UKOT'S BACK TO BASICS MCQs

OBSTETRICS AND GYNECOLOGY

Inyang Ukot

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Ukot's Back to Basics MCQs: Obstetrics and Gynecology

(Volume 1)

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CONTENTS

FOREWORD

I am delighted to be invited to write an introduction to this very important book, **Ukot's Back to Basics MCQs: Obstetrics and Gynecology,** by Inyang A. Ukot. Writing a book on basics is not a surprise to those who know Ukot, as he has been a strong proponent for basics in different fields of medicine and a strong advocate for the need to impart the basics to students, resident doctors, and colleagues over the years and not merely building on knowledge without a proper foundation. Most of us agree with the author as the volume of knowledge available in any field of medicine is so vast and deep that one needs the basics to be able to work out most of the manifestations and possible complications they find in their patients. Besides, a good grasp of the basics would help the reader retain the knowledge for a long time.

The author starts this book series with Obstetrics and Gynecology, being one of the most common areas of study and practice of medicine globally. An area of medicine with the most tragic form of death on a daily basis. According to the African Health Organization Maternal Mortality Fact Sheet, every day, approximately 830 women die from preventable causes related to pregnancy and childbirth, and 99% of these deaths occur in developing countries. Skilled care before, during, and after childbirth can save the lives of women and newborn babies. The implementation of the Millennium Development Goal (MDG), which ended in 2015, only resulted in the reduction of maternal mortality worldwide by about 44%. The current Sustainable Development Goal targets the reduction of the global maternal mortality ratio to less than 70 per 100,000 live births by 2030. To achieve this, there is a need for practitioners with a basic understanding of the subject rather than those who only memorize facts to pass examinations. We believe that the structure of this book supports this objective.Currently, there are numerous textbooks on the subject of Obstetrics and Gynecology but relatively few on MCQs alone. This is not surprising, as it is easier for specialists in the field to come together to produce voluminous textbooks on the subject than to organize textbooks in MCQs alone. Most especially the one that would be of global standard like Ukot's Back to Basics MCQs: Obstetrics and Gynecology. This book will help students to test their level of grasp of the subjects and also what they can recall of the subjects after reading through the main textbooks. Medical practitioners and other professionals who are involved in rendering care in the field of Obstetrics and Gynecology should regularly test themselves to ensure proper transfer of knowledge to practice on patients. This is very important when one remembers that most of them are very busy and may not be able to

regularly go through standard textbooks or attend conferences to update their knowledge. They are likely to benefit from a physically portable textbook (and an electronically convenient book) of this kind that addresses essentials in the subject and guides them on the practice of the discipline. Generally, the book can always allow the reader to self-test himself on the principles and practical application of Obstetrics and Gynecology. We would all agree that for us to make an effort towards attaining SDG-3 come 2030, we need medical students, physicians, and all other professionals who are involved in the medical care of women to return to the basics which is what this book emphasizes.

The questions in this book are mostly crafted to agree with Bloom's revised taxonomy, where questions are designed for valid assessment and ensure that instructions and assessments are aligned with objectives. The reader not only remembers but understands, applies, and analyses the subjects in the questions and therefore demonstrates his reading, supporting the development of real-life or authentic skills. The MCQs are the single best answer in nature which is now agreed to be a better form for assessment than the traditional True and False type.

The book is arranged in six (6) chapters.

Chapter 1: Obstetrics MCQs

This chapter consists of 160 single best of four (4) options MCQs in Obstetrics. The topics under consideration are those that are very commonly encountered in our practice, present challenges to the practitioners, and cause morbidity and the death of pregnant women and their babies. A complication like postpartum hemorrhage, one of the leading causes of maternal mortality, is treated. By the time the reader goes through the questions and the detailed explanations of the answers to the questions, such is most unlikely to easily forget the subject and how to manage the complication. The author also looks at antenatal care which itself is the basic gateway for the proper management of obstetric patients. Any reader who goes through this section of the book, along with the attached explanations, would find himself competent in proper history taking, physical examination, and the right investigations to request in the care of patients. This aspect of care enables the healthcare practitioner to establish rapport with the patient and a good patient-healthcare provider relationship. This creates confidence in the patient and makes the patient easily accept care from the caregiver.

Multiple pregnancy is another topic covered in this chapter. Multiple pregnancy has been a source of fascination in many cultures and attracts all forms of obstetric complications except probably prolonged pregnancy. It is also a common cause of perinatal and neonatal mortality. Its incidence has been observed to be highest in Nigeria and is now increasing all over the world because of the use of assisted reproductive technology and ovulation induction. Addressing this topic in this book is likely to resonate with readers, helping them appreciate how much they can retain about this important subject after reading standard textbooks. The practitioner would also appreciate how much of the knowledge can be translated into practice. Hypertensive disorders of pregnancy have now taken over from obstetric hemorrhage as the leading cause of maternal mortality in some communities. Globally, it affects 5–10% of pregnancies, and the incidence is increasing. Going through the MCQs on this topic with attached explanations may likely help the reader to become well-informed with the topic and the management intricacies in this important aspect of obstetric practice. Another crucial aspect of obstetric practice that this book covers is operative vaginal delivery. This is an area where the knowledge is waning every day, particularly regarding forceps delivery. Those of us who have been involved in the practice can testify that instrumental delivery can be lifesaving for the baby and the mother. One of the major reasons why practitioners desert this mode of delivery is an inability to align theory with practice. A short handbook of this nature, which reminds the reader of the procedure on a daily basis, would encourage the doctor to practice it. Generally, we always encourage medical practitioners after reading about it and testing their understanding with a book dealing with the basics such as this, to venture out with it; The best initial attempt would be when managing the delivery of a woman with an intrauterine fetal death. After successfully performing this procedure three or four times, delivering a live baby is more likely to be successful and may spare women the trauma of undergoing a cesarean section.

Chapter 2: Gynecology MCQs

This chapter contains 140 single best-of-four (4) options MCQs in Gynecological practice. It looks at the common areas in gynecology that practitioners, whether specialists or non-specialists encounter, making this book an indispensable read for all. Miscarriage is seen in our practice daily. It can present in different forms, either as spontaneous miscarriage or induced miscarriage. Miscarriage, particularly the induced variety, is one of the major causes of morbidity and death in women. It may present with complications such as hemorrhage, sepsis, cervical tears, and uterine perforation, and in the long run, result in secondary

infertility and chronic pelvic pain. When the woman survives these complications, her quality of life may be adversely affected, and marital disharmony commonly results. It becomes necessary that medical practitioners (specialists or nonspecialists) be conversant with the management of miscarriages. Ukot's Back to Basics MCQs: Obstetrics and Gynecology that can constantly remind the practitioner of the management of this common condition becomes indispensable. Ectopic pregnancy, a common cause of gynecological admissions, especially in the tropics, is also analyzed in this book. If it presents as a ruptured variety, it is usually associated with profuse intra-abdominal hemorrhage with resultant high maternal mortality. Again, a common challenge associated with ectopic pregnancy is the problem of diagnosis, and hence, the condition always calls for a high index of suspicion by the attending doctors. Another unique feature of ectopic pregnancy, which all medical practitioners must be familiar with, is that a ruptured ectopic pregnancy patient dies not because she was not offered adequate resuscitation but because she was not operated on. I cannot forget a patient with ruptured ectopic gestation who was brought to the emergency room with almost no signs of life. With very minimal resuscitative measures, we decided to operate on her using very minimal anesthesia. Signs of life only returned as we were closing the skin incision. To be conversant with the management of ectopic pregnancy, one needs a handbook that reminds a doctor of the intricacies involved in the total care of the patient; hence, the place of Ukot's Back to Basics MCQs: Obstetrics and Gynecology. This book presents the features, not in the usual mundane manner but in a way one would hardly forget.

This chapter also considers menstrual disorders. Menstrual disorders can present in the form of varieties in the timing of the menstruation, such as polymenorrhagia or oligomenorrhea; or in the quantity of blood loss as menorrhagia or hypomenorrhea; or time of onset as precocious puberty or delayed puberty; or it may be associated with a symptom like dysmenorrhea or with premenstrual syndrome. These disorders may adversely affect the quality of life of the affected women. Any healthcare provider who is involved in the care of women needs to be familiar with the management of menstrual disorders. Ukot's Back to Basics MCQs: Obstetrics and Gynecology will assist them to have a good grasp of the disorders and the approach to the management of the patients who consult them.

Endometriosis is a challenging condition for the clinician and the patient. Its presentation is variable, and the diagnosis is difficult even with the use of endoscopy. Determining who to treat, when to treat, and for how long to treat the patient after arriving at the diagnosis is usually challenging. A handbook that

challenges one with questions and provides appropriate explanations puts the reader on their toes regarding this condition and its management. The book also handles ovarian malignancy, the third most common female genital tract cancer globally but with the highest case fatality rate. It is more prevalent in elderly women than in younger ones. Although this cancer is more common in developed nations than in developing countries, it causes more deaths in the latter due to late presentation and inadequate management. Another feature of ovarian cancer is the absence of reliable screening modalities and the absence of early symptoms.

Hence, there is a need for a high index of suspicion for this condition. Every practitioner involved in the care of gynecological patients would benefit from this handbook, which serves as a constant and uniquely presented reminder of this deadly malignancy.

Chapter 3: Answers to Obstetrics MCQs With Explanations

This chapter contains 160 detailed comments/explanations on answers to the Obstetrics questions. It provides an in-depth analysis of why the correct answers are considered correct and why the incorrect options are deemed incorrect. With the attached explanations, it becomes difficult for the readers to forget the facts and, therefore, can easily apply the knowledge in their practice. This is different from a situation where a candidate memorizes facts to pass an examination.

Chapter 4: Answers to Gynecology MCQs With Explanations

This section has 140 detailed comments/explanations on answers to the gynecology questions. In this section, each question is analyzed, and the correct answers are given. The reader is made to understand why and how the correct answer is chosen and why others are wrong. With these explanations, the reader appreciates and would be able to retain facts better than reading an ordinary textbook. Practitioners would have no difficulty in applying these facts to their practice to the benefit of the patients.

Chapters 5 and 6:

These chapters deal with differential diagnoses of certain clinical conditions in the subject of Obstetrics and Gynecology. Every medical practitioner appreciates that many clinical conditions can present in such a manner that it may become difficult for the practitioner to pinpoint the exact diagnosis. When a practitioner finds themselves in this dilemma, where the symptoms of a disease match more than one condition, they need some form of detailed reasoning and ancillary

investigations to arrive at an accurate diagnosis. This is important since proper management of any medical condition depends on accurate diagnosis. Working with differential diagnoses is a common encounter in Obstetrics and Gynecology. Some conditions require medical treatment, while others need a surgical approach. When a medical practitioner subjects a patient who should naturally be treated medically to surgical care, it may end in a disaster for the patient. This explains the importance of these chapters of the book as they would guide the medical practitioner on the line of reasoning and relevant investigations that would lead to an accurate diagnosis and a proper treatment of the patient. These chapters also expose the doctor to the need to keep an open mind in the management of any patient and, hence, investigate appropriately before embarking on a definitive treatment of patients.

I am convinced that this book, **Ukot's Back to Basics MCQs: Obstetrics and Gynecology**, would be a valuable companion to medical students, resident doctors, general medical practitioners, and all other healthcare professionals who are involved in the practice of Obstetrics and Gynecology. With this book, the knowledge content and level of practice would certainly improve.

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PREFACE

The need for **Ukot's Back to Basics MCQs: Obstetrics and Gynecology** despite a plethora of standard textbooks in Obstetrics and Gynecology is because, currently, there are relatively few books on multiple-choice questions (MCQs). It is easier for specialists to work as a team and produce a voluminous textbook in any area of Medicine than to single-handedly craft an MCQ book that has a global appeal.

Prior to the professional examinations in medical school, a student should have and utilize a variety of good sources of MCQs to test the level of their understanding of lectures and the contents of textbooks on Obstetrics and Gynecology from many angles. Medical practitioners and other professionals who render care in Obstetrics and Gynecology should regularly test themselves to ensure a proper transfer of knowledge to practice on patients.

This book is designed to allow the reader to self-test on the principles and practical application of Obstetrics and Gynecology. The contents are restricted to the foundational and common topics in this popular specialty. The contents are also selected to have a global appeal, ensuring that the student and medical practitioner in developed countries find clinical correlates with their study and practice environment while their counterparts also find conditions in their practice setting; moreover, each learns from what applies to the other.

The relatively small size makes it easy for the user (student or practitioner in the medical field) and other healthcare professionals who render service in this specialty to have a good mix of theory and practice that aim at ensuring a good understanding of clients with obstetric or gynecological health challenges and rendering appropriate and safe service to these patients.

This book is Part 1 of a series of MCQ books. Part 2 is on Pharmacology and Therapeutics, Parasitology, and Internal Medicine while Part 3 covers Mental Health, General Pediatrics, and Family Medicine.

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DEDICATION

This book is dedicated to every woman
Who has walked into the clinic,
Emergency room, operating room, or ward
In any medical facility, because of
An obstetric or gynecological
Condition and received services
That they certified satisfactory –, and to
Those who, unfortunately, received less than
Optimal services. They all have contributed to
The need and actualization of this book.

ACKNOWLEDGEMENTS

The author acknowledges Professor Paul D. Ekwere, Professor of Urology at the University of Calabar, Nigeria, and formerly Provost, College of Medical Sciences, University of Uyo, Uyo, Nigeria, for being very instrumental in guiding the choice of inclusion of topics in the preliminary stages of the efforts that have led to this book.

Great thanks are also due to Dr. (Mrs.) Modupe Ladipo, Consultant Family Physician at the University College Hospital (UCH), Ibadan, Nigeria, and Senior Lecturer in Family Medicine at the College of Medicine, University of Ibadan, Ibadan, Nigeria, for providing insightful critique at the early stages of the author's MCQ book projects, that have given this book a balance of theory and practice and made it suitable for both medical students and general medical practitioners.

ABRIDGED INTRODUCTION BY THE AUTHOR

Ukot's Back to Basics MCQs: Obstetrics and Gynecology provides the users with the current single best answer (SBA) format of MCQs, each of which has a stem that poses a real question that ends with the question mark (?). The user benefits from the "best-of-four" options that this book utilizes – and should keep in mind that the "non-answers" may not always be wrong but also not always the best. The multiple-choice questions are in Chapters 1 and 2.

The book makes its users appreciate that they should not be stuck with just remembering and understanding facts on Obstetrics and Gynecology, but in the practice of this specialty, they would need to apply established facts in emergency clinical conditions or "cold cases," analyze information that patients present to them (and sometimes ask their patients questions to extract facts that they may have forgotten or ignored), or evaluate the progress of a patient who is undergoing treatment. Sometimes, they must use the body of information they obtain from patients' care to create novelty by carrying out research. These MCQs test the user's foundations in Obstetrics and Gynecology. If they are deficient at the foundational level, the MCQs redirect them to address the basics prior to attempting the higher-level MCQs.

A chunk of the MCQs in this book is only for users who have scaled the hurdle of the "only basics" to attempt questions that are crafted to task the users' comprehensive grasp of Obstetrics and Gynecology towards addressing their patient's needs in the emergency rooms, outpatients clinics, operating rooms, and in the wards for efficient nonoperative, preoperative, and postoperative care.

Chapters 3 and 4 of the book comprise Answers to the MCQs in Obstetrics and Gynecology, respectively. They are useful to every user of the book as they provide not only Answers to every question but also Notes that particularize the reasons why they are the answers and why the other three options are not.

Chapters 5 and 6 are on the differential diagnoses of obstetric and gynecological conditions.

Index: Although this is an MCQ book, the author found it expedient to include a robust Index. It is useful to the users as it directs them in times of urgent need to

cross-check facts and find where the relevant MCQ is and the pertinent information in the Notes.

This book covers essential topics in Obstetrics and Gynecology irrespective of the practice setting globally.

CHAPTER 1

MCQs on Obstetrics

This chapter has multiple-choice questions on the following topics: Antenatal care, Abnormal presentations, Sickle cell disease in pregnancy, Multiple pregnancy, Normal labor, Complications of labor, Operative vaginal deliveries, Cesarean delivery, Hypertensive disorders in pregnancy, Blood sugar derangements in pregnancy, Infections including HIV/PMTCT in pregnancy, Antepartum hemorrhage, Postpartum hemorrhage, and the puerperium.

This chapter is divided into two sections. The first sixty MCQs are a selection of questions that very superficially cover fundamental facts about obstetrics; every reader should attempt these multiple-choice questions for they test the reader's knowledge in terms of understanding and remembering. The remaining 100 MCQs equally cover obstetrics. They are mainly clinically oriented and require more effort by the reader and their involvement in the practice of obstetrics. Most of the questions are therefore targeted at medical students who are doing their clinical rotations in obstetrics or medical practitioners who attend to pregnant patients.

1. Which of the following constitutes a high-risk factor in obstetrics?

A. Booking blood pressure of 90/60mmHg.

B. First pregnancy at age 13 years.

C. First pregnancy at age 25 years.

D. Maternal height of 165cm.

2. Which of the following statements about the cervix is correct during pregnancy?

A. It is reddish because of congestion with blood.

B. It should be palpated if there is a history of drainage of liquor amnii.

C. It becomes a transverse slit at the external os in a primigravida.

D. It appears reddish and granular in cases of cervical ectropion.

3. Which of the following is abnormal in the first trimester of pregnancy?

A. Excessive vomiting with dehydration.

B. Nausea.

C. Tingling sensation in the breasts.

D. Weakness.

4. When should a pregnancy test, using a urine sample, be used to diagnose pregnancy?

A. Two weeks after the last menstrual period.

B. Three weeks after the last menstrual period.

C. Two weeks after the missed period.

D. One week after conception.

5. Which of the following information is essential for documentation during the patient's first ante-natal (pre-natal) visit?

A. Mid-arm circumference.

B. Last normal menstrual period.

C. Height.

D. Parity.

6. Which of the following should be checked at a routine follow-up ante-natal care?

A. Fetal weight.

B. Maternal height.

C. Maternal blood pressure.

D. Fetal respiratory rate.

7. Which of the following is a pointer to problems during pregnancy?

A. Blood pressure of 90/60mmHg at three consecutive ante-natal visits.

B. Increased maternal appetite.

C. Pitting pedal edema as the sole finding at 32 weeks gestation.

D. A finding of more than a trace of urine protein with a rising maternal blood pressure.

8. Which of the following statements about ante-natal visits is correct?

A. Vaginal discharge should not be investigated.

B. The anxious primigravida should be reassured, and her questions answered.

C. The patient's heart should not be auscultated.

D. A problem not directly related to pregnancy should not be attended to.

CHAPTER 2

Gynecology MCQs

This chapter covers multiple-choice questions on the following topics: Abnormal uterine bleeding, Amenorrhea in the non-pregnant, Management of miscarriages, Management of ectopic pregnancies, Infertility, Menstrual disorders, Polycystic Ovary Syndrome (PCOS), Sexual disorders, Sexually transmitted infections, Menopause, Contraception/Family planning, Bartholin's gland cyst and abscess, Uterine fibroids, Benign and malignant ovarian growths, Endometriosis, and Cervical lesions.

Multiple-choice questions 161–200 (a total of 40) are compressed questions on the foundational and globally relevant topics in gynecology. These questions require knowledge, understanding, and recall. They are suitable for every reader. However, the remaining 100 multiple-choice questions (201–300) are mainly on the practice of gynecology and generally test the practice of gynecology during a medical student's clinical postings in gynecology. The questions are also useful for medical practitioners managing women with gynecological conditions in the outpatients', emergency room, operating room, or ward settings.

161. Which of the following statements regarding abnormal uterine bleeding is correct?

A. The patient cannot be anemic.

B. Bleeding is irregular.

C. Infection and trauma are likely causes.

D. Estrogen is used for treatment.

162. Which of the following conditions would not precipitate an abortion?

A. Malaria

B. Incompetence of the cervix.

C. Vigorous sexual intercourse 10 days after onset of last menses.

D. Uterine fibroids.

163. Which of the statements about ectopic pregnancy is correct?

A. It usually occurs in the cervix.

B. It usually ruptures after 12 weeks of gestation.

C. It may result in tubal abortion.

D. When ruptured, it is no emergency.

164. Which of the following statements about ectopic pregnancy is incorrect?

A. It is a sequela of previous pelvic inflammatory disease.

B. It is a cause of acute abdomen in females of childbearing age.

C. It frequently presents as severe lower abdominal pain.

D. When ruptured it may be treated with methotrexate before surgical intervention.

165. Which of the following statements about hydatidiform mole is correct?

A. It is a variant of normal pregnancy.

B. It is a cause of early pre-eclampsia.

C. It does not produce symptoms of pregnancy in the early stages.

D. It is synonymous with choriocarcinoma.

166. Which of the following conditions may not complicate hydatidiform mole?

A. Excessive vaginal bleeding.

B. Perforation of the uterus.

C. Seizures

D. Infection.

167. Which of the following statements about cervical erosion is correct?

A. It is common in post-menopausal women.

B. It may be treated by electrocautery.

C. It does not manifest with post-coital bleeding.

D. It is uncommon in pregnancy.

168. Which of the following statements about gonorrhea is correct?

A. The causative organism can grow both intracellularly and extracellularly.

B. There is urinary frequency but no dysuria.

C. The causative organism is a diplococcus.

D. Arthritis is not a complication.

169. Which of the following statements about gonorrhea is correct?

A. Knowledge and use of the appropriate antibiotics by the patient ensure effective treatment and prevent reinfection.

B. It may result in urethral stricture in the male sexual partner.

C. The incubation period in males is longer than in females.

D. The gonococcus readily penetrates normal squamous epithelium.

CHAPTER 3

Answers and Notes on Obstetrics MCQs

This chapter provides answers and notes on the multiple-choice questions on the following topics: Antenatal care, Abnormal presentations, Sickle cell disease in pregnancy, Multiple pregnancy, Normal labor, Complications of labor, Operative vaginal deliveries, Cesarean delivery, Hypertensive disorders in pregnancy, Blood sugar derangements in pregnancy, Infections including HIV/PMTCT in pregnancy, Antepartum hemorrhage, Postpartum hemorrhage, and puerperium.

1. B When pregnancy occurs at an age as young as 13 years, the young mother-to-be has a pelvis that is anthropometrically unfavorable; this is because the pelvis is still developing, and even a baby of normal size at term is likely to be too big for the pelvis. The status is cephalon-pelvic disproportion, and there is a risk of the parturient developing vesicovaginal fistula (VVF) if there is an attempt at vaginal delivery. This ill-advised method is still onoging in economically disadvantaged communities, especially where illiteracy is rife, with a resultant increase in the prevalence of VVF. The alternative is to plan for cesarean delivery – this results in unnecessarily high rates of cesarean section in this age group. Young teenagers also tend to pay less-than-adequate attention to keeping antenatal care appointments. They need close monitoring during pregnancy to ensure that both the mother and the fetus have health indices that are normal; where there is a deviation, the identified issue is addressed promptly. In this age group, there is a tendency to start, maintain, or increase risky behavior – the manifestation is in smoking, drinking alcohol, and engaging in substance use. They are prone to having sexually transmitted infections.

At the other end of the age spectrum, pregnancy in women who are over 40 years old predisposes the mother and fetus to an increased risk. With respect to the fetus, the risks include esophageal atresia, hypospadias, cardiac abnormalities, and craniosynostosis [1].

2. D During pregnancy, the cervix appears reddish and granular in cases of cervical ectropion. The ectocervix may be covered with curd-like discharge in cases of candidiasis during pregnancy. Congestion with blood does not give the cervix a reddish coloration; rather it takes a bluish hue. In a primigravida, the external os is a small, circular opening which is found in women who have given birth at least

once that it takes the form of a transverse slit. A history of drainage of liquor amnii precludes palpation of the cervix. A speculum examination using a bivalve vaginal speculum is advised, and the procedure should be performed gently and carefully with the aid of a bright and focused light.

3. A In the first trimester of pregnancy, the normal features include nausea, a tingling sensation in the nipples, and weakness. Excessive vomiting and associated dehydration are abnormal and are features of hyperemesis gravidarum.

4. C Pregnancy test, using a urine sample, can be used to diagnose pregnancy two weeks after a missed period. This is synonymous with six weeks after the last documented period, the date being the first day of the last normal menstrual period (FDLMP). This is the earliest time when the patient and the doctor can rely on the result obtained. For patients who do not keep a record of their menstrual cycles, the FDLMP may be imprecise, and the patient may be glad to obtain a negative result (for the patient who does not expect the pregnancy and carries out the test too early) while the result would have been positive if the test was performed on the correct test date (later). This is a false negative pregnancy test result. Two weeks after the last menstrual period is the wrong timing because that is when conception occurs. Three weeks after the last menstrual period and one week after conception are the same – this test does not show a positive result at this point as it is too early for the urine to contain a satisfactory level of human chorionic gonadotropin (hCG) for a urine-based pregnancy test to detect.

5. A Mid-arm circumference is not a valuable anthropometric parameter in most pregnant women; it is only in patients who are obviously malnourished so that it could be added to the relevant tests for completeness. The usual information includes the last normal menstrual period (LMP), height, and parity. The patient's weight should be entered alongside the other listed parameters. For women who register their pregnancy early, their body mass index (BMI) may be calculated using Quetelet's index with the formula Weight divided by the square of height. Additionally, weight is measured in kilograms, and height is measured in meters. The height of the patient is particularly important in patients who are of short stature. Short stature used to be defined as an adult height that is less than 150cm (1.5m), but recently, it has been altered to a threshold of 160cm (1.6m). The newer and higher baseline makes it possible for a clinician to make decisions promptly and definitively and avoid risks that are associated with the zone between 150cm and 159cm. It, however, tends towards an increase in cesarean section rates among pregnant women. Short stature is recognized as an independent risk factor for dystocia and cesarean section [2].

6. C At a routine follow-up ante-natal care, maternal blood pressure should be checked. Uterine fundal height and maternal weight are parameters to be checked as well. Maternal height is unlikely to change during pregnancy and, so the booking weight is adequate information during a pregnancy. Fetal respiratory rate is not a parameter during intrauterine life instead, the fetal heart rate is checked. This can be performed with the aid of a portable electronic fetal heart rate monitor, but in rural areas in developing countries, nurses and doctors have been trained to use Pinard fetoscope (plastic or aluminum made) and their ears, by virtue of frequent use, can (with concentration) count the fetal heart rate to a reasonable degree of accuracy. This essentially outdated equipment consumes time as the test may be repeated when there is doubt or when there is variability in the values obtained – in such cases, the fluctuation could be significant enough to indicate further evaluation of the mother and fetus and provide the relevant care. Fetal weight may be determined by ultrasound scanning; when intrauterine growth restriction, serial measurements may produce a pattern that can correctly guide the obstetrician and other members of the obstetric team in providing care for the mother and the fetus.

7. D A finding of more than a trace of urine protein with rising maternal blood pressure is a pointer to a likely challenge during the index pregnancy; this is a part of the presentation of preeclampsia. Another indicator is maternal weight gain of 2.5kg at two consecutive ante-natal visits after 36 weeks gestation. Blood pressure readings of 90/60mmHg at three consecutive ante-natal visits are normal; many young pregnant women have blood pressure at, or slightly above, this value. When it is an isolated finding, mild pitting pedal edema at 32 weeks gestation is considered normal.

8. B During ante-natal (pre-natal) visits, an anxious primigravida should be reassured and her questions answered. Health education sessions should be held for expectant mothers. Pregnancy could exert cardiovascular effects on the patient. Checking the patient's heart rate by checking the pulse rate is a simple and quick assessment that could provide important information on the cardiovascular status of pregnant women, and so it must not be overlooked even in patients who have had normal blood pressure and pulse rates before pregnancy; if these show a deviation from the normal, the patient's heart should be auscultated. However, in patients with cardiac or cardiovascular disease prior to pregnancy, it is important to do a cardiovascular assessment as frequently as possible. It is important to treat a pregnant woman as a total person; if she has a problem that is not directly related to pregnancy, it should be attended to, or the patient should be referred to another specialist. The care that the patient requires may be provided by other healthcare personnel such as those in the social welfare unit of the hospital. Vaginal discharge

CHAPTER 4

Answers and Notes on Gynecology MCQs

This chapter provides answers and notes on the multiple-choice questions on the following topics: Abnormal uterine bleeding, Amenorrhea in the non-pregnant, Management of miscarriages, Management of ectopic pregnancies, Infertility; Menstrual disorders, Polycystic ovary syndrome (PCOS), Sexual disorders, Sexually transmitted infections, Menopause, Contraception/Family planning, Bartholin's gland cyst and abscess, Uterine fibroids, Benign and malignant ovarian growths, Endometriosis and Cervical lesions.

The notes for MCQs 161 to 200 are generally brief as they deal with foundational topics that do not need much more than the answers. From multiple-choice questions 201 to 300 the questions are more clinicals oriented. In any medicine specialty, there may be more than one approach to solving certain clinical problems. For this book an explanation is occasionally required for the answer selection. The reader should bear in mind that the answer in a single-best answer (SBA) MCQ format is the best option, however, not necessarily the only option. This should bring clarification for the space given to the notes for numbers 201 to 300 compared with the brevity of the contents for numbers 161 to 200.

161. B In abnormal uterine bleeding, the bleeding is irregular, there may be menorrhagia, and the patient may lose enough blood to become anemic. Norethisterone, a progestogen, may be used for treatment.

162. C For women with accurate dating of their last menstrual periods, fertilization and eventual implantation would not have taken place 10 days after the onset of last menses; the vigor of sexual intercourse is therefore irrelevant. In addition to uterine fibroids, malaria, and incompetence of the cervix, abortion may be caused by a blighted ovum and fetal chromosomal abnormalities.

163. C Ectopic pregnancy may be due to previous abdominal or pelvic surgery from associated adhesions or tubal damage. The fallopian tube is the usual site of ectopic pregnancy. When ruptured, ectopic pregnancy is one of the life-threatening emergencies if not diagnosed promptly and treated definitively. Most ectopic pregnancies rupture before 12 weeks gestational age – usually at about 8 weeks.

164. D Methotrexate is used for conservative management of ectopic pregnancy. The diagnosis should be made before rupture of the tube and associated blood vessels. Conservative management entails close monitoring by medical personnel and giving the patient, spouse, and any close caregiver adequate information regarding signs that may necessitate intervention in the hospital. Previous pelvic inflammatory disease is the main cause of ectopic pregnancy. Ectopic pregnancy is, however, one of the results of improperly conducted previous termination(s) of pregnancy. Diagnosis of ruptured ectopic pregnancy requires a high index of suspicion when a physician is consulted by a female of child-bearing age. When considering acute salpingitis, acute appendicitis, urinary tract infection, *etc.*, as causes of severe lower abdominal pain, ruptured ectopic pregnancy should also be considered and ruled out.

165. B Hydatidiform mole is an abnormal pregnancy. It is a benign tumor of trophoblastic tissue. It is a cause of early preeclampsia. In its early stage, it produces symptoms of pregnancy; if it is not diagnosed early and treated, the symptoms may be exaggerated.

166. C Hydatidiform mole may be complicated by excessive vaginal bleeding, perforation of the uterus, or infection. The cancerous variant of this benign gestational trophoblastic disease is gestational choriocarcinoma.

167. B Cervical erosion is actually "cervical columnar ectopy," which is a physiological condition. Cervical columnar ectopia usually does not require treatment unless there is recurrent cervicitis or bleeding during sexual intercourse. Cervical ectropion (also commonly referred to as cervical erosion) may be treated by electrocautery, chemical cautery by silver nitrate stick, or cryotherapy. It may manifest with post-coital bleeding. It presents as vaginal discharge. Cervical erosion is common in pregnancy.

168. C *Neisseria gonorrhoeae* (the gonococcus) is a Gram-negative diplococcus; it has a three-layer cell envelope that consists of an outer membrane, middle peptidoglycan, and an inner cytoplasmic membrane. The organism is a fastidious, obligate aerobic intracellular bacterium. Apart from causing gonococcal cervicitis in females it causes gonococcal urethritis in males. It infects the eyes to produce conjunctivitis, the throat to cause pharyngitis, the rectum to cause proctitis – it also infects other organs in the body, including joints (arthritis), skin (dermatitis), and blood (septicemia), thus presenting disseminated gonococcal infection [11, 12].

If gonorrhea is not treated, it may cause pelvic inflammatory disease which predisposes the woman to miscarriages and ectopic pregnancy [13-15].

169. B Regarding gonorrhea, the infection may result in urethral stricture in the male sexual partner. Knowledge and use of the appropriate antibiotics by the patient do not ensure effective treatment and prevent reinfection; this is because this genital infection has to do with the patient's behavior and level of discretion regarding sexual practices. The patient's behavior towards adherence to taking prescribed medications is another important determinant of the success of treatment of an index infection. In the management of a patient with gonorrhea, it is essential to identify and treat sexual partner(s).

170. A *Treponema pallidum* is the etiological agent of syphilis (Lues). The organism is related to the spirochete that causes yaws. The infection is less common than gonorrhea. This spirochetal bacterium can penetrate intact mucous membranes. Other spirochetes of medical importance are Borrelia, Leptospira, and the that causes Lyme disease.

171. A The incubation period of syphilis may be up to 10 weeks. Syphilis usually presents as a single labial ulcer; the ulcer is characterized by painlessness. There is non-tender lymphadenopathy. Syphilis may manifest as skin rashes. Syphilis has four stages: Primary, secondary, latent, and tertiary; excluding the latent stage, the stages used to be three stages. Latent syphilis is seroreactivity in a patient with no other evidence of primary, secondary, or tertiary disease. Chancre is a feature of primary syphilis – it is a syphilitic ulcer; it is painless, and the sites include the mouth, skin, genitalia, and rectum. Secondary syphilis presents as fever, malaise, rashes on the palms and soles, non-tender lymphadenopathy, and condylomata lata. Tertiary syphilis may take years to manifest; the presentation is in the central nervous system (neurosyphilis), cardiovascular system (aneurysms, aortitis), and destructive lesions of bone and skin (gummas). The treatment of early syphilis is with benzathine penicillin G as a single intramuscular dose of 2.4 million units; the alternative is Doxycycline 100mg twice daily for 14 days. The use of doxycycline is contraindicated in pregnancy.

172. B Chancroid is a sexually-transmitted disease caused by the fastidious Gram-negative bacillus, *Haemophilus ducreyi*. The incubation period is 3 to 10 days. Non-indurated ulcers with purulent discharge are painful; associated unilateral lymph nodes are tender – these may form buboes that discharge spontaneously or require aspiration before they discharge. Chancroid can be treated effectively with

Ukot's Back to Basics MCQs, Vol. 1, 2025, 177-189

CHAPTER 5

Obstetrics Differential Diagnoses

Hyperemesis Gravidarum

- Uremia
- Urinary tract infection
- Pancreatitis
- Gastritis
- Peptic ulcer disease
- Intestinal obstruction
- Diabetic ketoacidosis
- Thyrotoxicosis
- Hypercalcemia
- Drug-induced emesis

Malaria in Pregnancy

- Hypoglycemia
- Meningitis
- Encephalitis
- Electrolyte imbalance
- Typhoid fever
- Viral fevers – viral hepatitis, yellow fever
- Brain abscess
- Brain tumor

Cervical Insufficiency

- Multifetal pregnancy
- Premature rupture of membranes
- Preterm labor
- Fetal growth restriction
- Preeclampsia

Cardiac Failure in Pregnancy

- Nephrotic syndrome
- Chronic obstructive pulmonary disease
- Severe anemia
- Liver cirrhosis
- Acute kidney injury
- Cardiogenic pulmonary edema
- Acute respiratory distress syndrome
- Respiratory failure
- Obesity hypoventilation syndrome

Gestational Diabetes Mellitus/Blood Glucose Derangements in Pregnancy

- Insulin resistance
- Hyperthyroidism
- Glucagonoma
- Cushing syndrome
- Pancreatitis
- Pancreatic trauma
- Hemochromatosis
- Pheochromocytoma
- Aldosteronoma
- Thiazides
- Glucocorticoids
- Beta-adrenergic receptor agonists
- Atypical antipsychotics

Hypertensive Disorders in Pregnancy

- Hydatidiform mole (Molar pregnancy)
- Eclampsia
- Glomerulonephritis
- Hyperthyroidism
- Cushing syndrome
- Conn syndrome
- Aortic coarctation
- Antiphospholipid syndrome

CHAPTER 6

Gynecology Differential Diagnoses

Abnormal Uterine Bleeding

- Bleeding from the uterine corpus – PALM-COEIN
- Placenta previa
- Ectopic pregnancy
- Spontaneous abortion
- Benign or malignant vulval growths
- Foreign bodies in the vagina
- Vaginal trauma
- Sexually transmitted infections
- Pelvic inflammatory disease
- Urinary tract infections
- Benign or malignant cervical growth
- Benign of malignant vaginal growths
- Malignancy of the fallopian tubes
- Ovarian malignancy
- Inflammatory bowel disease
- Behçet syndrome

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Ectopic Pregnancy

- Acute appendicitis
- Torsion of ovarian cyst
- Rupture of ovarian cyst
- Incomplete miscarriage
- Threatened miscarriage
- Corpus luteum hemorrhage
- Pelvic inflammatory disease
- Tubo-ovarian abscess
- Calculi in the ureter

Hydatidiform Mole

- Hyperemesis gravidarum
- Hyperthyroidism
- Thyrotoxicosis
- Hydropic abortion
- Hypertensive crisis (Hypertensive emergency or hypertensive urgency)

Cervical Erosion (Cervical Ectropion)

- Pregnancy
- Cervicitis
- Vulvovaginitis
- Cervical intraepithelial neoplasia
- Chronic cervicitis
- Pelvic inflammatory disease
- Desquamative inflammatory vaginitis
- Cancer of the cervix

Cervicitis

- Pelvic inflammatory disease
- Chlamydia
- Candidiasis
- Herpes simplex
- Vaginosis – bacterial
- Elective abortion
- Chancroid
- Trichomoniasis
- Trigonitis
- Cystitis – nonbacterial
- Endometritis
- Tuberculosis
- Adnexal tumors
- Cervical carcinoma
- Endometrial carcinoma

Pelvic Inflammatory Disease

- Rupture of an ovarian cyst
- Ectopic pregnancy
- Endometriosis
- Appendicitis
- Pyelonephritis
- Torsion of an ovarian cyst
- Interstitial cystitis
- Diverticulitis
- Traumatic injury
- Adnexal tumors

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SUBJECT INDEX

A

B

C

D

E

F

G

H

I

K

L

M

N

O

P

Q

R

S

T

U

V

Z

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