# Final Year MBBS

## Gynaecology

# MCQs:

Q.1 A 38 years old $P_1A_3$ with BMI of more than 30 presented in Gynae OPD with gestational age of 8 weeks with previous three consecutive delayed second trimester miscarriages and one still birth due to early onset severe IUGR. She is very worried and keen to deliver a healthy baby. What could be the most probable cause in her case?

A: Advanced maternal age
B: Antiphosphlipid syndrome
C: Balanced chromosomal translocation
D: Obesity
E: Structural uterine abnormalities

Q.2 A 22 years old married for 2 years, suffering from primary infertility due to polycystic ovarian syndrome. Her menstrual cycle is 7/30. Her BMI was 32, she reduced 10% of her weight. She is very keen to conceive and she opted for medical management for her problem. What would be the first line management for her?

A: Antiestrogen agent
B: Aromatase inhibitors
C: Gonadotrophinss
D: Metformin
E: Myofolic

Q.3 A 36 years old school teacher presented in infertility clinic with 2 years history of subfertility. Husband is 40 years of age and non smoker. After standard investigation the couple is diagnosed as case of unexplained primary infertility. In vitrofertilization is being advised to the couple. Which of the following is most helpful in assessment of her ovarian reserve independent of menstrual cycle?

A: Anti Mullerian Hormone
B: Antral Follicle Count
C: Follicular Stimulating Hormone
D: Serum Estrogen
E: Serum Inhibin

Q.4 A 36 years old lady $P_2A_0$ having heavy menstrual bleeding for 1 year. She also complains of IMB, PCB and early fatigue. Pelvic examination is unremarkable. The investigation of choice will be:

A: Coagulation screen
B: High vaginal swab
C: Hormonal profile
D: Thyroid Function Test
E: TVS

Q.5 A 36 years old $P_4A_0$ presented with heavy menstrual bleeding. On evaluation, there is no structural or histological abnormality:- According to NICE guidelines what is the first line treatment

A: GnRH agonist
B: LNG – IUS
C: Mafenamic acid
D: Norethisterone
E: Trenexamic acid

Q. 6 A 48 years old woman presents to her GP with HMB. She is otherwise well. Examination reveals non tender normal size uterus. Her Haemoglobin is 8g/dl. What next investigation is indicated according to recent NICE guidelines.

A: Endometrial biopsy
B: Hormonal profile
C: Outpatient hysteroscopy
D: Serum ferritin
E: Thyroid function tests

Q. 7 A 30 years old nulliparous lady comes to you with amenorrhea for 8 months. No history of hirsuitism, weight changes and cyclical pain. She has hot flushes and night sweats for 1 month. She never took any medicine. Examination is unremarkable. The most likely diagnosis will be:

A: Asherman's syndrome
B: Cervical stenosis
C: Early ovarian insufficiency
D: Pitutary adenoma
E: Polycystic ovarian syndrome

Q. 8 A 20 years old unmarried lady underwent laparoscopic surgery for excision of endometriotic cysts. She has been advised concurrent long term medical therapy after surgery for more than 6 months but now she visited Gynae OPD with complaint of weight gain and acne. Changes in her lipid profile as well. The most likely drug causing these side effects would be:

A: COCs
B: Danazol
C: GnRH
D: NSAIDS
E: Progestogens

Q. 9 A 45 years old $P_5A_0$ presented in OPD with HMB and increasing dysmenorrhea. Her vaginal examination reveal, tender, uniformly enlarged uterus and clinical diagnosis of adenomyosis was made. The most definitive investigation of choice to confirm the diagnosis is:

A: CT Scan Pelvis
B: MRI Pelvis
C: Saline Sonography
D: Transabdominal scan
E: Transvaginal scan

Q.10 A 40 years $P_2A_2$ presented in Gynae OPD with complaint of increased vaginal discharge with lower abdominal pain. She also complains of dysuria, proctitis with rectal bleeding and discharge. No history of post coital or intermenstrual bleeding. The mainstay of treatment would be:

A: Azithromycin
B: Cephalosporins
C: Clindamycin
D: Doxycyclin
E: Metronidazole

Q.11 A 45 years old $P_4A_1$ presented in OPD with complaint of excessive vaginal discharge with lower abdominal pain and dysuria. She also gives the history of post coital and intermenstrual bleeding. The most common cause of this infection would be:

A: Bacterial vaginosis
B: Candidiasis
C: Chlamydia
D: Gonorrhoea
E: Trichomonas vaginalis

Q.12 A 42 years old $P_1A_0$ presented in Gynae OPD with complaint of lower abdominal pain and mucopurulent discharge. She is also suffering from fever for last 2 days. Pelvic examination revealed tenderness in the adnexa and palpable pelvic mass on right side. The gold standard investigation for definitive diagnosis would be:

A: CRP
B: ESR
C: Laparoscopy
D: Ultrasonography
E: White cell count

Q.13 A 30 years old lady $P_{3+0}$ presented in Gynae OPD with intermenstrual and PCB. Her pap smear and colposcopy revealed low grade CIN-I. Her conservative management planned with regular follow up. Because low grade CIN-I regress spontaneously in upto:

A: 40%
B: 45%
C: 50%
D: 55%
E: 60%

Q.14 A 35 years female presented in Gynae OPD with heavy menstrual bleeding with dragging sensation in lower abdomen for 2 years. She is married for last 5 years having only one alive issue. She is diagnosed as a case of intramural fibroid uterus 8cm x 9cm on MRI scan. She is very much concerned about her fertility. Most appropriate management option for her would be:

A: Laparoscopic myomectomy
B: Open myomectomy
C: Uterine artery embolization
D: MRI guided transcutaneous focused ultrasound
E: Transcervical intrauterine ultrasound guided radiofrequency ablation

Q.15 A 38 years old female presented with abnormal uterine bleeding in the form of heavy menstrual bleeding with moderate dysmenorrhoea. She also gives history of intramenstrual bleeding and using OCPs for contraception. We are suspecting endometrial polyp. What would be the most appropriate investigation to confirm the diagnosis?

A: Inpatient Hysteroscopy
B: OPD Hysteroscopy
C: Saline sonography
D: Transabdominal scan
E: Transvaginal scan

# SEQs

**Q.1** A 45 years old lady presented with bilateral complex ovarian masses with presence of ascites. She underwent staging laparotomy. On histopathology she was diagnosed to have stage IIa disease.

a) What is her 5 years survival rate according to FIGO? 01
b) What are risk factors in ovarian Ca? 03
c) What is her next management after staging laparotomy? 01

**Q.2** A 38 years old $G_5P_3A_1$ presented in labour room with history of 12 weeks amenorrhoea and having snow storm appearance with no fetus in the uterus on ultrasound.

a) What is the diagnosis? 01
b) What are risk factors of above diagnosis? 02
c) How will you follow up after treatment? 02

**Q.3** An obese 65 year old lady $P^{5+0}$, who is a known asthmatic is brought to you with a complaint of something coming out of vagina. She denies any significant urinary and bowel complaints. On examination, cervix is at the level of introitus.

a) What is the likely diagnosis? 01
b) Enumerate the risk factors for development of this condition. 02
c) What are the management options available for her? 02

**Q.4** 16 years old girl presented in Gynae OPD. She had not yet started her periods. She described her breast development at 12 years along with pubic hair growth. She also described cyclical, crampy abdomen pain since 4 years. On examination normal breast development and distribution of pubic and axillary hair. There was a firm mass in the lower abdomen reaching uptill the level umbilicus. On observation of the genitalia a blue swelling at the level of hymen was seen.

a) What is the most likely diagnosis? 01
b) Which investigation should be performed? 02
c) How she will be managed? 02

**Q. 5** A 32 years old woman presented in Gynae OPD with complaint of inability to conceive for last 3 years. Both husband and wife live together. Husband is 34 years old and his semen analysis is satisfactory. She gives history of weight gain, hirsuitism and oligomenorrhoea since 2 ½ years. She was never investigated or treated previously.

a) What could be the possible diagnoses? 01
b) What investigation would you request? 02
c) What advise will you give her and what are the treatment options? 02

# Obstetrics

# MCQs

**Q** No 1. A 29 years old G5P4A0 is admitted at 32 weeks of gestation with sudden painless bleeding. The pregnancy otherwise had been uncomplicated. Patient is not pale, pulse is 88/min, BP is 110/65 mmHg , her abdomen is not tender, symphysiofundal height is 32cm, fetus is lying transversely. Fetal heart rate is 152/min. the most appropriate investigation to diagnose the cause of bleeding should be

a. Send CBC
b. Do speculum examination
c. Perform obstetrical ultrasound for placental localization
d. Send coagulation profile

Q No. 2. A 21 year oldprimigravida at 34 weeks of gestation is brought to emergency with history of tonic clonic fits for 2 hours. Her B.P is 180/120 mmHg; SFH is 34cm and fetal heart rate is 148/min. Your management plan should be

a. Control B.P and give steroids
b. Control B.P and give steroids and prolong delivery till 37 weeks
c. Control B.P and give MgSO4 and deliver her
d. Control B.P and give MgSO4 and plan induction at 36 weeks

Q No. 3. A couple came to know about prenatal diagnosis for beta thalassemia as their previous baby was having thalassemia major, which one is correct.

a. Chorionic villous sampling performed at 10 weeks of gestation
b. Amniocentesis performed at 25 weeks of gestation
c. Triple test performed during first trimester
d. USG for soft markers

Q No. 4. With rising antibody levels in a rhesus negative woman, you will order which of the following investigation to see the signs of fetal anemia.

a. Umbilical artery Doppler
b. Uterine artery Doppler
c. Middle cerebral artery Doppler
d. Obstetric USG

Q NO 5. A 38 years old G4P1A2 has come to you at 6 weeks of gestation for booking. She has previous history of a baby having Down syndrome which test will you recommend her as screening tool according to current recommendations

a. Serum beta hcg
b. Triple test
c. Combined test
d. Quadruple test

Q No 6. A primigravida at 31+6 weeks of gestation with history of sudden gush of fluid per vagina for 10 hours walks to labor ward. On examination she is not pale, pulse is 84/min, temperature 98°F, on speculum examination she is draining clear liquor, B.P 110/80. Abdomen soft nontender, SFH 32cm. She should be managed as

a. Induce labor with prostaglandins
b. Give antibiotics, steroids and monitor for signs of chorioamninitis
c. Give antibiotics and prophylactic tocolytics
d. Give calcium channel blockers and steroids

Q No. 7. Mrs. XY, a 39 years old G4P0A3 with gestational amenorrhea of 10 weeks walks to antenatal clinic. She is highly worried as she had history of repeated midtrimester miscarriages

a. Advise USG for cervical length
b. Screen for bacterial vaginosis
c. Do fetal fibronectin
d. Offer cervical stitch

Q No. 8. An obese G3P2A0, with previous history of intrauterine death at term in first pregnancy and gestational diabetes in her second pregnancyhas presented in antenatal clinic at 13+ weeks. You should advice her

a. HbA1c
b. OGTT at 24-28 weeks (Oral Glucose Tolerance Test)
c. OGTT at 16-18 weeks

d. Fasting blood glucose

Q No 9. A 28 years old lady G4P3A0 at 28 weeks presented to antenatal clinic with C/O breathlessness and easy fatigability. Her CBC picture is Hb 7.6g/dl , MCV 70fl, MCH 29pg, MCHC 28g/dl. Her serum ferritin levels are also low. She gives H/O acid peptic disease and intake antacids off and on. Her anemia should be treated with

a. Oral iron
b. Blood transfusion
c. Injectable iron
d. Green leafy vegetables and oral iron

Q No. 10. A G3P2A0 at 34 weeks comes to you for routine antenatal clinic. On examination her SFH is 30cm, her USG shows decreased liquor. She was diagnosed as oligohydramnios. What is the cause of oligohydramnios.

a. Diabetes
b. Anencephaly
c. Oesophageal atresia
d. Renal agenesis
e. Twin gestation

Q no. 11. A primigravida diagnosed as pre eclampsia has come to your antenatal clinic at 32 weeks of gestation. On examination her SFH is 28cm, we are suspecting FGR (fetal growth restriction). Which test will you perform for fetal surveillace.

a. Serial biometry 2 weekly
b. Serial biometry and amniotic fluid measurement 2 weekly
c. Serial biometry weekly
d. Fetal cardiotocography twice a week

Q No. 12. Mrs XY, 30 years old primigravida conceived 5 years after marriage by ovulation induction walks to antenatal clinic at 18 weeks. On examination her SFH is 22cm and multiple fetal parts are palpable. USG shows twin fetuses each corresponding to dates. Her dating scan was done at 12 weeks. To determine chorionicity you should be interested in

a. No. of placental masses
b. Fetal genders
c. Thickness of inter twin membrane
d. Twin peak or lambda sign at 9-10 weeks scan

Q No. 13. Mrs XYZ has come to you for prenatal counselling 6 months after her miscarriage. She is obese having BMI of 34.6 $kg/m^2$. She is worried about increased risk during pregnancy related to her obesity. You will counsel her that

a. Risk of GDM is increased 3 times when maternal BMI is >30 $kg/m^2$
b. Risk of GDM is not affected by increased BMI
c. Her risk of miscarriage is same as baseline risk
d. Risk of macrosomia and shoulder dystocia are not affected by maternal obesity

Q No. 14. Regarding Rh incompatibility, which of the following statement is not true

a. If father is Rh positive and heterozygous (50% likelihood that the baby is rhesus positive) or a homozygous (100% likelihood)
b. Anti-D is given only as prophylaxis and is useless once sensitization has occurred
c. Prenatal diagnosis for karyotype, or invasive testing by CVS may make the antibody levels higher in already sensitized women
d. Risk of HDFN (Hemolytic disease of fetus and newborn) decrease with successive pregnancies

Q No. 15. Mrs XYZ has come to labor room emergency at 34 weeks of gestation with complaint of epigastric pain, nausea and vomiting. On examination, her B.P is 160/100 mmHg. Her investigations show elevated liver enzymes and low platelet count. Her LDH is also raised. What is her diagnosis

a. Hepatic cholestasis of pregnancy
b. HELLP syndrome
c. Acute fatty liver of pregnancy
d. Acute tubular necrosis

# SEQs

**Q No.1.** A 28 years old primigravida with single pregnancy at 30 weeks with 3 days history of rapidly enlarging abdomen and difficult breathing. On examination, fundal height is 36cm, and abdomen is shiny.

a. What are the causes of large for dates uterus? 1
b. What are the causes of polyhydramnios? 2
c. How will you manage her? 2

**Q No. 2.** A primigravida at 36 weeks with known case of mitral stenosis at antenatal clinic. On examination, she is 36 weeks with cephalic presentation fetal heart sounds normal.

a. What physiological changes occurring during pregnancy in CVS? 2.5
b. How you manage your patient in labor? 2.5

**Q No. 3.** An 18 year old female in her first pregnancy attends for review at antenatal clinic at 34 weeks gestation. Her dates were confirmed by ultrasound at booking(12 weeks). She is smoker. Her fundal height is 30 cm with cephalic presentation. B.P is 140/100 & proteinuria +3.

a. What is your diagnosis? 0.5
b. What is biophysical profile? 2.5
c. After doing ultrasound what other tests you would advice her? 2

**Q No. 4.** Primigravida at 34 weeks came in emergency with history of painful vaginal bleeding. On examination B.P 100/60, pulse 92/min, abdomen tense and tender, fundal height is 36 weeks, fetal heart sounds are not audible.

a. What is your diagnosis? 0.5
b. How will you manage her? 2.5
c. Enlist maternal complications? 2

**Q No. 5.** A gravida 2 para1+0 at 20 weeks comes to you for first antenatal visit. Her previous pregnancy was uneventful and she has delivered male baby vaginally.
She is rhesus negative. You advise her Anti-D level, which is 8 IU/ml.

a. What is the next investigation you will advise her? 1
b. What are the signs of fetal anemia on ultrasound and doppler? 2
c. What are the potential sensitizing events for rhesus disease? 2

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## Specific Instructions:

Attempt the following MCQs & SEQs

## General Instruction

1. All students are required to prepared individual assignments.
2. It will be assessed by the IT department for plagiarism/ copying etc.
3. It is required that no two assignments are similar/ identical, if so both will be cancelled.
4. This assignment carries weightage (%age) to be included in internal assessment.
5. Those who fail will have this percentage deducted from their internal assessment.
6. Format for first page is also provided on website.

**Note: Students are directed to submit their assignments on assignmentfmuf@gmail.com**
**For submission of assignment students must follow following format in subject bar**
Discipline Class Subject Name Roll No.

**Example:**
MBBS: Final Year: Surgery: Syed Abdul Ahad: 22: