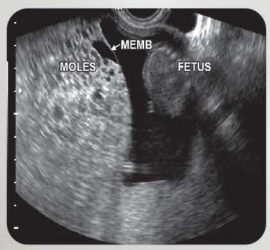
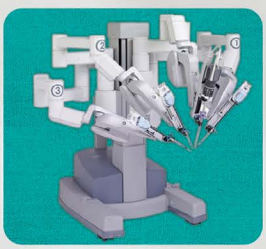
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Manual of Obstetrics & Gynecology for the Postgraduates

Obstetrics & Gynecology







Hiralal Konar

2nd Edition

JAYPEE

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2 Self-Assessment in Obstetrics

SINGLE BEST ANSWER (SBA) AND MULTIPLE CHOICE QUESTIONS (MCQs)

Q.1 The pelvis which has greater anteroposterior diameter at the inlet compared to that of transverse diameter is classified as:

a. Gynecoid
b. Android
c. Anthropoid
d. Platypelloid

Ans. c. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 403.

Q.2 Regarding germ cells:

a. Following birth, there is mitotic division of the primary oocytes
b. The final maturation of the oocytes occurs only before fertilization
c. Ovulation occurs soon after formation of secondary oocytes
d. Secondary oocytes completes the second meiotic division just before fertilization

Ans. c. At birth, there is no more mitotic division. Final maturation of the oocyte occurs after fertilization. Secondary oocyte completes the second meiotic division after fertilization (*See* Dutta's Textbook of Gynecology, 7th Edition, p. 66).

Q.3 Decidual space is obliterated by:

a. 10th week
b. 12th week
c. 14th week
d. 16th week

Ans. d. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 28.

Q.4 Tertiary villi are completed by:

a. 17th day
b. 19th day
c. 21st day
d. 23rd day

Ans. c. 21st day

Q.5 Regarding development, all the statements are correct except:

a. Gonads are developed from mesoderm and endoderm
b. Bartholin's glands are developed from endoderm
c. Most of the genital tract is developed from the endoderm
d. Urethra from endoderm

Ans. c. Most of the genital tract is developed from mesoderm.

Q.6 Blood flow in the intervillous space per minute is approximately:

a. 250 mL
b. 300 mL
c. 500 mL
d. 700 mL

Ans. c. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 37.

Q.7 Regarding human chorionic gonadotropin (hCG) all are correct except:

a. hCG is a glycoprotein
b. Plasma half-life is 24 hours
c. Site of origin is the syncytiotrophoblasts
d. Maximum secretion is at 6–7 weeks

Ans. d. Maximum secretion is at 6–7 weeks (60–70 days).

Q.8 Thickness of the placental membrane at term approximately:

a. 0.025 mm
b. 0.002 mm
c. 0.012 mm
d. 0.02 mm

Ans. a. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 38.

Q.9 Deeper penetration of the villi is prevented by:

a. Nitabuch's fibrinoid layer
b. Trophosphere
c. Mucopolysaccharides content of the decidua
d. Enzyme in cytotrophoblast

Ans. a. Nitabuch's fibrinoid layer

Q.10 Fetal sex can be determined by examining the genitalia with ultrasonography (USG) at:

a. 8th week
b. 10th week
c. 12th week
d. 16th week

Ans. d. Fetal gender identification by USG is possible in the second trimester though third trimester is the appropriate time.

Q.11 The following changes occur in the vascular system of the newborn after birth:

a. The proximal parts of the umbilical arteries become the lateral umbilical ligaments
b. Anatomical closure of the ductus arteriosus occurs soon after birth
c. Anatomical closure of the foramen ovale occurs with onset of respiration
d. Ductus venosus becomes ligamentum venosum

Ans. d. The proximal parts of the umbilical arteries remain open as superior vesical arteries. Anatomical closure of the ductus arteriosus occurs at about 1–3 months. Anatomic closure of foramen ovale occurs at about 1 year.

Q.12 The following are related to delivery of head in normal labor except:

a. During crowning, the biparietal diameter stretches the vulval outlet
b. Successive parts of the fetal head to be born are face, brow and vertex
c. Restitution occurs in the direction opposite to that of internal rotation
d. Head is delivered with slow extension

Ans. b. The successive parts to be born are vertex, brow and face.

Q.13 During the active phase of labor, the effective dilatation of the cervix in primigravida should be at the rate of:

a. 0.5 cm/hour
b. 1 cm/hour
c. 1.5 cm/hour
d. 2 cm/hour

Ans. b. 1 cm/hour

Q.14 The following are related to a normal pelvis:

a. Angle of inclination is 90°
b. Sacrocotyloid diameter measures from the sacral promontory to the iliopubic eminence
c. Waste space of Morris is about 2.5 cm
d. Bispinous diameter is 8.5 cm

Ans. b; c. Waste space of Morris should not be more than 1 cm. a. = 55°; d. = 10.5 cm.

Q.15 The perineal injury can be prevented in normal labor by all except:

a. To maintain flexion of the head
b. Timely episiotomy as a routine
c. Slow delivery of the head in between contractions
d. Effective perineal guard

Ans. b. Episiotomy in selected cases only.

Q.16 Regarding hyperemesis gravidarum all are correct except:

a. It is associated with weight loss of more than 5% of the body mass
b. Glycosuria is commonly observed
c. Thiamine supplementation is helpful
d. Omeprazole may relieve the symptoms

Ans. b. Ketonuria is common; c. Thiamine prevents Wernicke's encephalopathy and pontine myelinolysis. Dextrose containing solutions should be avoided as they may precipitate Wernicke's encephalopathy and pontine myelinolysis; d. Proton pump inhibitor, omeprazole has been used successfully. Severe, intractable hyperemesis may need corticosteroids. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 181).

Q.17 The following are the blood values following delivery:

a. Immediately following delivery, there is increased blood volume
b. Cardiac output remains as in prelabor value soon following delivery
c. Fibrinogen level remains high up to 2nd week postpartum
d. There is leukopenia

Ans. c. Immediately following delivery, there is slight decrease in blood volume and the cardiac output rises to about 60% above the prelabor values. There is leukocytosis.

Q.18 The following biochemical changes occur in hyperemesis gravidarum except:

a. Fall in plasma sodium and potassium
b. Fall in plasma chloride
c. Fall in urinary ketone bodies
d. Rise in blood urea and uric acid

Ans. c. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 182.

Q.19 Most common cause of first trimester miscarriage:

a. Chromosomal abnormality of the fetus
b. Endocrinal defect
c. Antiphospholipid antibodies
d. Immunological

Ans. a. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 187.

Q.20 Most common known cause of midtrimester miscarriage:

a. Uterine malformation
b. Fibroid
c. Cervical incompetence
d. Chronic maternal illness

Ans. c. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 187.

Q.21 Pregnancy should be strongly discouraged in a woman who has:

a. Atrial septal defect
b. Patent ductus arteriosus
c. Eisenmenger syndrome
d. Rheumatic mitral stenosis

Ans. c. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 187.

Q.22 Elective time of cerclage operation for midtrimester recurrent abortion:

a. Around 8 weeks
b. Around 14 weeks
c. Around 20 weeks
d. Prepregnant state

Ans. b. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 199.

Q.23 The best method of evacuation of a missed abortion in uterus of more than 12 weeks:

a. Oxytocin infusion
b. Intramuscular prostaglandin (15 methyl PGF2α)
c. Prostaglandin E_1 vaginal (misoprostol) followed by evacuation of the uterus
d. Suction evacuation

Ans. c. Success rate is more than 90%. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 191).

Q.24 Hydatidiform mole is principally a disease of:

a. Amnion
b. Chorion
c. Uterus
d. Decidua

Ans. b.

Q.25 Management of unruptured tubal ectopic pregnancy may be done by:

a. Expectantly in majority of the cases
b. Medically by Methotrexate in all cases
c. Laparoscopic conservative surgery is the gold standard
d. Salpingostomy, as it eliminates the risk of persistent ectopic pregnancy

Ans. c; a and b. Cases must be selected properly; d. Risk of persistence is 5–20%. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 216).

Q.26 The advantages of hysterectomy in molar pregnancy are:

a. Chance of choriocarcinoma becomes nil
b. Follow-up is not required
c. Enlarged ovaries can be removed during operation
d. Chance of pulmonary embolization is minimal.

Ans. d. Chance of choriocarcinoma may be reduced significantly but cannot be to nil. Follow-up is mandatory and the lutein cyst should not be removed as a routine during surgery.

Q.27 The following are related to prophylactic chemotherapy in molar pregnancy:

a. It may be given in 'at risk' patients
b. Multiple agents are preferred
c. Malignant sequelae becomes nil
d. Follow-up is not required

Ans. a. Cytotoxic drugs are hazardous and often prove fatal. However, in high risk patient specially where facilities for follow-up are not available, prophylactic chemotherapy has got a place following evacuation of mole. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 228).

Q.28 The most common type of monozygotic twins:

a. Diamniotic-monochorionic
b. Diamniotic-dichorionic
c. Monoamniotic-monochorionic
d. Monoamniotic-dichorionic

Ans. a. Types of placentations in twins are: Diamniotic-Dichorionic (Di-Di). Diamniotic-Monochorionic (Di-Mo) or Monoamniotic-Monochorionic (Mo-Mo). Dizygotic twins (80%) are always Di-Di. Monozygotic twins (20%) are Di-Mo in majority (13–14%), Di-Di in (6–7%) and Mo-Mo in only less than 1% of cases. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 231, 240).

Q.29 Absolute proof of monozygosity is determined by:

a. DNA finger printing
b. Intervening membrane layers
c. Sex of the babies
d. Reciprocal skin grafting

Ans. a. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 235.

Q.30 Monozygotic twins are associated with all except:

a. Twin transfusion syndrome
b. Vanishing twin
c. Different karyotype pattern
d. Fetal anomalies

Ans. c. Fetal risks depend more on chorionicity than on zygosity.

Q.31 Gestational trophoblastic disease (GTD):

a. Persistent trophoblastic tumor following H. mole is about 1%
b. Placental site trophoblastic tumor is very responsive to chemotherapy
c. Recurrence risk of GTD is 10%
d. Risk of choriocarcinoma is about 2%

Ans. d; a. 15–20%; b. less responsive; c. about 1%.

Q.32 Concerning hemolysis, elevated liver enzyme levels, low platelet count (HELLP) syndrome:

a. It is a manifestation of severe pre-eclampsia
b. Platelet transfusions are often indicated
c. Eclampsia is less likely to occur when compared to severe pre-eclampsia
d. Use of dexamethasone improves the outcome

Ans. d. *See* Manual of Obstetrics and Gynecology for the Postgraduates, p. 265; a. HELLP syndrome complicates around 20% of all cases of severe pre-eclampsia; b. Platelet transfusions are not generally indicated unless the count is less than 40,000/mL; c. Eclampsia is more common in HELLP syndrome compared to pre-eclampsia.

Q.33 Best method of induction of labor in hydramnios:

a. High rupture of the membranes
b. Low rupture of the membranes
c. Abdominal amniocentesis followed by stabilizing oxytocin drip
d. Prostaglandins

Ans. c. It minimizes sudden decompression of the uterine cavity, placental abruption and incidence of cord prolapse. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 215).

Q.34 Single umbilical artery is commonly associated with the following except:

a. Babies born from diabetic mothers
b. Congenitally malformed babies

c. More in twins
d. Is always associated with IUGR

Ans. d. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 254)

Q.35 About the recurrence all are true except:

a. Recurrence in HELLP syndrome is 5%
b. Recurrence of ectopic pregnancy is 10–15%
c. Recurrence in hydatidiform mole is 1–2%
d. Recurrence of abruptio placentae is 6–10%

Ans. a. It is about 20–25%.

Q.36 In twin pregnancy:

a. Fetal risks depend more on zygosity than on chorionicity
b. Chorionicity is best determined in the second trimester by USG
c. Presence of twin peak sign indicates dichorionicity
d. Monozygotic twins are always monochorionic

Ans. c; a. Fetal risk depend more on chorionicity than on zygosity; b. Accurate in the first trimester; d. about 80% of all twins are dichorionic. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 237).

Q.37 The following are the criteria of gestational hypertension, except:

a. No underlying cause of hypertension
b. Unassociated with edema and/or proteinuria
c. Normalization of BP within 6 weeks, following delivery
d. Pregnancy outcome is often poor

Ans. d. Pregnancy outcome is usually similar or superior to that of normotensive pregnancy.

Q.38 The following are related to essential hypertension with pregnancy, except:

a. Family history is often present
b. Platelet count is markedly low
c. About 20% may be superimposed with pre-eclampsia
d. About 30% have permanent deterioration of hypertension following delivery

Ans. b.

Q.39 The best way to diagnose the degree of placenta previa:

a. Transvaginal sonography
b. Double set up examination
c. Observation during CS
d. Examination of placenta following delivery

Ans. a. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 286.

Q.40 The following statements are related to placenta previa, except:

a. Incidence of placenta previa is decreasing
b. Type III and IV constitute about one-third
c. Posterior placenta previa is easy to diagnose
d. The amount of blood loss is not related to the degree of placenta previa

Ans. c. It is difficult to diagnose even with USG. Incidence of placenta previa is related to high parity and it is decreasing due to small family norm.

Q.41 Blood coagulopathy in abruptio placentae is mainly due to:

a. Decreased synthesis of fibrinogen
b. Consumption coagulopathy
c. Enhanced fibrinolytic activity with raised FDP and D-dimer
d. Increased activation of plasminogen

Ans. b. Consumption of fibrinogen intravascularly as well as retroplacentally. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 296).

Q.42 The best way to tackle the blood coagulation disorders in abruptio placentae:

a. Massive relatively fresh blood transfusion
b. To administer antifibrinolytic substances
c. To administer fibrinogen rich substances
d. Heparin

Ans. a. Massive relatively fresh blood transfusion improves hypovolemic state, increases tissue perfusion and increases production of procoagulants either from the liver or reticuloendothelial cells. This is in addition to the supply of fibrinogen in fresh blood. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 715).

Q.43 The incorrect statement in the management of couvelaire uterus is:

a. It can be diagnosed only by laparotomy
b. Most of the muscle dissociation occurs in the middle and outer muscle layers
c. The myometrial hematoma more often interferes with uterine contraction
d. Per se, it is not an indication for hysterectomy

Ans. c. Myometrial hematoma usually does not cause uterine atonicity. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 296).

Q.44 The following tests are related to blood coagulation disorders in obstetrics except:

a. Thrombocytopenia is a feature of fibrinolytic process and not of DIC
b. In DIC, RBC will be 'helmet' shaped or fragmented but in fibrinolytic process, the cell morphology is normal
c. Weiner clot observation test gives a rough estimate of total blood fibrinogen level
d. Thrombocytopenia can be diagnosed from the peripheral smear

Ans. a. Thrombocytopenia is a feature of DIC and not of fibrinolytic process; c. If clotting time is < 6 minutes, fibrinogen level is > 150 mg%. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 714).

Q.45 The physiological iron deficiency state during pregnancy is evidenced by the following except:

a. Fall in hemoglobin concentration
b. Fall in hematocrit value
c. Low serum iron
d. Low iron binding capacity

Ans. d. The serum iron binding capacity will be high. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 306).

Q.46 The following statements are related to the therapy of iron deficiency anemia except:

a. Oral iron can restore not only the serum iron but also the store iron
b. Parenteral iron therapy markedly increases the reticulocytic count within 7–14 days
c. Parenteral therapy is ideal during 30–36 weeks
d. Blood transfusion may be useful in severe anemia beyond 36 weeks

Ans. a.

Q.47 Which of the following to be avoided in the treatment of thalassemia:

a. Fresh (relatively) blood transfusion
b. Folic acid
c. Routine iron therapy
d. Deferoxamine improves pregnancy outcome

Ans. c. There is usually no deficiency of iron and exogenous iron therapy may precipitate hemochromatosis.

Q.48 Safe and effective method of contraception in sickle cell anemia:

a. Oral pill
b. IUCD
c. Barrier method
d. Progestin (only contraceptives)

Ans. d. It can be use safely. It also reduces 'sickling'. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 317).

Q.49 The statement that is not related to hemoglobinopathies is:

a. Hemoglobinopathies are specific inherited disorders within the polypeptide chains of globin fraction
b. Sickle cell disease is due to mutation causing substitution of valine for glutamic acid on the β chain
c. β-thalassemia is confirmed when the level of HbA_2 ($\alpha_2\ \delta_2$) is > 3.5% and HbF ($\alpha_2\ \gamma_2$) is > 2%
d. α and β polypeptide chains are controlled by four genes

Ans. d. Two genes (chromosome 11) direct β chain and four genes (chromosome 16) direct α chain production.

Q.50 Patients with organic heart disease in pregnancy most commonly die during:

a. 20–24 weeks of pregnancy
b. First stage of labor
c. Soon following delivery
d. 2 weeks of postpartum

Ans. c. Due to congestive cardiac failure with increased cardiac load. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 320).

Q.51 The best method of curtailing the second stage of labor in heart disease is by:

a. Prophylactic forceps
b. Ventouse
c. Spontaneous delivery with episiotomy
d. Cesarean section

Ans. b. Ventouse can be applied with the patient in dorsal postion. The lithotomy position during forceps delivery increases the venous return to the heart and may overload it. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 322).

Q.52 Regarding cytomegalovirus (CMV) infection in pregnancy:

a. Fetal organ damage occurs when infection is in the first trimester only
b. Is associated with hepatosplenomegaly in infancy
c. May be confirmed by culture of infant's nasal secretions
d. CMV vaccine is protective

Ans. b and c. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 349).

Q.53 The following are related to gestational diabetes, except:

a. Fasting hyperglycemia (> 105 mg/dL) is associated with increased risk
b. High risk for the development of type-2 diabetes in the postpartum period

c. Macrosomia is due to the proinsulin polypeptides (IGF–I and II)
d. Fetal anomalies are increased

Ans. d. It is only in overt diabetes. Fasting hyperglycemia is associated with increased risk of IUD and development of type-2 diabetes in the postpartum period.

Q.54 The following statements are related to diabetes with pregnancy except:

a. Good control of diabetes in prepregnant state reduces the incidence of congenital malformation of the fetus
b. The insulin requirement is diminished as pregnancy advances
c. There is increased risk of proliferative retinopathy and the need of laser photocoagulation
d. 'Unexplained' IUD may be due to fetal acidemia

Ans. b. The insulin requirement increases as pregnancy advances. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 331).

Q.55 The following are related to red degeneration of fibroid except:

a. Usually occurs in a big fibroid
b. Usually occurs in second half of pregnancy
c. The color is due to hemolyzed red cells and hemoglobin
d. There is associated leukopenia

Ans. d. There is leukocytosis.

Q.56 Concerning preterm labor and tocolytics:

a. Indomethacin reduces the risk of neonatal mortality
b. β mimetics are associated with constriction of the fetal ductus arteriosus
c. Atosiban has been shown to prolong pregnancy for 7 days
d. β mimetics are associated with maternal pulmonary edema

Ans. c and d; a. It is associated with neonatal constriction of ductus arteriosus: Intraventricular hemorrhage, necrotizing enterocolitis and oligohydramnios. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 584).

Q.57 Regarding anti-D prophylaxis in a RhD negative woman:

a. The use of anti-D has prevented all pregnant RhD negative women from developing anti-D antibodies
b. A 500 IU dose of anti-D is sufficient to cover a fetomaternal hemorrhage of 4 mL of red blood cells (125 IU/mL)
c. Antenatal prophylaxis of RhD negative women immunization during pregnancy will significantly reduce the sensitization
d. Kleihauer-Betke test is to note the number of maternal red bloods cells in fetal blood

Ans. b and c; a. Despite the use of anti-D IgG approximately 1% of the RhD negative women develop anti-D antibodies. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 390).

Q.58 Which of the statements are almost noncontroversial in the management of a post cesarean pregnancy:

a. Once a CS, always a CS
b. Once a CS, a mandatory hospital delivery and individualization of the case
c. Following vaginal delivery, exploration of uterus is a must
d. Prophylactic forceps is a routine

Ans. b. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 383 and 384.

Q.59 The following statements are related to antibody formation against Rhesus-antigen except:

a. Detectable antibodies usually develop at 6 months following large volume of fetomaternal bleed
b. 0.1 mL is considered as critical sensitising volume
c. Antibody once formed remains throughout life
d. Albumin agglutinin (IgG) is the first to appear and is not harmful to the fetus

Ans. d. IgM antibody is the first to appear and IgG crosses the placenta and is harmful to the fetus.

Q.60 Ultimate cause of fetal death in hydrops fetalis is due to:

a. Chronic placental insufficiency
b. Damage to the liver leading to hypoproteinemia and edema
c. Cardiac failure
d. Severe anemia and anoxia

Ans. c. *See* Dutta's Textbook of Obstetrics, 8th Edition, p. 571.

Q.61 Anti-D gammaglobulin should be administered to all the Rh-negative mother following delivery except:

a. Baby is Rh-positive with direct Coombs' test negative
b. Even when baby's Rh typing cannot be performed
c. Associated ABO group incompatibility
d. Baby is Rh-negative with absence of antibody

Ans. d.

Q.62 The objectives of exchange transfusion in hemolytic disease of newborn with direct Coombs' test positive are all except:

a. To correct anemia by replacing sensitized red blood cells with Rh-negative cells
b. To remove the circulatory antibodies
c. To eliminate the circulatory bilirubin
d. To alter the Rh-factor of the baby's blood

Ans. d. Rh-factor is not changed. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 396).

Q.63 The following statements are related to Rh-incompatibility:

a. Immunoprophylaxis against Rh-antigen by administration of 300 mg of anti-D gamma globulin following delivery is 100% protective
b. Exchange transfusion to the baby is to alter temporarily the Rh-factor of the baby's blood
c. The blood for exchange transfusion should be of group 'O' Rh-negative packed cells from unsensitized donors
d. Detection of antibody (IgG) in mother is called direct Coombs' test

Ans. c; a. It is not cent percent guaranted, ideally dose should be calculated by Kleihauer test; b. Not at all alter the Rh typing of the infant's blood; d. It is indirect Coombs' test.

Q.64 The following are related to contracted pelvis:

a. The words contracted pelvis and cephalopelvic disproportion are interchangeable
b. Engagement of the head clearly rules out contracted pelvis
c. Radiopelvimetry is invaluable and can even replace clinical pelvimetry
d. CT and MRI are accurate for the diagnosis

Ans. d. Contracted pelvis may be a cause of cephalopelvic disproportion (CPD) but CPD may occur even without contracted pelvis. Engagement of the head only rules out inlet contraction. Radiopelvimetry can be complementary to clinical pelvimetry but cannot replace it. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 403).

Q.65 The correct statement related to contracted pelvis is:

a. Trial of labor is conducted always in an institution
b. Isolated outlet contraction is rare
c. X-ray pelvimetry is less informative than clinical or MRI
d. Muller-Munro Kerr is an abdominal method of pelvic assessment

Ans. d. Muller-Munro Kerr is an abdominovaginal method. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 411).

Q.66 Regarding appendicitis in pregnancy:

a. Incidence is less compared to nonpregnant state
b. Predisposes to preterm labor
c. Conservative management should be the choice
d. Clinical features are very diagnostic

Ans. b. Incidence is same (1 in 2,000 pregnancies) as that of nonpregnant state. ***Management is always surgical*** and a ***rate of 30% of normal appendices at laparotomy is justified***. Mortality is higher because of late diagnosis. Usual features of nausea, vomiting, leukocytosis in normal pregnancy, displacement of the position of the appendix by the gravid uterus and finally suspicion of other conditions (pyelonephritis, placental abruption) make the diagnosis often late. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 354).

Q.67 Trial of labor is characterized by:

a. Labor is usually induced
b. Oxytocin stimulation should not be used
c. Should not be initiated in nonengaged head
d. Considered for cases with suspected cephalopelvic disproportion

Ans. d. Spontaneous onset of labor, oxytocin stimulation may be used.

Q.68 Diabetes in pregnancy with regard to labor and delivery:

a. Maternal hyperglycemia predisposes to neonatal hypoglycemia
b. Use of oxytocin is contraindicated
c. Incidence of cesarean delivery is more than 50%
d. The need of insulin is higher in breastfeeding woman

Ans. a and c; d. Insulin requirement falls in breastfeeding women. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 333).

Q.69 The following are related to retraction ring (Bandl's ring) except:

a. It is an end result of tonic uterine contraction and retraction
b. It invariably follows obstructed labor
c. It is always situated at the junction of upper and lower segment of the uterus
d. It is stationary

Ans. d. It is not stationary. (*See* Dutta's Textbook of Obstetrics, 8th Edition, p. 420).

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