

SBA and EMQs for MRCOG II

Addressing the
New Exam Format

Chinmayee Ratha
Janesh Gupta



Springer

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Foreword

The MRCOG Part II exam is a clinical exam consisting of two parts. The first part is a written assessment of two papers each consisting of single best answer (SBA) questions and extended matching questions (EMQ), each with 50 SBAs and 50 EMQs in a 3 h paper. SBAs are worth 40 % and EMQs are worth 60 % of the total mark. The reason for this spread is that EMQs contain a wide coverage and test *clinical* judgement. Evidence supports that it is the fairest format for testing and is based on standard practice in the UK. It is a requirement to pass the written paper before proceeding to the second OSCE assessment phase. This format is going to change in September 2016 when the written paper will be separated as a Part II exam, and if successful the candidate will be allowed to keep this pass and only have to repeat the Part III OSCE exam as required. The level of the MRCOG exam is equivalent to the UK ST5 level. At this level a ST5 specialist registrar should have the degree of knowledge to be able to effectively have good clinical management skills based on the best evidence available for managing patients, both in obstetrics and gynaecology. The MRCOG Part II written and OSCE exams are blueprinted against a comprehensive syllabus which is available on the RCOG website (<https://www.rcog.org.uk/en/careers-training/mrcog-exams/part-2-mrcog/syllabus/>).

In preparation for the Part II exam, it is important to go through the specified syllabus, but the candidate should acquire knowledge of UK practice by reading all Green Top RCOG Guidelines, National Institute of Clinical Excellence (NICE) Guidelines, Scottish Intercollegiate Guidelines Network (SIGN) Guidelines, Good Practice Series and Scientific Statements from the Royal College. Further broad reading should be specifically *The Obstetrician & Gynaecologist* (TOG) journal, Progress Series by Studd, *Recent Advances in Obstetrics and Gynaecology* by Bonnar and *Obstetrics, Gynaecology and Reproductive Medicine* journal, which is a monthly publication providing a great revision guide for MRCOG candidates which includes sample SBA and EMQ questions. All previous reports from MBRRACE-UK ('Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK') should be read. Past exam papers from the Royal College should also be practiced.

In essence the MRCOG Part II exam incorporates what a standard ST5 level specialist registrar would do on a 'day-to-day' basis of managing patients in UK hospitals. The disadvantage for non-UK graduates is that they do not have the level of exposure that the UK candidate would have in 'living and breathing' the way that

patients are clinically managed. In this context non-UK candidates find ‘difficult’ areas such as clinical governance, risk management, clinical audit and research which are almost certain to be included in the written and OSCE exams.

As the MRCOG Part II exam is a heavily clinical biased exam, all aspects of management plans in line with clinical guidelines should be discussed with senior colleagues on a regular basis. Further, an additional good source of information can be useful from making ‘hot dates’ with neonatologists, bereavement counsellors, birthing centre midwives who deal with low-risk pregnancies, patient liaison services (PALS) managers who deal with patient complaints, oncology register office staff to understand how follow-up of oncology patients are organised, and attending multidisciplinary team (MDT) meetings and clinical audit meetings.

We hope that our book, which is blueprinted against the MRCOG syllabus, and written by authors who have recently been successful candidates, will help you understand how the Part II written paper is set and allow you to practice the wide range of possible questions that are derived from specific sources to which we have given the reference. There is a short explanation for the correct answer, and we have done this as far as possible throughout the book. We hope the book will also show you the wide breath of information you need to acquire to be successful in the exam. This book should also help in preparation for the OSCE exam, which is however not specifically covered in this book. We wish you all the very best in being successful, but ultimately the aim in preparing and doing the exam is that you will put into practice all the knowledge you accumulate in preparation for the MRCOG Part II exam to better the outcomes for your patients. That is in effect the ultimate aim. Good luck!

31 July 2015

Chinmayee Ratha
Janesh Gupta

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This book is a result of a passion and effort put in towards preparing a comprehensive resource for candidates taking the part 2 MRCOG exam. The attempt has been to cover almost all general and subspecialty areas in obstetrics and gynaecology. The authors wish to specially acknowledge the contributions of some colleagues who provided extremely valuable inputs and helped framing questions in subspecialties. The contributions are from Dr Akanksha Sood, Sushma Hospital and Women Care Centre, Palampur, HP, India; Dr Anbu Subbian, Gynaecologic Oncology, Shankara Cancer Hospital and Research Centre & Sakra World Hospital, Bengaluru, KA, India; Dr Baljinder Kaur Chohan, ST5 O&G, Wexham Park Hospital, Slough, UK; Dr.Cecilia McKee, Northern Deanery, Royal Victoria Infirmary, Newcastle Upon Tyne, UK; Dr. Lauren Cowley University of Birmingham, Birmingham, UK; Dr Rohan Chodankar, SPR Obstetrics and Gynaecology, Frimley Park NHS Foundation Trust, Camberley, UK; and Dr Sushama Gupta, Obstetrics and Gynaecology, Birmingham Women's Hospital, Birmingham, UK, are particularly acknowledged. Their inputs provided multidimensionality in thought processes, and it is due to their contribution that the book appears to meaningfully cover most of the syllabus for the part 2 exam.

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Abbreviations

ACE	Angiotensin-converting enzyme
ARBs	Angiotensin receptor blockers
CRL	Crown rump length
DHEAS	Dehydroepiandrosterone
DSR	Daily symptom report
EOCs	Epithelial ovarian cancers
FGM	Female genital mutilation
FHR	Fetal heart rate
GBS	Group B streptococcus
GGT	Gamma glutamyl transferase
GS	Gestational sac
IAP	Intrapartum antibiotic prophylaxis
Ig	Immunoglobulin
LMWH	Low molecular weight heparin
MBRRACE-UK	Mothers and babies: reducing risk through audits and confidential enquiries across the UK
PEG-IFN	Pegylated interferon
TBG	Thyroxine binding globulin
THL	Transvaginal hydrolaparoscopy

Introduction

The MRCOG Part II exam is primarily designed along clinical care scenarios that test factual knowledge of the candidate as well as its practical application. The exam is based on fundamental principles of striving to provide exemplary patient care that incorporate safe practice on the basis of sound evidence. This means that success in the examination will depend on understanding the latest clinical guidelines, high-quality research articles and systematic reviews on the various subject areas. The implementation of such evidence should be evaluated through clinical audit and ensuring that best practice is done safely which is assessed through clinical governance.

This *MRCOG Part II* book is an elaborate collection of single best answer (SBA)-type questions and extended matching questions (EMQs) along with descriptive answers explaining the reasons supporting the correct alternative and excluding the distractors. Our aim is to familiarise the readers to this new pattern of questioning introduced in the membership exam from March 2015.

The exam is designed to revise your factual knowledge as well as clinical application. While reading the text you must take a moment and transpose a given fact into a clinically relevant situation and comprehend the exact answer to a given question.

Each question is designed such that it gets some important facts strongly ingrained in your mind. The distractors will help generate more inquisitiveness about the whole topic and drive you towards deeper learning.

The most productive way of using this book while preparing for the MRCOG II theory would be to practice the SBAs in this book on any one topic and then read up the given relevant reference documents. This will help you grasp the subtopics addressed in the question and will also orient you to other potential subtopics which can be presented as questions in your exam. Many questions are based on clinical case scenarios. Try and relate these situations to problems that you face in day-to-day clinical practice.

We have made an effort to cover as many varied topics as possible mapped against the MRCOG curriculum so as to provide an insight to the readers regarding potential questions.

These examinations aim at developing safe and sensitive doctors well equipped with evidence-based contemporary clinical practices and guidelines. The ultimate test of competence of any doctor is a combination of theoretical knowledge and

practical application to everyday scenarios in a sensitive manner keeping the patient at the centre of the situation. This book will help you take few steps in preparing for such an assessment but more importantly allow you to put into practice what you have learned for this exam.

We wish you the best of luck for the future success in your career, remembering that this small step for being successful in the MRCOG exam will be a lifelong change in how you provide the best evidence-based clinical care for many patients in the future.

Chinmayee Ratha
Janesh Gupta

Part I

SBA: Type Questions

ANC1

You are reviewing the notes of a 32-year-old woman in the antenatal clinic. She is 10 weeks pregnant based on her last period date and this is her third pregnancy. Her sons, aged 4 and 2 years, respectively, are fit and healthy. You are looking for risk factors to offer her screening for gestational diabetes. Which of the following conditions will you NOT offer her such screening:

- A. Body mass index above 30 kg/m²
- B. Family history of diabetes
- C. Family origin with a high prevalence of diabetes
- D. Previous macrosomic baby weighing 4.5 kg or above
- E. Previous type 2 diabetes

ANC2

Q2. Commercial flights of more than 4 h duration are known to be associated with a small increase in the relative risk of:

- A. Abruptio placentae
- B. Antepartum depression
- C. Deep vein thrombosis
- D. Prelabour rupture of membranes
- E. Preterm labour

ANC3

Which antibiotics should be given to prevent early onset neonatal GBS disease to women who have accepted intrapartum antibiotic prophylaxis (IAP) and are allergic to benzylpenicillin?

- A. Ampicillin
 - B. Clindamycin
 - C. Erythromycin
 - D. Gentamicin
 - E. Trimethoprim/sulfamethoxazole
-

ANC4

Placental abruption is seen more often in all of the following conditions except:

- A. Chorioamnionitis
 - B. Multiple pregnancies
 - C. Pre-eclampsia
 - D. Primigravidae
 - E. Trauma
-

ANC5

The incidence of low-lying placenta in second trimester ultrasound scan is as high as:

- A. 10 %
 - B. 15 %
 - C. 25 %
 - D. 35 %
 - E. 50 %
-

ANC6

You are preparing for the caesarean section of a multipara with central placenta previa. She is not anaemic, is haemodynamically stable and has never had any episode of vaginal bleeding. At least how many units of cross matched blood should be kept ready for use in anticipation of intraoperative blood loss?

- A. 1 unit
- B. 2 units
- C. 3 units
- D. 4 units
- E. None required unless the woman has a Hb < 10 g/dL

ANC7

Women with complex social factors have been identified as those needing special provisions in their antenatal care. Which of the following pregnant women would be identified as one with a complex social factor that warrants special attention by the antenatal healthcare providers?

- A. A 28-year-old primary school teacher who has recurrent migraine attacks
- B. A 36-year-old housewife with previous two caesarean sections
- C. A 42-year-old banker with a high paying but stressful job
- D. An 18-year-old English woman who is the lead ballet dancer in a renowned troupe
- E. An unmarried 38-year-old artist of Egyptian origin living legally with her partner in England for the last 12 years and running a successful boutique

ANC8

A 28-year-old woman is 22 weeks pregnant. She has long-standing type 1 diabetes mellitus. Her 20-week fetal anatomy ultrasound showed no structural fetal abnormalities. However, she is concerned about how her diabetes may cause congenital fetal anomalies in her unborn child.

Of the options listed below, which SINGLE action addresses her anxiety?

- A. Amniocentesis at 22 weeks.
- B. Fetal cardiac echocardiography at 24 weeks.
- C. Obstetric ultrasound scan for growth and umbilical artery Doppler at 28, 32 and 36 weeks.
- D. Offer reassurance as normal fetal anatomy survey at 20 weeks.
- E. Quadruple maternal biochemical screening test (HCG, inhibin-A, oestriol, AFP) at 20 weeks.

ANC9

A 24-year-old woman is 12 weeks pregnant. She is attending hospital for her dating scan and routine booking serological investigations. Screening and treating for the presence of a particular pathogen during early pregnancy will reduce the risk of developing congenital fetal abnormality. Which of the pathogens listed below fulfils this criterion?

- A. Hepatitis B
- B. Herpes simplex virus
- C. Rubella
- D. Syphilis
- E. Varicella zoster virus

ANC10

All pregnant women are advised to take folic acid supplements (0.4 mg, once daily) pre-pregnancy and antenatally. Nonetheless, which of the following groups of women is a dietary supplementation using a higher dose of folic acid (5 mg once daily) recommended?

- A. BMI < 30
 - B. Impaired glucose tolerance
 - C. Previous pre-eclampsia
 - D. Previous preterm delivery
 - E. Sickle cell disease
-

ANC11

All pregnant women are advised to take folic acid supplements (0.4 mg, once daily) pre-pregnancy and antenatally. Nonetheless, which of the following groups of women is a dietary supplementation using a higher dose of folic acid (5 mg once daily) recommended?

- A. BMI < 30
 - B. History of spina bifida in partner's family
 - C. Impaired glucose tolerance
 - D. Previous pre-eclampsia
 - E. Previous preterm delivery
-

ANC12

A 24-year-old woman is 22 weeks pregnant in her second pregnancy. She has had one previous caesarean delivery. Her routine 20-week obstetric ultrasound revealed a low-lying anterior placenta, partially covering the cervical os. Which SINGLE action is most appropriate?

- A. Organise elective caesarean section for 39 weeks
- B. Organise MRI pelvis at 32 weeks to check position of placenta.
- C. Re-assess at 38 weeks and allow vaginal delivery to occur if fetal head is clinically engaged and there has been no antenatal bleeding.
- D. Repeat ultrasound at 32 weeks to check position of placenta.
- E. Repeat ultrasound at 38 weeks to check position of placenta.

ANC13

Which of the following is NOT a known risk factor for vasa previa:

- A. Bilobed placenta
- B. Placental photocoagulation
- C. In vitro fertilisation
- D. Multifetal pregnancy
- E. Succenturiate lobes

ANC14

Drugs are prescribed in pregnancy upon the assumption that their positive effect on health outweighs the probability and severity of any harm to mother and fetus. On this basis, which of the following medications is the most likely to be contraindicated for antenatal use in pregnancy?

- A. Indomethacin
- B. Labetalol
- C. Low-dose aspirin
- D. Low molecular weight heparin
- E. Metformin

ANC15

A pregnant woman is seeking advice about the effects of smoking in pregnancy. Which of the following statements is correct in relation to pregnancy risks as a consequence of her smoking during pregnancy?

- A. Decreased risk of abruption
- B. Increased risk of gestational diabetes
- C. Increased risk of pre-eclampsia
- D. Increased risk of sudden infant death syndrome (SIDS)
- E. No effect on the risk of preterm delivery

ANC16

A 20-year-old woman is 33 weeks pregnant in her first pregnancy. She has a 6-h history of regular painful uterine contractions. Clinical examination confirms an appropriately sized fetus, longitudinal lie and cephalic presentation with normal fetal heart rate (155 bpm). Vaginal examination identifies a fully effaced cervix that is 5 cm dilated, with intact membranes. Which of the following is an appropriate next intervention step?

- A. Administer i.m betamethasone.
 - B. Commence i.v. atosiban.
 - C. Commence oral nifedipine.
 - D. Insert cervical cerclage.
 - E. Recommend emergency caesarean section.
-

ANC17

A 20-year-old woman is 36 weeks pregnant in her first pregnancy and is being reviewed in the antenatal clinic. A recent obstetric growth scan confirms breech presentation of a normally grown fetus with normal liquor volume. She has no other complicating medical or obstetric disorders. She is deciding between planned vaginal or elective caesarean (LSCS) modes of delivery. Which of the following is correct in relation to the counselling she will receive?

- A. External cephalic version (ECV) may be offered and has around a 50 % success rate for conversion to cephalic presentation.
 - B. Footling breech presentation is considered favourable for vaginal breech delivery.
 - C. If opting for vaginal breech delivery, induction of labour at 38 weeks is recommended to avoid excessive fetal growth.
 - D. Intermittent fetal heart rate monitoring is recommended for spontaneous onset vaginal breech labour.
 - E. LSCS and vaginal breech birth have similar rates of perinatal mortality and early neonatal morbidity.
-

ANC18

If the fetal crown rump length is disparate in twins at the 12 weeks scan, select the best method of dating the pregnancy.

Gestation is age can be allotted according to:

- A. Average CRL of the two foetuses.
 - B. CRL of the bigger fetus.
 - C. CRL of the smaller fetus.
 - D. CRL of the smaller fetus added to half the CRL of the bigger fetus.
 - E. Dating is best done by LMP in such cases.
-

ANC19

Screening for anemia in triplet pregnancy is advised at:

- A. Booking, 20–24 weeks and 28 weeks
- B. Booking, 20–24 weeks

- C. Booking, 28 weeks and 34 weeks
 - D. Booking, 28 weeks
 - E. Booking, 26 weeks
-

ANC20

A 34-year-old primigravida with dichorionic twins, both fetuses in cephalic presentation, declines the offer of elective delivery at 37 weeks of gestation. You have explained to her that with uncomplicated dichorionic twin pregnancies, elective birth from 37 weeks 0 days does not appear to be associated with an increased risk of serious adverse outcomes and that continuing uncomplicated twin pregnancies beyond 38 weeks 0 days increases the risk of fetal death. What is the next step in her antenatal care?

- A. Document her decision and allow pregnancy to continue for reassessment at term or when she sets into labour spontaneously, whichever is earlier.
 - B. Document her decision and call twice weekly for biophysical profile assessment.
 - C. Document her decision and call weekly for biophysical profile assessment.
 - D. Document her decision and take informed consent for risk of adverse outcome.
 - E. Refer her to another centre as the outcome is likely to be poor.
-

ANC21

A primigravida with twin pregnancy has booked for antenatal care at 16 weeks of gestation. Despite referral to higher centre, the chorionicity of the pregnancy could not be established by ultrasound. Fetal growth is within normal range and there are no obvious structural defects. What is the best option for further antenatal management in this case?

- A. Amniocentesis to determine fetal karyotyping.
 - B. Chorionic villous sampling for fetal genotyping.
 - C. Empirically manage as dichorionic twins as this is commoner.
 - D. Empirically manage as monochorionic twins.
 - E. Offer her an MRI which will help establish chorionicity.
-

ANC22

With regard to advice about diet, lifestyle and nutritional supplements in multiple pregnancy, which of the following is correct?

- A. Women with twins and triplets should be offered twice the dosage of supplements and asked to take an extra 220 cal per day.

- B. Women with twins should take an extra 220 cal per day with twice the dosage of supplements while women with triplets 330 extra calories per day with thrice the dosage of supplements.
- C. Women with twins should take an extra 220 cal per day with twice the dosage of supplements while women with triplets 330 extra calories per day with twice the dosage of supplements.
- D. Women with twins and triplets should take an extra 220 cal per day with twice the dosage of supplements.
- E. Women with twins and triplets should take the same diet and nutritional supplements as women with singletons.

ANC23

Ultrasound screening for structural anomalies in the second trimester of pregnancy:

- A. Is optimally offered between 15 week 0 day and 20 week 0 day
- B. Can be used for ruling out diagnosis of Down syndrome
- C. Can be used to diagnose inborn errors of metabolism
- D. Is more sensitive in women with high BMI
- E. Involves echocardiography with four chamber view of heart and outflow tract routinely

ANC24

A 32-year-old second gravida at 16 weeks of gestation is about to take a long haul flight to attend a family get together. Her previous pregnancy was generally uneventful but she had a caesarean section at term due to breech presentation of the fetus. Which of the following conditions is not a contraindication for her air travel in pregnancy?

- A. Haemorrhage in previous pregnancy
- B. Otitis media and sinusitis
- C. Recent gastrointestinal surgery
- D. Recent sickling crisis
- E. Severe anaemia with haemoglobin less than 7.5 g/dl

ANC25

Pregnant women with singleton pregnancies should be offered screening for anemia:

- A. At booking only
- B. At booking and 24 weeks

- C. At booking at 26 weeks
 - D. At booking and 28 weeks
 - E. Only if there is family history of haemoglobinopathies
-

ANC26

The recommended dose of vitamin D supplementation for women in pregnancy and lactation is:

- A. 2.5 µg/day
 - B. 5 µg/day
 - C. 7.5 µg/day
 - D. 10 µg/day
 - E. 12.5 µg/day
-

ANC27

In the recent “Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK” (MBRRACE-UK) report, it was recommended that all women with medical disorders in pregnancy should have access to a coordinated multidisciplinary obstetric and medical clinic, thereby avoiding the need to attend multiple appointments and poor communication between senior specialists responsible for their care.

For women with pre-existing medical conditions, the ideal time for planning multidisciplinary care in pregnancy is:

- A. First trimester before confirmation of fetal viability
 - B. First trimester after confirmation of fetal viability
 - C. Pre-pregnancy
 - D. Second trimester after screening for lethal fetal anomalies
 - E. Third trimester prior to confinement for delivery
-

ANC28

You are seeing a pregnant woman with trichorionic triplet pregnancy during her routine antenatal visit at 16 weeks. You are coordinating with a core team of midwives and sonographers for her care. You are also planning an enhanced team for referrals. You will routinely include all of the following in that team except:

- A. Cardiologist
- B. Dietician
- C. Infant feeding specialist

- D. Perinatal mental health specialist
 - E. Women's health physiotherapist
-

ANC29

Routine folic acid supplementation is advised to all pregnant women ideally starting pre-pregnancy and continuing upto 12 weeks of gestation. The advantages established with this supplementation are all of the following except:

- A. Reduced risk of cardiovascular defects
 - B. Reduced risk of childhood asthma
 - C. Reduced risk of limb defects
 - D. Reduced risk of leukemia and pediatric brain tumors
 - E. Reduced risk of neural tube defects
-

ANC30

A pregnant woman at 26 weeks of gestation presents with minimal painless bleeding following sexual intercourse. She is haemodynamically stable and has had no such episodes in the past. Which of the following confirms the diagnosis of placenta previa?

- A. Abnormal lie of the fetus with high presenting part.
 - B. Speculum examination showing healthy cervix and vagina and confirming bleeding through os.
 - C. Spongy tissue felt during per vaginal digital examination
 - D. Tightening of the abdomen during clinical examination
 - E. Ultrasound scan showing placenta inserted in the lower uterine segment
-

ANC31

You are about to counsel a woman with major placenta previa at 32 weeks who has just had a repeat scan for placental localisation. The ultrasound scan shows an anterior placenta covering the internal os with irregular retroplacental sonolucent zone and hypervascularity in serosa-bladder interface. Fetal parameters are appropriate for gestational age. She had her previous caesarean section for breech presentation 4 years back and has not had any episodes of bleeding in this pregnancy. What is the most appropriate course of action?

- A. Immediate caesarean section.
- B. Immediate MRI as it will definitively diagnose or rule out placenta accrete.
- C. Plan for elective caesarean at term with appropriate precautions for placenta accreta.

- D. Plan caesarean hysterectomy.
 - E. Rescan for placental localisation at 36 weeks as in a majority of cases; there is upward migration of placenta due to development of the lower uterine segment.
-

ANC32

You are seeing a 30-year-old primigravida at her booking visit. Her sister had deep vein thrombosis in her legs last year and suffered much pain and discomfort. She has heard that pregnancy increases risk for venous thrombosis and wants you to address her concern. What is the most appropriate action to take?

- A. Heparin
 - B. Low-dose aspirin
 - C. Reassure
 - D. Test for thrombophilias
 - E. Warfarin
-

ANC33

Which of the following statements does not agree with the recommendations given by NICE for the routine antenatal care of pregnant women in the UK?

- A. At the very first contact with a healthcare professional, information about folic acid supplementation, food hygiene, lifestyle advice and all antenatal screening, including screening for haemoglobinopathies, the anomaly scan and screening for Down's syndrome, as well as risks and benefits of the screening tests must be given.
 - B. Information about antenatal screening should not be given in group settings as it significantly hampers her privacy.
 - C. Information should be given in a form that is easy to understand and accessible to pregnant women with additional needs, such as physical, sensory or learning disabilities, and to pregnant women who do not speak or read English.
 - D. Options for management of prolonged pregnancy should be discussed at 38 weeks antenatal visit.
 - E. Women's decisions should be respected, even when this is contrary to the views of the healthcare professional.
-

ANC34

You are seeing a Somalian woman in her first pregnancy at 24 weeks of gestation. She has migrated to UK 5 years back with her husband. You are worried about the possibility of female genital mutilation.

What would be an appropriate approach to this case?

- A. A preformatted sheet with pre-drawn diagrams should never be used.
 - B. If she volunteers the history of FGM, you should inform her sensitively that she must have an elective LSCS.
 - C. In case she confirms history of genital mutilation, a psychological assessment should be made.
 - D. If you find in her case notes a confirmation of a reversal of genital mutilation by defibulation, then it is reassuring and no further assessment in this regard is warranted.
 - E. You should refrain from asking about genital mutilation procedures as this is considered rude and may hurt the feelings of the woman.
-

ANC35

A 17-year-old college student has discovered that she is pregnant possibly because she was irregular with the COCPs she was taking for the last year. By her dates, she is expected to be 9 weeks pregnant. She plans to complete her education and settle down with her partner after few years. She is however not willing to terminate the pregnancy due to strong religious beliefs and would like to book for antenatal care.

Which of the following will not be appropriate in your counselling?

- A. Advise screening for sexually transmitted infections.
 - B. Explain to her that teenage pregnancy is associated with a high risk of adverse pregnancy outcome in the adolescent and has been attributed to gynaecological immaturity and the growth and nutritional status of the mother.
 - C. Offer her social services support to plan for delivery and child care.
 - D. Reassure her that with proper nutritional supplements and regular antenatal care, her pregnancy outcome can be reasonably optimised.
 - E. Try and convince her sensitively for a termination as you don't think the case situation has a good prognosis anyway.
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All of the following are known complications of anemia in pregnancy except:

- A. Impaired psychomotor and/or mental development in infants
- B. Increased childhood cardiometabolic risk factors
- C. Low birth weight babies
- D. Placental abruption
- E. Preterm labour