniotic fluid confirms PPROM. If unclear, a test for IGFBP-1 or PAMG-1 in vaginal fluid can help. Digital exam is avoided as it raises infection risk.

Why not the others

- **A:** Amniocentesis is not used to diagnose PPROM.
- **B:** Digital exam increases infection risk.
- **C:** Nitrazine has high false positives.
- **E:** Low fluid supports but does not confirm.

Key point: PPROM: sterile speculum exam for pooling; avoid digital exam.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 477 · PPROM diagnosis · **Moderate** · C2

A woman at 30 weeks has a history suggestive of ruptured membranes. Speculum examination shows no pooling.

What is the most appropriate next step?

A. Amnioinfusion
B. Digital examination
C. Discharge without testing
D. Repeat speculum in 1 week
E. Test vaginal fluid for IGFBP-1 or PAMG-1

Answer: E. Test vaginal fluid for IGFBP-1 or PAMG-1

NICE advises that if pooling is not seen, an IGFBP-1 or PAMG-1 test of vaginal fluid can help. A negative result makes PPROM unlikely.

Why not the others

- **A:** Not a diagnostic test.
- **B:** Digital exam increases infection risk.
- **C:** Further testing is needed.
- **D:** Waiting delays diagnosis.

Key point: No pooling: IGFBP-1 or PAMG-1 test.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 478 · PPROM antibiotics · **Easy** · C2

A woman at 29 weeks has confirmed PPROM. She is not in labour and has no signs of infection.

Which antibiotic is recommended?

A. Ceftriaxone
B. Co-amoxiclav
C. Doxycycline
D. Erythromycin
E. Metronidazole

Answer: D. Erythromycin

NICE and RCOG advise erythromycin for 10 days (or until labour) after PPROM. It prolongs pregnancy and reduces neonatal infection.

Why not the others

- **A:** Not the standard choice.
- **B:** Co-amoxiclav is linked to NEC.
- **C:** Contraindicated in pregnancy.
- **E:** Not the standard choice.

Key point: PPROM: erythromycin for 10 days.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 479 · PPROM antibiotics · **Moderate** · C3

A woman with PPROM at 28 weeks is allergic to erythromycin.

Which antibiotic should be avoided?

A. Azithromycin
B. Clarithromycin
C. Co-amoxiclav
D. Penicillin
E. Penicillin with metronidazole

Answer: C. Co-amoxiclav

Co-amoxiclav is avoided in PPROM because of the link with necrotising enterocolitis in the ORACLE trial. A penicillin or other macrolide may be used instead.

Why not the others

- **A:** An alternative macrolide may be used.
- **B:** May be used.
- **D:** May be used.
- **E:** May be used.

Key point: Avoid co-amoxiclav in PPROM (NEC risk).

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 480 · PPROM steroids · **Moderate** · C2

A woman at 27 weeks has PPROM. She is well and the CTG is normal.

What is the most appropriate initial management?

A. Antibiotics, steroids and magnesium only if labour starts
B. Deliver by caesarean
C. Discharge
D. Induce labour
E. Tocolysis for 7 days

Answer: A. Antibiotics, steroids and magnesium only if labour starts

PPROM care includes erythromycin, corticosteroids, close monitoring for infection, and magnesium sulfate if birth is expected within 24 hours before 30 weeks.

Why not the others

- **B:** Not needed.
- **C:** She needs initial inpatient care.
- **D:** Too early without a reason.
- **E:** Tocolysis is not advised in PPROM.

Key point: PPROM: erythromycin, steroids, monitor; MgSO4 if birth imminent.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 481 · PPROM tocolysis · **Hard** · C3

A woman with PPROM at 30 weeks starts contractions.

What is the RCOG position on tocolysis in PPROM?

A. It is not recommended
B. It is required
C. It must be used for 48 hours
D. It must be used only with antibiotics
E. It must be used until 34 weeks

Answer: A. It is not recommended

RCOG says tocolysis is not recommended in PPROM as it does not improve outcomes and may increase chorioamnionitis.

Why not the others

- **B:** Not required.
- **C:** Not recommended.
- **D:** Not recommended.
- **E:** Not recommended.

Key point: Tocolysis is not recommended in PPROM.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 482 · PPROM timing · **Moderate** · C3

A woman with PPROM at 30 weeks remains well. There is no infection and the CTG is normal.

When should delivery usually be planned?

A. At 32 weeks
B. At 34 weeks
C. At 37 weeks
D. At 40 weeks
E. Immediately

Answer: C. At 37 weeks

RCOG (2019) advises expectant management until 37 weeks if there are no signs of infection or fetal compromise. Earlier delivery adds prematurity risks.

Why not the others

- **A:** Too early without reason.
- **B:** Older guidance; now expectant to 37 weeks.
- **D:** Too late.
- **E:** Not needed if stable.

Key point: Stable PPROM: expectant management to 37 weeks.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 483 · PPROM timing · **Hard** · C3

A woman with PPROM at 35 weeks has a vaginal swab positive for GBS.

What is the most appropriate action?

A. Await labour until 37 weeks
B. Discharge home
C. Offer immediate induction with IV antibiotics
D. Repeat swab
E. Start oral penicillin for a week

Answer: C. Offer immediate induction with IV antibiotics

RCOG advises that women with PPROM at 34 weeks or more who are GBS positive should be offered immediate induction with intrapartum antibiotics.

Why not the others

- **A:** Not advised with GBS.
- **B:** Not safe.
- **D:** Not needed.
- **E:** Not effective.

Key point: GBS-positive PPROM at ≥34 weeks: immediate induction.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 484 · Chorioamnionitis · **Moderate** · C2

A woman with PPROM at 30 weeks is being monitored.

Which finding most suggests chorioamnionitis?

A. Fetal heart rate of 140
B. Maternal fever with uterine tenderness and tachycardia
C. Normal CRP
D. Reduced amniotic fluid
E. Small pool of clear fluid

Answer: B. Maternal fever with uterine tenderness and tachycardia

Signs of chorioamnionitis are maternal fever, tachycardia, uterine tenderness, offensive discharge and fetal tachycardia. CRP and WCC help but are not diagnostic alone.

Why not the others

- **A:** This is normal.
- **C:** Normal CRP is reassuring.
- **D:** Expected in PPROM.
- **E:** Expected.

Key point: Fever, tachycardia and tender uterus suggest chorioamnionitis.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 485 · PPROM monitoring · **Moderate** · C2

A woman with PPROM at 32 weeks is stable.

Which monitoring is advised?

A. Daily digital VE
B. Daily speculum exam
C. No monitoring
D. Observation for infection: temperature, pulse and CTG
E. Weekly amniocentesis

Answer: D. Observation for infection: temperature, pulse and CTG

RCOG advises monitoring for signs of infection: temperature, pulse, CTG, and blood tests such as CRP and WCC.

Why not the others

- **A:** Digital exams increase infection risk.
- **B:** Not needed daily.
- **C:** Monitoring is needed.
- **E:** Not done.

Key point: PPROM: watch temperature, pulse and CTG.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 486 · PPROM outpatient · **Moderate** · C2

A woman with PPROM at 30 weeks has been an inpatient for 72 hours and is stable.

What is the advice about outpatient care?

A. It is never allowed
B. It is only allowed after 36 weeks
C. It may be considered after 48 hours in selected women
D. It must be in a different hospital
E. She must stay until delivery

Answer: C. It may be considered after 48 hours in selected women

RCOG says outpatient care may be considered after 48 hours of observation for selected women, with regular checks and advice on symptoms of infection.

Why not the others

- **A:** It can be allowed.
- **B:** Not a rule.
- **D:** Not needed.
- **E:** Not mandatory.

Key point: Selected PPROM women can go home after 48 hours.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 487 · Previable PPROM · **Hard** · C3

A woman has PPROM at 19 weeks with little fluid. She asks about the main risk to her baby if pregnancy continues.

What is the main fetal risk?

A. Down syndrome
B. Macrosomia
C. Pulmonary hypoplasia
D. Rhesus disease
E. Spina bifida

Answer: C. Pulmonary hypoplasia

Very early PPROM with low fluid causes pulmonary hypoplasia, which is often fatal. Limb contractures can also occur.

Why not the others

- **A:** Not caused by PPROM.
- **B:** Not related.
- **D:** Not related.
- **E:** Not related.

Key point: Previable PPROM: pulmonary hypoplasia is the main risk.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 488 · Term PROM · **Easy** · C2

A 25-year-old woman at 39 weeks has prelabour rupture of membranes. She is GBS negative and well.

What does NICE offer?

A. Caesarean
B. Expectant management for 2 weeks
C. Immediate induction or expectant management for up to 24 hours
D. No induction
E. Tocolysis

Answer: C. Immediate induction or expectant management for up to 24 hours

NICE offers a choice of immediate induction or expectant management up to 24 hours. Most women go into labour within 24 hours.

Why not the others

- **A:** Not needed.
- **B:** Too long.
- **D:** Induction is offered.
- **E:** Not appropriate.

Key point: Term PROM: induce now or within 24 hours.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 489 · Term PROM · **Moderate** · C2

A woman at 40 weeks has prelabour rupture of membranes. She is GBS positive.

What is the most appropriate management?

A. Expectant for 24 hours
B. Expectant for 48 hours
C. Immediate induction with IV antibiotics
D. Oral antibiotics only
E. Repeat GBS swab

Answer: C. Immediate induction with IV antibiotics

RCOG advises immediate induction with IV antibiotics for GBS-positive women with prelabour rupture of membranes at term.

Why not the others

- **A:** Not advised with GBS.
- **B:** Not advised.
- **D:** Not enough.
- **E:** Not needed.

Key point: GBS-positive term PROM: induce now with IV antibiotics.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 490 · PPROM complications · **Moderate** · C1

A student asks about complications of PPROM.

Which is a recognised complication?

A. Cord prolapse
B. Hyperemesis
C. Macrosomia
D. Placenta praevia
E. Pre-eclampsia

Answer: A. Cord prolapse

Complications of PPROM include chorioamnionitis, preterm birth, cord prolapse, abruption and pulmonary hypoplasia.

Why not the others

- **B:** Not linked.
- **C:** Not linked.
- **D:** Not linked.
- **E:** Not linked.

Key point: PPROM risks: infection, prematurity, cord prolapse, abruption.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 491 · Preterm labour · **Hard** · C3

A woman at 25 weeks is in preterm labour. The neonatal team has counselled her.

Which factor most improves outcomes at this gestation?

A. Being in a hospital with a neonatal intensive care unit
B. Caesarean section
C. Delivery in a midwifery unit
D. Early oxytocin
E. Vacuum delivery

Answer: A. Being in a hospital with a neonatal intensive care unit

Birth in a centre with a level 3 NICU improves survival for babies born extremely preterm. In-utero transfer is preferred.

Why not the others

- **B:** Not routinely needed.
- **C:** Not safe.
- **D:** Not appropriate.
- **E:** Contraindicated.

Key point: Extremely preterm: deliver in a centre with NICU.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 492 · Preterm labour · **Moderate** · C2

A woman at 32 weeks is in established preterm labour. She is GBS negative.

What is the advice about intrapartum antibiotics?

A. Antibiotics are not needed
B. Give IV benzylpenicillin
C. Give metronidazole
D. Give oral erythromycin
E. Wait for a swab result

Answer: B. Give IV benzylpenicillin

RCOG advises intrapartum antibiotic prophylaxis for GBS in women in confirmed preterm labour, whatever their GBS status.

Why not the others

- **A:** Advised.
- **C:** Not for GBS.
- **D:** Not for labour.
- **E:** Waiting delays prophylaxis.

Key point: Preterm labour: IV benzylpenicillin.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 493 · Preterm labour · **Hard** · C3

A woman at 34 weeks has preterm labour. She asks about steroids.

What does NICE advise at this gestation?

A. Consider steroids up to 35+6 weeks
B. Give steroids routinely up to 40 weeks
C. Never give steroids after 34 weeks
D. Only give steroids after birth
E. Steroids are mandatory

Answer: A. Consider steroids up to 35+6 weeks

NICE (2022): offer steroids at 24–33+6 weeks; consider at 34–35+6 weeks after discussing risks such as neonatal hypoglycaemia.

Why not the others

- **B:** Not advised.
- **C:** May be considered.
- **D:** Not a treatment.
- **E:** Not mandatory.

Key point: Steroids: offer at 24–33+6; consider at 34–35+6 weeks.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 494 · Preterm labour · **Easy** · C2

A 23-year-old woman at 28 weeks has painful tightenings every 5 minutes. Cervical length is 8 mm.

What is the most likely diagnosis?

A. Braxton Hicks contractions
B. Placental abruption
C. Preterm labour
D. Round ligament pain
E. Urinary infection

Answer: C. Preterm labour

Regular painful contractions with a short cervix confirm preterm labour.

Why not the others

- **A:** These are irregular and do not shorten the cervix.
- **B:** No bleeding or tenderness.
- **D:** Not linked to cervical change.
- **E:** No urinary symptoms.

Key point: Contractions plus short cervix: preterm labour.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 495 · Preterm labour · **Moderate** · C2

A woman at 33 weeks is in preterm labour. The baby is cephalic.

What is the recommended mode of delivery?

A. Caesarean
B. Forceps
C. Planned vaginal birth
D. Vacuum
E. Water birth

Answer: C. Planned vaginal birth

For cephalic preterm babies, vaginal birth is recommended unless there are other indications.

Why not the others

- **A:** Not routinely needed.
- **B:** Only if needed.
- **D:** Avoid before 34 weeks.
- **E:** Not appropriate for preterm.

Key point: Cephalic preterm: aim for vaginal birth.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 496 · PPROM · **Hard** · C3

A woman with PPROM at 31 weeks develops fever of 38.6 °C, uterine tenderness and fetal tachycardia.

What is the most appropriate management?

A. Continue erythromycin only
B. Give tocolysis
C. IV broad-spectrum antibiotics and expedite birth
D. Wait 48 hours for steroids
E. Wait until 34 weeks

Answer: C. IV broad-spectrum antibiotics and expedite birth

Chorioamnionitis needs IV broad-spectrum antibiotics and delivery, regardless of gestation.

Why not the others

- **A:** Not enough.
- **B:** Contraindicated.
- **D:** Delay is harmful.
- **E:** Delay is harmful.

Key point: Chorioamnionitis: antibiotics and delivery.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 497 · PPROM · **Moderate** · C2

A woman with PPROM at 28 weeks asks what she can do at home.

Which advice is appropriate?

A. Avoid intercourse
B. Daily long baths
C. Swimming is fine
D. Use tampons
E. Vaginal douching

Answer: A. Avoid intercourse

Women with PPROM should avoid intercourse and should not use tampons, and should report fever, discharge or pain.

Why not the others

- **B:** Not advised.
- **C:** Not advised.
- **D:** Not advised.
- **E:** Not advised.

Key point: PPROM: avoid sex and tampons.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 498 · PPROM · **Hard** · C2

A woman had PPROM at 24 weeks in her last pregnancy.

What is the risk in the next pregnancy?

A. It is increased
B. It is lower
C. It is the same
D. It never happens again
E. It only occurs with twins

Answer: A. It is increased

Previous PPROM increases the risk of recurrence and preterm birth in the next pregnancy.

Why not the others

- **B:** Previous PPROM raises, not lowers, the risk.
- **C:** The risk is higher than in women without this history.
- **D:** Recurrence is well recognised.
- **E:** Recurrence is not limited to twin pregnancy.

Key point: PPROM can recur.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 499 · Preterm labour · **Easy** · C2

A woman at 30 weeks is in preterm labour. The local unit has no NICU cots.

What is the most appropriate action?

A. Deliver locally and transfer the baby after birth
B. In-utero transfer to a unit with NICU if safe
C. Keep her locally and give oxytocin
D. Start tocolysis and discharge
E. Wait for labour to stop before deciding

Answer: B. In-utero transfer to a unit with NICU if safe

In-utero transfer is safer than transfer after birth for preterm babies.

Why not the others

- **A:** Neonatal transfer has higher risks.
- **C:** Oxytocin is not appropriate in preterm labour.
- **D:** She should not be discharged in labour.
- **E:** Delay may mean birth happens without NICU support.

Key point: In-utero transfer is preferred.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

MCQ 500 · Preterm labour · **Moderate** · C2

A woman at 26 weeks has preterm labour. She has a urinary infection.

What is the most appropriate action?

A. Antibiotics after delivery only
B. Discharge with advice
C. Repeat urine culture in 1 week
D. Tocolysis alone
E. Treat the urinary infection with antibiotics

Answer: E. Treat the urinary infection with antibiotics

Urinary infection can trigger preterm labour. It should be treated promptly with an antibiotic safe in pregnancy, alongside standard preterm labour care.

Why not the others

- **A:** Delay allows the infection to progress.
- **B:** She needs treatment and assessment.
- **C:** Waiting delays treatment.
- **D:** Tocolysis alone does not treat the cause.

Key point: Treat infections that may cause preterm labour.

Reference: Obstetrics by Ten Teachers — Preterm labour and PPROM

CHAPTER 11

Normal Labour

MCQ 501 · Stages of labour · **Easy** · C1

A first-year clinical student asks how NICE defines the established first stage of labour.

Which description is correct?

A. Any painful contractions at term

B. Cervix 2 cm with irregular tightenings

C. Regular painful contractions with progressive cervical dilatation from 4 cm

D. Rupture of membranes alone

E. Show with backache

Answer: C. Regular painful contractions with progressive cervical dilatation from 4 cm

NICE defines established first stage as regular painful contractions and progressive cervical dilatation from 4 cm. Before this is the latent phase, with painful contractions and some cervical change up to 4 cm.

Why not the others

- **A:** Contractions alone may be latent phase or false labour.
- **B:** This is latent phase.
- **D:** ROM alone is not labour.
- **E:** A show can occur days before labour.

Key point: Established labour: regular painful contractions plus dilatation from 4 cm.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 502 · Stages of labour · **Easy** · C1

A student asks when the second stage of labour begins.

When does the second stage begin?

A. At delivery of the head

B. At full cervical dilatation

C. At rupture of membranes

D. When the head is visible

E. When the woman starts pushing

Answer: B. At full cervical dilatation

The second stage starts at full dilatation (10 cm) and ends with birth of the baby. NICE splits it into a passive phase (full dilatation without urge to push) and active phase (expulsive contractions).

Why not the others

- **A:** Head delivery happens near the end of the second stage.
- **C:** ROM can occur at any stage.
- **D:** Head visible marks the active second stage.
- **E:** Pushing marks the active second stage.

Key point: Second stage starts at full cervical dilatation.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 503 · Progress in labour · **Moderate** · C2

A nulliparous woman in established labour had a cervix of 5 cm 4 hours ago. It is now 6 cm. Membranes are intact. CTG is normal.

What is the most appropriate next step?

A. Caesarean section
B. Continue to observe and reassess in 4 hours
C. Offer amniotomy and reassess in 2 hours
D. Start oxytocin immediately
E. Vacuum extraction

Answer: C. Offer amniotomy and reassess in 2 hours

NICE suspects delay if dilatation is less than 2 cm in 4 hours in a nulliparous woman. Amniotomy is offered if membranes are intact, with a repeat exam in 2 hours. If progress is still under 1 cm, delay is diagnosed.

Why not the others

- **A:** Not indicated yet.
- **B:** Delay is suspected and needs action.
- **D:** Oxytocin follows amniotomy if delay is confirmed.
- **E:** Not possible in the first stage.

Key point: Suspected first-stage delay: amniotomy, then review in 2 hours.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 504 · Progress in labour · **Moderate** · C2

A nulliparous woman had amniotomy for suspected delay at 6 cm. Two hours later the cervix is still 6 cm. The CTG is normal.

What is the most appropriate management?

A. Caesarean section now
B. Discharge
C. Oxytocin infusion with continuous CTG and review in 4 hours
D. Repeat exam in 6 hours
E. Start epidural only

Answer: C. Oxytocin infusion with continuous CTG and review in 4 hours

Delay in the first stage is confirmed if progress is less than 1 cm in 2 hours after amniotomy. Oxytocin is offered with continuous monitoring, and the woman is reassessed after 4 hours.

Why not the others

- **A:** Oxytocin should be tried first if there are no contraindications.
- **B:** Not appropriate.
- **D:** Too long.
- **E:** Epidural can be offered but does not treat delay.

Key point: Confirmed first-stage delay: oxytocin and continuous CTG.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 505 · Progress in labour · **Moderate** · C1

A midwife asks about NICE expectations for the duration of the first stage.

What is the usual duration of the established first stage in a first labour?

A. About 1 hour
B. About 4 hours
C. About 8 hours, rarely more than 18 hours
D. About 24 hours
E. About 36 hours

Answer: C. About 8 hours, rarely more than 18 hours

NICE: first labours last on average 8 hours and are unlikely to last more than 18 hours. Second and later labours average 5 hours and are unlikely to last more than 12 hours.

Why not the others

- **A:** Too short.
- **B:** Too short.
- **D:** Too long.
- **E:** Too long.

Key point: First labour: ~8 hours (rarely >18); later labours: ~5 hours (rarely >12).

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 506 · Second stage · **Moderate** · C2

A nulliparous woman has been actively pushing for 2 hours. The head is at the spines and progress is slow.

What does NICE advise?

A. Caesarean section immediately
B. Diagnose delay and refer to an obstetrician
C. Encourage pushing for another 3 hours
D. Give oxytocin without review
E. Perform episiotomy

Answer: B. Diagnose delay and refer to an obstetrician

NICE suspects delay after 1 hour of active second stage in nulliparous women, and diagnoses delay after 2 hours. An obstetric review is needed. Birth is expected within 3 hours of the start of the active second stage.

Why not the others

- **A:** Assessment comes first.
- **C:** Delay should be diagnosed.
- **D:** Requires review.
- **E:** Not the first step.

Key point: Nulliparous: delay in active second stage diagnosed at 2 hours.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 507 · Second stage · **Moderate** · C2

A multiparous woman has been actively pushing for 1 hour with no progress.

What does NICE advise?

A. Continue pushing for 3 hours
B. Diagnose delay and refer to an obstetrician
C. Give oxytocin and wait 4 hours
D. Perform caesarean immediately
E. Start epidural

Answer: B. Diagnose delay and refer to an obstetrician

In multiparous women, delay in the active second stage is diagnosed after 1 hour. Birth is expected within 2 hours of the start of active second stage.

Why not the others

- **A:** Too long.
- **C:** Requires review.
- **D:** Assessment first.
- **E:** Not the main step.

Key point: Multiparous: second stage delay at 1 hour of active pushing.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 508 · Third stage · **Easy** · C2

A woman has just given birth. She chooses active management of the third stage.

Which is part of active management?

A. Cord clamping within 10 seconds
B. Ergometrine IV
C. Oxytocin 10 IU IM
D. Uterine massage only
E. Waiting 2 hours for separation

Answer: C. Oxytocin 10 IU IM

Active management includes 10 IU oxytocin IM, delayed clamping of the cord (not before 1 minute, and before 5 minutes), and controlled cord traction after signs of separation.

Why not the others

- **A:** Clamping should be delayed.
- **B:** Not first-line routine.
- **D:** Not part of the package.
- **E:** This is too long.

Key point: Active third stage: oxytocin 10 IU IM, delayed clamping, CCT.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 509 · Third stage · **Moderate** · C2

A woman has an active third stage. The placenta has not been delivered after 40 minutes. She is not bleeding.

What is the diagnosis?

A. Normal third stage
B. Placenta accreta
C. Retained placenta
D. Uterine atony
E. Uterine inversion

Answer: C. Retained placenta

NICE defines a retained placenta as not delivered within 30 minutes of birth with active management, or 60 minutes with physiological management.

Why not the others

- **A:** This exceeds the time limit.
- **B:** Accreta is one cause.
- **D:** There is no bleeding.
- **E:** No inversion described.

Key point: Retained placenta: >30 min (active) or >60 min (physiological).

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 510 · Third stage · **Easy** · C1

A midwife is watching for signs of placental separation.

Which is a sign of separation?

A. Cord shortening
B. Increased uterine size
C. Lengthening of the cord and a gush of blood
D. Painful vaginal swelling
E. Uterus becomes soft and broad

Answer: C. Lengthening of the cord and a gush of blood

Signs of separation include the cord lengthening, a gush of blood, and the uterus becoming firm, smaller and more globular.

Why not the others

- **A:** The cord lengthens.
- **B:** The uterus becomes smaller.
- **D:** Suggests haematoma.
- **E:** The uterus becomes firm.

Key point: Separation: cord lengthens, gush of blood, uterus firm and globular.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 511 · Mechanism of labour · **Moderate** · C1

A student is learning the mechanism of normal labour with an occipito-anterior position.

What happens right after the head is delivered by extension?

A. Descent
B. Engagement
C. Flexion
D. Internal rotation
E. Restitution

Answer: E. Restitution

Order: engagement, descent, flexion, internal rotation, extension (head delivery), restitution, external rotation, then delivery of shoulders and body.

Why not the others

- **A:** Descent happens throughout.
- **B:** Engagement happens first.
- **C:** Flexion is early.
- **D:** Internal rotation is before extension.

Key point: After extension comes restitution, then external rotation.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 512 · Fetal skull · **Moderate** · C1

A student asks which diameter presents in a well-flexed vertex presentation.

Which is the presenting diameter?

A. Biparietal only
B. Mentovertical
C. Occipitofrontal
D. Submentobregmatic
E. Suboccipitobregmatic

Answer: E. Suboccipitobregmatic

In a well-flexed vertex, the suboccipitobregmatic diameter (9.5 cm) presents. It is the smallest diameter and allows easiest passage.

Why not the others

- **A:** Biparietal is transverse, not the presenting AP diameter.
- **B:** Mentovertical (13 cm) is brow.
- **C:** Occipitofrontal (11.5 cm) is deflexed OP.
- **D:** Submentobregmatic (9.5 cm) is face.

Key point: Well-flexed vertex: suboccipitobregmatic 9.5 cm.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 513 · Fetal skull · **Hard** · C1

A student asks about the brow presentation.

Which diameter presents in brow presentation?

A. Mentovertical
B. Occipitofrontal
C. Submentobregmatic
D. Suboccipitobregmatic
E. Suboccipitofrontal

Answer: A. Mentovertical

In brow presentation, the mentovertical diameter (13 cm) presents. It is too large for vaginal birth in a term baby.

Why not the others

- **B:** Occipitofrontal is deflexed vertex.
- **C:** Face presentation.
- **D:** Well-flexed vertex.
- **E:** Partly flexed vertex.

Key point: Brow: mentovertical 13 cm, not deliverable vaginally at term.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 514 · Pelvis · **Easy** · C1

A student asks about the most common female pelvis type.

Which pelvis type is best for vaginal birth?

A. Android
B. Anthropoid
C. Gynaecoid
D. Platypelloid
E. Rachitic

Answer: C. Gynaecoid

The gynaecoid pelvis has a round inlet and is the most common and favourable type for vaginal birth.

Why not the others

- **A:** Android is heart-shaped and less favourable.
- **B:** Anthropoid is oval front to back.
- **D:** Platypelloid is flat.
- **E:** Rachitic is due to rickets.

Key point: Gynaecoid pelvis is the most favourable.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 515 · Station · **Easy** · C1

On vaginal examination, the lowest part of the fetal head is at the level of the ischial spines.

What is the station?

A. −3
B. −1
C. 0
D. +2
E. +3

Answer: C. 0

Station describes the level of the presenting part relative to the ischial spines. At the spines it is 0, above is negative and below is positive.

Why not the others

- **A:** Higher than the spines.
- **B:** 1 cm above.
- **D:** 2 cm below.
- **E:** 3 cm below.

Key point: Station 0 = at the ischial spines.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 516 · Engagement · **Moderate** · C1

On abdominal palpation, 2/5 of the fetal head is palpable above the pelvic brim.

What does this mean?

A. The head is crowning
B. The head is engaged
C. The head is free
D. The head is not engaged
E. The head is on the perineum

Answer: B. The head is engaged

The head is engaged when the widest part has passed the pelvic brim. This is when 2/5 or less is palpable abdominally.

Why not the others

- **A:** Crowning is visible.
- **C:** Free would be 5/5.
- **D:** Not engaged would be 3/5 or more.
- **E:** This is very low.

Key point: Engaged when 2/5 or less is palpable.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 517 · Monitoring · **Easy** · C2

A low-risk woman is in established labour. She chooses intermittent auscultation.

How often should the fetal heart be listened to in the first stage?

A. Every 15 minutes for 1 minute after a contraction
B. Every 30 minutes
C. Every 5 minutes
D. Every hour
E. Only when she asks

Answer: A. Every 15 minutes for 1 minute after a contraction

NICE: in the first stage, auscultate every 15 minutes for at least 1 minute after a contraction. In the second stage, every 5 minutes.

Why not the others

- **B:** Too infrequent.
- **C:** This is the second stage.
- **D:** Too infrequent.
- **E:** Not safe.

Key point: IA: every 15 min in first stage; every 5 min in second stage.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 518 · Monitoring · **Moderate** · C2

A low-risk woman is in the second stage of labour. She is having intermittent auscultation.

How often should the fetal heart be checked?

A. Every 5 minutes
B. Every 15 minutes
C. Every 30 minutes
D. Every hour
E. Every contraction only

Answer: A. Every 5 minutes

In the second stage, auscultate at least every 5 minutes for 1 minute after a contraction. Maternal pulse should be checked to tell it apart.

Why not the others

- **B:** This is the first stage.
- **C:** Too infrequent.
- **D:** Too infrequent.
- **E:** Not the standard.

Key point: Second stage IA: every 5 minutes.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 519 · Pain relief · **Easy** · C2

A woman in established labour asks for an epidural.

What is a known effect of epidural analgesia?

A. It causes long-term back pain
B. It increases caesarean section rate
C. It increases the length of the second stage and instrumental birth
D. It reduces maternal pain relief
E. It stops labour

Answer: C. It increases the length of the second stage and instrumental birth

Epidural is the most effective pain relief. It lengthens the second stage and increases instrumental birth, but does not increase caesarean section or long-term backache.

Why not the others

- **A:** No link with long-term backache.
- **B:** It does not increase CS.
- **D:** It is the most effective.
- **E:** It does not stop labour.

Key point: Epidural: longer second stage and more instrumental births, no more CS.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 520 · Pain relief · **Moderate** · C2

A woman in labour is given pethidine. The baby is born 1 hour later with poor breathing.

Which drug may help?

A. Atropine
B. Flumazenil
C. Naloxone
D. Oxytocin
E. Salbutamol

Answer: C. Naloxone

Opioids such as pethidine can cause neonatal respiratory depression. Naloxone can reverse this, though airway support is the first step.

Why not the others

- **A:** Not for opioid reversal.
- **B:** Reverses benzodiazepines.
- **D:** Not for the baby.
- **E:** Not for this.

Key point: Neonatal opioid depression: support breathing; naloxone may help.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 521 · Perineal trauma · **Moderate** · C1

A woman has a perineal tear involving the external anal sphincter, with less than 50% of its thickness torn.

How is this tear classified?

A. First degree
B. Fourth degree
C. Second degree
D. Third degree 3a
E. Third degree 3b

Answer: D. Third degree 3a

RCOG: 3a – less than 50% of EAS torn; 3b – more than 50% of EAS; 3c – EAS and IAS torn; fourth degree – into the anal mucosa.

Why not the others

- **A:** Skin only.
- **B:** Involves anal mucosa.
- **C:** Perineal muscles, not sphincter.
- **E:** More than 50% of EAS.

Key point: 3a: <50% EAS; 3b: >50% EAS; 3c: IAS torn; 4th: anal mucosa.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 522 · Perineal trauma · **Moderate** · C2

A woman has an episiotomy for fetal distress.

What is the recommended technique?

A. J-shaped incision
B. Lateral incision at 90 degrees
C. Mediolateral incision at 60 degrees from midline
D. Midline incision
E. Transverse incision

Answer: C. Mediolateral incision at 60 degrees from midline

NICE advises a mediolateral episiotomy at 45–60 degrees from the midline, starting at the fourchette. Midline incisions have higher risk of anal sphincter injury.

Why not the others

- **A:** Not standard.
- **B:** Not standard.
- **D:** Increases risk of OASI.
- **E:** Not used.

Key point: Mediolateral episiotomy at about 60 degrees.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 523 · Perineal trauma · **Hard** · C2

A woman has a third-degree tear repaired.

Which treatment should be given after repair?

A. Antibiotics and laxatives
B. Codeine for constipation
C. Immediate pelvic floor surgery
D. No treatment
E. Steroids

Answer: A. Antibiotics and laxatives

After OASI repair, RCOG advises broad-spectrum antibiotics and laxatives to reduce wound infection and breakdown. Codeine is avoided as it causes constipation.

Why not the others

- **B:** Codeine causes constipation.
- **C:** Not needed.
- **D:** Treatment is needed.
- **E:** Not indicated.

Key point: After OASI: antibiotics and laxatives.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 524 · Place of birth · **Moderate** · C2

A low-risk multiparous woman asks where she should give birth.

What does NICE advise?

A. Home or midwife-led unit is particularly suitable
B. Must give birth in an obstetric unit
C. Only in a hospital with NICU
D. Only in a private hospital
E. Only via caesarean

Answer: A. Home or midwife-led unit is particularly suitable

NICE says home or midwife-led unit birth is particularly suitable for low-risk multiparous women, with lower intervention rates and similar baby outcomes.

Why not the others

- **B:** Not required for low-risk.
- **C:** Not required.
- **D:** Not relevant.
- **E:** Not indicated.

Key point: Low-risk multiparous women: home or MLU is suitable.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 525 · Place of birth · **Hard** · C2

A low-risk nulliparous woman asks about home birth.

What does NICE say about home birth for first babies?

A. It always needs a doctor
B. It has the same outcomes as an obstetric unit
C. It is banned
D. It reduces adverse outcomes for babies
E. There is a small increase in adverse outcomes for the baby

Answer: E. There is a small increase in adverse outcomes for the baby

For nulliparous women, planned home birth carries a small increase in serious adverse outcomes for the baby. A midwife-led unit is advised as suitable.

Why not the others

- **A:** Not required.
- **B:** There is a small increase in risk.
- **C:** It is not banned.
- **D:** Not true.

Key point: Nulliparous home birth: small increase in baby risk.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 526 · Latent phase · **Easy** · C2

A nulliparous woman at 40 weeks phones with irregular painful tightenings for 6 hours. On assessment the cervix is 2 cm and soft. She is coping well and the fetus is active.

What is the most appropriate advice?

A. Admit to the labour ward for oxytocin
B. Amniotomy now
C. Caesarean section
D. Epidural now
E. Return home with advice to come back when contractions become regular and stronger

Answer: E. Return home with advice to come back when contractions become regular and stronger

This is the latent phase. Women coping well can be supported at home with advice on when to return. Early admission is linked to more interventions.

Why not the others

- **A:** Not indicated in latent phase.
- **B:** Routine amniotomy is not advised.
- **C:** Not indicated.
- **D:** Epidural is not usually needed in early latent phase.

Key point: Latent phase: support at home if coping well.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 527 · Bishop score · **Moderate** · C1

A student asks about the Bishop score used before induction of labour.

Which feature is NOT part of the Bishop score?

A. Cervical consistency
B. Cervical dilatation
C. Cervical position
D. Fetal heart rate
E. Station of the presenting part

Answer: D. Fetal heart rate

The Bishop score includes cervical dilatation, length (effacement), consistency, position and the station of the presenting part. A score of 8 or more suggests a favourable cervix.

Why not the others

- **A:** Part of the score.
- **B:** Part of the score.
- **C:** Part of the score.
- **E:** Part of the score.

Key point: Bishop: dilatation, length, consistency, position, station.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 528 · Amniotomy · **Moderate** · C2

A woman is progressing normally in established labour with intact membranes.

What does NICE advise about routine amniotomy?

A. It is advised at 4 cm for all
B. It is advised to speed up all labours
C. It prevents caesarean
D. It reduces infection
E. It should not be offered routinely if labour is progressing normally

Answer: E. It should not be offered routinely if labour is progressing normally

NICE says amniotomy and oxytocin should not be used routinely in normally progressing labour.

Why not the others

- **A:** Not advised routinely.
- **B:** Not advised routinely.
- **C:** Does not reduce CS.
- **D:** May increase infection risk.

Key point: No routine amniotomy in normal labour.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 529 · Observations · **Easy** · C2

A woman is in the established first stage of labour.

How often should her pulse be checked?

A. Every 15 minutes
B. Every hour
C. Every 4 hours
D. Every 8 hours
E. Only at the start

Answer: B. Every hour

NICE: in the first stage, check pulse hourly, blood pressure and temperature every 4 hours, and record contractions every 30 minutes.

Why not the others

- **A:** Too frequent for routine checks.
- **C:** This is BP and temperature.
- **D:** Too infrequent.
- **E:** Too infrequent.

Key point: First stage: pulse hourly; BP and temp 4-hourly.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 530 · Eating in labour · **Easy** · C2

A low-risk woman in labour asks if she can eat.

What does NICE advise?

A. She may eat a light diet unless she has had opioids or is at risk of needing a general anaesthetic
B. She must have an IV drip
C. She must have nothing by mouth
D. She must take only water
E. She should only drink fizzy drinks

Answer: A. She may eat a light diet unless she has had opioids or is at risk of needing a general anaesthetic

Low-risk women may eat a light diet in labour. Isotonic drinks may be more helpful than water. Those with opioids or risk factors for GA should be assessed.

Why not the others

- **B:** Not needed routinely.
- **C:** Not needed for low-risk women.
- **D:** Not needed.
- **E:** Not advised.

Key point: Low-risk women may eat lightly in labour.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 531 · Delayed cord clamping · **Easy** · C2

A healthy term baby is born and cries at once.

When should the cord be clamped?

A. Between 1 and 5 minutes after birth
B. Immediately
C. Only after the placenta
D. Within 10 seconds
E. Within 30 seconds

Answer: A. Between 1 and 5 minutes after birth

NICE advises not clamping the cord in the first minute, and clamping before 5 minutes. Delayed clamping improves iron stores.

Why not the others

- **B:** Too soon.
- **C:** Not standard.
- **D:** Too soon.
- **E:** Too soon.

Key point: Clamp the cord between 1 and 5 minutes.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 532 · Newborn care · **Easy** · C2

A healthy term baby is born.

What is recommended immediately after birth?

A. Bath the baby at once
B. Separate mother and baby
C. Skin-to-skin contact
D. Start formula feeding
E. Weigh the baby first

Answer: C. Skin-to-skin contact

Skin-to-skin contact keeps the baby warm, helps breastfeeding and bonding. Bathing and weighing can wait.

Why not the others

- **A:** Bathing can wait.
- **B:** Not advised.
- **D:** Breastfeeding is encouraged.
- **E:** Weighing can wait.

Key point: Skin-to-skin contact straight after birth.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 533 · Newborn care · **Easy** · C2

A mother asks why her baby needs a vitamin K injection.

What does vitamin K prevent?

A. Haemolytic disease
B. Jaundice
C. Rickets
D. Sepsis
E. Vitamin K deficiency bleeding

Answer: E. Vitamin K deficiency bleeding

Babies have low vitamin K levels, which can cause bleeding (haemorrhagic disease of the newborn). Vitamin K IM is offered to all babies.

Why not the others

- **A:** Not related.
- **B:** Not related.
- **C:** Vitamin D is related.
- **D:** Not related.

Key point: Vitamin K prevents vitamin K deficiency bleeding.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 534 · Apgar · **Moderate** · C1

A baby at 1 minute has a heart rate of 110 bpm, a weak cry, some flexion, a grimace to stimulation and pink body with blue hands and feet.

What is the Apgar score?

A. 4
B. 5
C. 6
D. 7
E. 8

Answer: C. 6

Heart rate above 100 = 2; weak cry = 1; some flexion = 1; grimace = 1; pink body with blue hands and feet = 1. Total = 6.

Why not the others

- **A:** This undercounts the heart rate score.
- **B:** This misses one point.
- **D:** This adds a point not earned.
- **E:** This would need a strong cry or full pink colour.

Key point: Apgar: heart rate, breathing, tone, reflex, colour.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 535 · Uterine activity · **Moderate** · C2

A woman on oxytocin has 6 contractions in 10 minutes. The CTG is normal.

What is this called?

A. Hyperstimulation with fetal compromise
B. Normal labour
C. Tachysystole
D. Uterine inversion
E. Uterine rupture

Answer: C. Tachysystole

Tachysystole is more than 5 contractions in 10 minutes. The oxytocin infusion should be reduced or stopped.

Why not the others

- **A:** The CTG is normal.
- **B:** Not normal.
- **D:** Not related.
- **E:** Not related.

Key point: Tachysystole: >5 contractions in 10 minutes.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 536 · Second stage · **Moderate** · C2

A nulliparous woman with an epidural reaches full dilatation. She has no urge to push. The CTG is normal.

What does NICE advise?

A. Begin pushing at once
B. Caesarean section
C. Delay pushing for at least 1 hour unless she wants to push or the head is visible
D. Oxytocin infusion immediately
E. Vacuum extraction

Answer: C. Delay pushing for at least 1 hour unless she wants to push or the head is visible

NICE: with an epidural, delay pushing for at least 1 hour (longer if she wishes) after full dilatation unless she has the urge or the head is visible.

Why not the others

- **A:** Pushing can be delayed.
- **B:** Not indicated.
- **D:** Not the first step.
- **E:** Not indicated.

Key point: With epidural: delay pushing at least 1 hour.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 537 · Perineal care · **Moderate** · C2

A midwife wants to reduce perineal trauma as the head crowns.

Which measure is recommended?

A. Fundal pressure
B. Lithotomy position
C. Routine episiotomy
D. Vigorous pushing during crowning
E. Warm compress on the perineum

Answer: E. Warm compress on the perineum

NICE: warm compresses, perineal massage in the second stage, and a hands-on technique to control the head reduce perineal trauma.

Why not the others

- **A:** Fundal pressure is not advised.
- **B:** Not advised routinely.
- **C:** Routine episiotomy is not advised.
- **D:** Controlled pushing is advised.

Key point: Warm compress and controlled delivery reduce trauma.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 538 · Fetal skull · **Easy** · C1

On vaginal exam, a triangular fontanelle is felt at the front of the vagina.

Which structure is this?

A. Anterior fontanelle
B. Coronal suture
C. Posterior fontanelle
D. Sagittal suture
E. Sinciput

Answer: C. Posterior fontanelle

The posterior fontanelle is small and triangular. If it is anterior, the baby is occipito-anterior. The anterior fontanelle is diamond-shaped.

Why not the others

- **A:** Anterior fontanelle is diamond-shaped.
- **B:** A suture, not fontanelle.
- **D:** A suture, not fontanelle.
- **E:** The forehead.

Key point: Posterior fontanelle is triangular.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 539 · Fetal skull · **Moderate** · C1

A student asks about the bones that meet at the anterior fontanelle.

Which fontanelle is diamond-shaped?

A. Anterior fontanelle
B. Lambda
C. Mastoid fontanelle
D. Posterior fontanelle
E. Sphenoid fontanelle

Answer: A. Anterior fontanelle

The anterior fontanelle (bregma) is diamond-shaped where frontal and parietal bones meet. It closes at about 18 months.

Why not the others

- **B:** Lambda is the posterior fontanelle.
- **C:** Small lateral fontanelle.
- **D:** Triangular.
- **E:** Small lateral fontanelle.

Key point: Anterior fontanelle (bregma) is diamond-shaped.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 540 · Moulding · **Moderate** · C2

On vaginal exam, the parietal bones overlap and cannot be reduced with pressure.

What grade of moulding is this?

A. No moulding
B. +1
C. +2
D. +3
E. Caput

Answer: D. +3

Moulding grades: 0 – bones apart; +1 – bones touching; +2 – overlapping but reducible; +3 – overlapping and not reducible. +3 may suggest obstruction.

Why not the others

- **A:** Bones would be apart.
- **B:** Touching.
- **C:** Reducible.
- **E:** Caput is scalp swelling.

Key point: +3 moulding: overlapping, not reducible.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 541 · Positions · **Easy** · C2

A woman in the second stage asks which position is best.

What does NICE advise?

A. Any position she finds comfortable but avoid lying flat
B. Lie flat on her back
C. Lithotomy only
D. Squat only
E. Stand only

Answer: A. Any position she finds comfortable but avoid lying flat

NICE advises women not to lie flat, and to use any comfortable upright or side position.

Why not the others

- **B:** Lying flat can cause aortocaval compression.
- **C:** Not advised routinely.
- **D:** Not the only option.
- **E:** Not the only option.

Key point: Avoid lying flat; choose a comfortable position.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 542 · Third stage · **Moderate** · C2

A woman with severe pre-eclampsia gives birth. She needs active third stage management.

Which drug should be avoided?

A. Carboprost
B. Misoprostol
C. Oxytocin
D. Syntometrine
E. Tranexamic acid

Answer: D. Syntometrine

Syntometrine contains ergometrine, which causes vasoconstriction and is contraindicated in hypertension and pre-eclampsia. Oxytocin alone is used.

Why not the others

- **A:** Used for PPH (with care in asthma).
- **B:** Can be used.
- **C:** First line.
- **E:** Can be used.

Key point: Avoid ergometrine in hypertension.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 543 · Third stage · **Moderate** · C2

A low-risk woman chooses physiological management of the third stage.

When should she be advised to change to active management?

A. After 10 minutes
B. If the placenta is not delivered within 1 hour or there is haemorrhage
C. Only after 3 hours
D. Only if she asks
E. Only if the baby cries

Answer: B. If the placenta is not delivered within 1 hour or there is haemorrhage

NICE: change to active management if there is haemorrhage or the placenta is not delivered within 1 hour.

Why not the others

- **A:** Too early.
- **C:** Too long.
- **D:** Clinical triggers also apply.
- **E:** Not relevant.

Key point: Physiological third stage: switch to active after 1 hour or with bleeding.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 544 · Lie and presentation · **Easy** · C1

A student is learning obstetric terms.

What is the lie of the fetus?

A. How far the head has descended
B. The fetal part over the pelvic inlet
C. The part of the fetus felt first
D. The relationship of the denominator to the pelvis
E. The relationship of the long axis of the fetus to the long axis of the uterus

Answer: E. The relationship of the long axis of the fetus to the long axis of the uterus

Lie is the relationship of the long axis of the fetus to the uterus (longitudinal, transverse, oblique). Presentation is the part over the pelvic inlet. Position relates the denominator to the pelvis.

Why not the others

- **A:** This is station or engagement.
- **B:** This is presentation.
- **C:** This is not a definition.
- **D:** This is position.

Key point: Lie = fetal long axis vs uterine long axis.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 545 · Position · **Moderate** · C1

A student is asked about the denominator in a vertex presentation.

What is the denominator for a vertex presentation?

A. Chin
B. Occiput
C. Sacrum
D. Shoulder
E. Sinciput

Answer: B. Occiput

The denominator is the reference point for position. Vertex: occiput; face: mentum (chin); breech: sacrum; shoulder: acromion.

Why not the others

- **A:** Face presentation.
- **C:** Breech.
- **D:** Shoulder presentation.
- **E:** Not a standard denominator.

Key point: Denominators: occiput (vertex), mentum (face), sacrum (breech).

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 546 · Support in labour · **Easy** · C2

A woman in established labour asks about support.

What does NICE recommend?

A. Care only by a doctor
B. No support needed
C. One-to-one care by a midwife
D. Support only by family
E. Support only in the second stage

Answer: C. One-to-one care by a midwife

NICE: women in established labour should have one-to-one care from a midwife and should not be left alone.

Why not the others

- **A:** Midwives lead low-risk care.
- **B:** Support is needed.
- **D:** Family can help but a midwife is needed.
- **E:** Needed throughout.

Key point: One-to-one midwifery care in established labour.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 547 · Pain relief · **Easy** · C2

A woman in early labour wants pain relief that she can control and that wears off quickly.

Which is most suitable?

A. Diamorphine
B. Entonox (nitrous oxide and oxygen)
C. Epidural
D. General anaesthesia
E. Spinal anaesthesia

Answer: B. Entonox (nitrous oxide and oxygen)

Entonox works quickly, is self-administered and wears off quickly. It can cause nausea and lightheadedness.

Why not the others

- **A:** Lasts longer and can cause sedation.
- **C:** Effective but not self-controlled and wears off slowly.
- **D:** Not used for labour pain.
- **E:** Used for operative delivery.

Key point: Entonox: quick-acting, self-controlled.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 548 · Meconium · **Moderate** · C2

A woman in labour at 40 weeks has thick meconium-stained liquor at amniotomy.

What is the most appropriate action?

A. Advise continuous CTG and ensure a neonatal team is available
B. Caesarean section
C. Discharge
D. Intermittent auscultation
E. Stop labour

Answer: A. Advise continuous CTG and ensure a neonatal team is available

Significant meconium needs continuous CTG and a neonatal team at birth, and transfer to an obstetric unit if not already there.

Why not the others

- **B:** Not automatically required.
- **C:** Not appropriate.
- **D:** Not enough.
- **E:** Not possible.

Key point: Significant meconium: continuous CTG and neonatal team.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 549 · Water birth · **Moderate** · C2

A low-risk woman in labour asks about water immersion.

What is the advice?

A. Not allowed
B. Offer water for pain relief
C. Only after delivery
D. Only with a doctor
E. Only with an epidural

Answer: B. Offer water for pain relief

NICE says women should be offered the chance to labour in water for pain relief.

Why not the others

- **A:** It is allowed.
- **C:** Not relevant.
- **D:** Midwives provide this.
- **E:** Not compatible.

Key point: Offer water immersion for pain relief.

Reference: Obstetrics by Ten Teachers — Normal labour

MCQ 550 · Mechanism of labour · **Hard** · C1

A student asks about the position of the fetal head as it enters the pelvic inlet.

In which direction does the head usually enter the pelvic inlet?

A. Anteroposterior
B. Brow first
C. Face first
D. Oblique or transverse
E. Occipito-posterior always

Answer: D. Oblique or transverse

The head usually enters the pelvic inlet in the transverse or oblique diameter, as the inlet is widest transversely. It rotates to the AP diameter at the outlet.

Why not the others

- **A:** The inlet is widest transversely.
- **B:** Not usual.
- **C:** Not usual.
- **E:** Not always OP.

Key point: Head enters transverse or oblique; rotates to AP at the outlet.

Reference: Obstetrics by Ten Teachers — Normal labour

CHAPTER 12

Abnormal Labour and Fetal Monitoring

MCQ 551 · CTG features · **Easy** · C1

A student is learning to read a CTG.

What is the normal baseline fetal heart rate at term?

A. 90–110 bpm
B. 100–150 bpm
C. 110–160 bpm
D. 120–180 bpm
E. 160–200 bpm

Answer: C. 110–160 bpm

The normal baseline fetal heart rate at term is 110–160 bpm. A baseline above 160 is tachycardia and below 110 is bradycardia (100–109 can be normal with good variability).

Why not the others

- **A:** This is bradycardia.
- **B:** Not the accepted range.
- **D:** Includes tachycardia.
- **E:** This is tachycardia.

Key point: Normal baseline: 110–160 bpm.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 552 · CTG features · **Easy** · C1

A student is reviewing baseline variability on a CTG.

What is normal baseline variability?

A. 0–2 bpm
B. Less than 5 bpm
C. 5–25 bpm
D. More than 25 bpm
E. More than 40 bpm

Answer: C. 5–25 bpm

Normal variability is 5–25 bpm. Reduced variability (<5 bpm) can mean hypoxia, sleep or drugs. Increased variability (>25 bpm, saltatory) can mean acute hypoxia.

Why not the others

- **A:** Absent variability.
- **B:** Reduced variability.
- **D:** Increased (saltatory) variability.
- **E:** Not a normal range.

Key point: Normal variability: 5–25 bpm.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 553 · Decelerations · **Moderate** · C2

A CTG shows decelerations that start with the contraction, reach their lowest point at the peak of the contraction and recover by its end. Baseline and variability are normal.

What type of deceleration is this and what is the cause?

A. Early – head compression
B. Late – placental insufficiency
C. Prolonged – cord prolapse
D. Sinusoidal – fetal anaemia
E. Variable – cord compression

Answer: A. Early – head compression

Early decelerations mirror contractions and are due to head compression. They are benign and common in late first stage and second stage.

Why not the others

- **B:** Late decelerations begin after the contraction peak.
- **C:** Prolonged decelerations last over 3 minutes.
- **D:** Sinusoidal is a baseline pattern, not a deceleration.
- **E:** Variable decels vary in timing and shape.

Key point: Early decelerations mirror contractions; due to head compression.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 554 · Decelerations · **Moderate** · C2

A CTG shows decelerations that start after the peak of each contraction and return to baseline after the contraction ends. Variability is reduced.

What is the most likely cause?

A. Cord compression
B. Fetal sleep
C. Head compression
D. Maternal fever
E. Uteroplacental insufficiency

Answer: E. Uteroplacental insufficiency

Late decelerations (lowest point after the contraction peak) suggest reduced placental oxygen supply. With reduced variability, they are a worrying sign of fetal hypoxia.

Why not the others

- **A:** Gives variable decelerations.
- **B:** Reduces variability briefly but does not cause late decels.
- **C:** Gives early decelerations.
- **D:** Causes tachycardia.

Key point: Late decelerations: uteroplacental insufficiency.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 555 · Decelerations · **Moderate** · C2

A CTG shows sudden V-shaped decelerations of varying depth and timing with contractions. Baseline and variability are normal.

What is the most likely cause?

A. Cord compression
B. Fetal anaemia
C. Head compression
D. Maternal hypotension
E. Placental insufficiency

Answer: A. Cord compression

Variable decelerations are V-shaped, vary in timing and are due to umbilical cord compression. They are the most common decelerations in labour.

Why not the others

- **B:** Gives a sinusoidal trace.
- **C:** Gives early decelerations.
- **D:** May cause a prolonged deceleration.
- **E:** Gives late decelerations.

Key point: Variable decelerations: cord compression.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 556 · Acute bradycardia · **Hard** · C3

A woman in labour at 6 cm has a sudden drop in fetal heart rate to 80 bpm, lasting 4 minutes. Conservative measures have not helped.

What is the most appropriate action?

A. Continue monitoring for 30 minutes
B. Fetal blood sampling
C. Prepare for urgent birth
D. Start oxytocin
E. Wait for full dilatation

Answer: C. Prepare for urgent birth

NICE: a bradycardia lasting 3 minutes or more needs urgent action. If it continues after 9 minutes despite measures, the baby should be born urgently (category 1 caesarean if not fully dilated).

Why not the others

- **A:** Delay risks hypoxic injury.
- **B:** FBS is not done for a bradycardia.
- **D:** This would worsen hypoxia.
- **E:** Delay is unsafe.

Key point: Bradycardia >3 minutes: urgent help; birth if it continues to 9 minutes.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 557 · Conservative measures · **Moderate** · C2

A woman on oxytocin has 6 contractions in 10 minutes and the CTG shows repeated late decelerations.

What is the first step?

A. Caesarean section
B. Fetal blood sampling
C. Increase oxytocin
D. Reduce or stop the oxytocin and change her position
E. Vacuum extraction

Answer: D. Reduce or stop the oxytocin and change her position

Conservative measures come first: change maternal position, stop or reduce oxytocin, give IV fluids if hypotensive, and consider tocolysis for tachysystole.

Why not the others

- **A:** Not the first step.
- **B:** May be considered after conservative steps.
- **C:** This worsens the problem.
- **E:** Not possible in the first stage.

Key point: Abnormal CTG with tachysystole: stop oxytocin first.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 558 · Uterine hyperstimulation · **Hard** · C3

A woman has had dinoprostone for induction. She now has a contraction every 90 seconds and the CTG shows a prolonged deceleration.

Which drug is recommended to relax the uterus?

A. Atosiban
B. Ergometrine
C. Magnesium sulfate
D. Oxytocin
E. Terbutaline

Answer: E. Terbutaline

For uterine hyperstimulation with fetal compromise, NICE advises remove the prostaglandin and consider subcutaneous terbutaline 0.25 mg to relax the uterus.

Why not the others

- **A:** Used for preterm labour.
- **B:** This contracts the uterus.
- **C:** Not the standard tocolytic here.
- **D:** This increases contractions.

Key point: Hyperstimulation: terbutaline 0.25 mg SC.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 559 · Fetal blood sampling · **Moderate** · C2

A fetal blood sample in labour shows a pH of 7.18.

What is the most appropriate action?

A. Continue labour and repeat FBS in 1 hour
B. Continue labour and repeat FBS in 30 minutes
C. Expedite birth
D. Give oxytocin
E. Stop monitoring

Answer: C. Expedite birth

Fetal scalp pH: normal ≥7.25; borderline 7.21–7.24 (repeat in 30 minutes); abnormal ≤7.20 (expedite birth).

Why not the others

- **A:** For a normal result.
- **B:** For a borderline result.
- **D:** Not appropriate.
- **E:** Not appropriate.

Key point: Scalp pH ≤7.20: deliver.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 560 · Fetal blood sampling · **Moderate** · C2

A fetal blood sample shows a pH of 7.23.

What should be done?

A. Deliver immediately
B. Give tocolysis
C. Repeat FBS in 4 hours
D. Repeat FBS within 30 minutes if CTG remains abnormal
E. Stop monitoring

Answer: D. Repeat FBS within 30 minutes if CTG remains abnormal

A borderline pH (7.21–7.24) needs a repeat FBS within 30 minutes if the CTG is still abnormal.

Why not the others

- **A:** Not needed for a borderline result.
- **B:** Not indicated.
- **C:** Too long.
- **E:** Not appropriate.

Key point: Borderline pH 7.21–7.24: repeat within 30 minutes.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 561 · Fetal blood sampling · **Hard** · C3

A woman with HIV in labour has an abnormal CTG.

Why is fetal blood sampling avoided?

A. It always fails
B. It causes uterine rupture
C. It increases the risk of vertical transmission
D. It is painful for the mother
E. The result is always normal

Answer: C. It increases the risk of vertical transmission

FBS is contraindicated in maternal HIV, hepatitis B and C, HSV, fetal bleeding disorders and prematurity (<34 weeks), due to infection or bleeding risk.

Why not the others

- **A:** It does not always fail.
- **B:** Not related.
- **D:** Not the reason.
- **E:** Not true.

Key point: Avoid FBS with blood-borne viruses, bleeding disorders and <34 weeks.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 562 · Sinusoidal CTG · **Hard** · C2

A CTG shows a smooth, regular wave-like pattern with an amplitude of 5–15 bpm and a frequency of 3–5 cycles per minute. There are no accelerations.

What is the most likely cause?

A. Cord compression
B. Fetal anaemia
C. Fetal sleep
D. Head compression
E. Maternal fever

Answer: B. Fetal anaemia

A sinusoidal trace can be caused by severe fetal anaemia (from rhesus disease, fetomaternal haemorrhage or vasa praevia) or hypoxia. It needs urgent assessment.

Why not the others

- **A:** Gives variable decels.
- **C:** Gives reduced variability.
- **D:** Gives early decels.
- **E:** Gives tachycardia.

Key point: Sinusoidal CTG: think fetal anaemia.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 563 · Fetal tachycardia · **Moderate** · C2

A woman in labour has a temperature of 38.3 °C. The baseline FHR is 175 bpm.

What is the most likely cause of the fetal tachycardia?

A. Cord compression
B. Fetal sleep
C. Head compression
D. Maternal pyrexia or infection
E. Opioid use

Answer: D. Maternal pyrexia or infection

Maternal fever and chorioamnionitis are common causes of fetal tachycardia. Other causes include hypoxia, maternal dehydration and drugs such as terbutaline.

Why not the others

- **A:** Gives variable decels.
- **B:** Causes reduced variability.
- **C:** Gives early decels.
- **E:** Causes reduced variability.

Key point: Fetal tachycardia: maternal fever is a common cause.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 564 · Reduced variability · **Moderate** · C2

A woman received IV morphine 30 minutes ago. The CTG now shows reduced variability with a normal baseline and no decelerations.

What is the most likely cause?

A. Cord prolapse
B. Fetal anaemia
C. Fetal hypoxia
D. Maternal opioid
E. Placental abruption

Answer: D. Maternal opioid

Opioids cause a temporary reduction in variability. It should improve as the drug wears off. Fetal sleep also reduces variability for up to 40 minutes.

Why not the others

- **A:** Gives bradycardia.
- **B:** Gives sinusoidal trace.
- **C:** Possible but less likely here.
- **E:** Gives pain, bleeding and decels.

Key point: Opioids and fetal sleep cause temporary reduced variability.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 565 · Continuous CTG · **Easy** · C2

A woman is in labour.

Which finding is an indication for continuous CTG?

A. Age 30
B. Clear liquor
C. Maternal temperature of 38 °C
D. Normal BP
E. Spontaneous labour at 39 weeks

Answer: C. Maternal temperature of 38 °C

NICE indications for continuous CTG include maternal fever (38 °C or more), significant meconium, fresh bleeding, oxytocin use, hypertension and fetal heart rate concerns.

Why not the others

- **A:** Not an indication.
- **B:** Not an indication.
- **D:** Not an indication.
- **E:** Low risk.

Key point: Maternal fever is an indication for continuous CTG.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 566 · Delay in labour · **Easy** · C1

A student asks about the main causes of delay in labour.

Which describes the '3 Ps'?

A. Passages, passenger and powers
B. Pelvis, placenta and pain
C. Placenta, presentation and parity
D. Pressure, pulse and pain
E. Pushing, position and pain

Answer: A. Passages, passenger and powers

Delay in labour is caused by problems with the powers (contractions), passenger (baby size and position) or passages (pelvis and soft tissues).

Why not the others

- **B:** Not the correct terms.
- **C:** Not the correct terms.
- **D:** Not the correct terms.
- **E:** Not the correct terms.

Key point: Delay: powers, passenger, passages.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 567 · Delay in labour · **Moderate** · C2

A nulliparous woman has delay in the first stage. Contractions are 2 in 10 minutes. The baby is OA and the pelvis is normal.

What is the most likely cause?

A. Cephalopelvic disproportion
B. Inefficient uterine contractions
C. Obstructed labour
D. OP position
E. Shoulder dystocia

Answer: B. Inefficient uterine contractions

Inefficient uterine activity is the most common cause of delay in nulliparous women. Oxytocin is often effective.

Why not the others

- **A:** Not suggested.
- **C:** Not suggested.
- **D:** The baby is OA.
- **E:** Occurs at delivery.

Key point: Most common cause of delay in nulliparous women: inefficient contractions.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 568 · Obstructed labour · **Hard** · C3

A multiparous woman has been in labour for 18 hours. The cervix is 8 cm and oedematous. There is +3 moulding and large caput. A ridge is felt across the abdomen. Contractions are strong.

What is the most likely diagnosis?

A. Latent phase
B. Normal labour
C. Obstructed labour with a Bandl ring
D. Placental abruption
E. Uterine inversion

Answer: C. Obstructed labour with a Bandl ring

Signs of obstructed labour include severe moulding, caput, oedematous cervix and a Bandl's ring (a pathological retraction ring). It risks uterine rupture and needs urgent caesarean.

Why not the others

- **A:** She is in advanced labour.
- **B:** Not normal.
- **D:** No bleeding or tenderness.
- **E:** Not relevant.

Key point: Bandl ring and severe moulding: obstructed labour.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 569 · Malposition · **Moderate** · C2

A woman has a prolonged labour. Vaginal exam shows the anterior fontanelle is felt anteriorly.

What is the most likely position?

A. Direct OA
B. Left OA
C. OP
D. Right OA
E. Transverse

Answer: C. OP

If the anterior fontanelle is felt anteriorly, the baby is likely occipito-posterior. OP is linked to backache, prolonged labour and higher instrumental delivery.

Why not the others

- **A:** Posterior fontanelle would be anterior.
- **B:** Posterior fontanelle would be anterior left.
- **D:** Posterior fontanelle would be anterior right.
- **E:** The sagittal suture would be transverse.

Key point: Anterior fontanelle felt at front: OP position.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 570 · Deep transverse arrest · **Hard** · C3

A woman at full dilatation has been pushing for 2 hours. The head is at the spines with the sagittal suture transverse. There is no further descent.

What is the most likely diagnosis?

A. Brow presentation
B. Deep transverse arrest
C. Face presentation
D. OA position
E. Shoulder dystocia

Answer: B. Deep transverse arrest

Deep transverse arrest happens when the head does not rotate from transverse to OA. Rotational delivery (Kielland or rotational ventouse) or caesarean may be needed.

Why not the others

- **A:** Brow is a deflexed head.
- **C:** Face is fully deflexed.
- **D:** OA would progress.
- **E:** Shoulder dystocia occurs after head delivery.

Key point: Transverse head at spines with no descent: deep transverse arrest.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 571 · Induction of labour · **Easy** · C2

A healthy woman at 41 weeks has an uncomplicated pregnancy.

What does NICE offer?

A. Caesarean
B. Do nothing until 44 weeks
C. Induction of labour at 41 weeks
D. Weekly CTG only
E. Weekly scans only

Answer: C. Induction of labour at 41 weeks

NICE (2021) advises offering induction from 41+0 weeks to reduce stillbirth risk. Women can decline and have increased monitoring.

Why not the others

- **A:** Not indicated.
- **B:** Too late.
- **D:** Not enough alone.
- **E:** Not enough alone.

Key point: Offer induction at 41 weeks.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 572 · Induction of labour · **Moderate** · C2

A woman at 40+5 weeks attends for a check. She wants to avoid formal induction.

What can be offered first?

A. Amniotomy
B. Caesarean
C. Membrane sweep
D. Oxytocin
E. Prostaglandin

Answer: C. Membrane sweep

A membrane sweep separates the membranes from the cervix and releases prostaglandins. It increases the chance of spontaneous labour.

Why not the others

- **A:** Formal method.
- **B:** Not indicated.
- **D:** Formal method.
- **E:** Formal method.

Key point: Membrane sweep reduces the need for formal induction.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 573 · Induction of labour · **Moderate** · C2

A woman with a Bishop score of 4 is having induction of labour.

What is the most appropriate first method?

A. Amniotomy alone
B. Caesarean
C. Oxytocin alone
D. Vaginal prostaglandin or a balloon catheter
E. Wait for labour

Answer: D. Vaginal prostaglandin or a balloon catheter

An unfavourable cervix (Bishop ≤6) needs ripening with vaginal dinoprostone, oral misoprostol or a balloon catheter.

Why not the others

- **A:** Not possible with an unripe cervix.
- **B:** Not indicated.
- **C:** Not effective with unripe cervix.
- **E:** Induction was indicated.

Key point: Unfavourable cervix: prostaglandin or balloon first.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 574 · Induction of labour · **Hard** · C3

A woman with one previous caesarean section needs induction at 41 weeks.

Which method is safest?

A. Balloon catheter
B. High-dose misoprostol
C. Oxytocin before cervical ripening
D. Prostaglandin with oxytocin together
E. Repeated prostaglandin doses

Answer: A. Balloon catheter

Mechanical methods (balloon catheter) are preferred in women with a previous caesarean because they have a lower risk of uterine hyperstimulation and rupture.

Why not the others

- **B:** Raises rupture risk.
- **C:** Not effective.
- **D:** Raises rupture risk.
- **E:** Raises rupture risk.

Key point: Previous CS: balloon induction preferred.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 575 · Oxytocin · **Moderate** · C2

A woman is on an oxytocin infusion for delay.

What is the aim for contraction frequency?

A. 1 in 10 minutes
B. 2 in 10 minutes
C. 4–5 in 10 minutes
D. 7 in 10 minutes
E. Continuous

Answer: C. 4–5 in 10 minutes

Oxytocin is increased every 30 minutes to achieve 4–5 contractions in 10 minutes. More than 5 is tachysystole.

Why not the others

- **A:** Too few.
- **B:** Too few.
- **D:** Tachysystole.
- **E:** Dangerous.

Key point: Aim for 4–5 contractions in 10 minutes.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 576 · CTG features · **Easy** · C1

A student is asked what an acceleration on a CTG means.

What is an acceleration?

A. A decrease of 15 bpm for 15 seconds
B. A rise lasting more than 10 minutes
C. A rise of 5 bpm for 5 seconds
D. A rise of at least 15 bpm lasting at least 15 seconds
E. A smooth wave-like pattern

Answer: D. A rise of at least 15 bpm lasting at least 15 seconds

An acceleration is a rise in fetal heart rate of 15 bpm or more for 15 seconds or more. Accelerations are reassuring and show a healthy, responsive fetus.

Why not the others

- **A:** This is a deceleration.
- **B:** This is a baseline change.
- **C:** Too small to count.
- **E:** This describes a sinusoidal pattern.

Key point: Acceleration: ≥15 bpm for ≥15 seconds; reassuring.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 577 · CTG features · **Moderate** · C2

A CTG shows a single deceleration of 60 bpm below the baseline that lasts 4 minutes, then recovers with normal variability.

What is this called?

A. Early deceleration
B. Late deceleration
C. Prolonged deceleration
D. Sinusoidal pattern
E. Variable deceleration

Answer: C. Prolonged deceleration

A prolonged deceleration lasts more than 3 minutes. Causes include cord compression, hypotension after epidural, tachysystole and abruption. Urgent review is needed.

Why not the others

- **A:** Mirrors contractions.
- **B:** Begins after contraction peak.
- **D:** A baseline pattern.
- **E:** Short, V-shaped.

Key point: A deceleration over 3 minutes is prolonged; needs urgent review.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 578 · Epidural and CTG · **Moderate** · C3

Ten minutes after an epidural top-up, the CTG shows a prolonged deceleration. Maternal BP is 80/45 mmHg.

What is the most appropriate first step?

A. Caesarean section
B. Fetal blood sampling
C. Increase oxytocin
D. IV fluids and a left lateral position
E. Stop monitoring

Answer: D. IV fluids and a left lateral position

Epidural-related hypotension reduces placental blood flow. Treat with IV fluids, left lateral tilt and a vasopressor if needed. The CTG usually recovers.

Why not the others

- **A:** Not needed if the cause is corrected.
- **B:** Not the first step.
- **C:** Worsens the problem.
- **E:** Unsafe.

Key point: Epidural hypotension: fluids, left lateral position, vasopressor.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 579 · Cord gases · **Moderate** · C2

After an emergency birth for fetal distress, paired cord gases are taken.

Why are paired samples (artery and vein) taken?

A. To check blood group only
B. To confirm the sample came from both vessels and reflects fetal status
C. To diagnose jaundice
D. To measure glucose only
E. To screen for infection

Answer: B. To confirm the sample came from both vessels and reflects fetal status

Paired arterial and venous samples confirm both vessels were sampled. The arterial sample reflects the fetus's acid–base status.

Why not the others

- **A:** Not the reason.
- **C:** Not for jaundice.
- **D:** Not the reason.
- **E:** Not for infection.

Key point: Paired cord gases: the artery reflects fetal status.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 580 · Fetal scalp electrode · **Moderate** · C2

A woman's abdominal CTG is poor quality because of her high BMI. The cervix is 5 cm and membranes have ruptured.

What is the most appropriate option?

A. Fetal blood sampling
B. Fetal scalp electrode
C. Stop monitoring
D. Ultrasound every hour
E. Use only maternal pulse

Answer: B. Fetal scalp electrode

A fetal scalp electrode gives a reliable signal when the external CTG is poor. It needs ruptured membranes and is avoided with blood-borne viruses.

Why not the others

- **A:** FBS is for pH, not ongoing monitoring.
- **C:** Unsafe.
- **D:** Not practical.
- **E:** Maternal pulse does not show fetal heart.

Key point: Poor external CTG: fetal scalp electrode.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 581 · Maternal heart rate · **Hard** · C3

In the second stage, a CTG shows a heart rate of 110 bpm with accelerations during each push. The mother's pulse is 112 bpm.

What is the most likely explanation?

A. Fetal anaemia
B. Fetal sleep
C. Fetal tachycardia
D. Normal fetal trace
E. The CTG is recording the maternal heart rate

Answer: E. The CTG is recording the maternal heart rate

Maternal heart rate can be picked up by an external transducer, especially in the second stage, and often rises with pushing. Checking the maternal pulse at the same time helps tell them apart.

Why not the others

- **A:** Gives a sinusoidal trace.
- **B:** Not consistent with this.
- **C:** Rate is not tachycardic.
- **D:** The trace may be maternal.

Key point: Always check maternal pulse to avoid recording the mother's heart rate.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 582 · VBAC · **Moderate** · C2

A woman with one previous caesarean for breech is now 38 weeks with a cephalic baby and asks about VBAC.

What is the approximate success rate of planned VBAC?

A. 10–20%
B. 30–40%
C. 50–60%
D. 72–75%
E. 95–99%

Answer: D. 72–75%

About 72–75% of women with one previous caesarean who plan VBAC have a vaginal birth. Success is higher with previous vaginal birth (85–90%).

Why not the others

- **A:** Too low.
- **B:** Too low.
- **C:** Too low.
- **E:** Too high.

Key point: VBAC success is about 72–75%.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 583 · VBAC · **Hard** · C3

A woman is considering VBAC.

Which is a contraindication to VBAC?

A. One previous lower segment caesarean
B. Previous caesarean for fetal distress
C. Previous classical caesarean section
D. Previous vaginal birth
E. Short interval of 2 years

Answer: C. Previous classical caesarean section

VBAC is contraindicated after a previous classical (vertical upper segment) incision, previous uterine rupture, or other standard contraindications to vaginal birth.

Why not the others

- **A:** Suitable for VBAC.
- **B:** Non-recurrent indication, suitable.
- **D:** Improves success.
- **E:** Not a contraindication.

Key point: Previous classical caesarean: no VBAC.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 584 · VBAC · **Moderate** · C2

A woman is in labour planning VBAC.

What monitoring is recommended?

A. Continuous CTG
B. Intermittent auscultation every hour
C. No monitoring
D. Only maternal pulse
E. Ultrasound every hour

Answer: A. Continuous CTG

Continuous electronic fetal monitoring is advised in VBAC because an abnormal CTG is often the first sign of uterine rupture.

Why not the others

- **B:** Not enough.
- **C:** Unsafe.
- **D:** Not enough.
- **E:** Not practical.

Key point: VBAC labour: continuous CTG.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 585 · Cephalopelvic disproportion · **Hard** · C2

A woman of short stature has a big baby. In labour, the head remains 4/5 palpable with +3 moulding at full dilatation.

What is the most appropriate management?

A. Caesarean section
B. Forceps
C. Oxytocin
D. Push for another 2 hours
E. Vacuum

Answer: A. Caesarean section

A high head (more than 1/5 palpable) with severe moulding at full dilatation suggests cephalopelvic disproportion. Instrumental delivery is unsafe; caesarean is needed.

Why not the others

- **B:** Unsafe with a high head.
- **C:** Risks rupture.
- **D:** Unsafe.
- **E:** Unsafe with a high head.

Key point: High head with severe moulding: caesarean.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 586 · Prolonged pregnancy · **Moderate** · C2

A woman at 41+3 weeks declines induction.

What does NICE advise?

A. Discharge with no plan
B. Force induction
C. Increased monitoring with CTG and ultrasound for fluid
D. No change in care
E. Weekly blood tests

Answer: C. Increased monitoring with CTG and ultrasound for fluid

Women who decline induction from 41 weeks should be offered increased monitoring, such as twice-weekly CTG and liquor volume scans.

Why not the others

- **A:** Unsafe.
- **B:** Not ethical.
- **D:** Extra monitoring is advised.
- **E:** Not useful.

Key point: Declined induction: increased fetal monitoring.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 587 · Induction of labour · **Moderate** · C1

A student asks about the risks of induction of labour.

Which is a recognised risk?

A. Fewer interventions
B. Lower PPH
C. Lower risk of infection
D. Shorter labour always
E. Uterine hyperstimulation

Answer: E. Uterine hyperstimulation

Risks of induction include uterine hyperstimulation, failed induction, longer labour, more interventions and cord prolapse with ARM.

Why not the others

- **A:** Interventions may increase.
- **B:** PPH may increase.
- **C:** Not lower.
- **D:** Not always shorter.

Key point: Induction risks hyperstimulation.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 588 · Induction of labour · **Moderate** · C2

After induction with a vaginal prostaglandin, the cervix becomes favourable.

What is the next step?

A. Amniotomy followed by oxytocin if needed
B. Caesarean
C. More prostaglandin
D. Send home
E. Vacuum

Answer: A. Amniotomy followed by oxytocin if needed

Once the cervix is favourable, amniotomy is done, and oxytocin is added if contractions do not establish.

Why not the others

- **B:** Not indicated.
- **C:** Not needed if favourable.
- **D:** Not appropriate.
- **E:** Not possible.

Key point: Favourable cervix: ARM, then oxytocin if needed.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 589 · Cord prolapse · **Moderate** · C2

A woman has amniotomy for induction. The head is high.

What complication is increased?

A. Cord prolapse
B. PPH
C. Pre-eclampsia
D. Retained placenta
E. Uterine inversion

Answer: A. Cord prolapse

ARM with a high presenting part increases the risk of cord prolapse. ARM should be done when the head is well applied to the cervix.

Why not the others

- **B:** Not directly.
- **C:** Not related.
- **D:** Not related.
- **E:** Not related.

Key point: ARM with a high head risks cord prolapse.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 590 · Second stage · **Hard** · C3

A woman at full dilatation has been pushing for 2 hours. The head is OP at +1 station. CTG is normal. She is exhausted.

What is the most appropriate management?

A. Caesarean section without assessment
B. Continue pushing for another 2 hours
C. Obstetric review for possible rotational instrumental delivery
D. Oxytocin infusion without review
E. Wait 6 hours

Answer: C. Obstetric review for possible rotational instrumental delivery

Prolonged second stage with an OP baby at +1 station needs obstetric review. A rotational instrumental delivery (in theatre if needed) or caesarean is considered.

Why not the others

- **A:** Assessment first.
- **B:** Too long.
- **D:** Review first.
- **E:** Too long.

Key point: Second-stage delay with OP: review for rotational delivery.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 591 · Uterine rupture · **Hard** · C3

A woman with a previous caesarean is on oxytocin for VBAC. The CTG shows a sudden prolonged bradycardia and she has scar pain.

What is the most appropriate action?

A. Category 1 caesarean section
B. Continue oxytocin
C. Fetal blood sampling
D. Increase IV fluids
E. Wait 30 minutes

Answer: A. Category 1 caesarean section

Uterine rupture is suspected. Stop oxytocin and arrange an immediate category 1 caesarean.

Why not the others

- **B:** Worsens rupture.
- **C:** Not appropriate.
- **D:** Not enough.
- **E:** Unsafe.

Key point: Suspected rupture: category 1 caesarean.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 592 · Caesarean categories · **Moderate** · C1

A student asks about caesarean categories.

What is a category 1 caesarean?

A. Early delivery needed but no compromise
B. Elective
C. Immediate threat to life of mother or fetus
D. Maternal or fetal compromise not immediate
E. Planned at a convenient time

Answer: C. Immediate threat to life of mother or fetus

Category 1: immediate threat to life (aim within 30 minutes). Category 2: compromise not immediately life-threatening (75 minutes). Category 3: needs early birth without compromise. Category 4: elective.

Why not the others

- **A:** Category 3.
- **B:** Category 4.
- **D:** Category 2.
- **E:** Category 4.

Key point: Category 1 CS: immediate threat to life.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 593 · Caesarean categories · **Moderate** · C2

A woman needs a category 1 caesarean for fetal bradycardia.

What is the target time from decision to delivery?

A. 15 minutes
B. 30 minutes
C. 60 minutes
D. 75 minutes
E. 120 minutes

Answer: B. 30 minutes

NICE target for category 1 is within 30 minutes, and for category 2 within 75 minutes.

Why not the others

- **A:** Not the standard.
- **C:** Too long.
- **D:** Category 2.
- **E:** Too long.

Key point: Category 1 within 30 minutes; category 2 within 75.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 594 · CTG interpretation · **Moderate** · C2

A CTG shows baseline 150 bpm, variability 10 bpm, accelerations present and no decelerations.

How is this CTG described?

A. Abnormal
B. Normal (reassuring)
C. Pathological
D. Sinusoidal
E. Suspicious

Answer: B. Normal (reassuring)

All features are within normal limits, with accelerations. This is a normal, reassuring CTG.

Why not the others

- **A:** No abnormal features.
- **C:** Not pathological.
- **D:** No sinusoidal pattern.
- **E:** No non-reassuring features.

Key point: Normal baseline, variability and accelerations: normal CTG.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 595 · Augmentation · **Hard** · C3

A multiparous woman has delay in the first stage of labour.

Why must oxytocin be used with special care in multiparous women?

A. It causes diabetes
B. It causes fetal anaemia
C. It is not effective in multiparas
D. There is a higher risk of uterine rupture
E. They always need a caesarean

Answer: D. There is a higher risk of uterine rupture

In multiparous women, delay may be due to malposition or obstruction. Oxytocin increases rupture risk, so a senior review is needed first.

Why not the others

- **A:** Not related.
- **B:** Not related.
- **C:** It can be effective.
- **E:** Not true.

Key point: Multiparous delay: senior review before oxytocin; rupture risk.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 596 · Oxytocin · **Hard** · C2

A woman has been on high-dose oxytocin for 12 hours.

Which side effect of oxytocin is most likely?

A. Hyperkalaemia
B. Hypernatraemia
C. Hypoglycaemia
D. Hyponatraemia (water intoxication)
E. Hypothyroidism

Answer: D. Hyponatraemia (water intoxication)

Oxytocin has an antidiuretic effect. High doses with large volumes of hypotonic fluid can cause water intoxication and hyponatraemia, leading to seizures.

Why not the others

- **A:** Not the effect.
- **B:** Not the effect.
- **C:** Not the effect.
- **E:** Not related.

Key point: Prolonged oxytocin can cause hyponatraemia.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 597 · Second stage · **Moderate** · C2

A woman in the second stage has a CTG with a baseline of 140 bpm and early decelerations with normal variability.

What is the most appropriate management?

A. Category 1 caesarean
B. Continue normal care
C. Fetal blood sampling
D. Stop pushing
E. Vacuum

Answer: B. Continue normal care

Early decelerations are common in the second stage and due to head compression. With normal baseline and variability, normal care can continue.

Why not the others

- **A:** Not indicated.
- **C:** Not needed.
- **D:** Not needed.
- **E:** Not indicated.

Key point: Early decels in the second stage are benign.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 598 · Uterine rupture · **Hard** · C1

A student asks about the most consistent first sign of uterine rupture.

Which is most common?

A. Abdominal pain only
B. Abnormal CTG
C. Haematuria
D. Loss of station
E. Vaginal bleeding

Answer: B. Abnormal CTG

An abnormal CTG, especially prolonged bradycardia, is the most common early sign of uterine rupture.

Why not the others

- **A:** Can occur but is less consistent.
- **C:** Can occur with bladder involvement.
- **D:** Can occur.
- **E:** Can occur.

Key point: Abnormal CTG is the most common first sign of rupture.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 599 · Fetal monitoring · **Moderate** · C2

A low-risk woman in established labour has intermittent auscultation. A deceleration is heard after a contraction.

What is the most appropriate action?

A. Caesarean section
B. Continue intermittent auscultation
C. Give oxytocin
D. Offer continuous CTG
E. Stop monitoring

Answer: D. Offer continuous CTG

NICE: if a deceleration is heard or the baseline changes on IA, offer continuous CTG and reassess.

Why not the others

- **A:** Not indicated.
- **B:** Not enough.
- **C:** Not appropriate.
- **E:** Unsafe.

Key point: Deceleration on IA: offer continuous CTG.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

MCQ 600 · Prolonged labour · **Hard** · C2

A woman had a prolonged labour of 24 hours and an instrumental delivery.

Which complication is she at increased risk of?

A. Gestational diabetes
B. Hyperemesis
C. Placenta praevia
D. Postpartum haemorrhage
E. Pre-eclampsia

Answer: D. Postpartum haemorrhage

Prolonged labour leads to uterine fatigue and atony, raising the risk of PPH. Infection is also more common.

Why not the others

- **A:** Not related.
- **B:** Not related.
- **C:** Not related.
- **E:** Not related.

Key point: Prolonged labour raises PPH risk.

Reference: Obstetrics by Ten Teachers — Abnormal labour and fetal monitoring

CHAPTER 13

Malpresentation and Operative Delivery

MCQ 601 · Breech · **Easy** · C1

A student asks about the most common type of breech presentation at term.

In which type are the hips flexed and knees extended, with the feet near the face?

A. Complete (flexed) breech
B. Footling breech
C. Frank (extended) breech
D. Kneeling breech
E. Transverse lie

Answer: C. Frank (extended) breech

Frank (extended) breech has flexed hips and extended knees. It is the most common type at term, especially in nulliparous women.

Why not the others

- **A:** Hips and knees both flexed.
- **B:** One or both feet present below the buttocks.
- **D:** Knees present; rare.
- **E:** Not a breech.

Key point: Frank breech: hips flexed, knees extended; commonest at term.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 602 · Breech · **Easy** · C2

A 30-year-old nulliparous woman at 36 weeks has an uncomplicated breech presentation confirmed on ultrasound.

What is the most appropriate next step?

A. Caesarean section at 37 weeks
B. Do nothing until labour
C. Induction of labour at 37 weeks
D. Offer external cephalic version
E. Postural exercises only

Answer: D. Offer external cephalic version

ECV is offered from 36 weeks in nulliparous women and from 37 weeks in multiparous women. It halves the chance of breech at birth and reduces caesarean section.

Why not the others

- **A:** ECV should be offered first.
- **B:** ECV should be offered.
- **C:** Induction with breech is not advised.
- **E:** No proven benefit.

Key point: Breech at 36 weeks (nullip) or 37 weeks (multip): offer ECV.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 603 · ECV · **Moderate** · C2

A woman with a breech at 37 weeks is considering ECV.

What is the approximate success rate of ECV?

A. About 5%
B. About 20%
C. About 50%
D. About 80% in all women
E. About 99%

Answer: C. About 50%

ECV is successful in about 50% of women (around 40% in nulliparous and 60% in multiparous women). After success, about 3% revert to breech.

Why not the others

- **A:** Too low.
- **B:** Too low.
- **D:** Too high overall.
- **E:** Too high.

Key point: ECV success is about 50%.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 604 · ECV · **Moderate** · C2

A woman at 37 weeks with a breech asks if ECV is possible.

Which is an absolute contraindication to ECV?

A. Antepartum haemorrhage within the last 7 days
B. Maternal age over 35
C. Nulliparity
D. One previous caesarean section
E. Rh-negative blood group

Answer: A. Antepartum haemorrhage within the last 7 days

Absolute contraindications to ECV include caesarean already needed for another reason, APH in the last 7 days, abnormal CTG, major uterine anomaly, ruptured membranes and multiple pregnancy (except second twin).

Why not the others

- **B:** Not a contraindication.
- **C:** Not a contraindication.
- **D:** A relative, not absolute, contraindication.
- **E:** Give anti-D afterwards.

Key point: APH in last 7 days is an absolute contraindication to ECV.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 605 · ECV · **Moderate** · C2

An RhD-negative woman has a successful ECV.

What is needed afterwards?

A. Admit for 48 hours
B. Anti-D and a Kleihauer test
C. Antibiotics
D. Caesarean section
E. Oxytocin

Answer: B. Anti-D and a Kleihauer test

ECV is a sensitising event. RhD-negative women need anti-D and a Kleihauer test. A CTG is done after the procedure.

Why not the others

- **A:** Not needed.
- **C:** Not needed.
- **D:** Not needed after a successful ECV.
- **E:** Not needed.

Key point: RhD-negative ECV: give anti-D.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 606 · Breech delivery · **Moderate** · C2

A woman with a term breech declines ECV. She asks about the safest mode of birth for the baby.

What does the evidence (Term Breech Trial) show?

A. Caesarean increases neonatal death
B. Planned caesarean lowers perinatal death and serious morbidity
C. Planned vaginal birth is safer for the baby
D. There is no difference at all
E. Vaginal breech birth is banned

Answer: B. Planned caesarean lowers perinatal death and serious morbidity

The Term Breech Trial showed planned caesarean reduces perinatal mortality and early neonatal morbidity compared with planned vaginal breech birth. Long-term outcomes were similar. Women should be counselled about both options.

Why not the others

- **A:** Not true.
- **C:** Not true in the trial.
- **D:** Short-term outcomes differed.
- **E:** Vaginal breech birth is still an option with counselling.

Key point: Planned CS for term breech lowers short-term perinatal risk.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 607 · Breech delivery · **Hard** · C3

A woman is having a vaginal breech birth. The baby's body has delivered up to the umbilicus.

What is the most important principle at this point?

A. Hands off the breech and allow descent
B. Pull firmly on the legs
C. Push the fundus hard
D. Rotate the baby to sacro-posterior
E. Use a vacuum on the buttocks

Answer: A. Hands off the breech and allow descent

The key principle is 'hands off the breech'. Traction can cause extension of the arms and head. Manoeuvres are used only if there is delay.

Why not the others

- **B:** Traction causes nuchal arms and head extension.
- **C:** Not advised.
- **D:** The back should stay anterior.
- **E:** Vacuum is not used on the breech.

Key point: Vaginal breech: hands off the breech.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 608 · Breech delivery · **Hard** · C2

During a vaginal breech birth, the arms are extended above the head and delay occurs.

Which manoeuvre is used?

A. Lovset manoeuvre
B. Mauriceau-Smellie-Veit manoeuvre
C. McRoberts manoeuvre
D. Rubin manoeuvre
E. Woods screw manoeuvre

Answer: A. Lovset manoeuvre

The Lovset manoeuvre rotates the baby's body to bring the arms down. Mauriceau-Smellie-Veit is for delivering the aftercoming head.

Why not the others

- **B:** For the aftercoming head.
- **C:** For shoulder dystocia.
- **D:** For shoulder dystocia.
- **E:** For shoulder dystocia.

Key point: Extended arms in breech: Lovset manoeuvre.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 609 · Breech delivery · **Hard** · C2

During a vaginal breech birth, the aftercoming head needs delivery.

Which manoeuvre helps flex the head?

A. Lovset
B. Mauriceau-Smellie-Veit
C. McRoberts
D. Wood's screw
E. Zavanelli

Answer: B. Mauriceau-Smellie-Veit

The Mauriceau-Smellie-Veit manoeuvre flexes the head by pressure on the malar bones and the occiput. Forceps can also be used for the aftercoming head.

Why not the others

- **A:** For extended arms.
- **C:** For shoulder dystocia.
- **D:** For shoulder dystocia.
- **E:** For severe shoulder dystocia.

Key point: Aftercoming head: Mauriceau-Smellie-Veit.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 610 · Face presentation · **Hard** · C3

A woman at full dilatation has a face presentation with the chin anterior (mento-anterior). Progress is good.

What is the most appropriate management?

A. Allow vaginal birth
B. Caesarean section
C. Kielland rotation
D. Turn to vertex manually
E. Vacuum extraction

Answer: A. Allow vaginal birth

Mento-anterior face presentation can deliver vaginally by flexion. Mento-posterior cannot deliver vaginally and needs caesarean. Vacuum is contraindicated in face presentation.

Why not the others

- **B:** Not needed if progressing.
- **C:** Not standard.
- **D:** Not done.
- **E:** Contraindicated.

Key point: Mento-anterior face: vaginal birth possible.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 611 · Face presentation · **Hard** · C3

A woman in labour has a face presentation with the chin posterior (mento-posterior) at full dilatation. There is no progress.

What is the most appropriate management?

A. Caesarean section
B. Forceps delivery
C. Oxytocin
D. Vacuum extraction
E. Wait 4 hours

Answer: A. Caesarean section

A persistent mento-posterior face cannot deliver vaginally because the neck cannot extend further. Caesarean is required.

Why not the others

- **B:** Not possible.
- **C:** Risks rupture.
- **D:** Contraindicated.
- **E:** Unsafe.

Key point: Persistent mento-posterior face: caesarean.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 612 · Brow presentation · **Moderate** · C2

A woman in labour at term has a brow presentation confirmed on VE. The baby is of normal size.

What is the most appropriate management?

A. Caesarean section
B. Forceps
C. Oxytocin
D. Vacuum
E. Wait for full dilatation and push

Answer: A. Caesarean section

A persistent brow presentation at term presents the mentovertical diameter (13 cm), which cannot pass through the pelvis. Caesarean is needed.

Why not the others

- **B:** Not possible.
- **C:** Risks rupture.
- **D:** Not appropriate.
- **E:** Will not progress.

Key point: Persistent brow at term: caesarean.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 613 · Unstable lie · **Moderate** · C2

A multiparous woman at 38 weeks has a transverse lie that keeps changing.

What is the most appropriate management?

A. Admit and plan delivery
B. Discharge until labour
C. Induce with prostaglandin
D. Postural exercises only
E. Vacuum

Answer: A. Admit and plan delivery

Unstable lie after 37 weeks risks cord prolapse if membranes rupture. Admission is often advised, with options of ECV or stabilising induction, or caesarean if it persists.

Why not the others

- **B:** Risks cord prolapse.
- **C:** Not with an unstable lie.
- **D:** Not effective.
- **E:** Not appropriate.

Key point: Unstable lie at term: admit; risk of cord prolapse.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 614 · Transverse lie · **Moderate** · C2

A woman in labour at term has a transverse lie with ruptured membranes.

What is the most appropriate mode of delivery?

A. Caesarean section
B. Forceps
C. Oxytocin
D. Vacuum
E. Vaginal birth

Answer: A. Caesarean section

A transverse lie in labour cannot deliver vaginally. Caesarean is needed.

Why not the others

- **B:** Not possible.
- **C:** Risks rupture.
- **D:** Not possible.
- **E:** Not possible.

Key point: Transverse lie in labour: caesarean.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 615 · Instrumental delivery · **Easy** · C1

A student asks about prerequisites for instrumental vaginal birth.

Which is required?

A. Fully dilated cervix
B. Head 3/5 palpable abdominally
C. Membranes intact
D. Unknown position
E. Woman under general anaesthesia

Answer: A. Fully dilated cervix

Prerequisites: full dilatation, ruptured membranes, head no more than 1/5 palpable, known position, adequate analgesia, empty bladder, consent and an experienced operator.

Why not the others

- **B:** Head must be 1/5 or less.
- **C:** Membranes must be ruptured.
- **D:** Position must be known.
- **E:** Not required.

Key point: Instrumental birth needs full dilatation and head ≤1/5 palpable.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 616 · Instrumental delivery · **Moderate** · C2

A woman is having a vacuum delivery.

Compared with forceps, vacuum is more likely to cause which problem?

A. Facial nerve palsy
B. Failed delivery and cephalohaematoma
C. More perineal trauma
D. Third-degree tear
E. Vaginal lacerations

Answer: B. Failed delivery and cephalohaematoma

Vacuum has a higher failure rate and more cephalohaematoma and retinal bleeds. Forceps cause more perineal trauma and facial injuries.

Why not the others

- **A:** More with forceps.
- **C:** More with forceps.
- **D:** More with forceps.
- **E:** More with forceps.

Key point: Vacuum: more failure and cephalohaematoma; forceps: more perineal trauma.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 617 · Instrumental delivery · **Moderate** · C2

A vacuum delivery has had three pulls with good descent but the head is not yet delivered.

What does RCOG advise?

A. Abandon unless birth is imminent
B. Continue for 10 more pulls
C. Increase suction pressure
D. Use forceps as a routine next step
E. Wait 1 hour

Answer: A. Abandon unless birth is imminent

RCOG advises that instrumental birth should be abandoned if there is no evidence of progressive descent with each pull or if birth is not imminent after three pulls by an experienced operator.

Why not the others

- **B:** Too many pulls.
- **C:** Not advised.
- **D:** Sequential instruments increase trauma.
- **E:** Not appropriate.

Key point: Abandon if not delivered after three pulls.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 618 · Instrumental delivery · **Moderate** · C2

A woman needs an instrumental birth. The baby is at 33 weeks.

Which instrument should be used?

A. Forceps
B. Kiwi vacuum
C. Metal vacuum cup
D. Silastic vacuum
E. Vacuum of any type

Answer: A. Forceps

Vacuum is contraindicated before 34 weeks due to risk of intracranial bleeding. Forceps should be used.

Why not the others

- **B:** Vacuum is contraindicated.
- **C:** Vacuum is contraindicated.
- **D:** Vacuum is contraindicated.
- **E:** Vacuum is contraindicated.

Key point: Before 34 weeks: forceps, not vacuum.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 619 · Instrumental delivery · **Hard** · C2

A woman needs a mid-cavity instrumental birth with doubt about the outcome.

Where should it be done?

A. At home
B. In a delivery room without preparation
C. In the antenatal ward
D. In the corridor
E. In theatre as a trial of instrumental delivery

Answer: E. In theatre as a trial of instrumental delivery

Where the chance of failure is higher, RCOG advises a trial in theatre so that caesarean can be done at once if it fails.

Why not the others

- **A:** Unsafe.
- **B:** Not advised for a trial.
- **C:** Not appropriate.
- **D:** Not appropriate.

Key point: Uncertain instrumental birth: trial in theatre.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 620 · Instrumental delivery · **Moderate** · C2

A woman has just had a forceps delivery.

What is recommended to reduce infection?

A. A single dose of IV prophylactic antibiotic
B. Antibiotics are not useful
C. Oral antibiotics for 2 weeks
D. Topical antiseptic only
E. Vaginal pessary

Answer: A. A single dose of IV prophylactic antibiotic

The ANODE trial showed that a single dose of IV antibiotic after operative vaginal birth reduces infection. RCOG now recommends it.

Why not the others

- **B:** Not true.
- **C:** Not needed.
- **D:** Not enough.
- **E:** Not standard.

Key point: After instrumental birth: single dose IV antibiotic.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 621 · Caesarean section · **Easy** · C2

A woman is having an elective caesarean section.

When should prophylactic antibiotics be given?

A. After the baby is born only
B. Before skin incision
C. Only after discharge
D. Only if she has a fever
E. Only if surgery lasts 2 hours

Answer: B. Before skin incision

NICE advises antibiotics before skin incision. This reduces maternal infection more than giving them after cord clamping.

Why not the others

- **A:** Less effective.
- **C:** Too late.
- **D:** Not the standard.
- **E:** Not the standard.

Key point: CS antibiotics: before skin incision.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 622 · Caesarean section · **Moderate** · C1

A student asks which incision is commonly used for lower segment caesarean section.

Which skin incision is recommended?

A. Lower midline
B. Paramedian
C. Transverse (Joel-Cohen)
D. Upper midline
E. Vertical

Answer: C. Transverse (Joel-Cohen)

NICE recommends a transverse lower abdominal incision, such as the Joel-Cohen. It causes less pain and has better cosmetic results.

Why not the others

- **A:** Used in some cases.
- **B:** Not standard.
- **D:** Not used for caesarean.
- **E:** Used in specific cases.

Key point: Use a transverse (Joel-Cohen) skin incision.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 623 · Caesarean section · **Hard** · C2

A caesarean is needed at 26 weeks with a poorly formed lower segment and a transverse lie.

Which uterine incision may be required?

A. Classical (vertical upper segment)
B. Joel-Cohen
C. Low transverse
D. Pfannenstiel
E. Transverse skin

Answer: A. Classical (vertical upper segment)

A classical incision may be needed when the lower segment is not formed (very preterm), with a transverse lie, or with a large fibroid. It carries a higher risk of rupture in future pregnancy.

Why not the others

- **B:** A skin incision.
- **C:** May not be possible.
- **D:** A skin incision.
- **E:** A skin incision.

Key point: Classical CS: poorly formed lower segment; higher future rupture risk.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 624 · Caesarean section · **Moderate** · C2

A woman asks about the risks of a caesarean section in future pregnancies.

Which risk increases?

A. Gestational diabetes
B. Hyperemesis
C. Placenta accreta and praevia
D. Post-term pregnancy
E. Pre-eclampsia

Answer: C. Placenta accreta and praevia

Previous caesarean increases the risk of placenta praevia, accreta spectrum, uterine rupture and stillbirth in future pregnancies.

Why not the others

- **A:** Not related.
- **B:** Not related.
- **D:** Not related.
- **E:** Not related.

Key point: Previous CS raises praevia and accreta risk.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 625 · Caesarean section · **Moderate** · C2

A woman is having an elective caesarean section under spinal anaesthesia.

What is given before surgery to reduce aspiration risk?

A. Antacid and H2 blocker
B. Antibiotic only
C. Laxative
D. Oxytocin
E. Steroid

Answer: A. Antacid and H2 blocker

An antacid and an H2 blocker or proton pump inhibitor are given before caesarean section to reduce the risk of aspiration pneumonitis.

Why not the others

- **B:** Not for aspiration.
- **C:** Not relevant.
- **D:** Not relevant.
- **E:** Not relevant.

Key point: Before CS: antacid and H2 blocker.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 626 · Breech · **Easy** · C1

A woman at 30 weeks has a breech baby on ultrasound and is worried.

What is the most appropriate advice?

A. Book a caesarean now
B. ECV now
C. Most breech babies turn by term; review at 36 weeks
D. Postural exercises cure breech
E. Stay in hospital until term

Answer: C. Most breech babies turn by term; review at 36 weeks

About 20% of babies are breech at 28 weeks, but only 3–4% at term. Most turn spontaneously. Presentation is checked again at 36 weeks.

Why not the others

- **A:** Too early.
- **B:** ECV is not done this early.
- **D:** Not proven.
- **E:** Not needed.

Key point: Breech at 30 weeks usually turns; recheck at 36 weeks.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 627 · Breech · **Moderate** · C1

A student asks about factors associated with breech presentation.

Which factor is linked to breech?

A. Engaged head at 36 weeks
B. Fundal placenta only
C. Male fetus
D. Placenta praevia
E. Post-term pregnancy

Answer: D. Placenta praevia

Breech is linked to prematurity, placenta praevia, uterine anomalies, fibroids, polyhydramnios or oligohydramnios, multiple pregnancy and fetal anomalies.

Why not the others

- **A:** Not consistent.
- **B:** Not a factor.
- **C:** Not a factor.
- **E:** Not linked.

Key point: Praevia, uterine anomalies and prematurity are linked to breech.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 628 · Breech · **Hard** · C3

A woman with a breech presentation is in advanced labour at 39 weeks. She is 9 cm and the breech is low in the pelvis.

What is the most appropriate approach?

A. Caesarean section automatically
B. Discuss options; vaginal breech birth may be appropriate with a skilled attendant
C. ECV now
D. Oxytocin to speed labour
E. Vacuum on the breech

Answer: B. Discuss options; vaginal breech birth may be appropriate with a skilled attendant

RCOG advises that women in advanced labour with a breech should be counselled. Caesarean may not be better if birth is imminent. A skilled attendant is needed.

Why not the others

- **A:** Not automatically.
- **C:** Not possible in advanced labour.
- **D:** Not routinely advised.
- **E:** Not appropriate.

Key point: Advanced labour with breech: vaginal birth may be best.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 629 · Breech · **Hard** · C2

A woman with a term breech wants a vaginal birth.

Which feature makes vaginal breech birth less safe?

A. Estimated weight 3200 g
B. Extended (frank) breech
C. Hyperextended fetal neck on scan
D. Multiparity
E. Spontaneous labour

Answer: C. Hyperextended fetal neck on scan

Factors that make vaginal breech birth less safe include hyperextended neck, footling breech, large baby (>3.8 kg), small baby (<2 kg), previous caesarean and lack of a skilled attendant.

Why not the others

- **A:** Normal size.
- **B:** Favourable.
- **D:** Favourable.
- **E:** Favourable.

Key point: Hyperextended neck: avoid vaginal breech birth.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 630 · Compound presentation · **Moderate** · C2

A woman in labour has a fetal hand presenting beside the head.

What is the most appropriate management?

A. Caesarean section
B. Oxytocin
C. Pull the hand down
D. Vacuum
E. Wait; the hand often moves back

Answer: E. Wait; the hand often moves back

A compound presentation of a hand beside the head often resolves as the head descends. If not, gentle pressure or caesarean may be needed.

Why not the others

- **A:** Not needed initially.
- **B:** Not needed.
- **C:** Not advised.
- **D:** Not appropriate.

Key point: Hand with head: often resolves.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 631 · Instrumental delivery · **Moderate** · C2

A woman needs instrumental delivery. The head is OP and the operator is not skilled in rotation.

What is the most appropriate action?

A. Attempt rotation anyway
B. Caesarean immediately
C. Call a senior colleague
D. Pull the head down OP with Kielland
E. Use vacuum with high pressure

Answer: C. Call a senior colleague

Operators should only perform procedures they are trained for. A senior colleague should be called for rotational delivery.

Why not the others

- **A:** Unsafe.
- **B:** May not be needed.
- **D:** Kielland requires training.
- **E:** Unsafe.

Key point: Call senior help for rotational deliveries.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 632 · Instrumental delivery · **Moderate** · C2

A woman has a failed vacuum. The head is low.

What does RCOG say about using forceps after a failed vacuum?

A. Always use forceps
B. Increases the risk of neonatal injury
C. Is mandatory
D. Safer than caesarean always
E. Should be done by a junior

Answer: B. Increases the risk of neonatal injury

Sequential use of instruments raises the risk of neonatal and maternal trauma. It may be justified in some cases but should be done by a senior.

Why not the others

- **A:** Not always.
- **C:** Not mandatory.
- **D:** Not always.
- **E:** Should be senior.

Key point: Sequential instruments increase trauma risk.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 633 · Instrumental delivery · **Easy** · C1

A student asks which indication supports instrumental delivery.

Which is an indication?

A. Breech
B. Fetal compromise in the second stage
C. First stage delay
D. Head 3/5 palpable
E. Unknown position

Answer: B. Fetal compromise in the second stage

Indications include fetal compromise, prolonged second stage, maternal exhaustion and maternal conditions where pushing should be avoided.

Why not the others

- **A:** Not a vacuum indication.
- **C:** Not possible.
- **D:** Contraindicated.
- **E:** Contraindicated.

Key point: Fetal compromise in second stage is an indication.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 634 · Instrumental delivery · **Moderate** · C2

A woman with severe heart disease is in labour.

Why may an instrumental delivery be planned?

A. It avoids prolonged pushing
B. It increases blood loss
C. It is safer than caesarean always
D. It prevents infection
E. It reduces perineal trauma

Answer: A. It avoids prolonged pushing

Women with conditions such as severe heart disease may be advised to avoid prolonged pushing. A shortened second stage with an instrumental delivery may be planned.

Why not the others

- **B:** Not true.
- **C:** Not always.
- **D:** Not true.
- **E:** Not true.

Key point: Avoid prolonged pushing in severe heart disease.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 635 · Instrumental delivery · **Hard** · C2

After a forceps delivery, the baby has a weak face on the left side.

What is the most likely cause?

A. Brachial plexus injury
B. Erb's palsy
C. Facial nerve palsy
D. Klumpke's palsy
E. Phrenic nerve palsy

Answer: C. Facial nerve palsy

Forceps can compress the facial nerve, causing a temporary facial palsy, which usually resolves within weeks.

Why not the others

- **A:** Affects the arm.
- **B:** Affects the arm.
- **D:** Affects the hand.
- **E:** Affects breathing.

Key point: Forceps can cause temporary facial palsy.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 636 · Instrumental delivery · **Moderate** · C2

After a vacuum delivery, the baby has a swelling over the parietal bone that does not cross suture lines.

What is the most likely diagnosis?

A. Caput succedaneum
B. Cephalohaematoma
C. Chignon
D. Skull fracture
E. Subgaleal haemorrhage

Answer: B. Cephalohaematoma

Cephalohaematoma is bleeding under the periosteum, so it does not cross sutures. It appears hours after birth and resolves over weeks. Jaundice may increase.

Why not the others

- **A:** Crosses sutures and resolves in days.
- **C:** Normal swelling from the vacuum cup.
- **D:** Not suggested.
- **E:** Crosses sutures and is life-threatening.

Key point: Cephalohaematoma does not cross sutures.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 637 · Instrumental delivery · **Hard** · C3

After a difficult vacuum delivery, a baby has a boggy swelling across the whole scalp, pallor and a rising heart rate.

What is the most likely diagnosis?

A. Caput succedaneum
B. Cephalohaematoma
C. Chignon
D. Subconjunctival haemorrhage
E. Subgaleal haemorrhage

Answer: E. Subgaleal haemorrhage

Subgaleal haemorrhage is bleeding beneath the aponeurosis that crosses sutures. It can cause major blood loss and shock. It needs urgent neonatal care.

Why not the others

- **A:** Not linked to shock.
- **B:** Limited by sutures.
- **C:** A benign swelling.
- **D:** Not linked to shock.

Key point: Subgaleal haemorrhage: boggy scalp swelling with shock.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 638 · Caesarean section · **Moderate** · C2

A woman requests a caesarean section with no medical indication.

What does NICE advise?

A. Discuss, offer support and, if she still wants it, offer a planned caesarean
B. Never agree
C. Refer to a psychiatrist always
D. Tell her it is illegal
E. Use vaginal birth only

Answer: A. Discuss, offer support and, if she still wants it, offer a planned caesarean

NICE: discuss reasons and risks, offer support (including perinatal mental health support for anxiety). If she still requests caesarean after discussion, a planned caesarean should be offered.

Why not the others

- **B:** Not advised.
- **C:** Only if needed.
- **D:** Not illegal.
- **E:** Her choice should be respected.

Key point: Maternal request CS: discuss, support, then offer.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 639 · Caesarean section · **Moderate** · C2

A woman is having an elective caesarean with no complications.

When should elective caesarean usually be planned?

A. At 40 weeks always
B. From 34 weeks
C. From 37 weeks
D. From 39 weeks
E. From 41 weeks

Answer: D. From 39 weeks

NICE: elective caesarean is not routinely done before 39 weeks to reduce neonatal respiratory problems.

Why not the others

- **A:** Not required.
- **B:** Too early.
- **C:** Higher neonatal respiratory risk.
- **E:** Too late.

Key point: Elective CS from 39 weeks.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 640 · Caesarean section · **Hard** · C2

After a caesarean, a woman has blood in her urinary catheter.

Which injury is most likely?

A. Bladder injury
B. Bowel injury
C. Liver injury
D. Spleen injury
E. Ureteric injury only

Answer: A. Bladder injury

Bladder injury is the most common visceral injury at caesarean, especially with repeat surgery. Haematuria suggests it.

Why not the others

- **B:** Less common.
- **C:** Rare.
- **D:** Rare.
- **E:** Less common.

Key point: Bladder injury is the most common CS visceral injury.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 641 · Caesarean section · **Moderate** · C2

A woman has an emergency caesarean.

Which measure reduces VTE risk after caesarean?

A. Avoid mobilisation
B. Bed rest
C. Dehydration
D. Early mobilisation and LMWH if risk factors
E. Tight bandages

Answer: D. Early mobilisation and LMWH if risk factors

After caesarean, early mobilisation and hydration help. LMWH is given based on risk assessment (e.g. 10 days for emergency CS with other factors, or 6 weeks for high risk).

Why not the others

- **A:** Increases risk.
- **B:** Increases risk.
- **C:** Increases risk.
- **E:** Not effective.

Key point: Post-CS: mobilise early; LMWH based on risk.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 642 · Caesarean section · **Moderate** · C2

A woman has had a caesarean. She asks about the risk of the scar tearing in labour next time.

Which incision has the lowest risk of rupture?

A. Classical
B. Inverted T
C. J-shaped
D. Low transverse
E. Vertical

Answer: D. Low transverse

A low transverse uterine incision has the lowest rupture risk (about 0.5%). Classical, T and J incisions have higher risk.

Why not the others

- **A:** Higher risk.
- **B:** Higher risk.
- **C:** Higher risk.
- **E:** Higher risk.

Key point: Low transverse scar has the lowest rupture risk.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 643 · Episiotomy · **Moderate** · C2

A woman is having a forceps delivery.

What does RCOG say about episiotomy?

A. It causes more harm always
B. It is banned
C. It is required with vacuum always
D. It should be considered as it may reduce OASI
E. It should be midline

Answer: D. It should be considered as it may reduce OASI

RCOG says mediolateral episiotomy should be considered in instrumental births, especially forceps, to reduce OASI.

Why not the others

- **A:** Not always.
- **B:** Not banned.
- **C:** Not required always.
- **E:** Mediolateral is advised.

Key point: Consider episiotomy for instrumental birth.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 644 · Malpresentation · **Moderate** · C2

A woman at term has a shoulder presentation.

What is the most appropriate management?

A. Caesarean section
B. Forceps
C. Oxytocin
D. Vacuum
E. Wait

Answer: A. Caesarean section

A shoulder presentation cannot deliver vaginally. Caesarean is needed.

Why not the others

- **B:** Not possible.
- **C:** Risks rupture.
- **D:** Not possible.
- **E:** Unsafe.

Key point: Shoulder presentation: caesarean.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 645 · Malpresentation · **Easy** · C1

A student is asked about the definition of malpresentation.

What is malpresentation?

A. Any presentation other than vertex
B. Breech presentation only
C. Brow presentation only
D. OP position
E. Transverse lie only

Answer: A. Any presentation other than vertex

Malpresentation is any presentation other than vertex, including breech, face, brow and shoulder.

Why not the others

- **B:** Too narrow.
- **C:** Too narrow.
- **D:** This is malposition.
- **E:** Too narrow.

Key point: Malpresentation: any non-vertex presentation.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 646 · Malposition · **Moderate** · C1

A student is asked about malposition.

What is malposition?

A. Abnormal lie
B. Abnormal presentation
C. Any position other than occipito-anterior
D. Breech
E. Face presentation

Answer: C. Any position other than occipito-anterior

Malposition refers to an abnormal position of the vertex, such as OP or OT, rather than an abnormal presentation.

Why not the others

- **A:** Not the definition.
- **B:** Malpresentation.
- **D:** Malpresentation.
- **E:** Malpresentation.

Key point: Malposition: vertex not OA.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 647 · ECV · **Moderate** · C2

A woman is having ECV at 37 weeks.

Which drug may be given to improve success?

A. Atosiban
B. Ergometrine
C. Oxytocin
D. Terbutaline
E. Tramadol

Answer: D. Terbutaline

Tocolysis with a beta-agonist such as terbutaline improves ECV success by relaxing the uterus.

Why not the others

- **A:** Not standard.
- **B:** Contracts the uterus.
- **C:** Contracts the uterus.
- **E:** Not relevant.

Key point: Terbutaline improves ECV success.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 648 · Caesarean section · **Hard** · C3

A woman has an emergency caesarean at full dilatation. The head is deeply impacted in the pelvis.

What technique may help deliver the head?

A. Fundal pressure
B. Push the head up from below or a reverse breech extraction
C. Use oxytocin
D. Use vacuum on the head
E. Wait

Answer: B. Push the head up from below or a reverse breech extraction

Impacted fetal head at caesarean can be delivered by pushing the head up vaginally, a reverse breech extraction or a tocolytic. It needs an experienced operator.

Why not the others

- **A:** Not helpful.
- **C:** Worsens.
- **D:** Not standard.
- **E:** Unsafe.

Key point: Impacted head at CS: push up or reverse breech extraction.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 649 · Instrumental delivery · **Moderate** · C2

A registrar is called to a woman at full dilatation with a prolonged second stage. Vaginal examination finds the fetal mouth and orbital ridges presenting.

Which feature here is a contraindication to vacuum extraction?

A. Face presentation
B. Fully dilated cervix
C. Head 1/5 palpable
D. OA position
E. Ruptured membranes

Answer: A. Face presentation

Vacuum is contraindicated in face presentation, before 34 weeks, and with known fetal bleeding disorders.

Why not the others

- **B:** Required.
- **C:** Allowed.
- **D:** Ideal.
- **E:** Required.

Key point: No vacuum for face presentation.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

MCQ 650 · Instrumental delivery · **Moderate** · C2

A woman needs forceps. Before delivery, the operator must check one more thing.

Which step is important before applying forceps?

A. Bladder emptied
B. Give oxytocin
C. Lie flat
D. Rupture membranes
E. Stop analgesia

Answer: A. Bladder emptied

The bladder should be emptied before instrumental delivery to reduce bladder injury and help descent.

Why not the others

- **B:** Not required.
- **C:** Lithotomy is used.
- **D:** Should already be ruptured.
- **E:** Analgesia is needed.

Key point: Empty the bladder before instrumental birth.

Reference: Obstetrics by Ten Teachers — Malpresentation and operative delivery

CHAPTER 14

Obstetric Emergencies

MCQ 651 · Shoulder dystocia · **Easy** · C2

After delivery of the head, the head retracts against the perineum (the 'turtle sign') and gentle downward traction does not deliver the shoulders.

What is the most appropriate first manoeuvre after calling for help?

A. Fundal pressure
B. McRoberts manoeuvre
C. Posterior arm delivery
D. Woods screw manoeuvre
E. Zavanelli manoeuvre

Answer: B. McRoberts manoeuvre

After calling for help, McRoberts (flexing and abducting the hips onto the abdomen) is the first manoeuvre. It straightens the lumbosacral angle and frees the anterior shoulder in many cases. Suprapubic pressure is often added.

Why not the others

- **A:** Fundal pressure is contraindicated; it worsens impaction.
- **C:** An internal manoeuvre used later.
- **D:** An internal manoeuvre used later.
- **E:** A last-resort measure.

Key point: Shoulder dystocia: call help, then McRoberts plus suprapubic pressure.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 652 · Shoulder dystocia · **Moderate** · C2

McRoberts manoeuvre has failed in a shoulder dystocia.

What is the next step?

A. Cleidotomy
B. Fundal pressure
C. Suprapubic pressure
D. Symphysiotomy
E. Zavanelli manoeuvre

Answer: C. Suprapubic pressure

Suprapubic pressure applied behind the anterior shoulder pushes it towards the fetal chest, reducing the bisacromial diameter. It is used with McRoberts.

Why not the others

- **A:** Very last resort.
- **B:** Contraindicated.
- **D:** Last resort.
- **E:** Last resort.

Key point: After McRoberts: suprapubic pressure.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 653 · Shoulder dystocia · **Hard** · C3

McRoberts and suprapubic pressure have failed in a shoulder dystocia.

What is the next most appropriate step according to RCOG?

A. Apply stronger traction on the head
B. Cleidotomy
C. Fundal pressure
D. Internal manoeuvres such as delivery of the posterior arm
E. Zavanelli manoeuvre

Answer: D. Internal manoeuvres such as delivery of the posterior arm

RCOG advises internal manoeuvres next: delivery of the posterior arm or internal rotation (Rubin II, Woods screw). An episiotomy may help access. All-fours is an alternative.

Why not the others

- **A:** Increases brachial plexus injury.
- **B:** Last resort.
- **C:** Contraindicated.
- **E:** Last resort.

Key point: Next: internal manoeuvres (posterior arm or rotation).

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 654 · Shoulder dystocia · **Moderate** · C1

A student asks about risk factors for shoulder dystocia.

Which is a recognised risk factor?

A. Fetal macrosomia
B. Low BMI
C. Placenta praevia
D. Short labour
E. Small baby

Answer: A. Fetal macrosomia

Risk factors include macrosomia, maternal diabetes, high BMI, previous shoulder dystocia, prolonged labour and instrumental delivery. Most cases occur without risk factors.

Why not the others

- **B:** Not a risk factor.
- **C:** Not a risk factor.
- **D:** Not a risk factor.
- **E:** Not a risk factor.

Key point: Macrosomia and diabetes are key risk factors.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 655 · Shoulder dystocia · **Moderate** · C2

After a shoulder dystocia, the baby's right arm is limp and internally rotated with the wrist flexed ('waiter's tip').

Which injury is most likely?

A. Erb's palsy (C5–C6)
B. Facial palsy
C. Klumpke's palsy (C8–T1)
D. Phrenic nerve injury
E. Radial nerve injury

Answer: A. Erb's palsy (C5–C6)

Erb's palsy involves C5–C6 roots and causes the waiter's tip posture. Most recover within a year.

Why not the others

- **B:** Affects the face.
- **C:** Affects the hand (claw).
- **D:** Affects breathing.
- **E:** Affects wrist only.

Key point: Waiter's tip: Erb's palsy (C5–C6).

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 656 · Cord prolapse · **Easy** · C2

After spontaneous rupture of membranes at 38 weeks, the midwife sees the cord at the introitus. The CTG shows bradycardia.

What is the most appropriate immediate action?

A. Allow vaginal birth
B. Elevate the presenting part and arrange immediate delivery
C. Give oxytocin
D. Push the cord back into the uterus
E. Wait for full dilatation

Answer: B. Elevate the presenting part and arrange immediate delivery

Cord prolapse: call for help, elevate the presenting part manually or by filling the bladder, use knee-chest or left lateral position, and arrange category 1 caesarean unless vaginal birth is imminent.

Why not the others

- **A:** Only if birth is imminent.
- **C:** Not appropriate.
- **D:** Not advised.
- **E:** Delay is dangerous.

Key point: Cord prolapse: elevate presenting part; category 1 CS.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 657 · Cord prolapse · **Moderate** · C2

A cord prolapse occurs and the woman is being transferred to theatre.

Which measure can relieve pressure on the cord during transfer?

A. Fill the bladder with 500 mL saline
B. Give oxytocin
C. Lie supine
D. Pull on the cord
E. Squeeze the cord

Answer: A. Fill the bladder with 500 mL saline

Filling the bladder with 500 mL saline via a catheter raises the presenting part off the cord and can reduce contractions.

Why not the others

- **B:** Worsens.
- **C:** Knee-chest or left lateral is better.
- **D:** Not advised.
- **E:** Causes spasm.

Key point: Bladder filling elevates the presenting part.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 658 · Cord prolapse · **Moderate** · C2

A cord prolapse is found. The cord is outside the vagina.

What is the advice about handling the cord?

A. Handle as little as possible to avoid spasm
B. Pull on it gently
C. Push it back fully
D. Squeeze it to check pulse
E. Wrap it in ice

Answer: A. Handle as little as possible to avoid spasm

Handling the cord can cause vasospasm. Minimal handling is advised; it can be kept warm in the vagina if possible.

Why not the others

- **B:** Not advised.
- **C:** Not advised.
- **D:** Causes spasm.
- **E:** Cold causes spasm.

Key point: Minimise handling of a prolapsed cord.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 659 · PPH · **Easy** · C1

A student asks how PPH is defined.

What is primary postpartum haemorrhage?

A. Any blood loss after birth
B. Bleeding from 6 weeks
C. Blood loss after 24 hours
D. Blood loss of 250 mL
E. Blood loss of 500 mL or more within 24 hours

Answer: E. Blood loss of 500 mL or more within 24 hours

Primary PPH is blood loss of 500 mL or more from the genital tract within 24 hours of birth. Minor is 500–1000 mL; major is more than 1000 mL.

Why not the others

- **A:** Not the definition.
- **B:** Not the definition.
- **C:** Secondary PPH.
- **D:** Too low.

Key point: Primary PPH: ≥500 mL within 24 hours.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 660 · PPH · **Easy** · C1

A student asks about the most common cause of primary PPH.

Which of the '4 Ts' is most common?

A. Thrombin
B. Tissue
C. Tone
D. Transfusion
E. Trauma

Answer: C. Tone

Uterine atony (tone) causes about 70% of PPH. Others are trauma, tissue (retained placenta) and thrombin (clotting disorders).

Why not the others

- **A:** Less common.
- **B:** Less common.
- **D:** Not one of the 4 Ts.
- **E:** Second most common.

Key point: Tone (atony) is the most common cause of PPH.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 661 · PPH · **Moderate** · C2

A woman has a PPH of 800 mL from uterine atony. She has had oxytocin.

What is the next most appropriate step?

A. B-Lynch suture
B. Bimanual compression and further uterotonics
C. Hysterectomy
D. Interventional radiology
E. Wait

Answer: B. Bimanual compression and further uterotonics

Initial steps are uterine massage, bimanual compression, empty bladder and uterotonics (oxytocin infusion, ergometrine, carboprost, misoprostol) plus tranexamic acid.

Why not the others

- **A:** Surgical step later.
- **C:** Last resort.
- **D:** Later step.
- **E:** Unsafe.

Key point: Atony: massage, bimanual compression, uterotonics.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 662 · PPH · **Hard** · C3

A woman with PPH from atony has had oxytocin and ergometrine. She has asthma.

Which drug should be avoided?

A. Carboprost
B. Misoprostol
C. Oxytocin infusion
D. Tranexamic acid
E. Uterine massage

Answer: A. Carboprost

Carboprost (prostaglandin F2α) can cause bronchospasm and should be avoided or used with care in asthma. Misoprostol can be used.

Why not the others

- **B:** Safe in asthma.
- **C:** Safe.
- **D:** Safe.
- **E:** Not a drug.

Key point: Avoid carboprost in asthma.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 663 · PPH · **Hard** · C3

A woman has ongoing PPH from atony despite all drugs. She is in theatre.

What is the next step before laparotomy?

A. Bakri balloon tamponade
B. Hysterectomy
C. More oxytocin
D. Uterine artery embolisation
E. Wait

Answer: A. Bakri balloon tamponade

Intrauterine balloon tamponade (e.g. Bakri) is the first surgical step for atony not responding to drugs. Laparotomy with B-Lynch suture or hysterectomy follow if needed.

Why not the others

- **B:** Last resort.
- **C:** Not effective.
- **D:** Option if available and stable.
- **E:** Unsafe.

Key point: Atony not responding to drugs: balloon tamponade.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 664 · PPH · **Moderate** · C2

A woman has a PPH. The uterus is well contracted.

What is the most likely cause?

A. Atony
B. Genital tract trauma
C. Retained placenta
D. Thrombin
E. Uterine inversion

Answer: B. Genital tract trauma

If the uterus is contracted but bleeding continues, look for genital tract trauma (cervical, vaginal or perineal tears).

Why not the others

- **A:** The uterus is contracted.
- **C:** Possible but less likely.
- **D:** Possible but less likely.
- **E:** Not suggested.

Key point: Bleeding with a contracted uterus: look for trauma.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 665 · Secondary PPH · **Moderate** · C2

A woman 10 days after a vaginal birth has heavy bleeding, fever and a tender uterus.

What is the most likely cause?

A. Cervical cancer
B. Endometritis with or without retained tissue
C. Placental abruption
D. Uterine atony
E. Uterine inversion

Answer: B. Endometritis with or without retained tissue

Secondary PPH (24 hours to 12 weeks after birth) is commonly caused by infection (endometritis) and retained tissue.

Why not the others

- **A:** Unlikely.
- **C:** Not after birth.
- **D:** Causes primary PPH.
- **E:** Occurs at birth.

Key point: Secondary PPH: endometritis or retained tissue.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 666 · Uterine inversion · **Hard** · C3

During the third stage, the midwife pulls on the cord. The woman suddenly collapses with heavy bleeding. The uterus cannot be felt abdominally and a mass is seen at the introitus.

What is the most likely diagnosis?

A. Amniotic fluid embolism
B. Placental abruption
C. Retained placenta
D. Uterine inversion
E. Uterine rupture

Answer: D. Uterine inversion

Uterine inversion causes shock out of proportion to blood loss due to vagal stimulation. Immediate manual replacement (Johnson manoeuvre) is needed.

Why not the others

- **A:** No mass.
- **B:** Before birth.
- **C:** No mass.
- **E:** Abdomen would be tender.

Key point: Uterine inversion: shock, mass at introitus; replace immediately.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 667 · Uterine inversion · **Hard** · C3

A uterine inversion is diagnosed. Manual replacement has failed.

What is the next step?

A. Hydrostatic replacement (O'Sullivan)
B. Hysterectomy
C. Oxytocin
D. Remove the placenta first
E. Wait

Answer: A. Hydrostatic replacement (O'Sullivan)

If manual replacement fails, hydrostatic replacement with warm fluid into the vagina is used. Surgery may be needed if this fails. Oxytocin is given after replacement.

Why not the others

- **B:** Last resort.
- **C:** Only after replacement.
- **D:** Not before replacement.
- **E:** Unsafe.

Key point: Failed manual: hydrostatic (O'Sullivan) method.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 668 · Amniotic fluid embolism · **Hard** · C3

During labour, a woman suddenly becomes breathless, hypotensive and cyanosed, then has a seizure. Shortly after, she bleeds heavily from cannula sites.

What is the most likely diagnosis?

A. Amniotic fluid embolism
B. Eclampsia
C. Pulmonary embolism
D. Septic shock
E. Uterine rupture

Answer: A. Amniotic fluid embolism

AFE presents with sudden collapse, hypoxia, hypotension and seizures, followed by DIC. It needs immediate resuscitation and support.

Why not the others

- **B:** No DIC.
- **C:** No DIC typically.
- **D:** Slower onset.
- **E:** Pain and fetal distress.

Key point: Sudden collapse with DIC in labour: AFE.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 669 · Maternal collapse · **Hard** · C3

A woman at 34 weeks has a cardiac arrest. CPR has started.

What is a key modification in pregnancy?

A. Avoid adrenaline
B. Manual left uterine displacement
C. No chest compressions
D. Place her flat supine without change
E. Wait for an obstetrician

Answer: B. Manual left uterine displacement

After 20 weeks, the uterus compresses the vena cava. Manual left uterine displacement (or left lateral tilt) improves venous return during CPR.

Why not the others

- **A:** Standard drugs are used.
- **C:** Compressions are needed.
- **D:** Displacement is needed.
- **E:** Start CPR at once.

Key point: CPR in pregnancy: left uterine displacement.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 670 · Maternal collapse · **Hard** · C3

A woman at 32 weeks has cardiac arrest. CPR has been going for 4 minutes without return of circulation.

What is the most appropriate step?

A. Continue CPR only
B. Perimortem caesarean section
C. Stop resuscitation
D. Transfer to theatre first
E. Wait for 20 minutes

Answer: B. Perimortem caesarean section

Perimortem caesarean should be started by 4 minutes and the baby delivered by 5 minutes, in the place of arrest. It helps maternal resuscitation.

Why not the others

- **A:** Not enough.
- **C:** Not appropriate.
- **D:** Do it where she is.
- **E:** Too late.

Key point: Perimortem CS by 5 minutes.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 671 · Eclampsia · **Moderate** · C2

A woman with pre-eclampsia has a seizure.

What is the first-line drug?

A. Diazepam
B. Labetalol
C. Magnesium sulfate
D. Phenytoin
E. Propofol

Answer: C. Magnesium sulfate

Magnesium sulfate (4 g loading dose then 1 g per hour for 24 hours) is the drug of choice for eclampsia (Collaborative Eclampsia Trial).

Why not the others

- **A:** Not first line.
- **B:** For BP.
- **D:** Less effective.
- **E:** Not first line.

Key point: Eclampsia: magnesium sulfate.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 672 · Pulmonary embolism · **Moderate** · C2

A woman 5 days after caesarean has sudden chest pain and breathlessness. Oxygen saturation is 90%.

What is the most appropriate immediate step?

A. Await imaging before treatment
B. Discharge
C. Give LMWH while arranging imaging
D. Give oral antibiotics
E. Give paracetamol

Answer: C. Give LMWH while arranging imaging

If PE is suspected, start LMWH immediately unless contraindicated, then confirm with imaging (CTPA or V/Q).

Why not the others

- **A:** Treatment should not wait.
- **B:** Unsafe.
- **D:** Not appropriate.
- **E:** Not appropriate.

Key point: Suspected PE: start LMWH, then image.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 673 · Local anaesthetic toxicity · **Hard** · C3

During an epidural top-up, a woman becomes agitated, has tinnitus, then collapses with ventricular arrhythmia.

What is the specific treatment?

A. Calcium gluconate
B. Intralipid (lipid emulsion)
C. Naloxone
D. Oxytocin
E. Protamine

Answer: B. Intralipid (lipid emulsion)

Local anaesthetic systemic toxicity is treated with 20% lipid emulsion (Intralipid) plus standard resuscitation.

Why not the others

- **A:** For magnesium toxicity.
- **C:** For opioids.
- **D:** Not relevant.
- **E:** For heparin.

Key point: LA toxicity: Intralipid.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 674 · Retained placenta · **Moderate** · C2

A woman's placenta has not delivered after 60 minutes. She is stable.

What is the most appropriate management?

A. Ergometrine and wait
B. Leave it and discharge
C. Manual removal in theatre with anaesthesia
D. Pull on the cord hard
E. Wait 6 hours

Answer: C. Manual removal in theatre with anaesthesia

A retained placenta needs manual removal in theatre with regional or general anaesthesia. Antibiotics are given.

Why not the others

- **A:** Not standard.
- **B:** Unsafe.
- **D:** Risks inversion.
- **E:** Too long.

Key point: Retained placenta: manual removal in theatre.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 675 · Massive haemorrhage · **Hard** · C3

A woman with PPH of 2500 mL is in theatre.

What is the target for fibrinogen?

A. Above 0.5 g/L
B. Above 1 g/L
C. Above 2 g/L
D. Above 5 g/L
E. Not relevant

Answer: C. Above 2 g/L

In obstetric haemorrhage, fibrinogen should be kept above 2 g/L. Low fibrinogen predicts severe bleeding.

Why not the others

- **A:** Too low.
- **B:** Too low.
- **D:** Not needed.
- **E:** It is very relevant.

Key point: Keep fibrinogen above 2 g/L.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 676 · Shoulder dystocia · **Moderate** · C2

A shoulder dystocia is diagnosed. The midwife calls for help.

Which action should be avoided?

A. Episiotomy if needed for access
B. Fundal pressure
C. McRoberts manoeuvre
D. Recording the time of head delivery
E. Suprapubic pressure

Answer: B. Fundal pressure

Fundal pressure should not be used in shoulder dystocia because it worsens impaction and increases uterine rupture and brachial plexus injury.

Why not the others

- **A:** May help internal manoeuvres.
- **C:** First-line.
- **D:** Important for records.
- **E:** Recommended.

Key point: Never use fundal pressure in shoulder dystocia.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 677 · Shoulder dystocia · **Hard** · C3

A woman with a BMI of 42 has a shoulder dystocia. McRoberts and suprapubic pressure fail. Internal access is difficult.

Which alternative position can help?

A. All-fours position
B. Lithotomy without leg flexion
C. Prone
D. Supine flat
E. Trendelenburg

Answer: A. All-fours position

The all-fours (Gaskin) position can help release the shoulders and gives easier access to the posterior arm, especially with high BMI.

Why not the others

- **B:** Less effective.
- **C:** Not standard.
- **D:** Not helpful.
- **E:** Not helpful.

Key point: All-fours position can help in shoulder dystocia.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 678 · Shoulder dystocia · **Moderate** · C2

A woman had a shoulder dystocia in her last pregnancy.

What is the most appropriate advice?

A. Caesarean is mandatory
B. Discuss options including caesarean or vaginal birth
C. Induction at 36 weeks
D. No discussion needed
E. Vaginal birth is forbidden

Answer: B. Discuss options including caesarean or vaginal birth

After a previous shoulder dystocia, the recurrence risk is higher (1–25%). Options for caesarean or vaginal birth should be discussed.

Why not the others

- **A:** Not mandatory.
- **C:** Not standard.
- **D:** Discussion is needed.
- **E:** Not forbidden.

Key point: Previous shoulder dystocia: discuss options.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 679 · Cord prolapse · **Moderate** · C1

A student asks about risk factors for cord prolapse.

Which is a risk factor?

A. Cephalic engaged head
B. Low parity alone
C. Oligohydramnios
D. Small placenta
E. Transverse lie

Answer: E. Transverse lie

Risk factors include malpresentation (transverse lie, breech), polyhydramnios, prematurity, multiparity, ARM with a high head and second twin.

Why not the others

- **A:** Protective.
- **B:** Not a risk factor.
- **C:** Polyhydramnios is the risk.
- **D:** Not a risk factor.

Key point: Malpresentation and polyhydramnios raise cord prolapse risk.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 680 · Cord prolapse · **Hard** · C3

A woman at full dilatation has a cord prolapse. The head is at +2 station in OA position.

What is the most appropriate management?

A. Caesarean section
B. Delay delivery
C. Expedite vaginal birth with an instrument
D. Push the head up
E. Wait

Answer: C. Expedite vaginal birth with an instrument

If the woman is fully dilated and vaginal birth is quick and safe, an instrumental delivery is appropriate.

Why not the others

- **A:** Slower than instrumental here.
- **B:** Unsafe.
- **D:** Not needed.
- **E:** Unsafe.

Key point: Cord prolapse at full dilatation: quick vaginal birth if possible.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 681 · PPH · **Easy** · C1

A student asks which drug is first line for preventing PPH.

What is the first-line uterotonic?

A. Carboprost
B. Ergometrine
C. Misoprostol
D. Oxytocin
E. Tranexamic acid

Answer: D. Oxytocin

Oxytocin 10 IU IM is first line for prevention of PPH in the third stage.

Why not the others

- **A:** Used for treatment.
- **B:** Second line.
- **C:** Used where oxytocin is not available.
- **E:** Not a uterotonic.

Key point: Oxytocin is first line for PPH prevention.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 682 · PPH · **Moderate** · C1

A student asks about risk factors for PPH.

Which is a risk factor?

A. Low parity
B. Prolonged labour
C. Short labour
D. Single pregnancy
E. Small baby

Answer: B. Prolonged labour

Risk factors for PPH include prolonged labour, multiple pregnancy, macrosomia, polyhydramnios, previous PPH, APH, and anaemia.

Why not the others

- **A:** Not a risk factor.
- **C:** Not a risk factor.
- **D:** Not a risk factor.
- **E:** Not a risk factor.

Key point: Prolonged labour raises PPH risk.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 683 · PPH · **Hard** · C3

A woman with PPH is bleeding from all cannula sites and the uterus is contracted.

What is the most likely cause?

A. Coagulopathy
B. Retained placenta
C. Trauma
D. Uterine atony
E. Uterine rupture

Answer: A. Coagulopathy

Bleeding from cannula sites suggests coagulopathy (DIC). It can follow abruption, AFE, sepsis or massive transfusion.

Why not the others

- **B:** No oozing from cannulas.
- **C:** Local.
- **D:** Uterus is contracted.
- **E:** Local.

Key point: Oozing from cannula sites: coagulopathy.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 684 · PPH · **Hard** · C3

A woman with ongoing atonic PPH has failed balloon tamponade. A laparotomy is done.

Which surgical step helps to compress the uterus?

A. B-Lynch suture
B. Caesarean
C. Cervical cerclage
D. Episiotomy
E. Manual removal

Answer: A. B-Lynch suture

The B-Lynch compression suture compresses the uterus. Other options include uterine artery ligation and hysterectomy.

Why not the others

- **B:** Not relevant.
- **C:** Not relevant.
- **D:** Not relevant.
- **E:** Not relevant.

Key point: B-Lynch suture compresses the atonic uterus.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 685 · PPH · **Moderate** · C2

A woman with PPH is given tranexamic acid.

When is it most effective?

A. After 24 hours
B. Only after transfusion
C. Only with surgery
D. Within 3 hours of birth
E. Within 7 days

Answer: D. Within 3 hours of birth

Tranexamic acid is most effective when given within 3 hours of birth (WOMAN trial).

Why not the others

- **A:** Too late.
- **B:** Not needed.
- **C:** Not required.
- **E:** Too late.

Key point: Give tranexamic acid within 3 hours.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 686 · Sepsis · **Moderate** · C2

A woman 2 days after birth has a temperature of 39 °C, heart rate 120/min and respiratory rate 24/min. Her lactate is 4 mmol/L.

What is the most appropriate action?

A. Give IV fluids and IV antibiotics within 1 hour
B. Give oral antibiotics
C. Recheck in 4 hours
D. Send home
E. Wait for cultures

Answer: A. Give IV fluids and IV antibiotics within 1 hour

She has sepsis with high lactate. The Sepsis Six should be completed within 1 hour.

Why not the others

- **B:** Not enough.
- **C:** Delay is harmful.
- **D:** Unsafe.
- **E:** Delay is harmful.

Key point: Maternal sepsis: Sepsis Six within 1 hour.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 687 · Anaphylaxis · **Moderate** · C2

A woman develops wheeze, hypotension and a rash during IV antibiotics at caesarean.

What is the first-line treatment?

A. Adrenaline IM 0.5 mg
B. Chlorphenamine only
C. Hydrocortisone only
D. Salbutamol only
E. Stop the drug and wait

Answer: A. Adrenaline IM 0.5 mg

Anaphylaxis is treated with IM adrenaline (0.5 mg). Stop the trigger, give oxygen and fluids, and use left lateral tilt if pregnant.

Why not the others

- **B:** Second line.
- **C:** Second line.
- **D:** Not enough.
- **E:** Not enough.

Key point: Anaphylaxis: IM adrenaline.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 688 · High spinal · **Hard** · C3

After a spinal anaesthetic, a woman has difficulty breathing, weak hands and hypotension.

What is the most likely cause?

A. Amniotic fluid embolism
B. Anaphylaxis
C. Eclampsia
D. High spinal block
E. Pulmonary embolism

Answer: D. High spinal block

A high spinal block causes hypotension, bradycardia, arm weakness and breathing difficulty. It needs airway support and vasopressors.

Why not the others

- **A:** Would cause DIC.
- **B:** Would cause rash.
- **C:** Seizures.
- **E:** Sudden pleuritic pain.

Key point: High spinal: arm weakness, breathing difficulty.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 689 · Uterine rupture · **Hard** · C2

A woman with no previous surgery has obstructed labour and develops sudden abdominal pain and shock.

What is the most likely diagnosis?

A. Amniotic fluid embolism
B. Placenta praevia
C. Placental abruption
D. Uterine inversion
E. Uterine rupture

Answer: E. Uterine rupture

Uterine rupture can occur in obstructed labour even without a scar, especially in multiparous women.

Why not the others

- **A:** Not linked to obstruction.
- **B:** Painless.
- **C:** Possible but less likely.
- **D:** After birth.

Key point: Obstructed labour can cause rupture of an unscarred uterus.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 690 · Sheehan syndrome · **Hard** · C2

A woman had a massive PPH. Weeks later she cannot breastfeed and feels tired and cold.

What is the most likely diagnosis?

A. Cushing syndrome
B. Hyperthyroidism
C. Postnatal depression
D. Sheehan syndrome
E. Thyroiditis

Answer: D. Sheehan syndrome

Sheehan syndrome is pituitary necrosis after severe PPH. Failure of lactation is often the first sign. Hypothyroidism and adrenal insufficiency may follow.

Why not the others

- **A:** Opposite effect.
- **B:** Opposite symptoms.
- **C:** Does not stop lactation.
- **E:** Does not stop lactation.

Key point: No lactation after severe PPH: Sheehan syndrome.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 691 · Maternal collapse · **Moderate** · C1

A student asks about the most common causes of maternal collapse.

Which is a common cause?

A. Haemorrhage
B. Hyperthermia
C. Hypoglycaemia only
D. Migraine
E. Thyroid storm

Answer: A. Haemorrhage

Common causes of collapse include haemorrhage, VTE, sepsis, AFE, eclampsia and drug toxicity.

Why not the others

- **B:** Rare.
- **C:** Possible but less common.
- **D:** Not a cause.
- **E:** Rare.

Key point: Haemorrhage is a common cause of maternal collapse.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 692 · Eclampsia · **Hard** · C3

A woman with eclampsia has another seizure while on a magnesium infusion.

What is the most appropriate step?

A. Do nothing
B. Give a further 2 g bolus of magnesium
C. Give diazepam only
D. Give phenytoin
E. Stop magnesium

Answer: B. Give a further 2 g bolus of magnesium

For a recurrent seizure, a further 2 g (or 4 g if weight >70 kg) magnesium bolus is given.

Why not the others

- **A:** Unsafe.
- **C:** Not first choice.
- **D:** Not first choice.
- **E:** Not appropriate.

Key point: Recurrent eclamptic seizure: further magnesium bolus.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 693 · Pulmonary embolism · **Hard** · C2

A pregnant woman with suspected PE has a normal chest X-ray.

Which test is often preferred to limit breast radiation?

A. CT pulmonary angiogram
B. D-dimer
C. Echocardiogram
D. MRI
E. V/Q scan

Answer: E. V/Q scan

With a normal chest X-ray, a V/Q or perfusion scan is often preferred because it gives less breast radiation than CTPA.

Why not the others

- **A:** More breast radiation.
- **B:** Not reliable in pregnancy.
- **C:** Not diagnostic.
- **D:** Not standard.

Key point: Normal CXR: V/Q scan preferred in pregnancy.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 694 · PPH · **Moderate** · C2

A woman with PPH needs ergometrine.

Which condition is a contraindication?

A. Asthma
B. Diabetes
C. Hypertension
D. Migraine without aura
E. Normal BP

Answer: C. Hypertension

Ergometrine causes vasoconstriction and raises BP. It is avoided in hypertension and pre-eclampsia.

Why not the others

- **A:** Avoid carboprost.
- **B:** Not a contraindication.
- **D:** Not standard.
- **E:** Not a contraindication.

Key point: Avoid ergometrine in hypertension.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 695 · Obstetric emergencies · **Easy** · C1

A student asks about early warning scores.

What is MEOWS used for?

A. Diagnosing diabetes
B. Early detection of maternal deterioration
C. Fetal monitoring
D. Neonatal resuscitation
E. Pain relief

Answer: B. Early detection of maternal deterioration

The Modified Early Obstetric Warning Score (MEOWS) records maternal observations to detect early deterioration.

Why not the others

- **A:** Not relevant.
- **C:** Not relevant.
- **D:** Not relevant.
- **E:** Not relevant.

Key point: MEOWS detects maternal deterioration early.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 696 · Placental abruption · **Hard** · C3

A woman with abruption and IUFD has a platelet count of 40 × 10^9/L and fibrinogen of 1 g/L. She is bleeding.

What is the most appropriate step?

A. Give aspirin
B. Give blood products to correct clotting
C. Give heparin
D. Immediate caesarean
E. Wait for labour

Answer: B. Give blood products to correct clotting

DIC with bleeding needs correction with platelets, cryoprecipitate and FFP before or during delivery.

Why not the others

- **A:** Increases bleeding.
- **C:** Increases bleeding.
- **D:** Not before correction.
- **E:** Delay risks worsening.

Key point: DIC: correct with blood products.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 697 · Shoulder dystocia · **Moderate** · C2

After a shoulder dystocia is resolved, the team must complete paperwork.

What is essential to record?

A. Nothing
B. Only the baby's weight
C. Only the mother's name
D. Only the time of birth
E. The head-to-body delivery interval and manoeuvres used

Answer: E. The head-to-body delivery interval and manoeuvres used

Documentation should include the time of head delivery, the time of body delivery, the manoeuvres used, which shoulder was anterior and staff present.

Why not the others

- **A:** Not acceptable.
- **B:** Not enough.
- **C:** Not enough.
- **D:** Not enough.

Key point: Record the head-to-body interval and manoeuvres.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 698 · Cord prolapse · **Moderate** · C2

A woman with cord prolapse is waiting for theatre.

Which position is helpful?

A. Knee-chest position
B. Lithotomy
C. Sitting up
D. Standing
E. Supine

Answer: A. Knee-chest position

The knee-chest position or exaggerated Sims position reduces pressure on the cord.

Why not the others

- **B:** Not helpful.
- **C:** Not helpful.
- **D:** Not helpful.
- **E:** Not helpful.

Key point: Knee-chest position in cord prolapse.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 699 · PPH · **Hard** · C3

A woman with PPH after vaginal birth is stable but still bleeding. The uterus is firm and the vagina shows a large haematoma.

What is the most appropriate management?

A. Bakri balloon
B. Carboprost
C. Evacuation of haematoma and repair
D. Hysterectomy
E. More oxytocin

Answer: C. Evacuation of haematoma and repair

A large genital tract haematoma needs evacuation, haemostasis and repair, often in theatre.

Why not the others

- **A:** For atony.
- **B:** For atony.
- **D:** Not needed.
- **E:** For atony.

Key point: Vaginal haematoma: evacuate and repair.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

MCQ 700 · Maternal collapse · **Moderate** · C2

A woman at 30 weeks collapses and becomes unresponsive.

What is the first step?

A. Call for help and assess airway and breathing
B. Deliver the baby
C. Give oxytocin
D. Start antibiotics
E. Wait for an obstetrician

Answer: A. Call for help and assess airway and breathing

Follow the ABC approach: call for help, check airway and breathing, then circulation. Left lateral tilt is used in pregnancy.

Why not the others

- **B:** Not first.
- **C:** Not appropriate.
- **D:** Not first.
- **E:** Delay is harmful.

Key point: Maternal collapse: call for help and ABC.

Reference: Obstetrics by Ten Teachers — Obstetric emergencies

CHAPTER 15

The Puerperium and Postnatal Care

MCQ 701 · Physiology · **Easy** · C1

A woman on day 2 after a normal birth asks about the vaginal discharge she is having.

Which description of normal lochia is correct?

A. Green and offensive from day 1
B. Lochia rubra first, then serosa, then alba over several weeks
C. No discharge after day 2
D. Purulent discharge for 2 weeks
E. White discharge from day 1

Answer: B. Lochia rubra first, then serosa, then alba over several weeks

Lochia is red (rubra) for the first few days, then pinkish-brown (serosa), then yellow-white (alba). It can last up to 6 weeks. Offensive lochia suggests infection.

Why not the others

- **A:** Suggests infection.
- **C:** Lochia continues for weeks.
- **D:** Suggests infection.
- **E:** Not the first stage.

Key point: Lochia: rubra → serosa → alba over up to 6 weeks.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 702 · Physiology · **Easy** · C1

A student asks about uterine involution after birth.

When is the uterus usually no longer palpable abdominally?

A. Day 1
B. Day 3
C. About 10–14 days
D. 6 months
E. 1 year

Answer: C. About 10–14 days

After birth the fundus is at the umbilicus. It falls by about 1 cm a day and is usually not palpable abdominally by 10–14 days.

Why not the others

- **A:** Still at the umbilicus.
- **B:** Still palpable.
- **D:** Too long.
- **E:** Too long.

Key point: Uterus not palpable abdominally by about 10–14 days.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 703 · Breastfeeding · **Easy** · C1

A new mother asks about the benefits of breastfeeding.

Which is a benefit to the mother?

A. Higher risk of breast cancer
B. Lower risk of breast and ovarian cancer
C. More osteoporosis always
D. More PPH
E. More weight gain

Answer: B. Lower risk of breast and ovarian cancer

Breastfeeding lowers the mother's risk of breast and ovarian cancer and helps uterine involution. For the baby it reduces infections, SIDS and obesity.

Why not the others

- **A:** The opposite.
- **C:** Not shown.
- **D:** It helps the uterus contract.
- **E:** May help weight loss.

Key point: Breastfeeding lowers maternal breast and ovarian cancer risk.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 704 · Mastitis · **Moderate** · C2

A woman 3 weeks after birth has a red, tender, hot wedge-shaped area on her left breast and a fever of 38.3 °C. She is breastfeeding.

What is the most appropriate management?

A. Continue breastfeeding and start flucloxacillin if symptoms persist or worsen
B. Incision and drainage
C. Stop breastfeeding immediately
D. Switch to formula permanently
E. Ultrasound before any treatment

Answer: A. Continue breastfeeding and start flucloxacillin if symptoms persist or worsen

Mastitis is managed by continuing to feed or express to empty the breast, analgesia and, if symptoms do not settle in 12–24 hours or she is unwell, flucloxacillin (erythromycin if allergic).

Why not the others

- **B:** For an abscess.
- **C:** Stopping worsens milk stasis.
- **D:** Not needed.
- **E:** Only if abscess suspected.

Key point: Mastitis: keep feeding; flucloxacillin if needed.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 705 · Breast abscess · **Moderate** · C2

A breastfeeding woman treated for mastitis has a tender, fluctuant lump in her breast.

What is the most appropriate management?

A. Massage only
B. Mastectomy
C. Stop breastfeeding on both sides forever
D. Ultrasound-guided aspiration and antibiotics
E. Watch and wait

Answer: D. Ultrasound-guided aspiration and antibiotics

A breast abscess needs ultrasound-guided aspiration (or incision and drainage) and antibiotics. Breastfeeding can usually continue from the other breast.

Why not the others

- **A:** Not enough.
- **B:** Not indicated.
- **C:** Not needed.
- **E:** Not enough.

Key point: Breast abscess: aspiration and antibiotics.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 706 · Contraception · **Moderate** · C2

A breastfeeding woman 3 weeks after birth asks about contraception.

Which method is unsuitable at this time?

A. Barrier methods
B. Combined oral contraceptive pill
C. Implant
D. Progestogen injection
E. Progestogen-only pill

Answer: B. Combined oral contraceptive pill

The combined pill is UKMEC 4 in the first 6 weeks after birth in breastfeeding women due to VTE risk. Progestogen-only methods are safe.

Why not the others

- **A:** Safe.
- **C:** Safe.
- **D:** Safe.
- **E:** Safe.

Key point: No combined pill in the first 6 weeks while breastfeeding.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 707 · Contraception · **Moderate** · C2

A woman asks when a copper IUD can be inserted after birth.

When can it be fitted?

A. Only after 3 months
B. Only after 6 months
C. Only after the first period
D. Only after weaning
E. Within 48 hours or from 4 weeks after birth

Answer: E. Within 48 hours or from 4 weeks after birth

An IUD can be fitted within 48 hours of birth or from 4 weeks. Between 48 hours and 4 weeks, expulsion and perforation risks are higher.

Why not the others

- **A:** Too restrictive.
- **B:** Too restrictive.
- **C:** Not required.
- **D:** Not required.

Key point: IUD: within 48 hours or from 4 weeks after birth.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 708 · Contraception · **Moderate** · C2

A woman is exclusively breastfeeding her 2-month-old baby day and night and has no periods.

How effective is the lactational amenorrhoea method?

A. About 50%
B. About 70%
C. No protection
D. Only effective for 1 week
E. Over 98%

Answer: E. Over 98%

LAM is over 98% effective if the woman is fully breastfeeding, has no periods and the baby is under 6 months.

Why not the others

- **A:** Too low.
- **B:** Too low.
- **C:** Not true.
- **D:** Lasts up to 6 months.

Key point: LAM: >98% if all three criteria are met.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 709 · Contraception · **Easy** · C1

A non-breastfeeding woman asks when she could become fertile again after birth.

When is ovulation possible?

A. After 1 year
B. After 6 months
C. From day 21 after birth
D. Never while recovering
E. Only after periods start

Answer: C. From day 21 after birth

Ovulation can occur from day 21 after birth in women who are not breastfeeding. Contraception is needed from day 21.

Why not the others

- **A:** Too late.
- **B:** Too late.
- **D:** Not true.
- **E:** Ovulation comes before the first period.

Key point: Contraception is needed from day 21 after birth.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 710 · Baby blues · **Easy** · C2

A woman 4 days after birth is tearful and anxious but is eating, sleeping when the baby sleeps and caring for the baby well.

What is the most likely diagnosis?

A. Baby blues
B. Post-traumatic stress
C. Postnatal depression
D. Postpartum psychosis
E. Thyroid storm

Answer: A. Baby blues

Baby blues affect up to 80% of women around days 3–5. They are mild and resolve within 2 weeks with support.

Why not the others

- **B:** Not suggested.
- **C:** Lasts longer than 2 weeks.
- **D:** Includes psychosis.
- **E:** Not suggested.

Key point: Baby blues: days 3–5, resolve within 2 weeks.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 711 · Postnatal depression · **Moderate** · C2

A woman 6 weeks after birth has low mood, poor sleep even when the baby sleeps, guilt and loss of interest for 3 weeks.

What is the most likely diagnosis?

A. Baby blues
B. Normal tiredness
C. Postnatal depression
D. Postpartum psychosis
E. Postpartum thyroiditis

Answer: C. Postnatal depression

Postnatal depression affects about 10–15% of women. Symptoms last more than 2 weeks. The Edinburgh Postnatal Depression Scale is used for screening.

Why not the others

- **A:** Resolves within 2 weeks.
- **B:** Symptoms are more than tiredness.
- **D:** No psychotic features.
- **E:** Check thyroid, but depression is most likely.

Key point: Low mood for over 2 weeks after birth: postnatal depression.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 712 · Postpartum psychosis · **Hard** · C3

A woman with bipolar disorder delivered 5 days ago. She is confused, agitated, believes her baby is evil and has not slept.

What is the most appropriate management?

A. Advise rest at home
B. Discharge with GP follow-up
C. Psychiatric emergency referral and admission to a mother and baby unit
D. Start oral antidepressant only
E. Wait for 2 weeks

Answer: C. Psychiatric emergency referral and admission to a mother and baby unit

Postpartum psychosis is a psychiatric emergency with risk to mother and baby. It needs urgent psychiatric review and usually admission to a mother and baby unit.

Why not the others

- **A:** Unsafe.
- **B:** Unsafe.
- **D:** Not enough.
- **E:** Unsafe.

Key point: Postpartum psychosis: emergency; mother and baby unit.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 713 · Postpartum psychosis · **Moderate** · C1

A student asks which woman is at highest risk of postpartum psychosis.

Which is the strongest risk factor?

A. Bipolar disorder
B. Caesarean section
C. First baby only
D. Formula feeding
E. Young age

Answer: A. Bipolar disorder

Bipolar disorder (personal or family history) and previous postpartum psychosis are the strongest risk factors. The risk is about 1 in 4 for women with bipolar disorder.

Why not the others

- **B:** Not a strong risk.
- **C:** A weaker factor.
- **D:** Not a risk factor.
- **E:** Not a strong risk.

Key point: Bipolar disorder is the strongest risk factor.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 714 · Urinary retention · **Moderate** · C2

A woman 6 hours after a vaginal birth with an epidural has not passed urine.

What is the most appropriate action?

A. Discharge
B. Encourage fluids and wait 24 hours
C. Give diuretics
D. Measure bladder volume and catheterise if needed
E. Start antibiotics

Answer: D. Measure bladder volume and catheterise if needed

Women should pass urine within 6 hours of birth. If not, assess bladder volume and catheterise to prevent overdistension and long-term damage.

Why not the others

- **A:** Unsafe.
- **B:** Too long.
- **C:** Not appropriate.
- **E:** Not appropriate.

Key point: No void within 6 hours: assess and catheterise.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 715 · Pelvic floor · **Easy** · C2

A woman 3 months after birth has stress urinary incontinence.

What is the first-line treatment?

A. Colposuspension
B. Mesh sling
C. Pelvic floor muscle training for at least 3 months
D. Stop drinking fluids
E. Urethral bulking

Answer: C. Pelvic floor muscle training for at least 3 months

Supervised pelvic floor muscle training for at least 3 months is first line for stress incontinence after childbirth.

Why not the others

- **A:** Surgical.
- **B:** Surgical.
- **D:** Not advised.
- **E:** Surgical.

Key point: Postnatal stress incontinence: pelvic floor training.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 716 · Endometritis · **Moderate** · C2

A woman 4 days after caesarean has fever, lower abdominal pain, a tender uterus and offensive lochia.

What is the most likely diagnosis?

A. Endometritis
B. Mastitis
C. Pyelonephritis
D. Thrombophlebitis
E. Wound infection

Answer: A. Endometritis

Endometritis presents with fever, uterine tenderness and offensive lochia. It is more common after caesarean. IV antibiotics are needed if she is unwell.

Why not the others

- **B:** Breast signs.
- **C:** Loin pain.
- **D:** Leg signs.
- **E:** Wound signs.

Key point: Fever, tender uterus and offensive lochia: endometritis.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 717 · VTE · **Moderate** · C2

A woman with a BMI of 42 had a vaginal birth. She has no other risk factors.

What postnatal thromboprophylaxis is advised?

A. Aspirin only
B. LMWH for 6 months
C. LMWH for at least 10 days
D. No treatment
E. Stockings only

Answer: C. LMWH for at least 10 days

RCOG: BMI 40 or more is a significant risk factor; LMWH for at least 10 days postnatally is advised.

Why not the others

- **A:** Not advised.
- **B:** Too long.
- **D:** Treatment is needed.
- **E:** Not enough.

Key point: BMI ≥40: LMWH for 10 days postnatally.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 718 · VTE · **Moderate** · C2

A woman on day 7 after birth has a swollen, painful left calf.

What is the most appropriate investigation?

A. Compression duplex ultrasound
B. CT head
C. D-dimer only
D. Venogram first
E. X-ray of the leg

Answer: A. Compression duplex ultrasound

Compression duplex ultrasound is the investigation of choice for suspected DVT. LMWH is started while awaiting the scan.

Why not the others

- **B:** Not relevant.
- **C:** Unreliable postnatally.
- **D:** Not first line.
- **E:** Not useful.

Key point: Suspected DVT: compression duplex ultrasound.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 719 · Anti-D · **Moderate** · C2

An RhD-negative woman delivers an RhD-positive baby.

When should anti-D be given?

A. At the 6-week check
B. Before the next pregnancy
C. Not needed
D. Only if she plans more children
E. Within 72 hours of birth

Answer: E. Within 72 hours of birth

Anti-D is given within 72 hours of birth if the baby is RhD positive. A Kleihauer test guides extra doses.

Why not the others

- **A:** Too late.
- **B:** Too late.
- **C:** Needed.
- **D:** Given regardless.

Key point: Anti-D within 72 hours of birth.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 720 · Postpartum thyroiditis · **Hard** · C2

A woman 3 months after birth has palpitations and weight loss. TSH is low and T4 is high. Thyroid uptake scan shows low uptake.

What is the most likely diagnosis?

A. Graves disease
B. Postpartum thyroiditis
C. Sheehan syndrome
D. Thyroid cancer
E. Toxic multinodular goitre

Answer: B. Postpartum thyroiditis

Postpartum thyroiditis has a hyperthyroid phase with low uptake, then often a hypothyroid phase. Beta-blockers help symptoms.

Why not the others

- **A:** High uptake.
- **C:** Low thyroid levels.
- **D:** Not suggested.
- **E:** High uptake.

Key point: Postnatal hyperthyroid with low uptake: thyroiditis.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 721 · Postnatal hypertension · **Moderate** · C2

A breastfeeding woman with pre-eclampsia still needs BP treatment after birth.

Which drug is recommended?

A. Atenolol
B. Enalapril
C. Lisinopril
D. Losartan
E. Ramipril

Answer: B. Enalapril

NICE advises enalapril for postnatal hypertension in breastfeeding women. Nifedipine or amlodipine are alternatives. Monitor renal function.

Why not the others

- **A:** Not first line.
- **C:** Less data in breastfeeding.
- **D:** Not advised in breastfeeding.
- **E:** Less data.

Key point: Breastfeeding hypertension: enalapril.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 722 · Post-dural puncture headache · **Moderate** · C2

A woman had an epidural with an accidental dural puncture. Two days later she has a severe headache when sitting up that improves lying down.

What is the most likely diagnosis?

A. Migraine
B. Post-dural puncture headache
C. Pre-eclampsia
D. Subarachnoid haemorrhage
E. Tension headache

Answer: B. Post-dural puncture headache

Post-dural puncture headache is postural (worse upright, better lying down). Treatment is analgesia, fluids and, if severe, an epidural blood patch.

Why not the others

- **A:** Not postural.
- **C:** Check BP, but this pattern is postural.
- **D:** Sudden thunderclap.
- **E:** Not postural.

Key point: Postural headache after epidural: dural puncture; blood patch.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 723 · Postnatal care · **Easy** · C1

A woman asks when she will have her routine postnatal check with the GP.

When is it usually done?

A. At 1 week
B. At 1 year
C. At 6 months
D. At 6–8 weeks
E. Not needed

Answer: D. At 6–8 weeks

The postnatal check is done at 6–8 weeks to review recovery, mental health, contraception and BP.

Why not the others

- **A:** Too early.
- **B:** Too late.
- **C:** Too late.
- **E:** Needed.

Key point: Postnatal check at 6–8 weeks.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 724 · Lactation suppression · **Moderate** · C2

A woman had a stillbirth at 36 weeks. She does not want to breastfeed.

What can be given to suppress lactation?

A. Bromocriptine as first line
B. Cabergoline
C. Domperidone
D. Metoclopramide
E. Oxytocin

Answer: B. Cabergoline

Cabergoline (1 mg single dose) suppresses lactation. It should be avoided in hypertension or pre-eclampsia.

Why not the others

- **A:** Not first line due to side effects.
- **C:** Increases milk.
- **D:** Increases milk.
- **E:** Causes milk let-down.

Key point: Cabergoline suppresses lactation.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 725 · Peripartum cardiomyopathy · **Hard** · C3

A woman 3 weeks after birth has breathlessness, ankle swelling and orthopnoea. Echocardiogram shows an ejection fraction of 35%.

What is the most likely diagnosis?

A. Anaemia
B. Peripartum cardiomyopathy
C. Pneumonia
D. Pre-eclampsia
E. Pulmonary embolism

Answer: B. Peripartum cardiomyopathy

Peripartum cardiomyopathy is heart failure with reduced ejection fraction in late pregnancy or up to 5 months after birth, with no other cause.

Why not the others

- **A:** Does not reduce EF.
- **C:** Not suggested.
- **D:** Possible but not with this EF.
- **E:** Not suggested.

Key point: Heart failure with low EF after birth: peripartum cardiomyopathy.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 726 · Breastfeeding · **Moderate** · C2

A breastfeeding woman needs anticoagulation for a postnatal DVT.

Which drug is safe in breastfeeding?

A. Apixaban
B. Dabigatran
C. LMWH or warfarin
D. Phenindione
E. Rivaroxaban

Answer: C. LMWH or warfarin

LMWH and warfarin are both safe in breastfeeding. Direct oral anticoagulants are not advised.

Why not the others

- **A:** Not advised.
- **B:** Not advised.
- **D:** Phenindione is avoided in breastfeeding.
- **E:** Not advised.

Key point: LMWH and warfarin are safe in breastfeeding.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 727 · Breastfeeding · **Moderate** · C2

A breastfeeding woman has sore, cracked nipples on day 3.

What is the most likely cause?

A. Bacterial infection
B. Eczema
C. Poor latch or attachment
D. Thrush
E. Too much milk

Answer: C. Poor latch or attachment

Sore nipples in the first days are most often due to poor positioning or attachment. Support with latch helps.

Why not the others

- **A:** Less likely.
- **B:** Less likely.
- **D:** Less likely early.
- **E:** Not the cause.

Key point: Sore nipples early: check the latch.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 728 · Breastfeeding · **Hard** · C2

A breastfeeding woman has burning nipple pain and shooting pains in the breast after feeds. The baby has white patches in the mouth.

What is the most likely cause?

A. Breast abscess
B. Mastitis
C. Nipple thrush
D. Poor latch
E. Raynaud's of the nipple

Answer: C. Nipple thrush

Nipple thrush causes burning and shooting pain. Both mother and baby should be treated (topical miconazole for both; oral fluconazole for mother if needed).

Why not the others

- **A:** Would have a lump.
- **B:** Would have a red, hot area.
- **D:** Possible, but oral thrush suggests candida.
- **E:** Colour change with cold.

Key point: Nipple thrush: treat mother and baby.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 729 · Perineal care · **Easy** · C2

A woman 5 days after a second-degree tear has perineal pain.

What is the first-line analgesic?

A. Codeine
B. Diclofenac or paracetamol
C. Morphine
D. Pethidine
E. Tramadol

Answer: B. Diclofenac or paracetamol

Paracetamol and NSAIDs such as diclofenac or ibuprofen are first line. Codeine is avoided in breastfeeding.

Why not the others

- **A:** Avoided in breastfeeding.
- **C:** Not needed.
- **D:** Not appropriate.
- **E:** Not first line.

Key point: Perineal pain: paracetamol and NSAIDs.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 730 · Perineal care · **Moderate** · C2

A woman 7 days after a tear repair has fever and a red, swollen perineum with pus.

What is the most appropriate management?

A. Antibiotics and wound care
B. Immediate resuturing
C. Leave it
D. Steroids
E. Stop washing

Answer: A. Antibiotics and wound care

Perineal infection is treated with antibiotics and wound care. Resuturing is not done while infection is present.

Why not the others

- **B:** Not while infected.
- **C:** Not enough.
- **D:** Not appropriate.
- **E:** Hygiene helps.

Key point: Perineal infection: antibiotics; no immediate resuture.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 731 · Wound infection · **Moderate** · C2

A woman 7 days after caesarean has a red, tender wound with discharge. She is well.

What is the most appropriate management?

A. Antibiotics and a wound swab
B. Hysterectomy
C. Laparotomy
D. No action
E. Steroids

Answer: A. Antibiotics and a wound swab

A superficial wound infection is treated with a swab and antibiotics such as flucloxacillin.

Why not the others

- **B:** Not indicated.
- **C:** Not indicated.
- **D:** Treatment is needed.
- **E:** Not appropriate.

Key point: Wound infection: swab and antibiotics.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 732 · Postnatal depression · **Moderate** · C2

A breastfeeding woman has moderate postnatal depression and needs medication.

Which antidepressant is commonly used?

A. Fluoxetine as first choice
B. Lithium
C. Phenelzine
D. Sertraline
E. Venlafaxine

Answer: D. Sertraline

Sertraline is commonly used in breastfeeding because little passes into breast milk.

Why not the others

- **A:** Long half-life; not first choice.
- **B:** Mood stabiliser.
- **C:** MAOI; not advised.
- **E:** Not first choice.

Key point: Sertraline is preferred in breastfeeding.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 733 · Postnatal depression · **Easy** · C1

A health visitor wants to screen for postnatal depression.

Which tool is used?

A. AUDIT
B. CAGE
C. Edinburgh Postnatal Depression Scale
D. GCS
E. MMSE

Answer: C. Edinburgh Postnatal Depression Scale

The EPDS is a 10-question screening tool for postnatal depression.

Why not the others

- **A:** Alcohol.
- **B:** Alcohol.
- **D:** Consciousness.
- **E:** Cognition.

Key point: EPDS screens for postnatal depression.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 734 · Postpartum psychosis · **Moderate** · C2

A pregnant woman with bipolar disorder asks about her risk after birth.

What is the most appropriate plan?

A. Do nothing
B. Perinatal mental health referral and a care plan
C. Stop all medication in pregnancy
D. Termination
E. Wait until after birth

Answer: B. Perinatal mental health referral and a care plan

Women with bipolar disorder should be referred to perinatal mental health services in pregnancy and have a plan for after birth.

Why not the others

- **A:** Unsafe.
- **C:** Risks relapse.
- **D:** Not indicated.
- **E:** Too late.

Key point: Bipolar in pregnancy: perinatal mental health plan.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 735 · Postnatal care · **Easy** · C1

A woman asks when she can resume sex after birth.

What is the advice?

A. After 1 year
B. After 6 months
C. Never before the 6-week check
D. Only after periods return
E. When she feels ready and comfortable

Answer: E. When she feels ready and comfortable

Women can resume sex when they feel ready and comfortable. Contraception should be discussed.

Why not the others

- **A:** Not needed.
- **B:** Not needed.
- **C:** Not required.
- **D:** Not required.

Key point: Resume sex when ready; discuss contraception.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 736 · Postnatal care · **Moderate** · C2

A woman with gestational diabetes has delivered.

What is the advice about diabetes after birth?

A. Continue insulin for 1 year
B. No follow-up needed
C. Start metformin long term
D. Stop glucose-lowering treatment and test fasting glucose at 6–13 weeks
E. Test HbA1c at 1 week

Answer: D. Stop glucose-lowering treatment and test fasting glucose at 6–13 weeks

After GDM, stop treatment after birth and test fasting glucose or HbA1c at 6–13 weeks, then annually.

Why not the others

- **A:** Not needed.
- **B:** Follow-up is needed.
- **C:** Not routine.
- **E:** Too early.

Key point: After GDM: stop treatment; test at 6–13 weeks.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 737 · Postnatal care · **Easy** · C2

A non-immune woman asks about rubella vaccine after birth.

What is the advice?

A. Avoid breastfeeding
B. Avoid pregnancy for 1 month after MMR
C. It is not allowed
D. Only after the next pregnancy
E. Wait 1 year

Answer: B. Avoid pregnancy for 1 month after MMR

MMR can be given after birth, including while breastfeeding. Pregnancy should be avoided for 1 month.

Why not the others

- **A:** Breastfeeding is fine.
- **C:** It is allowed.
- **D:** Too late.
- **E:** Not needed.

Key point: Avoid pregnancy for 1 month after MMR.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 738 · Secondary PPH · **Moderate** · C2

A woman 3 weeks after birth has heavy bleeding. Ultrasound shows retained tissue. She is stable without fever.

What is the most appropriate management?

A. Antibiotics and surgical evacuation if bleeding continues
B. Hysterectomy
C. No action
D. Oxytocin only
E. Tranexamic acid only

Answer: A. Antibiotics and surgical evacuation if bleeding continues

Retained tissue with secondary PPH is treated with antibiotics and, if bleeding persists, surgical evacuation by an experienced operator.

Why not the others

- **B:** Not indicated.
- **C:** Not safe.
- **D:** Not enough.
- **E:** Not enough.

Key point: Secondary PPH with retained tissue: antibiotics and evacuation.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 739 · VTE · **Hard** · C2

A woman had a previous unprovoked DVT. She has delivered.

What postnatal prophylaxis is advised?

A. 10 days of LMWH
B. 6 weeks of LMWH
C. Aspirin
D. No treatment
E. Stockings only

Answer: B. 6 weeks of LMWH

Women with a previous VTE are high risk and need LMWH for 6 weeks after birth.

Why not the others

- **A:** Too short.
- **C:** Not advised.
- **D:** Treatment needed.
- **E:** Not enough.

Key point: Previous VTE: LMWH for 6 weeks postnatally.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 740 · Postnatal care · **Moderate** · C2

A woman 5 days after birth has a headache, BP 165/110 mmHg and protein in the urine.

What is the most likely diagnosis?

A. Migraine
B. Post-dural puncture headache
C. Postnatal pre-eclampsia
D. Sinusitis
E. Tension headache

Answer: C. Postnatal pre-eclampsia

Pre-eclampsia can appear for the first time after birth. It needs urgent assessment and treatment.

Why not the others

- **A:** Not with this BP.
- **B:** Postural.
- **D:** Not suggested.
- **E:** Not with this BP.

Key point: Postnatal pre-eclampsia can occur after birth.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 741 · Postnatal care · **Easy** · C1

A student asks how long the puerperium lasts.

What is the puerperium?

A. First 24 hours
B. First week
C. Six weeks after birth
D. Six months
E. One year

Answer: C. Six weeks after birth

The puerperium is the 6 weeks after birth, when the body returns to its non-pregnant state.

Why not the others

- **A:** Too short.
- **B:** Too short.
- **D:** Too long.
- **E:** Too long.

Key point: Puerperium: 6 weeks after birth.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 742 · Breastfeeding · **Moderate** · C2

A breastfeeding woman asks about drugs that are unsafe.

Which drug should be avoided in breastfeeding?

A. Codeine
B. Ibuprofen
C. LMWH
D. Paracetamol
E. Penicillin

Answer: A. Codeine

Codeine is avoided due to the risk of neonatal opioid toxicity in ultra-rapid metabolisers.

Why not the others

- **B:** Safe.
- **C:** Safe.
- **D:** Safe.
- **E:** Safe.

Key point: Avoid codeine in breastfeeding.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 743 · Postnatal care · **Moderate** · C2

A woman with a third-degree tear asks about follow-up.

What is advised?

A. Follow-up at 6–12 weeks with a specialist
B. No follow-up
C. Only GP review
D. Surgery at 1 week
E. Wait 1 year

Answer: A. Follow-up at 6–12 weeks with a specialist

RCOG advises review at 6–12 weeks after OASI, ideally in a specialist clinic, to check for symptoms and plan future births.

Why not the others

- **B:** Follow-up needed.
- **C:** Specialist review advised.
- **D:** Not needed.
- **E:** Too late.

Key point: OASI: specialist review at 6–12 weeks.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 744 · Postnatal care · **Hard** · C3

A woman with a 3b tear asks about her next birth.

What is the advice?

A. Caesarean is mandatory
B. Discuss mode of birth; vaginal birth is possible if asymptomatic
C. Never get pregnant again
D. Only home birth
E. Vaginal birth forbidden

Answer: B. Discuss mode of birth; vaginal birth is possible if asymptomatic

After OASI, vaginal birth is possible if she has no symptoms and normal tests. Caesarean may be offered if she has symptoms or abnormal tests.

Why not the others

- **A:** Not mandatory.
- **C:** Not needed.
- **D:** Not advised.
- **E:** Not forbidden.

Key point: After OASI: vaginal birth possible if asymptomatic.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 745 · Postnatal care · **Moderate** · C2

A woman 2 days after birth has calf pain. She is breastfeeding.

Which test is unreliable in the postnatal period?

A. Compression ultrasound
B. D-dimer
C. Full blood count
D. Renal function
E. Urine dip

Answer: B. D-dimer

D-dimer is raised in normal pregnancy and after birth, so it is unreliable for VTE.

Why not the others

- **A:** Reliable.
- **C:** Not used for DVT.
- **D:** Not used for DVT.
- **E:** Not used for DVT.

Key point: D-dimer is unreliable postnatally.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 746 · Postnatal care · **Easy** · C2

A breastfeeding mother asks about vitamin D.

What is the advice?

A. Avoid vitamin D
B. Daily 10 micrograms vitamin D
C. Only for formula-fed babies
D. Only in summer
E. Vitamin D is harmful

Answer: B. Daily 10 micrograms vitamin D

UK advice: breastfeeding women should take 10 micrograms vitamin D daily, and breastfed babies should have vitamin D drops.

Why not the others

- **A:** Not advised.
- **C:** Formula already contains vitamin D; breastfed babies need drops.
- **D:** All year.
- **E:** Not true.

Key point: Breastfeeding women: 10 µg vitamin D daily.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 747 · Postnatal care · **Moderate** · C2

A woman with epilepsy on lamotrigine delivers.

What change is often needed after birth?

A. Dose increase
B. Dose reduction back towards pre-pregnancy levels
C. No change ever
D. Stop the drug
E. Switch to valproate

Answer: B. Dose reduction back towards pre-pregnancy levels

Lamotrigine levels fall in pregnancy, so doses are often increased. After birth, levels rise, so doses are reduced to avoid toxicity.

Why not the others

- **A:** Levels rise after birth.
- **C:** Often needed.
- **D:** Risks seizures.
- **E:** Not appropriate.

Key point: After birth, reduce lamotrigine dose.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 748 · Postnatal care · **Moderate** · C2

A woman with an epidural during labour now has numbness over the outer thigh after birth.

What is the most likely cause?

A. DVT
B. Epidural haematoma
C. Lateral cutaneous nerve of thigh compression
D. Spinal cord injury
E. Stroke

Answer: C. Lateral cutaneous nerve of thigh compression

Meralgia paraesthetica from compression of the lateral cutaneous nerve of the thigh is common after birth. It usually resolves.

Why not the others

- **A:** Causes swelling.
- **B:** Causes weakness and back pain.
- **D:** Causes weakness.
- **E:** Causes other signs.

Key point: Outer thigh numbness: lateral cutaneous nerve.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 749 · Postnatal care · **Hard** · C3

A woman 2 days after epidural has severe back pain and leg weakness.

What is the most important diagnosis to exclude?

A. Epidural abscess or haematoma
B. Mechanical back pain
C. Muscle strain
D. Post-dural puncture headache
E. Sciatica

Answer: A. Epidural abscess or haematoma

Severe back pain with leg weakness after an epidural needs urgent MRI to exclude an epidural haematoma or abscess.

Why not the others

- **B:** Not with weakness.
- **C:** Not with weakness.
- **D:** Causes headache.
- **E:** Less likely.

Key point: Back pain with leg weakness after epidural: urgent MRI.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

MCQ 750 · Postnatal care · **Moderate** · C2

A woman 6 weeks after birth asks about exercise.

What is the advice?

A. Avoid all exercise
B. Exercise is harmful
C. Gradually return to exercise with pelvic floor training
D. Only swimming after 1 year
E. Start high-impact sport on day 1

Answer: C. Gradually return to exercise with pelvic floor training

Women can gradually return to exercise after birth, with pelvic floor exercises. High-impact activity is built up slowly.

Why not the others

- **A:** Not needed.
- **B:** Not true.
- **D:** Too restrictive.
- **E:** Too early.

Key point: Gradual return to exercise with pelvic floor work.

Reference: Obstetrics by Ten Teachers — The puerperium and postnatal care

CHAPTER 16

Rhesus Disease and the Newborn

MCQ 751 · Rhesus disease · **Easy** · C1

A student asks how haemolytic disease of the fetus and newborn (HDFN) develops.

What is the basic mechanism?

A. Fetal antibodies attack maternal red cells
B. Maternal IgG antibodies cross the placenta and destroy fetal red cells
C. Maternal IgM antibodies cross the placenta
D. Placental infection destroys fetal cells
E. Viral infection of fetal marrow

Answer: B. Maternal IgG antibodies cross the placenta and destroy fetal red cells

An RhD-negative mother exposed to RhD-positive fetal cells makes anti-D antibodies. In a later pregnancy, IgG anti-D crosses the placenta and destroys RhD-positive fetal red cells, causing anaemia and hydrops.

Why not the others

- **A:** The reverse.
- **C:** IgM does not cross the placenta.
- **D:** Not the mechanism.
- **E:** Describes parvovirus.

Key point: Maternal IgG crosses the placenta and destroys fetal red cells.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 752 · Anti-D prophylaxis · **Easy** · C2

An RhD-negative woman with no antibodies is 28 weeks pregnant.

What does NICE recommend?

A. Anti-D only at delivery
B. Anti-D only if bleeding occurs
C. Kleihauer test every month
D. No action until 36 weeks
E. Routine antenatal anti-D prophylaxis

Answer: E. Routine antenatal anti-D prophylaxis

Routine antenatal anti-D prophylaxis (RAADP) is offered to all RhD-negative women without antibodies: a single dose at 28 weeks or two doses at 28 and 34 weeks.

Why not the others

- **A:** Antenatal doses are also needed.
- **B:** Routine doses are also needed.
- **C:** Not routine.
- **D:** Too late.

Key point: RAADP at 28 weeks (single or two-dose).

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 753 · Anti-D prophylaxis · **Moderate** · C2

An RhD-negative woman at 10 weeks has a threatened miscarriage with light bleeding. No intervention is needed.

Does she need anti-D?

A. No
B. Only if she bleeds again after 20 weeks
C. Yes, 1500 IU
D. Yes, 250 IU
E. Yes, 500 IU with Kleihauer

Answer: A. No

Before 12 weeks, anti-D is not needed for threatened miscarriage or complete miscarriage without surgery. It is given for surgical management or ectopic pregnancy.

Why not the others

- **B:** Not the reason.
- **C:** Not needed.
- **D:** Not needed for threatened miscarriage before 12 weeks.
- **E:** Not needed.

Key point: No anti-D for threatened miscarriage before 12 weeks.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 754 · Anti-D prophylaxis · **Moderate** · C2

An RhD-negative woman at 16 weeks has a fall onto her abdomen.

What is the correct dose of anti-D?

A. 1500 IU
B. 250 IU without Kleihauer
C. 500 IU with Kleihauer
D. Anti-D only if bleeding
E. No anti-D

Answer: B. 250 IU without Kleihauer

Between 12 and 20 weeks, 250 IU anti-D is given within 72 hours of a sensitising event. A Kleihauer test is not needed. After 20 weeks, at least 500 IU with Kleihauer.

Why not the others

- **A:** Routine prophylaxis dose.
- **C:** For events after 20 weeks.
- **D:** Trauma is sensitising.
- **E:** Needed after a sensitising event.

Key point: 12–20 weeks: 250 IU anti-D.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 755 · Anti-D prophylaxis · **Moderate** · C2

An RhD-negative woman forgot to come for anti-D after a sensitising event 5 days ago.

What is the advice?

A. Anti-D can still be given up to 10 days, with some benefit
B. Give blood
C. Give double dose
D. It is too late
E. Start steroids

Answer: A. Anti-D can still be given up to 10 days, with some benefit

Anti-D should be given within 72 hours, but if missed, it may still give some protection up to 10 days.

Why not the others

- **B:** Not appropriate.
- **C:** Not needed.
- **D:** Some benefit remains.
- **E:** Not relevant.

Key point: Missed 72 hours: anti-D can still help up to 10 days.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 756 · cffDNA · **Moderate** · C2

An RhD-negative woman at 13 weeks asks if she can avoid unnecessary anti-D.

Which test predicts the fetal RhD type?

A. Amniocentesis
B. Cell-free fetal DNA test on maternal blood
C. Fetal scalp sample
D. Kleihauer test
E. Paternal antibody screen

Answer: B. Cell-free fetal DNA test on maternal blood

High-throughput cffDNA testing of maternal blood predicts fetal RhD type. If the fetus is RhD negative, anti-D is not needed.

Why not the others

- **A:** Invasive.
- **C:** Labour only.
- **D:** Measures fetal cells.
- **E:** Not diagnostic.

Key point: cffDNA predicts fetal RhD; avoids unnecessary anti-D.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 757 · Antibodies · **Hard** · C2

A woman has anti-Kell antibodies in pregnancy.

How does anti-Kell differ from anti-D?

A. It does not cause anaemia
B. It does not cross the placenta
C. It is IgM
D. It only affects the mother
E. It suppresses fetal red cell production as well as haemolysis

Answer: E. It suppresses fetal red cell production as well as haemolysis

Anti-Kell suppresses fetal erythropoiesis as well as causing haemolysis. Titres correlate less well, so MCA Doppler monitoring starts at lower titres.

Why not the others

- **A:** It causes anaemia.
- **B:** It crosses.
- **C:** It is IgG.
- **D:** Affects the fetus.

Key point: Anti-Kell suppresses erythropoiesis.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 758 · Antibodies · **Hard** · C3

A woman with anti-D antibodies has a level of 6 IU/mL at 20 weeks.

What is the most appropriate action?

A. Give anti-D
B. Ignore
C. Refer to fetal medicine for MCA Doppler monitoring
D. Repeat in 3 months
E. Termination

Answer: C. Refer to fetal medicine for MCA Doppler monitoring

Anti-D levels above 4 IU/mL warrant referral to fetal medicine for MCA Doppler monitoring for anaemia. Above 15 IU/mL risk is high.

Why not the others

- **A:** Not helpful once sensitised.
- **B:** Unsafe.
- **D:** Too long.
- **E:** Not indicated.

Key point: Anti-D >4 IU/mL: refer for MCA Dopplers.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 759 · Fetal anaemia · **Hard** · C3

A fetus at 26 weeks with maternal anti-D has an MCA peak systolic velocity above 1.5 MoM and early ascites.

What is the most appropriate management?

A. Deliver now
B. Intrauterine transfusion
C. Maternal steroids
D. Repeat scan in 4 weeks
E. Termination

Answer: B. Intrauterine transfusion

High MCA velocity shows fetal anaemia. Intrauterine transfusion of O-negative blood is the treatment.

Why not the others

- **A:** Too premature.
- **C:** Not treatment.
- **D:** Unsafe.
- **E:** Not indicated.

Key point: Fetal anaemia: intrauterine transfusion.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 760 · Hydrops · **Moderate** · C1

A student asks about the definition of hydrops fetalis.

What is it?

A. Fluid in two or more body compartments
B. Large head
C. Low fluid
D. Single cyst
E. Small baby

Answer: A. Fluid in two or more body compartments

Hydrops is fluid in two or more fetal compartments (ascites, pleural effusion, pericardial effusion, skin oedema). Causes include immune (rhesus) and non-immune.

Why not the others

- **B:** Not hydrops.
- **C:** Not hydrops.
- **D:** Not hydrops.
- **E:** Not hydrops.

Key point: Hydrops: fluid in ≥2 compartments.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 761 · Neonatal jaundice · **Easy** · C2

A baby develops visible jaundice at 12 hours of age.

What is the significance?

A. Breast milk jaundice
B. Normal physiological jaundice
C. Not important
D. Pathological; needs urgent assessment
E. Prolonged jaundice

Answer: D. Pathological; needs urgent assessment

Jaundice in the first 24 hours is always pathological. Causes include haemolysis (rhesus, ABO) and sepsis. Urgent bilirubin measurement is needed.

Why not the others

- **A:** Later onset.
- **B:** Starts after 24 hours.
- **C:** It is important.
- **E:** After 14 days.

Key point: Jaundice in first 24 hours is pathological.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 762 · Neonatal jaundice · **Moderate** · C2

A term baby has jaundice at 14 days. Stools are pale and urine is dark.

What is the most important diagnosis to exclude?

A. Biliary atresia
B. Breast milk jaundice
C. Gilbert syndrome
D. Physiological jaundice
E. Rhesus disease

Answer: A. Biliary atresia

Prolonged jaundice with pale stools and dark urine suggests biliary atresia. Early surgery (Kasai) improves outcome.

Why not the others

- **B:** Stools are normal.
- **C:** Rare in neonates.
- **D:** Resolves by 14 days.
- **E:** Early jaundice.

Key point: Prolonged jaundice with pale stools: biliary atresia.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 763 · Neonatal jaundice · **Moderate** · C2

A baby has high unconjugated bilirubin above the phototherapy line.

What is the treatment?

A. Antibiotics
B. Exchange transfusion first
C. Phototherapy
D. Stop feeding
E. Vitamin K

Answer: C. Phototherapy

Phototherapy converts bilirubin into water-soluble forms. Exchange transfusion is for very high levels or failure of phototherapy.

Why not the others

- **A:** Only if infection.
- **B:** For very high levels.
- **D:** Feeding helps.
- **E:** Not relevant.

Key point: Above threshold: phototherapy.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 764 · Neonatal jaundice · **Hard** · C2

A baby with very high bilirubin develops lethargy, poor feeding, arching of the back and a high-pitched cry.

What is the most likely complication?

A. Hypoglycaemia
B. Kernicterus (bilirubin encephalopathy)
C. Meningitis
D. Seizures from hypocalcaemia
E. Sepsis

Answer: B. Kernicterus (bilirubin encephalopathy)

Very high unconjugated bilirubin can cross the blood–brain barrier, causing kernicterus with lethargy, opisthotonus, high-pitched cry and long-term deafness and cerebral palsy.

Why not the others

- **A:** Not this picture.
- **C:** Possible but bilirubin points to kernicterus.
- **D:** Not suggested.
- **E:** Possible but bilirubin points to kernicterus.

Key point: High bilirubin with arching: kernicterus.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 765 · ABO incompatibility · **Moderate** · C2

A group O mother has a group A baby who develops jaundice on day 1. Direct Coombs test is weakly positive.

What is the most likely cause?

A. ABO incompatibility
B. Biliary atresia
C. Breast milk jaundice
D. G6PD deficiency
E. Rhesus disease

Answer: A. ABO incompatibility

ABO incompatibility usually occurs with group O mothers and group A or B babies. It can affect the first pregnancy because anti-A and anti-B antibodies exist naturally.

Why not the others

- **B:** Later.
- **C:** Later.
- **D:** Coombs negative.
- **E:** Needs RhD-negative mother.

Key point: O mother with A or B baby: ABO incompatibility.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 766 · Newborn examination · **Easy** · C2

A newborn examination is being done within 72 hours of birth.

Which is checked for congenital cataract?

A. Fundoscopy
B. Hearing test
C. Red reflex
D. Squint
E. Visual acuity

Answer: C. Red reflex

The red reflex is checked with an ophthalmoscope. An absent red reflex can mean cataract or retinoblastoma.

Why not the others

- **A:** Not routine.
- **B:** Different test.
- **D:** Not for cataract.
- **E:** Not possible.

Key point: Red reflex screens for cataract.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 767 · Newborn examination · **Moderate** · C2

A baby born by breech has a normal hip examination.

What is the most appropriate follow-up?

A. Hip ultrasound at about 6 weeks
B. Hip X-ray at birth
C. No follow-up
D. Pavlik harness
E. Surgery

Answer: A. Hip ultrasound at about 6 weeks

Babies with breech presentation after 36 weeks or family history of DDH need hip ultrasound by 6 weeks, even with a normal exam.

Why not the others

- **B:** Not useful at birth.
- **C:** Risk factor present.
- **D:** Only if DDH.
- **E:** Not indicated.

Key point: Breech: hip ultrasound by 6 weeks.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 768 · Newborn examination · **Easy** · C1

A student asks when the heel-prick blood spot test is done.

When is it taken?

A. At birth
B. Day 5
C. Day 14
D. 6 weeks
E. 1 year

Answer: B. Day 5

The newborn blood spot test is ideally taken on day 5. It screens for conditions including PKU, congenital hypothyroidism, sickle cell disease and cystic fibrosis.

Why not the others

- **A:** Too early.
- **C:** Too late.
- **D:** Too late.
- **E:** Too late.

Key point: Blood spot test on day 5.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 769 · Neonatal resuscitation · **Moderate** · C2

A newborn is floppy and not breathing after drying and stimulation.

What is the next step?

A. Chest compressions
B. Five inflation breaths
C. Intubate immediately
D. IV adrenaline
E. Oxygen only

Answer: B. Five inflation breaths

After drying and stimulation, if not breathing, open the airway and give five inflation breaths. Then reassess heart rate.

Why not the others

- **A:** Only if HR <60 after ventilation.
- **C:** Not first.
- **D:** Later step.
- **E:** Breaths are needed.

Key point: Not breathing: five inflation breaths.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 770 · Neonatal resuscitation · **Hard** · C2

A newborn has a heart rate below 60 bpm despite good ventilation for 30 seconds.

What is the ratio of compressions to breaths?

A. 15:2
B. 30:2
C. 3:1
D. 5:1
E. 10:1

Answer: C. 3:1

Neonatal chest compressions are 3 compressions to 1 breath.

Why not the others

- **A:** Child ratio.
- **B:** Adult ratio.
- **D:** Not used.
- **E:** Not used.

Key point: Neonatal CPR: 3:1.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 771 · Neonatal hypoglycaemia · **Moderate** · C2

A baby of a mother with diabetes is jittery at 3 hours of age.

What is the most likely cause?

A. Hyperglycaemia
B. Hypocalcaemia
C. Hypoglycaemia
D. Hyponatraemia
E. Sepsis

Answer: C. Hypoglycaemia

Babies of diabetic mothers have high insulin levels and are prone to hypoglycaemia after birth. Early feeding and glucose checks are needed.

Why not the others

- **A:** Opposite.
- **B:** Possible but less likely early.
- **D:** Not typical.
- **E:** Possible, but hypoglycaemia is most likely.

Key point: Infant of diabetic mother: hypoglycaemia.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 772 · Respiratory problems · **Moderate** · C2

A term baby born by elective caesarean has fast breathing for 24 hours, then improves. Chest X-ray shows fluid in the fissures.

What is the most likely diagnosis?

A. Meconium aspiration
B. Pneumonia
C. Pneumothorax
D. Respiratory distress syndrome
E. Transient tachypnoea of the newborn

Answer: E. Transient tachypnoea of the newborn

TTN is due to delayed clearance of lung fluid, common after caesarean. It resolves within 24–48 hours.

Why not the others

- **A:** Meconium history.
- **B:** Signs of infection.
- **C:** Sudden deterioration.
- **D:** Preterm.

Key point: Fast breathing after elective CS: TTN.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 773 · Respiratory problems · **Moderate** · C2

A baby born at 41 weeks with thick meconium has breathing difficulty. Chest X-ray shows patchy shadowing and hyperinflation.

What is the most likely diagnosis?

A. Meconium aspiration syndrome
B. Pneumonia
C. Pneumothorax only
D. RDS
E. TTN

Answer: A. Meconium aspiration syndrome

Meconium aspiration causes chemical pneumonitis and airway obstruction. It is more common in post-term and stressed babies.

Why not the others

- **B:** Possible but meconium history points to MAS.
- **C:** May occur as a complication.
- **D:** Preterm.
- **E:** No meconium.

Key point: Meconium with breathing difficulty: MAS.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 774 · HIE · **Hard** · C3

A term baby has cord pH 6.9, low Apgars and seizures within 6 hours of birth.

What is the most appropriate treatment?

A. Antibiotics only
B. Phenobarbital only
C. Steroids
D. Surgery
E. Therapeutic hypothermia

Answer: E. Therapeutic hypothermia

Hypoxic-ischaemic encephalopathy is treated with therapeutic hypothermia (33–34 °C for 72 hours) started within 6 hours.

Why not the others

- **A:** Not enough.
- **B:** For seizures but not the main treatment.
- **C:** Not effective.
- **D:** Not relevant.

Key point: HIE: cooling within 6 hours.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 775 · Neonatal sepsis · **Moderate** · C2

A baby born after prolonged rupture of membranes has poor feeding, temperature instability and grunting at 12 hours.

Which organism is the most common cause of early-onset sepsis?

A. Candida
B. Group B streptococcus
C. Listeria
D. Pseudomonas
E. Staphylococcus epidermidis

Answer: B. Group B streptococcus

Group B streptococcus is the most common cause of early-onset neonatal sepsis in the UK. E. coli is also common.

Why not the others

- **A:** Late-onset.
- **C:** Less common.
- **D:** Less common.
- **E:** Late-onset.

Key point: GBS is the main cause of early-onset sepsis.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 776 · Anti-D prophylaxis · **Moderate** · C2

An RhD-negative woman at 32 weeks had anti-D 4 days ago (RAADP). Her antibody screen now shows anti-D.

What is the most likely explanation?

A. Active sensitisation
B. Laboratory error always
C. Passive anti-D from the recent injection
D. She is RhD positive
E. The baby is RhD negative

Answer: C. Passive anti-D from the recent injection

Anti-D given recently shows up on antibody tests as passive anti-D. It is usually at a low level. Communication with the lab helps tell it apart from immune anti-D.

Why not the others

- **A:** Possible but recent injection explains it.
- **B:** Not always.
- **D:** Not correct.
- **E:** Not relevant.

Key point: Recent anti-D shows as passive anti-D.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 777 · Anti-D prophylaxis · **Moderate** · C2

An RhD-negative woman has a stillbirth at 30 weeks. The baby's blood group is unknown.

What is the most appropriate action?

A. Anti-D and Kleihauer test
B. Anti-D only at the next pregnancy
C. Kleihauer only
D. No action
E. Wait for the post-mortem

Answer: A. Anti-D and Kleihauer test

After a stillbirth, if the baby is RhD positive or unknown, anti-D and a Kleihauer test are needed.

Why not the others

- **B:** Too late.
- **C:** Anti-D also needed.
- **D:** Risk of sensitisation.
- **E:** Too late.

Key point: Stillbirth in RhD-negative woman: anti-D and Kleihauer.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 778 · Anti-D prophylaxis · **Hard** · C2

An RhD-negative woman is already sensitised with immune anti-D.

Should she receive anti-D prophylaxis?

A. No, it will not help
B. Only after delivery
C. Yes, double dose
D. Yes, every month
E. Yes, routine dose

Answer: A. No, it will not help

Anti-D prophylaxis prevents sensitisation but does not help once a woman has immune anti-D.

Why not the others

- **B:** Not helpful.
- **C:** Not helpful.
- **D:** Not helpful.
- **E:** Not helpful.

Key point: Sensitised women do not benefit from anti-D.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 779 · Sensitising events · **Easy** · C1

A student asks about sensitising events in RhD-negative women.

Which is a sensitising event?

A. Amniocentesis
B. Blood pressure check
C. Glucose test
D. Urine test
E. Weight check

Answer: A. Amniocentesis

Sensitising events include amniocentesis, CVS, APH, abdominal trauma, ECV, ectopic pregnancy and miscarriage with surgery.

Why not the others

- **B:** Not sensitising.
- **C:** Not sensitising.
- **D:** Not sensitising.
- **E:** Not sensitising.

Key point: Invasive tests are sensitising events.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 780 · Kleihauer · **Moderate** · C1

A student asks what the Kleihauer test measures.

What does it measure?

A. Fetal red cells in maternal blood
B. Fetal white cells
C. Maternal antibodies
D. Maternal haemoglobin
E. Platelets

Answer: A. Fetal red cells in maternal blood

The Kleihauer test detects fetal red cells in maternal circulation to estimate the size of a feto-maternal haemorrhage.

Why not the others

- **B:** Not measured.
- **C:** Antibody screen.
- **D:** FBC.
- **E:** FBC.

Key point: Kleihauer measures fetal cells in maternal blood.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 781 · Newborn care · **Easy** · C1

A student asks about the normal heart rate of a newborn.

What is the normal range?

A. 60–80 bpm
B. 80–100 bpm
C. 100–160 bpm
D. 180–220 bpm
E. 220–260 bpm

Answer: C. 100–160 bpm

A normal newborn heart rate is about 100–160 bpm.

Why not the others

- **A:** Bradycardia.
- **B:** Low.
- **D:** Tachycardia.
- **E:** Tachycardia.

Key point: Newborn heart rate: 100–160 bpm.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 782 · Newborn care · **Easy** · C2

A newborn has bluish hands and feet but a pink body.

What is this called?

A. Acrocyanosis
B. Central cyanosis
C. Jaundice
D. Pallor
E. Plethora

Answer: A. Acrocyanosis

Acrocyanosis is common and normal in the first days. Central cyanosis (blue tongue and lips) is abnormal.

Why not the others

- **B:** Abnormal.
- **C:** Yellow colour.
- **D:** Pale colour.
- **E:** Red colour.

Key point: Blue hands and feet with pink body: normal acrocyanosis.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 783 · Newborn examination · **Moderate** · C2

A newborn has a heart murmur with weak femoral pulses.

What is the most likely diagnosis?

A. ASD
B. Coarctation of the aorta
C. Innocent murmur
D. PDA
E. VSD

Answer: B. Coarctation of the aorta

Weak or absent femoral pulses suggest coarctation of the aorta. It can present with collapse when the duct closes.

Why not the others

- **A:** Normal pulses.
- **C:** Normal pulses.
- **D:** Bounding pulses.
- **E:** Normal pulses.

Key point: Weak femorals: coarctation.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 784 · Newborn examination · **Moderate** · C2

A newborn boy has one undescended testis on exam.

What is the most appropriate plan?

A. Hormone therapy
B. Immediate surgery
C. No action ever
D. Review at 6–8 weeks; refer if still undescended by 3 months
E. Ultrasound immediately

Answer: D. Review at 6–8 weeks; refer if still undescended by 3 months

Many testes descend in the first months. Review at 6–8 weeks and refer to surgeons if still undescended by 3 months.

Why not the others

- **A:** Not standard.
- **B:** Too early.
- **C:** Follow-up needed.
- **E:** Not routine.

Key point: Undescended testis: review; refer by 3 months.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 785 · Newborn screening · **Easy** · C1

A student asks about the newborn hearing screen.

Why is it done early?

A. Early detection improves language development
B. It is only for preterm babies
C. It prevents ear infections
D. It replaces the 6-week check
E. It treats deafness

Answer: A. Early detection improves language development

Early detection of hearing loss allows early support and better speech and language.

Why not the others

- **B:** For all babies.
- **C:** Not the purpose.
- **D:** Not a replacement.
- **E:** Screening only.

Key point: Early hearing detection improves outcomes.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 786 · Feeding · **Easy** · C2

A breastfed baby has lost 7% of birth weight on day 4.

What is the most appropriate advice?

A. Admit to NICU
B. Formula only
C. IV fluids
D. Normal; support feeding and recheck weight
E. Stop breastfeeding

Answer: D. Normal; support feeding and recheck weight

Weight loss up to about 10% in the first days is common. Support feeding and recheck. Most regain birth weight by 2 weeks.

Why not the others

- **A:** Not needed.
- **B:** Not needed.
- **C:** Not needed.
- **E:** Not needed.

Key point: Up to 10% weight loss is common early.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 787 · Neonatal hypoglycaemia · **Moderate** · C2

A baby born at 37 weeks weighing 2.1 kg has a blood glucose of 1.5 mmol/L and is feeding poorly.

What is the most appropriate management?

A. Do nothing
B. IV dextrose
C. Recheck in 6 hours
D. Stop feeding
E. Water feeds

Answer: B. IV dextrose

A low glucose with poor feeding needs IV dextrose. Small babies have low glycogen stores.

Why not the others

- **A:** Unsafe.
- **C:** Too long.
- **D:** Unsafe.
- **E:** Not appropriate.

Key point: Symptomatic hypoglycaemia: IV dextrose.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 788 · Prematurity · **Moderate** · C2

A baby born at 28 weeks develops abdominal distension, bloody stools and bilious vomiting on day 10.

What is the most likely diagnosis?

A. Hirschsprung disease
B. Intussusception
C. Necrotising enterocolitis
D. Pyloric stenosis
E. Volvulus

Answer: C. Necrotising enterocolitis

NEC is a serious bowel condition in preterm babies. X-ray may show pneumatosis intestinalis.

Why not the others

- **A:** Not typical.
- **B:** Older babies.
- **D:** Non-bilious vomiting.
- **E:** Possible but NEC is likely here.

Key point: Preterm with distension and bloody stools: NEC.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 789 · Prematurity · **Moderate** · C2

A baby born at 30 weeks has grunting, recession and a ground-glass chest X-ray.

What is the most likely diagnosis?

A. Meconium aspiration
B. Pneumonia
C. Pneumothorax
D. Respiratory distress syndrome
E. TTN

Answer: D. Respiratory distress syndrome

RDS is due to surfactant deficiency in preterm babies. Treatment includes CPAP and surfactant.

Why not the others

- **A:** Term.
- **B:** Possible but RDS likely.
- **C:** Sudden.
- **E:** Term, fluid in fissures.

Key point: Preterm with ground-glass CXR: RDS.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 790 · Prematurity · **Hard** · C2

A baby born at 26 weeks needs eye screening.

Which condition is screened for?

A. Cataract only
B. Glaucoma
C. Retinoblastoma
D. Retinopathy of prematurity
E. Squint

Answer: D. Retinopathy of prematurity

Retinopathy of prematurity is screened for in babies born before 31 weeks or under 1501 g.

Why not the others

- **A:** Not specific.
- **B:** Not routine.
- **C:** Not specific.
- **E:** Not the reason.

Key point: ROP screening for very preterm babies.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 791 · Neonatal jaundice · **Easy** · C1

A student asks why physiological jaundice occurs.

What is the cause?

A. Biliary atresia
B. High red cell breakdown and immature liver
C. Infection
D. Maternal antibodies
E. Rhesus disease

Answer: B. High red cell breakdown and immature liver

Physiological jaundice occurs from day 2–3 due to high red cell turnover and immature liver enzymes.

Why not the others

- **A:** Pathological.
- **C:** Pathological.
- **D:** Pathological.
- **E:** Pathological.

Key point: Physiological jaundice: red cell breakdown and immature liver.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 792 · Neonatal jaundice · **Moderate** · C2

A baby with rhesus disease has rapidly rising bilirubin despite phototherapy.

What is the next step?

A. Exchange transfusion
B. More sunlight
C. Stop feeds
D. Vitamin K
E. Wait

Answer: A. Exchange transfusion

Exchange transfusion removes bilirubin and antibody-coated red cells when phototherapy fails.

Why not the others

- **B:** Not safe.
- **C:** Not helpful.
- **D:** Not relevant.
- **E:** Unsafe.

Key point: Failing phototherapy: exchange transfusion.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 793 · Newborn care · **Moderate** · C2

A baby is born to a mother with hepatitis B.

What should the baby receive?

A. Antibiotics
B. BCG only
C. Hepatitis B vaccine within 24 hours
D. Nothing
E. Vitamin K only

Answer: C. Hepatitis B vaccine within 24 hours

Babies of HBsAg-positive mothers need hepatitis B vaccine within 24 hours (with immunoglobulin if high risk).

Why not the others

- **A:** Not relevant.
- **B:** Not relevant.
- **D:** Unsafe.
- **E:** Not enough.

Key point: Hep B mother: vaccine within 24 hours.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 794 · Newborn care · **Easy** · C1

A student asks about the safest sleep position for babies.

What is the advice?

A. Any position
B. On the back
C. On the side
D. On the tummy
E. Propped up

Answer: B. On the back

Babies should sleep on their back to reduce the risk of sudden infant death syndrome.

Why not the others

- **A:** Not advised.
- **C:** Risk of rolling.
- **D:** Increases SIDS.
- **E:** Not advised.

Key point: Back to sleep reduces SIDS.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 795 · Birth injuries · **Moderate** · C2

A baby has a soft swelling over the scalp at birth that crosses suture lines and resolves within 2 days.

What is the most likely diagnosis?

A. Caput succedaneum
B. Cephalohaematoma
C. Encephalocele
D. Skull fracture
E. Subgaleal haemorrhage

Answer: A. Caput succedaneum

Caput succedaneum is scalp oedema from pressure in labour. It crosses sutures and resolves within days.

Why not the others

- **B:** Does not cross sutures.
- **C:** Midline defect.
- **D:** Not suggested.
- **E:** Causes shock.

Key point: Caput crosses sutures and resolves quickly.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 796 · Birth injuries · **Moderate** · C2

After a difficult birth with shoulder dystocia, a baby has a lump over the collarbone and reduced arm movement on one side.

What is the most likely diagnosis?

A. Clavicle fracture
B. Erb's palsy alone
C. Humerus fracture
D. Klumpke's palsy
E. Shoulder dislocation

Answer: A. Clavicle fracture

Clavicle fracture is the most common birth fracture. It heals well without treatment.

Why not the others

- **B:** No lump.
- **C:** Less common.
- **D:** Hand weakness.
- **E:** Rare.

Key point: Clavicle fracture is the commonest birth fracture.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 797 · Congenital anomalies · **Moderate** · C2

A newborn has a cleft lip and palate.

What is the main early concern?

A. Breathing only
B. Feeding
C. Hearing
D. Speech
E. Teeth

Answer: B. Feeding

Feeding is the main early problem. Special bottles and support are needed. Surgery is usually done at 3 months for lip and 6–12 months for palate.

Why not the others

- **A:** Not usually.
- **C:** Later concern.
- **D:** Later concern.
- **E:** Later concern.

Key point: Cleft lip and palate: feeding is the main early issue.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 798 · Neonatal sepsis · **Moderate** · C2

A baby has suspected early-onset sepsis.

Which antibiotics are first line in the UK?

A. Benzylpenicillin and gentamicin
B. Ceftriaxone alone
C. Clindamycin
D. Metronidazole
E. Vancomycin

Answer: A. Benzylpenicillin and gentamicin

NICE: benzylpenicillin and gentamicin are first line for suspected early-onset neonatal sepsis.

Why not the others

- **B:** Not first line.
- **C:** Not standard.
- **D:** Not standard.
- **E:** Not first line.

Key point: Early-onset sepsis: benzylpenicillin and gentamicin.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 799 · Neonatal jaundice · **Hard** · C2

A baby with jaundice has a negative Coombs test. The family is from the Mediterranean region.

Which condition should be considered?

A. ABO incompatibility
B. G6PD deficiency
C. Kell disease
D. Rhesus disease
E. Thalassaemia only

Answer: B. G6PD deficiency

G6PD deficiency is common in Mediterranean, African and Asian families and causes Coombs-negative haemolysis.

Why not the others

- **A:** Coombs positive.
- **C:** Coombs positive.
- **D:** Coombs positive.
- **E:** Less likely in newborns.

Key point: Coombs-negative haemolysis: consider G6PD deficiency.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn

MCQ 800 · Rhesus disease · **Moderate** · C2

A sensitised woman with anti-D is planning another pregnancy.

What is the most appropriate advice?

A. Anti-D will prevent problems
B. Early referral to fetal medicine
C. Home birth
D. No special care
E. Termination

Answer: B. Early referral to fetal medicine

Women with alloantibodies should be referred early to fetal medicine to monitor titres and fetal anaemia.

Why not the others

- **A:** Not helpful once sensitised.
- **C:** Not appropriate.
- **D:** Needs care.
- **E:** Not indicated.

Key point: Sensitised women: early fetal medicine referral.

Reference: Obstetrics by Ten Teachers — Rhesus disease and the newborn