OSPE

Gynaecology & Obstetrics

Comprehensive and Solved Past University OSPEs

SurgicoMed.com
Station
1. Tell features which can differentiate benign from malignant tumor?
2. What is the method to stage ovarian CA?
3. Name two malignant tumors of ovary and two benign tumors of the ovary?

**KEY**

1. Mobility, consistency, capsule intact or not, size more than 10cm, confirm on histopathology.
2. Surgical (Staging Laparotomy).
3. Serous adenoma, mucinous adenoma and undifferentiated teratoma.

Station
1. What is Depo-Provera and what does it contain?
2. List its side effects?

**KEY**

1. It is used for contraception. It contains (progesterone) Medroxyprogesterone acetate
2. Side effects
   - Abnormal bleeding
   - Headache
   - Mood changes
   - Weight gain
Station (Interactive)

1. What is this?
2. Purpose of the device shown?
3. Name the pre malignant condition of cervix?
4. Name 2 predisposing factor of CA cervix?

Key

1. Ayer’s spatula
2. Cervical smear
3. CIN (Cervical Intraepithelial Neoplasia)
4. Multiple pantries, HPV

Station (interactive)

Antenatal Record

Read the scenario carefully and answer the examiner’s questions regarding the provided scenario.

A 25 year old G3P2+0 presents at 34 weeks of gestation for routine antenatal visits. Study the antenatal record in front of you.

1. What problem have you detected?
2. List three possible causes for this.
3. Name two test you would perform on this patient.

**Key**

Answers to examiner

Candidate approach

1. Large for dates the patient has a fundal height of 38.5cm at 34 weeks.
2. Polyhydramnios, Macrosomia, Undiagnosed twin pregnancy
3. Ultrasound to differentiate between the above two conditions, Glucose challenge test to rule out diabetes.

**Station**

1. Identify the device?
2. List 2 side effects?
3. List 2 complications?

**Key**

1. IUCD
2. Side effects
   - Prolonged and heavy bleeding
   - Cramps and pain
3. Complications
   - Perforation of the wall of uterus
   - Miscarriage.
   - Preterm birth on infection if the woman becomes pregnant with the IUD in place.
**Station**
A 19 year old girl comes to you for emergency contraception. She had intercourse 24 hours ago

1. What are important points in history to ask?
2. What investigations you will do?
3. What treatment options are available and what are her success rates?

**KEY**
1. Whether first unprotected intercourse or had same more in his cycle.
   - Any PID in Past.
2. Uterine pregnancy test, anti-HCV
3. Levonorgestrel (1.5 mg stat) - can be used up till 72-75% IUCD - can be used up till 5 days after intercourse.

**Station**
The baby shown below in a picture is 5 hours old & is 4.8 kg:

1. What is the term use to describe this baby?
2. What complication can occur during labor & delivery of such baby? Name two.
3. What complications can baby have during early neonatal period? Name two.
4. Where should baby be care during first 24 hours?
KEY

1. Macrosomia.
2. Obstructed labor & shoulder dystocia.
3. Hypoglycemia, birth asphyxia, hypocalcaemia & RDS.

Station (interactive)
P4+1 presents in labor room with heavy p/v bleeding and shock after one hour of home delivery:

1. What is your diagnosis?
2. What initial measures you will take?
3. What specific treatment will be given to patient?

Key

1. Postpartum hemorrhage.
2. Resuscitative measures: Airway, breathing, 2 I/v lines, start fluids, send investigations, arrange four unit of blood, catheterize, raise foot end, keep patient warm and blood transfusion.
3. If retained product of conception then evacuation, if perineal tears than stitch them, if uterine atony than message the uterus, syntocinon stat & infusion, ergometrine, PGF₂α, bimanual compression, uterine & cervical temponade, surgical measures if all above measures fails (vessels ligation, B-Lynch, hysterectomy & uterine artery embolization).
1. Identify?

2. Assemble?

3. Narrate its applications??

4. What are the Complications??

5. How to minimize complications?

**Key**

1. Outlet forceps

2. 2 & 3 According to examiner’s discretion.

3. Cervical tears, vaginal tears, perineal tears, injury to the baby, subgaleal hemorrhage, failed attempt, injury to the bladder and fistula formation.

4. Fulfill pre requisites, Proper expertise, back up facility (Blood, theater, staff, and pediatrician).

**Station**

A young 25 year old lady missed one period presents in LR with H/O dizziness and vomiting and abdominal pain. Pregnancy test is positive. She is tender on pelvic examination with fullness in right fornix.

1. What is likely diagnosis?

2. How you will confirm and what is the medical treatment for it?

3. What is management?

**KEY**

1. Ectopic pregnancy

2. TVS and Beta-hCG

3. Methotrexate 50mg/m².
If beta HCG < 1000 IU and Patient is a symptomatic then the patient can be kept under observation and if repeated level decreases it means trophoblast is resolving.

Station
A 30 years old $P_{3+1}$ come with P/V bleeding at 10 weeks on P/A fundal height is 14 weeks size and an USG snow storm appearance is seen.

1. What is the diagnosis? How many types are there?
2. What investigations you will do?
3. What is her treatment and follow up?

**KEY**

1. Molar pregnancy
   
   Types,
   - Complete hydatiform mole
   - Partial hydatiform mole
   - Invasive mole

2. CXR, Serum HCG, TFTs.

3. Following ERPC following and $\beta$ HCG levels after every 2 weeks until undetectable, then monthly for 6 months and 3 monthly for second year.
Station
1. Identify
2. What is this instrument used for
3. Name the complications

Key
1. Hegar’s Dilator.
2. To dilate the undilated cervix for evacuation of uterus and to take endometrial biopsy D & C.
3. Complications
   - Creation of false passage
   - Cervical incompetence

Station (Interactive)
Active management of 3rd stage of Labor
Take obstetrical history of the patient.

Key
- G\textsubscript{5}P\textsubscript{3+1}
- 5 year FTP SVD with Epi at SHL male alive healthy.
- 4 year FTP SVD at SHL female alive healthy.
- 3 years back, missed abortion at two months followed by E&C.
- 2 years FTP. LSCS due to fetal distress at SHL Male alive healthy.
- Present pregnancy.
Station
Carefully see the instrument shown in picture below & identify it

1. Name two sites for port for laparoscopy?
2. What medium is use to inflate abdomen laparoscopy?
3. Name the sites which are used for this instrument?
4. Name two complications which can occur on insertion of trocar?
5. Name two advantages of laparoscopic surgery over open surgery.

**KEY**
1. Laparoscope
2. Carbon dioxide
3. Infraumbilical & suprapubic
4. Hemorrhage, infection & perforation of viscera
5. Short hospital stay & cosmetically better

Station
A 55 Year old P3+0 comes to OPD with h/o abdominal mass and distention, USG reveals 10X 15cm pelvic mass and her laparotomy is carried out. It reveals the following picture.

1. What is the diagnosis?
2. How will you manage her further?
3. What complications can occur?
4. How will you follow up?
Key (For Examiner)
1. Malignant ovarian tumour
2. Management
   - Staging of tumour
   - Ascites or peritoneal washings for cytology
   - TAH + BSO + infracolic omentectomy
   - Removal of metastasis if possible
   - Send for histopathology
3. Complications due to anesthesia
   - Complication due to surgery
   - Immediate: hemorrhage, infection, trauma to structures
   - Delayed: hemorrhage, infection, recurrence of tumor
4. Follow up with CA 125 and history, examination and investigations
   - Every 3 months for six months

Station (Interactive)
A 30 Year old house wife married for 6 year, nulliparous comes with report of hysterosalpingogram showing
1. What is the diagnosis?
2. How will you evaluate her on history?
3. What further investigations will you carry out?
4. What treatment will you offer her?
Key (For Examiner)

1. Bilateral blocked tubes

2. History of first marriage of both partners
   - Husband’s history of smoking, diabetes
   - Menstrual cycle details
   - History of vaginal discharge
   - History of Dai, LHV, insertion of vaginal medicine
   - Any investigations and treatment carried out previously

3. Further investigations
   - Laparoscopy
   - Husband semen analysis
   - Ovulation status

4. Laparoscopic surgery
   - IVF

Station
A 32 years old lady G5P3+1, no alive issue presents in antenatal clinic at 30 weeks gestation. Her fundal height is 36 weeks and she is having an obstetrical USG showing increase amount of liquor.

1. What medical disorder she could have?

2. What are the fetal, maternal, neonatal complications?

Key

1. Diabetes mellitus

2.

a) Fetal complications
Congenital anomalies
  - Increase risk of still birth
  - Increase risk of miscarriage
  - Macrosomia

b) Maternal complications
  - Polyhydramnios
  - Increase risk of instrumental delivery
  - Sepsis
  - Perineal trauma

c) Neonatal Complications
  - C-Section risk increased
  - Hypoglycemia
  - RDS

**Station**
A 25 years old lady G2P1+0 at 34 weeks with h/o PIH and headache.

1. What are the indications for urgent delivery in the patients of PIH?
2. What is HELP syndrome?

**Key**

1.
- BP persisting at 160/100 mmHg or more with significant protein urea.
- Elevated liver enzymes
- Low platelet count
- Eclamptic fit
- Fetal distress

2. It is a combination of hemolysis, elevated liver enzymes, low platelet count seen in 5 – 10% of cases of severe pre-eclampsia.

**Station**

1. Identify the instrument?
2. What are its indications in gynaecological procedure?
3. What are its contraindications?
4. What are its advantages?
5. What is its success rate?

**KEY**

1. Pipelle biopsy from uterus
2. Endometrial sampling in DUB post-menopausal bleeding.
3. Pregnancy - PID
4. Simple out-patient procedure, least invasive no anesthesia required.
5. 70 – 80% success rate.

**Station**

1. Identify the specimen
2. What are its types?
3. How will the patient present?
4. Give management options?

**KEY**

1. Fibroid uterus

2. Types
   - Intramural
   - Subserous
   - Submucous

3. Patient presents with,
   - Menorrhagia
   - Dysmenorrhea
   - Pressure symptoms

4. Management
   - Conservative
   - Medical
   - Surgical

**Station**

A 48 year old c/o amenorrhea for 10 months have pregnancy test is –ve. She reports symptoms of vaginal dryness and night sweats

1. What is diagnosis?

2. What investigation you will perform?

3. What further management she will require?

**KEY**

1. Menopause
2. Investigations
   - FSH, LH
   - Prolactin
   - Oestradiol
   - Bone scan

3. Further management,
   - Prevent osteoporosis by increasing calcium intake, vitamin D supplement, good food and exercise, HRT if indicated.
   - Lubricant for local use.
   - HRT / SERM for night sweats.

Station
A 25 year old obese woman noticed excessive growth of hair and scanty periods over last 12 months. She comes for consultation.

1. What is most likely diagnosis?
2. What are treatment options?
3. What general measures you would suggest other than treatment?

KEY

1. PCOS
2. Medical and Surgical Treatment
   a) Medical treatment
      - OCPs
      - Anti-androgen
      - Anti-progesterone
   b) Surgical
3. Other Measures,
   - Weight loss
   - Waxing – electrolysis.

**Station**
A 50 year old woman presents with irregular P/V bleeding from 6 months has been diagnosed as DUB.

1. What is DUB?
2. What is Menorrhagia?
3. What are treatment options for DUB?
4. Patient’s family is complete and her Hb 6g%. What would you offer her?

**KEY**
1. Abnormal vaginal bleeding without any organic cause.
2. Excessive cyclical bleeding
3. Treatment
   a) Symptomatic treatment
      - Iron supplements
      - NSAIDs
      - Multivitamins
   b) Hormonal treatment
      - OCPs
      - Progesterone only pills
      - Mirena
4. After building her Hb we will offer her TAH.

**Station**

A G4P3+0 at term came in active labour after delivery of head shoulders did not deliver.

1. What is this condition called?
2. What are predisposing factors of this condition?
3. What are complications of this condition?

**Key**

1. Shoulder dystocia
2. Risk factors of shoulder dystocia
   - Large baby
   - Small mother
   - Excessive maternal birth weight
   - Maternal obesity
   - DM
3. Forceps/ vacuum extractions complications
   - Post maturity
   - Previous shoulder dystocia or big baby
   - Prolonged first and second stage of labour
a) Fetal
   - Damage to cervical plus plexus
   - Hypoxia
   - Death

b) Maternal
   - Soft tissue injuries

**Station**
A G3P2+0 comes at 30 weeks with P/V bleeding. Abdomen is soft, bleeding is fresh and painless. On scan following picture is obtained.

1. What is it called?
2. How many types are these?
3. What are predisposing factors?

**KEY**
1. Major placenta previa
2. Types
   - Minor I encroaches lower segment
   - II (marginal) reaches interval os
   - Major III (Partially) covers part of os
   - IV (complete) covers interval os
3. Predisposing conditions,
   - Previous caesarean section
   - Increasing maternal age
   - Uterine anomaly i.e. bicornate uterus, fibroid.
**Station**

A young 25 year old woman presents with h/o dysmenorrhea and infertility for 2 years with 3 X 3 cm complex adnexal mass on USG.

1. What is the most likely diagnosis?
2. What is the gold standard for diagnosis?
3. What are treatment options?

**Key**

1. Endometriosis
2. Laparoscopy
3. Medical & Surgical
   a) Medical
      - OCPs
      - Progesterone
      - Danazol
      - GnRH Analogue
   b) Surgical
      - Laparoscopy
      - Laparotomy

**Station**

A 35 years old woman underwent emergency LSCS for twins and presented in LR with swollen and painful legs on 2nd post-partum day.

1. What is likely diagnosis?
2. What are risk factors for this disease?
3. What is antidote of heparin?
KEY

1. DVT

2. Risk factors
   - Over-35 years
   - Multi-parity
   - Obesity
   - Paraplegia
   - Clotting defects
   - Surgical procedures
   - Hyperemesis
   - Immobility

3. Protamine sulphate
**Station**

A 37 year old teacher at 10 week concerned about Down syndrome comes to OPD. Answer her questions

1. What investigation can be done to rule out Down syndrome?
2. When is CVS and amniocentesis done?
3. What is triple test?

**KEY**

1. Investigations
   - USG
   - CVS
   - Amniocentesis
   - Serum test

2. CVS is done after 10week + 0
   Amniocentesis is done after 14 week

3. Triple Test
   - Decrease β-hCG
   - Decrease Serum estrole
   - Increase α feto-protein.
Station
1. What are causes of IUGR?
2. How we can diagnose whether baby is IUGR?
3. What are long term effects of IUGR in the new born?

Key
1. Causes of IUGR
   - Fetal causes: - congenital anomaly, multiple pregnancy in utero infection
   - Maternal causes: - smoking, nutrition, alcohol, drugs, Rh ISO-immunization, medical problems
   - Uteroplacental insufficiency. P & T, abruption or idiopathic.
2. Diagnosis
   - Clinical examination – SFH (Symphysio-fundal height)
   - USG measurement
   - Doppler
3. Long term effects are,
   - Delayed mile stares
   - Under-weight prone to infections
   - Tendency of developing hypertension
   - Diabetes
   - Mental handicap
Station
A women presented in L.R in unconscious state with H/O fits at home. On receiving her B.P was 170/110.

1. What is the diagnosis?
2. Initial management
3. When and how will you deliver?

Key

1. Eclampsia
2. Initial Management
   - Resuscitation, Control of BP
   - Bishop score, induce if FHR is normal
3. Depends on the patient’s Bishop Score, progress of labour and condition of the patient. If progress is labour is satisfactory and BP and Fits are controlled vaginal delivery is opted. If BP and fits are uncontrolled or there is failure to progress or fetal distress then Em. C/S will be done.

Station (Interactive)
(Examiner observes and asks questions, one role player acts as the patient.)

A G7P6+0 at 36 weeks presented in OPD with significant pallor and breathlessness. Her HB is 7.

1. What question will you ask in history?
2. How will you investigate her?
3. How will you manage her?
Key
1. Diet, worm infestation, bleeding P/R, menorrhagia, Obstetric history (APH, PPH)
2. RBC indices + peripheral smear, Hb electrophoresis to rule out Thalassemia.
3. Admission, determine cause and Blood transfusion.

Station
1. What normally happens to blood pressure in first trimester?
2. What normally happens to blood pressure in second trimester?
3. What normally happens to blood pressure in third trimester?

G₃P₂+⁰ presents to you at 11wks gestation with blood pressure of 140/100mmhg, again after rest her Blood pressure reading is 140/100mmhg.
4. What will be your diagnosis?
5. What is the commonest cause of death in hypertensive disorders?

Key
2. Blood pressure falls more significantly.
3. Blood pressure returns to first trimester levels.
4. Known hypertension.
5. Adult respiratory distress syndrome.

Station (interactive)
1. Identify the instrument shown below.
2. Name its four uses.

Key
1. Cusco’s speculum.

2. Pap smear, to confirm p/v leaking & discharge, insertion of IUCD, to see any vaginal & cervical growth.

**Station**

A 24 years old woman presents in labour room at 32 weeks gestation with complaint of heavy watery discharge per vaginum.

1. Give two differential diagnoses.

2. Name two investigations you will like to carry out in this woman.

3. Which two drugs you will give to her and why?

4. What is the chance of spontaneous labour in this patient with in next week?

**Key**

1. Premature rupture of membranes & pelvic infection.

2. TLC & obstetrical ultrasound for amount of amniotic fluid.


4. 90%.

**Station**

A G2P1+0 with hypertension at 24 weeks presents to you for antenatal check up

1. Take BP.

2. Position for BP in pregnancy?

3. Which sound corresponds to diastolic blood pressure in pregnant patients?

4. Define PIH?

5. What precaution would you take for a very obese patient while taking blood pressure?
Key

2. Sitting or 45 Degree.
4. Raised BP with or without proteinuria after 20 weeks gestation.
5. Take a bigger cuff.

Station
A young G2P1+0 with Previous 1 C/S for fetal distress comes to OPD at 28 weeks. Answer following questions.

1. What is VBAC?
2. Can she be induced or augmented?
3. Can she be given epidural anesthesia?

KEY

1. VBAC means vaginal birth after C/Section
2. Yes. But the risk of uterine rupture is 1.5 fold.
3. Yes.

Station (Interactive)
Take obstetrical history of this patient. (An actor will act as patient, examiner will observe while the student takes history)

KEY

- G8P5A2
- Previous 1 LSCS due to fetal distress at GR Hospital.
4 SVDs
- Abortion at 3 months followed by D & C
- 1 Laparotomy for ectopic pregnancy at 8 weeks.

**Station**
Take blood pressure of this patient

Your methodology of this taking is being assessed.

**KEY**
- All clothing should be removed from upper arm
- The cuff should be apply closely to upper arm and lower border should be 2.5cm from cubital fossa.
- The radial pulse is palpated while the cuff is inflated to the pressure of 30mmHg above the level at which radial pulsation can no longer be felt.
- The stethoscope is then placed lightly over the brachial artery the pressure in the cuff is lowered five mmHg at our time until the first sounds are heard. This is the systolic blood pressure continue to lower the pressure in the cuff until the sound suddenly become faint. This is diastolic pressure and when pressure is reduced further the sound disappear.

**Station (Interactive)**
Perform the obstetrical abdominal examination in this patient.

**KEY**
- Students should perform the abdominal examination.
- Examiner should mark according to
- Inspection
- Consent / Bladder should be empty
- Fundal height
Station
A 70 year old come with complaint of something coming out of vagina. On examination following findings were seen.

1. What is this condition? Write its classification?
2. What are predisposing factors?
3. What are treatment options?

KEY

1. Uterovaginal prolapse

   Types
   - 1st degree – Cervix displaced downwards up to introitus
   - 2nd degree – Cervix lying outside introitus.
   - 3rd degree- completes uterus lying outside vagina.
2. Predisposing factors

- Delivery of good size babies
- Prolonged 2nd stage of labour
- Chronic condition causing increase intra-abdominal pressure, constipation, cough.
- Congenital weakness of uterine support
- Menopause.

3. Treatment options,

a) Conservative
   - Pelvic floor exercise
   - Pessaries

b) Surgical
   - Vaginal hysterectomy
   - Sling operations
   - Manchester repair

**Station**

A PG comes in LR at term. She is in active labour with breech presentation.

1. How many types of breech presentation we come across in a pregnant patient?

2. What conditions predispose breech presentation?

3. What are the delivery options in a patient with extended breech at 37 weeks?
Key
1. 3 types (Frank (extended), Flexed and Footling)

2. Predisposing conditions
   - Multiple pregnancy
   - Uterine anomalies
   - Fibroids
   - Placenta previa
   - Polyhydramnios
   - Oligohydroamnios
   - Prematurity
   - Fetal anomaly (hydrocephaly)

3. ECV
   - Caesarean section
   - Vaginal delivery

Station (Interactive)
A 43 year old lady has presented in the OPD with history of heavy bleeding. During initial assessment what questions would you ask to the patient?

KEY
Students ask questions to the patient, while the examiner observes.

- How long have periods been heavy?
- Is their bleeding or passage of clots?
- How long do periods last and how often do they occur.
- (Cycle length)
- Has there been any change.
- Is there Intermenstrual or post coital bleeding.
- Is there pelvic pain or dyspareunia.
Station
1. Identify the instrument.
2. Name the contraindications for the use of this device.
3. Name the side effects which can occur with this device.

KEY
1. Ventouse
2. Malpresentation, breech presentation, face presentation, not fully dilated cervix.
3. PPH, vaginal and cervical trauma, cephalhematoma, interventricular hemorrhage.

Station
1. Carefully see the picture given above and name the gynaecological condition shown in the picture.
2. Name two predisposing factors leading to above shown condition.
3. Name the drug use for the medical treatment of above shown condition.
4. Name one surgical method to treat the above shown condition.
KEY

1. Ectopic pregnancy
2. Previous ectopic pregnancy, tubal surgery and PID
3. Methotrexate
4. Salpingectomy

Station

1. What is following trace called?

2. What are 5 components we check in this trace?

KEY

1. Cardio tocography of fetus (CTG)

2. 5 components are
   - Baseline heart rate
   - Baseline variability
   - Acceleration
Station
A PG comes at 32 weeks with regular painful uterine contractions. On per speculum os is still closed. On USG fetus is normal with fundal placenta.

1. What is her condition called? Define it.

2. What are tocolytic agents?

3. What surgical procedure can be performed in early pregnancy to prevent preterm birth in patient with cervical incompetence?

KEY


2. Tocolytics,
   - Ritodrine
   - Nifedipine
   - Indomethacin
   - Triglyceride
   - MgSO4

3. Cervical circlage

Station
1. What are causes of obstetrical collapse?

2. What is Mendelsohn’s syndrome?

3. What are basic steps of resuscitation?
Key

1. Causes of obstetrical collapse,
   - Amniotic fluid embolism
   - Pulmonary embolism
   - Eclampsia
   - Uterine inversion
   - Haemorrhage (APH/PPH)
   - Anaphylaxis
   - Cerebrovascular accidents
   - Myocardial infarction
   - Tension Pneumothorax

2. This is due to inhalation of acid gastric contents. There is rapid onset of cyanosis, bronchospasm, tachycardia and pulmonary oedema.

3. Basic steps of resuscitation are
   - Open airway, left lateral position
   - Check breathing, give O2
   - Check pulse, ensure 1/v access
   - Drugs accordingly.

Station
A 26 years P1+0 presents in gynae outpatient department with the complaint of vaginal discharge for last one week. On per speculum examination, discharge is curdy white shown in picture below.

1. What is the most likely cause for this discharge?
2. Name two common predisposing factors for fungal vaginal discharge.
3. Name organisms responsible for vaginal discharge (any two).

KEY

1. Fungal (candidial).
2. Diabetes, repeated use of antibiotics, immunocompromised individuals.
3. Candida albicans & trichomonias.

**Station**

PG presents in labour ward at 30+4 weeks of gestation with history of sudden gush of fluid per vaginum one hour back at home and continuous watery discharge per vaginum since that time.

1. What is the diagnosis?
2. Name two medicines use in the management of above mentioned patient.
3. Name two predisposing factors for the above mentioned condition.

**KEY**

1. PPROM (Preterm premature rupture of membranes)
2. Antibiotic & steroid.
3. Vaginal infection, urinary tract infection & epidemiological factors.

**Station**

A gestational diabetic woman at term with a known large baby has been in second stage of labour for two hours. You are immediately called to delivery room, on entering you find that house officer is unable to deliver the shoulders of the baby:

1. What is the diagnosis?
2. What will you do? Name initial three maneuvers.
3. If initial maneuvers fail what second line maneuvers you will carry out?
4. If all the maneuvers fail what destructive procedures you will carry out?
5. What will you advise her for next pregnancy if baby is of same size or large?
KEY

1. Shoulder dystocia.
5. Elective caesarean section.

Station

P₄+1 presents in labour room with heavy p/v bleeding and shock after one hour of home delivery:

1. What is your diagnosis?
2. What initial measures you will take?
3. What specific treatment will be given to patient?

KEY

1. Postpartum hemorrhage (PPH)
2. Resuscitative measures: Airway, breathing, 2 I/v lines, start fluids, send investigations, arrange four unit of blood, catheterize, raise foot end, keep patient warm and blood transfusion.
3. If retained product of conception then evacuation, if perineal tears than stitch them, if uterine atony than message the uterus, syntocinon stat & infusion, ergometrine, PGF₂α, bimanual compression, uterine & cervical temponade, surgical measures if all above measures fails (vessels ligation, B-Lynch, hysterectomy & uterine artery embolization).

Station

32 years old G₂P₁+₀ presents at 28 weeks gestation with complaint of lower abdominal pain:

1. Write two uterine causes for lower abdominal pain.
2. Write two non-uterine causes for lower abdominal pain.

3. Write three signs which will help in diagnosis.

**KEY**

1. Abruptio placentae, preterm labour & chorioamnionitis.

2. Urinary tract infection, ovarian cyst complication & appendicitis.

3. Tachycardia, pyrexia, abdominal tenderness, uterine consistency, vaginal examination to rule out leaking, discharge & cervical changes.

**Station**

A 17 years old girl presents with complaint of pelvic bleeding at 10 weeks gestation. On abdominal examination her fundal height is 16 cm. On per speculum examination grape-like structure were seen coming out of os. On pelvic examination uterine size is 16 weeks. Her ultrasound shows following picture:

1. What is the most likely diagnosis?

2. What is its incidence?

3. What is the name use for the appearance in the above shown ultrasonic picture?

4. Name the hormone which is use in the management of this patient.

5. How will you treat this patient?
KEY

1. Complete molar pregnancy.
2. 1/1000 pregnancies.
4. β-hCG
5. Evacuation & β-hCG follow up

Station

29 years old nulliparous woman married for five years presents with investigation shown below as a part of her infertility work up:

Name: Mrs. ABC Sex: female Date: 28-09-07

1. Name the investigation.
2. Describe this investigation.
3. On the basis of this investigation what treatment option you will discuss with her?

KEY

1. HSG (Hysterosalpingography)
2. Name, date and time, name of investigation showing no dye spill so diagnosis is bilateral tubal-blockage.

3. In vitro fertilization.

**Station**

37 years old lady present in gynaec outpatient department with complaint of swelling in right side of vulva along with foul smelling vaginal discharge for last one week. The pain is throbbing in nature & she has difficulty in her walking:

1. What structure is involved in above scenario?
2. What is the function of this structure?
3. What is the diagnosis on the basis of scenario and picture given above?
4. How does it occur?
5. How will you treat it?

**KEY**

2. Secretion of mucoid fluid for lubrication.
5. Deroofing of Bartholin abscess and maintaining duct patency.

**Station**

1. Identify the instrument shown in the picture:
2. Name two indications for the use for this instrument.
3. Name two complications which can occur with this instrument.

**KEY**
1. Curette.
2. Endometrial biopsy & evacuation.
3. Infection & perforation.

**Station**
1. Identify the instrument shown in the picture below.

2. Name four procedures in which this instrument is use.

**KEY**
1. Sims’s speculum.
2. PAP smear, IUCD insertion, E&C, examination of U/V prolapsed.
Station (Interactive)

36 Years lady presents in gynae OPD with Pap smear reporting showing CIN III. How will you counsel her?

**KEY**

- Greet examiner.
- Take permission to sit.
- Talk to patient in her language.
- Introduce yourself.
- Take introduction of patient.
- Ask if she wants anyone to be with her.
- Ask regarding her education status (if educated then chances of understanding is better).
- Tell her regarding the diagnosis.
- Chances that diagnosis is correct and incorrect.
- Chances of advance disease.
- Confirmation with colposcopy.
- If diagnosis confirmed then what treatment option will be given.
- Follow up.
- If she understood whatever told to her.
- Want to ask any questions.
- Give her everything in written form.
- Say thanks to her.
Station (Interactive)
25 years old woman presents to you with history of unprotected intercourse 10 hours back and wants to know that how can she avoid pregnancy. How will you counsel her?

KEY
- Greet examiner and ask permission to take seat.
- Introduction.
- Take history to rule out any contraindication for contraceptive use.
- Ask if she is regular user of emergency contraception.
- Tell her regarding various methods of contraception, their doses, side effects and success rate.
- Follow up.
- Ask her if she understood everything.
- Any questions she want to ask.
- Giver her everything in a written form.
- Say thanks to her.

Station
A man was investigated for infertility & found to have no sperm in ejaculate. He has no sexual problem & has normal secondary sexual characteristics. His wife has no significant finding & was found to be ovulating & have patent tubes. How will you manage this case.

KEY
- Medical & surgical history (history of chemotherapy, radiotherapy, inguinal surgery, vasectomy, orchitis & STD’S).
- Drug history (androgens, steroids, antihypertensive.
- Testicular examination (size, consistency,).
Investigations (repeat semen analysis, FSH, karyotype).

- If cause is testicular than management is: ICSI, donor insemination,
- If cause is post testicular than management is: surgical re-anastomosis & ICSI.

**Station**

A 26 years old obese lady presents in gynae outpatient department with complaint of primary infertility for last 3 years, she also gives history of excessive hair growth on face. On examination her weight was 92 kg and hirsutism is present. Ovaries on pelvic ultrasound are shown in picture below:

1. Give three differential diagnoses.
2. On the basis of ultrasonic picture given above what is your diagnosis?
3. Name one important advice you will give her for fertility.

**KEY**

1. Polycystic ovarian syndrome, Cushing’s disease, hypothyroidism & ovarian tumors.
2. Polycystic ovarian syndrome.
3. Weight loss.

**Station**

In the picture below uterus is shown with pathology identify that pathology.

1. Write two symptoms associated with this pathology
2. Write two complications associated with it.
3. Write the name of drug use for the treatment of this pathology.
4. Write the name of two surgical methods for the treatment of this pathology.

**KEY**

1. Multiple fibroids.
3. Degeneration & infection.
5. Myomectomy & hysterectomy.

**Station**

1. Identify the instrument.
2. Name four indications.

**KEY**

1. Hager’s dilator.
2. Irregular p/v bleeding, miscarriage misplaced IUCD & Suspected endometrial malignancy.

**Station**

1. Identify & describe the investigation shown in the picture.
2. Name two indications for this investigation.
3. Name two complications associated with this investigation.


**KEY**

1. HSG showing uterus, tubes & ovaries along with dye spill on both sides.

2. Tubal patency, site of tubal blockage, uterine abnormality & intrauterine adhesions.

3. Dye reaction, trauma with cervical catheter, infection & intravasation of dye.

**Station**

G3P2+0 woman presents at 37 weeks gestation with the complaint of p/v spotting for last 3 days:

1. See the picture below and make diagnosis.

2. On the basis of above diagnosis name two features you will find on abdominal examination.

3. What will be the mode of delivery for this patient?

4. Name two other causes of p/v bleeding.

**KEY**

1. Placenta previa (major degree)

2. High presenting part, malpresentation & soft uterus.

3. Caesarean section.

4. Placental abruption & vasa previa.

**Station**

A 38 years old primigravida has been admitted at 32 weeks gestation with blood pressure of 160/110 mmHg, headache, visual disturbance along with proteinuria of 2+. She has no history of raise blood pressure in her pregnancy.

1. What is your diagnosis?

2. Name two investigations you would like to carry out?

3. What emergency drug you will consider to lower down her blood pressure?
4. After one hour she develops abdominal pain. Name two causes for this pain.

5. Name two complications which can occur in this woman.

**KEY**

1. Preeclampsia.

2. RFT’S, uric acid & CBC.

3. Calcium channel blocker, labetalol & hydralazine.

4. HELLP syndrome & abruption.

5. Eclampsia, HELLP syndrome, stroke & renal failure.

**Station**

Mrs. ABC 39 years old G3P2+0 at 18 weeks gestation had procedure shown below 2 weeks ago. Its results are as follow:

Sample: amniotic fluid                                      Cell culture +ve, karyotype 47XY

1. Name the procedure.

2. What is the risk of miscarriage after this procedure?

3. Name two complications of this procedure.

4. On the basis of the results what intervention should be advised to Mrs. ABC?

5. Name two routes of performing amniocentesis.
**KEY**

1. Amniocentesis.
2. 1%.
3. Infection & APH.
4. Termination of pregnancy.
5. Transabdominal & transcervical.

**Station**

1. Identify the procedure.

2. Name four complications associated with this procedure.

**KEY**

1. Chorionic villus sampling.
2. Miscarriage, infection, antepartum hemorrhage & limb abnormalities.

**Station**

1. Identify the abnormality shown on the hysterosalpingogram 1.
2. Identify the abnormality in HSG 2.

3. Name two complications associated with these two abnormalities shown above.

Key

1. Septate uterus.
2. Bicornuate uterus

Station
Carefully see the picture given below:

1. Name the measurement shown in this picture.
2. Name four causes of large for date fundal height.
3. Name four causes for small for date fundal height.

KEY

1. Symphysio-fundal height.
2. Macrosomia, mistaken dates, polyhydramnios & fibroid uterus.
3. Mistaken dates, oligohydramnios, transverse lie & IUGR.

Station
Miss ABC 15 year old school girl presents at 28 weeks gestation with uterine contractions at interval of 4 minutes. She has history of E & C twice at 10 & 12 weeks respectively 1 year back for social reason. She is smoker & living with her unemployed mother:

1. Define preterm labour.
2. What is the incidence of preterm labour?
3. Name two risk factors for preterm labour in this girl.
4. Why Ventolin is not preferred for tocolysis now?
5. What will you give her for fetal lung maturity?

**KEY**
1. Onset of uterine contraction between 24 & 37 weeks gestation.
2. 4-8%.
3. Age < 20 years, smoking & previous evacuation.
4. Due to its side effects.
5. Steroids.

**Station**
G2P1+0 had uterine inversion during third stage of labour:
1. Name two causes for uterine inversion.
2. Name two maneuvers to manage uterine inversion
3. Name surgical method to manage uterine inversion.

**KEY**
1. Morbid adherence of placenta & excessive cord traction.
3. Haultin’s procedure.

**Station**
Mrs. ABC is 25 years old primigravida. Her hemoglobin electrophoresis result is shown below:

<table>
<thead>
<tr>
<th>Hemoglobin</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA</td>
<td>65%</td>
</tr>
<tr>
<td>HbS</td>
<td>30%</td>
</tr>
<tr>
<td>HbF</td>
<td>3%</td>
</tr>
</tbody>
</table>

1. What hemoglobinopathy Mrs. ABC is suffering from?
2. Who else should be tested?

3. Mrs. ABC husband is also suffering from this hemoglobinopathy, what are the chances of fetus being normal?

4. Name two prenatal diagnostic tests for confirmation test for hemoglobinopathy.

5. At what gestation prenatal diagnostic test should be carried out?

**KEY**

1. Sickle cell trait.

2. Her husband.

3. 1:4.

4. Amniocentesis & chorionic villus sampling.

5. CVS at 10-12 weeks & amniocentesis at 15 weeks onwards.

**Station**

1. Identify the instrument shown below.

2. What is the use of this instrument?

3. Name two contraindications for the procedure associated with above shown instrument.

4. Name two side effects related to procedure associated with above shown instrument.
KEY

1. Epidural catheter.
2. Epidural anesthesia.
3. Bleeding disorders & infection at the site of epidural.

Station

1. What is shown in the picture?

Name: Mrs. ABC                  Time & date: 3:45 p.m.  27th Oct 08

2. Describe it

3. What is other method to access fetal wellbeing during labour?

   KEY

1. CTG.

2. This is CTG of Mrs. ABC done on 28th October 2008 at 3:45 pm showing baseline FHR of 150 bpm, beat to beat variability of 5 to 10 beats is present & two acceleration are also present. CTG is also showing two uterine contraction upto amplitude of 55mmhg. This CTG is normal.

3. Fetal scalp electrode.
Station
Mrs. XYZ primigravida at 40 weeks gestation at 4 cm dilatation had CTG shown below:

1. Describe it.
2. How will you manage this patient?

**KEY**
1. This is CTG of Mrs. XYZ showing baseline FHR of 150 bpm along with almost absent beat to beat variability & no acceleration.
2. Left lateral, oxygen inhalation, hydration & continuous CTG. If pattern persist then emergency C/section.

Station
45 years old woman presents in gynaec outpatient department with complaint of Menorrhagia for last one year. Her blood picture is as follow:

- Hb: 7.6 g/dl
- WBC: 11 x 109
- Platelet count: 247 x 1012
- PCV: 39 %
- MCV: 76fl
- MCH: 25pg
- MCHC: 27g/dl
1. What is normal blood loss per menstruation?

2. Name two courses of action you will take.

3. Name 4 drugs which you can use for treatment of this woman.

**KEY**

1. Less than 80 ml.

2. History & examination.

3. NSAIDS, Transaxemic acid, combine oral contraceptive pills & GnRH analogue.

**Station**

You will be provided with gloves & gown; examiner will ask you to wash up & wear them in front of examiner:

**KEY**

- Greet examiner.
- Examiner will observe your way of getting wash up.
- Examiner will observe how you are placing your hands after wash up.
- How you are opening gown and wearing it
- Your gloving technique.


**Station**

Bladder will be provided to you and examiner can ask you to repair bladder:

You will be provided with the sutures and examiner can ask you to apply any type of sutures e.g., mattress)

---

**Station**

Mrs. ABC is 34 years old primigravida at 37 weeks gestation sitting in front of you. You have to check her blood pressure, examine her abdomen & examine her edema.

---

**KEY**

- Greet.
- Introduction.
- Position of woman.
- Application of cuff.
- Blood pressure measurement.
- Check edema on sacrum.
- Ask the patient to lie down.
- Place sheets and wedge under her buttock.
- Take permission to uncover her abdomen.
- Inspect (movement, position of umbilicus, shape of abdomen, scar mark, pulsations & veins), palpate (fundal height, lie, presentation, estimated fetal weight, amount of liquor & engagement) & auscultate fetal heart rate.
- Cover patient.
- Check for pedal edema.
- Thanks her.
- Tell your findings to examiner.
Station
Examiner has three pair of forceps as shown below in picture:

1. Identify various types of forceps.
2. A woman has been in labour in second stage of labour for last two hours & she is exhausted, head of the baby is at +2 station & direct occipito-anterior. Which pair of forceps’ you will use?
3. What analgesia you will use for forceps’ delivery? Name two.
4. Before applying the forceps what requirements must be fulfilled? Name two.
5. Name two differences between first & second pair of forceps.

**KEY**
1. Wrigley’s forceps, Simpson’s forceps & Kielland’s forceps.
2. Wrigley’s forceps.
4. Fully dilated cervix, empty bladder & head below 0 station.
5. Wrigley’s have both (cephalic & pelvic) curve, small handle & no finger grip, while middle one has only cephalic curve, long handle & finger grip is present.

**Station**

G3P2+0 is in labour for last one and half hour but in spite of adequate uterine contraction her head is at 0 station & in transverse position, three instrument are present in front of you as shown in picture.

1. What instrument you will like to apply for delivery?

2. Conduct delivery in above mention woman with instrument.

**KEY**

1. Vacuum.

2. Introduction, explain procedure to patient, fulfill prerequisites, take informed consent, shift patient to stage two labour room, place her in lithotomy position, take aseptic measures, empty bladder, give analgesia if not already given, carry out pelvic examination, set vacuum apparatus, apply vacuum cup on the head of the fetus & assure that there is not maternal tissue in the cup, start pressure take it upto 0.2kg/cm², again insure that there is no tissue(maternal) in cup, again start pressure and take it upto 0.8 kg/cm², hold cup handle and ask the assistant to give perineal support, along with uterine contraction ask the patient to push, initially direction is upward at crowning it changes to downward (parallel to pelvic canal), give episiotomy, then deliver head and remove cup, deliver rest of baby, clamp & cut cord, hand over baby to pediatrician, examine pelvis for any tear and PPH, stich episiotomy & documentation.
Station (Interactive)
As in station 41 examiners can also ask you to conduct outlet forceps and Kielland’s forceps delivery so do practice it on dummy.

Station
You are provided with model of female pelvis and fetal skull and you can be asked to perform normal mechanism of labour.

On dummy demonstrate.

a) Deep transverse arrest.
b) Occipito posterior.
c) Brow presentation.
d) Face presentation.

Station
G2P1+0 previous spontaneous vaginal delivery at 39 weeks gestation presents in labour room in labour. On abdominal examination presentation is breech, estimated fetal weight is about 3.0 kg, amount of liquor seems to be adequate & FHR is 130 – 140 bpm. On pelvic examination os is 5 cm dilated and presenting part is at 0 station, membranes are intact & patient wants to have vaginal delivery. Conduct vaginal breech delivery.

KEY
Introduction, explain procedure along with risk & benefits to woman, take informed consent, access woman to rule out any contraindication for this delivery, when breech starts to climb perineum shift woman to second stage, place her in lithotomy position,
take aseptic measures, empty bladder, give analgesia if not given already, pelvic examination to confirm your findings & to see the position of legs, episiotomy, if the legs are in extended position then deliver them by Pinnard’s maneuver, if legs are flexed they will deliver with uterine contraction, shift baby to sacroanterior position, allow the legs to hang until delivery occurs upto level of umbilicus, carry out pelvic examination to loosen the cord & position of arms, if legs are extended then deliver them by Lovset maneuver, if arms are flexed they will deliver with uterine contraction, allow the baby to hang upto the level of nape of neck, then deliver head by one of the following methods: Piper forceps, Burn’s Marshal & Smellie veit, clamp & cut the cord, deliver P/M, hand over the baby to pediatrician, stitch episiotomy, pelvic examination to rule out any tears and PPH & documentation.

**Station**

G2P1+0 previous C/section presents to you at 40 weeks gestation in labour room with uterine contractions. On per abdominal examinations lie is longitudinal, presentation is breech, EFW is 3.2-3.5 kg & FHR 140-150bpm. She is having uterine contraction of 20 sec after every 3 minutes. On pelvic examination os is 2 cm dilated, breech is high, membranes are intact & pelvis seems to be adequate.

1. What will be the best mode of delivery for her?
2. What is the incidence of breech presentation at term?
3. What risk is involved in the vaginal delivery of this patient?
4. Name two fetal complications of vaginal breech delivery.
5. Name two causes of breech presentation.

**KEY**

1. C/ section.
2. 3-4%.
3. Uterine rupture.
5. Congenital anomaly of fetus, placenta previa & liquor abnormality.
Station
36 years old P_21_, known diabetic for last 6 years presents to you in outpatient department & wants to conceive. What advice you will give her?

KEY

- Control of blood sugar levels.
- Chances of anomaly with control and uncontrolled blood sugar levels.
- No oral hypoglycemic agents during pregnancy.
- Folic acid.
- Change any teratogenic agent.
- Baseline weight & blood pressure.
- Early booking.
- Avoid smoking.
- If working then tells she might need repeated admissions.
- Anything she wants to ask.
- Give her everything in written form.

Station
24 years old lady G2P1+0 presents at 28 weeks gestation & her investigations are shown below:

- Hb: 7.6g/dl
- MCV: 70fl
- MCHC: 28g/dl

1. What is the diagnosis?
2. How will you treat this patient?
3. If the same patient is at 37 weeks gestation then how will you manage her?
KEY

1. Iron deficiency anemia.
2. Oral iron.

Station

27 years old primigravida, known case of mitral stenosis presents at 38 weeks gestation with labour pains in labour room:

1. What is the incidence of cardiac disease in pregnancy?
2. Name two cardiac diseases in which pregnancy is contraindicated.
3. Name the investigation of choice for cardiac disease in pregnancy.
4. Name two factors which can aggravate cardiac problem in pregnancy.
5. Name anticoagulant which is safe in pregnancy.

KEY

1. 0.1 – 4%.
2. Pulmonary hypertension & hypertrophic cardiomyopathy.
3. Echocardiography.
4. Anemia & infection.
5. Heparin.

Station

Primigravida presents at 30 weeks gestation with abdominal discomfort. On abdominal examination abdomen is tense, fundal height is 34 weeks & liquor seems to be excessive. Ultrasound shows AFI 26-28:

1. What is the diagnosis?
2. Name its two causes.
3. Name two complications which can occur with it.
4. How will you treat this patient?

**KEY**
1. Polyhydramnios.
3. Preterm labour & malpresentation.
4. Therapeutic paracentesis.

**Station**
4 days old baby had jaundice and the treatment given to him is shown in picture below:

![Image of baby under phototherapy]

1. What is the treatment baby getting?
2. Name four causes of jaundice persisting for more than seven day in neonate.

**KEY**
1. Phototherapy.
2. Persistent physiological jaundice, persistent hemolysis, infection, neonatal hepatitis & metabolic cause.
**Station**

1. Name two uses of this drug.

2. Name four parameters to monitor this drug infusion.

3. Name the antidote of this drug.

**KEY**

1. To prevent fits & preterm labour.

2. Pulse, temperature, respiratory rate, reflexes & magnesium levels.

3. Calcium gluconate.

**Station**

Above are OCPs.

1. Name hormones present in the packet shown above.

2. Name two side effects of this medicine.

3. Name two contraindications for this medicine.
KEY

1. Estrogen & progesterone.

2. Cardiovascular problems, headache, bloating, breast tenderness & increase incidence of endometrial carcinoma.

3. Uncontrolled blood pressure, hepatic disorders, diabetes with vascular complications & history of embolism.

Station

1. What is pharmacological content of drug shown above?

2. Give its two uses.

3. Name two side effects.

KEY

1. Calcium channel blocker.

2. Preterm labour & control of blood pressure.

3. Headache & tachycardia.

Station

G4P2+1 presents in labour room at 39 weeks gestation with intermittent abdominal pain. On examination she is having palpable contraction of 30 sec every 3 minutes. Your diagnosis is labour:

1. Define labour.
2. What is normal duration of labour?
3. What is partogram?
4. Name two signs of labour.

**KEY**
1. Onset of regular, painful & effective uterine contractions (causing cervical dilatation & effacement) resulting in delivery of baby & expulsion of placenta.
2. In nulliparous on average 20 hours & in multiparous on average 14 hrs.
3. Graphical presentation of events of labour.
4. Uterine contractions & P/V leaking.

**Station**
1. In the image above fertilization is shown. Define fertilization.
2. Name two functions of placenta.
3. Name two hormones produce by placenta.
4. What is normal site for fertilization to take place in fallopian tube?
5. How long sperm is capable of fertilization in female genital tract?

**KEY**
1. Union of male & female gamete.
4. Ampulla.
5. 24 – 48 hours.

Station

1. Name three benefits of antenatal care.
2. How frequently antenatal visits should be planned in pregnancy without risk factors?
3. Woman presents in outpatient department on 9th October 2008 & her LMP is 2nd March 2008, calculate her duration of pregnancy.
4. G6P5 presents in outpatient department saying that she had her LMP 6 months back but unable to recall exact date. Name two methods which will help you to calculate her gestational age.

KEY

1. Prevention, early detection & management of any adverse condition, educate women regarding physiological changes of pregnancy & preparation of women for forthcoming event of labour.
2. Four weekly till 28 weeks, then two weekly till 36 weeks afterwards weekly.
3. 27+2 weeks.
4. Dating scan & date of quickening.

Station

1. Define primary amenorrhea.
2. Define menarche.
3. Name secondary sexual characteristics.
4. Define secondary amenorrhea.
5. Name two causes of secondary amenorrhea.
KEY

1. Failure of menarche & sexual characters to develop by age of 14 years or failure of menarche with developed sexual characters by 16 years of age.

2. First menstrual cycle.

3. Breast development, pubic hair, axillary hair, menarche & growth spurt.

4. Amenorrhea of six months or more during reproductive life after development of normal menstruation.

5. Pregnancy, menopause, stress, exercise & hysterectomy.

Station

48 years old woman presents in gynae outpatient department with complaint of Menorrhagia for last 6 months & soaks about 6-8 pads per day:

1. Define Menorrhagia.

2. What is the most likely cause of Menorrhagia in this age?

3. What is the medical treatment for this woman? Name two.

KEY

1. Cyclical bleeding at normal intervals which is excessive in amount or duration.

2. Dysfunctional uterine bleeding.

3. NSAIDs, OCPs & progesterone only pills.

Station

52 years old lady presents in gynae outpatient department with complaint of amenorrhea for last one year along with hot flushes and joint pain:

1. What is most likely diagnoses?

2. Name two investigations which will confirm your diagnoses.

3. Name two treatment modalities for bone pains in this woman.
4. Name two long term effects of menopause.
5. Name two short term effects of menopause.

**KEY**
1. Menopause.
2. LH & FSH
3. Life modification, exercise, bisphosphonates & calcium supplements.
4. Cardiovascular & osteoporosis.
5. Hot flushes & urological problems.

**Station**
23 years old primigravida presents in labour room with complaint of P/V bleeding at ten weeks gestation.
1. Give two differential diagnoses.
2. On pelvic examination of above woman os is open & retained product of conception is protruding from os, what is the diagnosis?
3. How will you confirm diagnosis of incomplete abortion?
4. How will you treat incomplete abortion?
5. What treatment options are available for missed abortion?

**KEY**
1. Miscarriage, ectopic pregnancy & molar pregnancy.
2. Incomplete miscarriage.
3. Ultrasound.
4. Evacuation & curettage.
5. Medical & surgical.
Station
27 years old primigravida conceived after ovulation induction presents in labour ward at 8 weeks gestation in shock. Her pulse was 120 bpm, blood pressure 80/40 mmHg, tenderness positive on left side of lower abdomen. On pelvic examination tenderness & fullness positive in left fornix. After resuscitative measures her laparotomy was done, during laparotomy picture of fallopian tube shown below is taken:

1. See the picture given above & make diagnosis.
2. What is its incidence?
3. Write 4 predisposing factors.
5. If in above scenario peritoneal cavity is full of blood what procedure you will carry out?

**KEY**
1. Ectopic pregnancy (tubal).
2. 1.5 -2.5%.
3. Previous ectopic pregnancy, pelvic inflammatory disease, infertility treatment & tubal abnormalities.
4. Sac size less than 5 cm, hemodynamically stable patient, B- HCG level less than 3000 IU/l.

5. Salpingectomy.

**Station**

Write steps of caesarean section.

**KEY**

See from text book

**Station**

1. In the picture above tubal intact pregnancy is shown, on ultrasound intact sac size is 2 cm & β-hCG level is 500IU/l. How will you treat it?

2. What are the chances of fertility after ectopic pregnancy?
3. Name four side effects of methotrexate.

**KEY**

1. Expectant management.
2. 50 – 70% intrauterine pregnancy.
3. Photosensitivity, alopecia, stomatitis, gastritis & renal toxicity.

**Station**

Carefully see the picture given below & answer the questions:

1. Name the malpresentation shown in the picture above.
2. What is its incidence at term?
3. Primigravida presents at 40 weeks gestation with presentation shown above, how will you deliver her?

**KEY**

1. Transverse lie (shoulder presentation).
2. 0.3 – 0.4%.
3. External cephalic version (ECV) followed by spontaneous vaginal delivery or cesarean section.

**Station**

Mrs. ABC presents in antenatal clinic at 8 weeks gestation. Her weight is 136 kg & BMI is 40. What problems you will anticipate during her pregnancy and labour in view of her obesity?

**KEY**

- Medical disorders (pregnancy induced hypertension & diabetes).
- Embolism
- Difficulty in palpation of fundal height.
- Difficulty in auscultation of fetal heart.
- Shoulder dystocia.
- Cesarean section is more hazardous both surgically as well as anesthetically.

**Station**

Primigravida presents at 12 weeks amenorrhea conceived after infertility treatment with complaint of excessive vomiting, she is unable to take anything by mouth. Ultrasound is done & it is shown below:

1. What is the cause of excessive vomiting?
2. What is predisposing factor of this pregnancy in this woman?
3. Name two maternal complications associated with this pregnancy.
4. Name two fetal complications associated with this pregnancy.
5. What is the incidence of this pregnancy?

**KEY**

1. Twin pregnancy.
3. Hypertension, hyperemesis gravidarum, anemia & pressure symptoms.
5. 1 -2% of all pregnancies.
Station
A couple presents at 24 weeks gestation with scan showing hydrocephalus. How will you counsel them?

Key
- Greet.
- Introduction.
- Explain regarding diagnosis.
- Prognosis.
- Chances of other anomalies.
- Mild, moderate & severe.
- Conservative management in isolated mild & moderate cases.
- Termination of pregnancy in rest.
- In conservative management follow up with scans and delivery by c/section, shunt in neonate.
- Explain risks of shunt.
- Give everything in written form.
- Set another appointment.
- Thank you.

Station
A pregnant woman presents at 12 weeks gestation with history of exposure with the child having chicken pox & she is worried. How will you counsel her?

KEY
- Greet.
Introduction.

Want to call anyone else.

Education status.

History of chicken pox, if uncertain then antibody levels.

Till her antibody levels are being checked she should avoid contact with any pregnant woman.

If immunized then nothing to worry.

If not immunized then give varicella zoster immunoglobulin as soon as possible.

Tell her is develops rash immediately report to hospital.

If she develops chickenpox then chances of fetal anomaly is 2% so do get anomaly-scan.

Neonatal ophthalmic examination at birth.

Give everything to her in written form.

Station

You are called to see 26 years old woman who has presented with acute pelvic pain to labour ward. She has her normal period ten days ago; she has been evaluated by surgeon who has ruled out surgical cause for the pain. Name five gynecological causes related to acute pelvic pain:

KEY

a) Ectopic pregnancy

b) Acute pelvic inflammatory disease.

c) Ovarian cyst accidents.
d) Fibroid degeneration.
e) Pelvic trauma.

**Station**
Identify the device and insert it:

**KEY**
Intrauterine contraceptive device.

- Greet.
- Introduction.
- Rule out any contraindication for insertion, explain procedure to woman, take informed consent, ask her to empty bladder and lie on couch, put sheet on her, ask her to remove her trouser, put her in lithotomy position, take aseptic measures, load IUCD, pelvic examination, retract vaginal wall with speculum (Cusco’s), hold anterior lip of cervix with sponge holding forceps, measure the length of uterine cavity with uterine sound, set guard of IUCD according to length of uterus, insert it into uterine cavity & remove plunger, cut thread up to two centimeter, help her get dressed, follow up & thanks her.

**Station**
29 years old P3+0 presents in gynae outpatient department saying she has premenstrual syndrome (PMS)

1. Name two physiological symptoms of PMS.
2. Name two psychological symptoms of PMS.
3. How will you diagnose PMS?
4. Is there any role of psychotherapy in PMS?
5. Name two treatment options for PMS.
KEY

1. Weight gain, breast tenderness & headache.

2. Irritability, anxiety & depression.

3. Menstrual symptoms diary.

4. Yes.

5. Reassurance, relaxation therapy, NSAID, vitamin supplements, combine oral contraceptive pills & GnRH analogue.

Station

63 years old P₈+₂ presents in gynae outpatient department with complaint of something coming out of vagina. Vaginal examination shows picture shown below:

1. What is the diagnosis?

2. What is the predisposing factor for above shown problem in this woman?

3. What is conservative therapy for the treatment of above condition?

4. Name surgical method which can be offered to above woman.

5. What is the etiology of this condition in postmenopausal woman?

KEY

1. U/V prolapsed.

2. Multiparity.

3. Pessaries.

4. Vaginal hysterectomy.

5. Lack of hormones.
Station
1. Identify the device.
2. Name the mechanism of action of this device.
3. What is it failure rate?
4. Name two contraindications for this device.
5. Name two complications for this device.

KEY
1. Intrauterine device.
2. Foreign body reaction.
3. 0.8 HWY.
4. Pregnancy, unexplained vaginal bleeding & vaginal infection.
5. Insertion, expulsion & perforation.

Station
Mrs. ABC 28 years old presents in emergency department with complaint of pain in right iliac fossa for last four hours, gripping in nature. She also has history of three episodes of vomiting. On examination tenderness & guarding is positive in RIF. On pelvic examination fullness and tenderness is positive in right fornix. Her pregnancy test is positive. Her CBC & TVS report is shown below: CBC: Hb: 11.6g/dl WBC: 17.9 X 10^9/l platelet count: 199 X 10^12/l TVS: uterus is anteverted & measures 12 X 5 cm, no intrauterine gestational sac seen, left ovary is normal. 7 cm cystic area seen in right adnexa.

1. Name 2 differential diagnosis.
2. What is most likely diagnosis?
3. What is definitive diagnostic test?
4. What will your mode of management?
KEY

1. Ovarian cyst accident.
2. Ectopic pregnancy & ovarian cyst accidents.
3. Laparoscopy.
4. Surgical.

Station
A woman presents in labour with twin pregnancy. After the delivery of first twin second twin found to be present in transverse lie, how will you deliver second twin in presence of normal fetal heart rate?

KEY
If membranes are intact then carry out external cephalic version or internal podalic version. If these measures fail or membranes are absent for long time then cesarean section.

Station
Immediately after normal vertex delivery healthy full term infant woman collapses. Name five differential diagnoses.

KEY
1. Pulmonary embolism.
2. Amniotic fluid embolism.
3. Postpartum hemorrhage.
4. Hypoglycemia.
5. Eclampsia.
Station
Primigravida presents at 28 weeks gestation with jaundice. Give five differential diagnoses:

KEY

- Acute viral hepatitis.
- Acute fatty liver.
- Obstetrical cholestasis.
- Drugs e.g. halothane.
- Preeclampsia.
- Chronic liver disease.

Station
Primigravida presents at 35 weeks gestation with generalized seizures. Give five differential diagnoses.

KEY

a) Eclampsia.
b) Epilepsy.
c) Cerebral tumors.
d) Intracerebral infections.
e) Drug or alcohol abuse.

Station
A 25 years old woman has 3 years history of unexplained infertility. How will you counsel her?
KEY

- Greet.
- Introduction.
- Want to call her husband.
- Management options (conservative & assisted reproductive).
- Documentation.

Station

1. Name the high risk pregnancy shown in the pictures below.

2. Tell the types of the high risk pregnancy shown in the pictures above.

3. Tell three maternal complications associated with the above mentioned pregnancy.

4. Tell three common fetal complications associated with the above mentioned pregnancy.
5. Carefully see the picture given below and name the complication.

**KEY**
1. Twin pregnancy.
2. Monozygotic twin and dizygotic twin.
3. Hyperemesis gravidarum anemia, pregnancy induced hypertension, pressure symptoms, operative delivery and post-partum hemorrhage.
5. Twin-twin transfusion syndrome (TTTS).

**Station**
1. Name the malpresentation shown in the picture below.
2. Incidence of malpresentation at term.
3. Name four causes leading to this malpresentation.
4. Name four complications which can occur during the delivery of this malpresentation.
5. Name the types of malpresentation shown in the picture below.
KEY

1. Breech presentation.

2. 3 – 4 percent.


5. Extended breech, flexed breech and footling breech.

Station
Primigravida presents in outpatient department at 10 weeks of gestation for first antenatal checkup.

1. Name the baseline investigation, which you will advise her.

2. At what gestation you would like to carry out her anomaly scan.

3. What is the best to carry out amniocentesis if required?

KEY

1. Hemoglobin, Blood group antibody screening, urine complete, hepatitis profile and ultrasound.

2. 20 – 22 weeks of gestation.

3. 15 weeks onward.
Station

G3P2+0 presents at 37+2 weeks with breech presentation. After evaluation obstetrician decide to change the presentation to cephalic as shown in the picture below. Carefully see the picture.

1. Name and define the procedure.

2. Name two complications associated with the above shown procedure.

3. Name two contraindications for the above shown procedure.

**KEY**

1. External Cephalic Version (ECV). Abdominal manipulation to convert breech presentation into cephalic.

2. Preterm labour, Pre-PROM, uterine rupture and placental abruption.

3. Contraindication to vaginal delivery, uterine scar, oligohydramnios, uterine anomaly and pre-eclampsia.

Station

G2P1+0 (previous 1 C-section) presents at 36 weeks of gestation with history of P/V bleeding for the last two days.

1. See the picture below and make the diagnosis.

2. What is the mode of delivery in above shown condition?
3. See the picture below and name the types of placenta previa.

1. Placenta previa
2. Caesarean section.
3. Placenta previa type (1, 2, 3 & 4)

**Station**
Picture given below shows various maneuver of delivery of head in breech presentation. Name and described them.
KEY

1. Station of fetal head.

2. Location of presenting part of fetus in birth canal.

3. Entrance of widest diameter of fetal head into pelvic inlet.

4. Rotation of fetal head occurs at ischial spine, station of head can be judged by this bony part.

Station

1. Carefully see the picture shown below and identify the procedure.

2. What is the significance of this procedure?

3. Name the muscles cut in this procedure.

KEY

1. Episiotomy.

2. Helps in delivery of head by increasing space

Station
1. Identify the type of breech.
2. How will you deliver this breech?
3. How will you deliver preterm breech?

**KEY**
1. Footling breech.
2. Cesarean section.
3. Decision on individual basis weighing risks & benefits.

Station
You are senior medical officer and came to take over in labour room along with your team at 8.00 A.M.; your team includes three medical officers including you, one senior house officer & one sister. Now carefully take over of the patients as given below and decide which patient should be assigned to which person and why? Detail of the patients present in labour room is given below:

G₄P₃+₀ is in labour fully dilated with normal fetal heart rate.

PG at term in labour at 4 cm dilatation along with dipping fetal heart rate.

Woman delivered about 15 minutes ago in post-partum hemorrhage.

PG at 3 months amenorrhoea with heavy p/v bleeding (incomplete miscarriage).

G₂P₁+₀ previous SVD fully dilated since 7.30 A.M. without epidural analgesia, fetal head present at -1 station; fetal heart rate is normal.

**KEY**
- House officer to deliver her.
- Medical officer as fetal heart are dipping.
- PPH myself as its life threatening condition; might need intervention.
Medical officer as it needs urgent evacuation.

She can wait till other high risk patient get manage.

**Station**

You are asked to see 28 years old teacher who has been referred to you with P/V spotting during first trimester gestation.

1. What is differential diagnosis?
2. Discuss with examiner what will you do and how would you counsel her?

**KEY**

1. D/D: miscarriage, ectopic pregnancy, molar pregnancy, local trauma & polyp.
2. HISTORY: LMP to calculate gestational age, parity, duration of spotting, how much bleeding, any pain, passage of clots or products, risk factors for ectopic pregnancy & any history of fainting.

EXAMINATION: general physical examination, abdominal tenderness, vaginal examination (trauma, uterine size, tenderness, os, fornice & any polyp).

INVESTIGATIONS: routine, ultrasound & B-HCG to rule out ectopic.

SYMPATHETIC EXPLAINATION: regarding diagnosis and further management.

**Station**

Write ten steps of WHO for successful breastfeeding:

**KEY**

- Have a written breastfeeding policy of which all health care staff is aware.
- Train staff in the skills required to implement the policy.
Inform all pregnant women regarding benefits & management of breast feeding.

Help mother in initiating breastfeeding within 30 minutes of birth.

Show mothers how to breastfeed and maintain lactation if they are separated from the baby.

Babies should be exclusively breast fed.

Keep mother and baby together during hospital stay.

Encourage breastfeeding on demand.

Avoid pacifiers in newborn.

Know regarding breast feeding support groups and inform mothers regarding them.

**Station**

48 years old woman presents in gynae outpatient department with complaint of abdominal heaviness, anorexia & weight loss. On abdominal examination there is mass in right lower abdomen not felt separate from uterus of about 6X6 cm, hard in consistency, irregular surface & restricted mobility. Ultrasound shows mass arising from right adnexa. Picture of mass during surgery is shown below:

1. What is most probable diagnosis?

2. Give two differences between benign & malignant tumors.
3. How will you stage this tumor?

4. If this tumor is stage IIIa how will you manage it?

5. Name two predisposing factors for ovarian carcinoma.

KEY

1. Ovarian malignant tumor.

2. Benign tumor is mobile and have smooth surface.

3. Surgical staging.

4. Chemotherapy or radiotherapy.

5. Family history & pelvic irradiation for some other tumor.

Station

1. Identify the picture?

2. Give the differences between benign & malignant tumors.

3. A patient 52 year old P₃+0 presented with malignant ovarian tumor. What surgical treatment will you offer?
KEY

1. Ovarian malignant tumor.
2. Benign tumor is mobile and have smooth surface.
3. Staging laparotomy. TAH + BSO.

Station
30 years old known epileptic & her husband comes to see you for counseling as they want to conceive. Woman is taking sodium valproate as her fits are only control on this medicine.

KEY

- Introduction.
- Continue with the drug even during pregnancy.
- Folic acid 5mg/day start three months before pregnancy & during pregnancy.
- Chances of neural tube defect with valproic acid are approx. 1%.
- Early booking.
- Anomaly scans during pregnancy.
- Fits can increase during pregnancy so we may need to increase the dose of drug.
- Anything couple wants to ask.
- Documentation.

Station
You will be provided with the pelvis model and examiner will ask you to carry out pelvimetry:

KEY

- Introduction.
- Explain the procedure to woman.
- Take informed consent.
- Ask her to empty bladder.
- Lie on couch and cover her.
- Take aseptic measures.
- Lubricate index & middle finger of right hand.
- Apart the labias with fingers of left hands.
- Gently introduce left hand index finger into vagina then middle.
- Press on fourchete to relax the woman.
- Rotate finger.
- Then introduce further gently & measure diagonal conjugate.
- Feel for sacrum curve & ala of sacrum.
- Feel sciatic notches.
- Feel ischial spines.
- Remove fingers gently outwards and measure pubic arch by fist.
- Help woman in getting dressed.
- Say thanks.
- Documentation.
Station
1. Name the embryological duct responsible for origin of uterus & fallopian tube.

2. Carefully see the picture given below & identify the vaginal anomaly.

3. Name two surgical procedures for treatment of above anomaly?

KEY
1. Paramesonephric duct.

2. Vaginal agenesis.

3. McIndoe vaginoplasty & William’s vaginoplasty.

Station
Define maternal mortality, still birth & perinatal mortality rate:

KEY
Maternal mortality is defined as death of the woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by pregnancy or its management, but not from accidental and incidental causes.

Child born after 24 completed weeks of gestation, which does not breathe or show any signs of life at any time after being completely expelled from its mother.

Perinatal mortality rate is defined as the number of still births plus early neonatal deaths per 1000 total births.
Station
Baby is born whose extremities are blue but body is pink, pulse is 110 bpm, grimace, showing only flexion at extremities & week cry.

1. Calculate Apgar score:

PG presents to you at 41 weeks gestation & your plan is to induce the patient, on pelvic examination cervix is 1cm long, 2 cm dilated, soft in consistency & central in position, fetal head is at -1 station.

2. Calculate bishop score:

KEY

1. Six.
2. Eight.

Station
A 70 year old come with complaint of something coming out of vagina. On examination following findings were seen.

1. What is this condition? Write its classification?
2. What are predisposing factors?
3. What are treatment options?

KEY

1. Uterovaginal prolapse
   Classification
   1st degree – cervix just visible at introits
   2nd degree – cervix outside the introits up to
   3rd degree- complete uterus laying outside vagina.
2. Predisposing factors
- Delivery of good size babies
- Prolonged 2nd stage of labour
- Chronic condition causing increase intra-abdominal pressure i.e. constipation, cough
- Congenital weakness of uterine support
- Menopause.

3. Treatment options
   - Conservative - Pelvic floor exercise
     - Penuries
   - Surgical - Vaginal hysterectomy
     - Sling operations

**Station**

Measure the blood pressure in this patient.

**Key**

Interactive Station

- Method
- Patient should be seated or semi recumbent don’t lie her in the left lateral position.
- Use cuff of appropriate size.
- Use K-V is disappearance of sounds
- Deflate the cuff slowly.

**Station**

Measure the fundal height in this patient.
KEY

Interactive station

- Students measures while the examiner gives marks according to:
  - Approach to patient
  - Consent
  - Exposure
  - Measure by fingers
  - Measures by tape

Station
A 40 year old, P₂₄₀ come to Gynae OPD with severe pelvic pain for past few months. She thinks it is related with periods. She doesn’t have menorrhagia. Her bowels habits are normal.

1. What can be causes of her pain?
2. Which test is gold standard for diagnosis in chronic pelvic pain?
3. What are management options?

KEY

1. Causes of pain
   a) Gynaecological Causes
      - Ectopic
      - PID
      - Endometriosis
   b) GIT related causes
      - IBD
      - Appendicitis
      - Fibroids
      - Adhesions
      - Idiopathic
      - Diverticulitis
c) Urinary Tract related causes
   - UTI
   - Calculus – ureter – Bladder

2. Diagnostic laparoscopy

3. Treatment options
   a) Simple analgesics.
      - NSAIDs
   b) Hormonal treatment
      - OCPs
      - GnRH
      - Progestogen
   c) Surgical
      - Removal of cysts, adhesion lysis
      - Laser ablation of endometriosis
      - TAH + BSO

Station
A 20 year old PG comes with right iliac fossa pain at 5 weeks of gestation. Her pregnancy test is positive and a scan there is no fetal pole in the uterine cavity.

1. What is her differential diagnosis?

2. If she is ectopic pregnancy what are her management options.

3. What are risks factors predisposing to ectopic pregnancy.

    **KEY**

1. D/D
   - Ectopic pregnancy
- Early pregnancy
- Miscarriage

2. Management options
   a) Conservative - resolve spontaneously
   b) Medical - Methotrexate (50mg/m2/m) without folate rescue
   c) Surgical - laparoscopy

3. Risk/Predisposing factors
   - Previous ectopic pregnancy
   - Endometriosis
   - Previous pelvic / abdominal surgery
   - IVF
   - PPD
   - Idiopathic

**Station**
A young 20 year old girl comes with increase weight and oligomenorrhea. She is also developing hirsutism.

1. What is most probable diagnosis?
2. What biochemical + sonographic features are diagnostic of PCOS?
3. What are treatment options?

**KEY**

1. Poly cystic ovarian syndrome

2.
   a) Biochemical parameters - increase testosterone
   b) Clinical features - increase LH
   c) TVS - Bilaterally enlarged ovarian with multiple small peripherally situated cysts in a dense stroma.
3. Treatment options
   a) Medical. Metformin
      Coc with cyproterone acetate
   b) Surgical laparoscopy + ovarian drifting

**Station**
A 60 year old, menopausal lady came with vaginal spotting for 3 days. Her last pap smear was done 10 years ago. Which was normal. She is on HRT.

1. What can be cause of her postmenopausal bleeding?
2. What further diagnostic investigations are required?
3. What are long term adverse effects of HRT?

**KEY**

1. Causes of postmenstrual bleeding
   - Cervical CA
   - Ovarian CA
   - Genital tract atrophy
   - Polyps
   - Endometrial hyperplasia
   - Endometrial CA

2. Diagnostic investigations
   - TVS
   - Hysteroscopy + endometrial biopsy

3. Adverse effects of HRT
   - HRT increase risk of breast CA
   - Coronary heart disease
   - Stroke
   - Venous thromboembolism
Station
Answer the following questions regarding breech vaginal delivery.

1. What are ways of breech vaginal delivery?
2. What is the simplest way of conducting breech vaginal delivery?
3. What is Lovset’s Maneuver?

KEY
1. Ways of breech vaginal delivery
   - Spontaneous breech delivery
   - Assisted breech delivery
   - Breech extractions
2. Assisted breech delivery
   Rotation of breech through 180 degree if arms are extended.

Station
A G5P4+0 presents in emergency LR at 37 weeks with heavy P/V bleeding and on USG placenta totally covering the os.

1. What is the diagnosis?
2. What would be mode of delivery?
3. If per operatively placenta was retain what would be the problem.

KEY
1. Placenta previa Type IV
2. Emergency C/Section
3. Placenta accreta
Station
A young 25 year PG with flexed breech at 37 weeks comes to antenatal OPD answer her questions.

1. What would be mode of delivery?
2. Is there any other options?
3. What is the success rate of ECV?
4. What are complications of procedures?

KEY
1. Breech vaginal delivery / C-Section
2. ECV
3. 30 – 80%
4. Complications
   - Uterine rupture
   - Rupture of membrane
   - Fetal distress
   - Placental abruption

Station
A G3P2+0 at 20 weeks presented with c/o occasional spells of dizziness, palpitations and heart burn.

1. What physiological change responsible?
2. What advise you will give her?

KEY
1. Increased cardiac output and heart rate, postural hypotension. Reduced GI motility due to Increase hormone levels of progestogen.
2. Re-assurance (Normal physiological changes), counseling, dietary advise

**Station**
A PG at 40 weeks presented in Labour Room with h/o labour pains for 14 hours and h/o trial of labour by Dai for 8 hrs. On examination her vulva was swollen, hot vagina, caput +3.

1. What is diagnosis?
2. What will be the Initial management?
3. What will be the mode of delivery?

**KEY**
1. Obstructed labour
2. History, examination, investigations,
3. C-Section, IV hydration

**Station**
A G4P2+1 at 37 weeks with h/o PIH presented in LR with complaint of vaginal bleeding. On examination pulse – 116/mm, Afebrile, BP-90/60. On abdominal examination uterus tense, tender, FHR 80 – 90b/min.

1. What is the Diagnosis?
2. What Investigations are required?
3. How will you manage?

**KEY**
1. Placental abruption
2. BG and save, FBC, urine C/E, PT/APTT, S/fibrinogen, RFTs & LFTs, USG obs.
3. Resuscitation, Emergency LSCS
Station
A PG at 34 weeks presented in LR with C/O increase BP for 1 week and C/O headache, vertigo, blurring of vision. On examination B.P is 160/110

1. What is the diagnosis?
2. What Management is to be done?
3. When & how will you deliver?

KEY
1. Severe PIH
2. History, Examination, investigation, Antihypertensive, MgSO4.
3. If feto maternal condition is satisfactory wait for term delivery.
   If feto maternal is unsatisfactory then Induce if Bishop Score is good and vaginal delivery / Emergency LSCS if bishop score is poor or there is fetal distress and deteriorating maternal condition.

Station
A 35 year old P8+1 has come to L.R with H/O home delivery 6 hours back and heavy vaginal bleeding. She is pale, pulse is 1/10 p/m, BP is 90/60mmhg.

1. What is the diagnosis?
2. What initial management will you give her?
3. What steps will you take to control her bleeding?

KEY
1. PPH
3. Bimanual massage, utero tonics drugs, EUA to rule out vaginal / cervical tears or retain placenta, laparotomy with ligations of uterine and ovarian vessels, B-lynch suture, Obstetrical hysterectomy, or if expertise is available, ligations of the anterior division of the internal iliac artery.

**Station**

A 45 year old P5+0 presented with c/o menorrhagia for 2 year. She took medical treatment but no relief. On examination uterus is 18 weeks size.

1. What is the most likely diagnosis?
2. How you will investigate her
3. What treatment option you can offer.

**Station**

G3P2+1 at 39 weeks presented in OPD. For routine antenatal checkup. On examination she has breech presentation.

1. What information you will hive her on ECV
2. What is the mode of delivery?
3. When to deliver?

**Station**

P3+0 delivered by emergency LSCS 6 weeks back. She is lactating. She wants contraception.

1. What method you can offer?
2. What are few advantages of hormonal contraception?
3. What are the contraindications of hormonal contraception?

**Station**

G3P2+1 at 10 weeks presented in LR with C/o P/V bleeding with passage of clots. On examination internal os was open.
1. What is the diagnosis?
2. How you will counsel her?
3. How you will treat her?

**Station**

G3P2+0 at 16 weeks presented with c/o recurrent episodes of P/V bleeding on USG. Snow storm appearance.

1. What is the diagnosis?
2. What investigations you will advise.
3. How you will manage her.

**Station**

In C/o CA Cervix related is the management of following

Stage I a
Stage I b
Stage I c

**Station**

A 60 year old patient presented in gynae OPD with c/o something coming out of vagina for 2 years. On examination there is a mass protruding thus introits but reducible.

1. What is the diagnosis?
2. What treatment you will offer her
3. How will you follow her?

**Station**

A 45 year old P5+0 presented with c/o menorrhagia for 2 year. She look medical treatment but no relief. On examination uterus is 18 weeks size.
1. What is the most likely diagnosis?
2. How you will investigate her?
3. What treatment option you can offer.

**Station**

A PG at 37 weeks presented in OPD. For routine antenatal checkup. On examination she has breech presentation.

1. What information you will give her on ECV?
2. What factors would determine the mode of delivery?

**KEY**

1. ECV is a safe procedure provided contraindications have been ruled out. Its success rate is 50 – 60%.

2. Mode of delivery will depend on type of breech, extension / flexion of the fetal head, estimated fetal weight, and amount of liquor, placental localization and ruling out fetal congenital abnormality. Any contraindication to vaginal delivery should be ruled out.

**Station**

A G2P1+0 with hypertension at 24 weeks presents to you for antenatal check up

1. Take BP
2. Position for BP in pregnancy
3. Which sound corresponds to diastolic blood pressure in pregnant patients?
4. Define PIH?
5. What precaution would you take for a very obese patient while taking blood pressure?
KEY

2. Sitting or 45 Degree.
4. Raised BP with or without proteinuria after 20 weeks gestation.
5. Take a bigger cuff.

Station (Interactive)

Outlet forceps

1. Identify the instrument
2. Assemble
3. Narrate application
4. Complications
5. How to minimize complications?

KEY

1. Outlet forceps
2. According to examiner’s discretion.
3. According to examiner’s discretion.
4. Cervical tears, vaginal tears, perineal tears, injury to the baby, subgaleal hemorrhage, failed attempt, injury to the bladder and fistula formation.
5. Fulfill pre requisites, Proper expertise, Back up facility (Blood, theater, staff, pediatrician)

Station

1. Define miscarriage
2. Types

3. How do you distinguish between threatened & inevitable on history and examination?

**KEY**

1. Expulsion of products of conception before 24 weeks of pregnancy.

2. Types of miscarriages
   - Missed miscarriage
   - Threatentned
   - Inevitable
   - Incomplete
   - Complete
   - Septic

3. Threatened: history of red colour mild bleeding usually without pain on examination. Os is closed, uterus corresponds to dates and there is only mild bleeding.

**Station**

IUCD

1. Identify

2. What is the Pearl Index?

3. For how many years can copper T-380 be placed before it needs replacement?

4. Complications of inserting IUCD?

5. What are the contraindications?

**KEY**

1. Intrauterine copper device
2. 0.8 Per 100 women years
3. 8 years
4. Infection, perforation, failure to place, dysmenorrhea, menorrhagia and if infection gets chronic can lead to ectopic pregnancy and infertility.
5. Active pelvic inflammatory disease, malignant trophoblastic disease, endometrial tuberculosis and endometrial carcinoma. Relative contraindications are distorted cavity and unexplained vaginal bleeding (which should be investigated prior to insertion).

Station

A 24 year old G₂P₂+₀ with previous uncomplicated C/Section at 36 weeks pregnancy comes to OPD and is concerned about mode of delivery of present pregnancy.

1. What are the available options regarding mode of delivery?
2. What are the chances of successful VBAC?
3. In a woman with one C/S followed by successful VBAC. What are the chances of next vaginal delivery?
4. What would be the complications in mother if she opts for vaginal delivery after C/S?
5. If this patient decides for elective section what is the risk of rupture?

KEY

1. VBAC, Elective LSCS
2. 72 – 76%
3. 86 – 90%
4. Rupture, haemorrhage, risk of transfusion, hysterectomy, damage to neighboring viscera’s, thromboembolism, and maternal death.
5. Nil
Station

CTG

1. Read the given CTG
2. Define Normal CTG
3. Define Acceleration?
4. Define Deceleration?
5. What does sinusoidal pattern on CTG means?

KEY

1. CTG of patient name Mrs. Azra done on 3rd September at 8:45pm. Pulse of patient is not mention. Basal heart rate is 140 bpm, good beat to beat variability and accelerations in 25min, no decelerations. It is a reactive trace.

2. A reactive CTG has baseline 110 – 150BPM with variability of 5 – 25 bpm at least two accelerations in 15-20 min and no deceleration.

3. Increase in FHR of >15bpm and persists for 15 second.

4. Drop in FHR of > 15 bpm lasting for 10 seconds

5. It sign wave of fixed periodicity of 2 – 5 cycles/min having one amplitude of > 25bpm with profound loss of variability. It is characteristics of intrauterine fetal anemia.
Station

A 26 year old G3P2+0 at 39 weeks of gestation come to OPD for first time with following USG showing BPD of 12 cm

1. What is your diagnosis?
2. What will you counsel her?
3. What is the %age of associated spina bifida with the given problem?
4. What is its recurrence?

KEY

1. Hydrocephalus
2. Introduction, eye contact, sympathetic attitude, telling diagnosis, compatibility with life, looking for other anomalies, session with pediatrician, mode of delivery, patient’s wishes, treatment options.
3. 30%
4. 1 ratio 30

Station

A 29 year old G5P4 is admitted at 36 weeks gestation with sudden painless (200ml) bleeding. The pregnancy had been uncomplicated. Patient is not pale, pulse is 88/min, BP is 105/65mmHg, her abdomen is non-tender, FH is 33cm and fetus is lying transversely. FHR is 152/min

1. What is most likely diagnosis?
2. How do you support your diagnosis?
3. Write two D/D?
4. How would you confirm your diagnosis?
5. If it was vasa previa, how can you confirm that?
KEY
1. Placenta previa
2. Painless bleeding, non-tender abdomen, transverse fetus.
3. Abruption, vasa previa.
4. TVS
5. Kleihauer test.

Station
Mrs. Atif is 32 year old house wife who had termination for Down’s syndrome baby 2 years ago. She is 10 weeks pregnant again.

1. What is Down’s syndrome?
2. What is the risk of her baby being affected again?
3. What test can identify Down syndrome on USG?
4. Triple test for D.S?
5. What USG anomalies can show Down syndrome?

KEY
1. This is trisomy 21 due to translocation or non-disjunction of chromosomes. Characterized by cardiac heart disease, duodenal atresia, facial defects, and ventriculomegaly.
2. If translocation is 14:21 then it is 1:10. In non-disjunction it is 75%
4. ↑ Serum β HCG, ↓ serum estriole, α feto protein.
5. Cardiac anomalies, GI atresia facial defects, nuchal edema, shortening of limbs, sandal gaps.

Station
Mrs. Rehman 37 year old nulliparous woman c/o of heavy and regular periods. She presents in OPD with following USG

1. What is your diagnosis?
2. What could be other symptoms of the disease?
3. If she wants to bear children what treatment would you offer her?
4. What could be the complication of above treatment?
5. Is there any medical treatment available?

**KEY**

1. Fibroid uterus
3. Myomectomy
4. Hysterectomy
5. GnRH analogue – Short term

**Station**

A 25 years old woman at 10 weeks of gestation presents with vaginal bleeding uterus is enlarged to 14 weeks and USG shows “snow storm” appearance.

1. What is the most likely diagnosis?
2. What pre-operative investigations should be performed?

3. What is the primary management of condition?

4. What follow up is indicated?

5. What could be complications of treatment?

**KEY**

1. Molar pregnancy

2. Hb, USG, CXR, LFTs, β-hCG

3. Suction Evacuation

4. Fortnightly until β-hCG undetectable and then 6 monthly for 1 year and then 3 monthly for 2 year.

5. Perforation, Haemorrhage, infection.

**Station**

24 year old young girl presents in emergency with pain right lower abdomen. She missed her one period and her pregnancy test is positive. On pelvic examination cervical excitation present.

1. What is most likely diagnosis?

2. How would you confirm it?

3. What are treatment options?

4. What is medical treatment?

5. What is the rate of recurrence?

**KEY**

1. Ectopic pregnancy

2. TVS

3. Treatment options – Surgery as well medical
Surgical laparoscopy or surgical laparotomy

4. Medical treatment. Methotrexate 50mg/kg body weight

5. 10 – 20%

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