Тестовые задания по акушерству для студентов, обучающихся на английском языке

MCQ Obstetrics

1.
At pregnancy, the following physiological changes occur in the external genital organs:
1
the mucous membrane at the entry of vagina is cyanotic;
increased secretion of the sebaceous glands of vulva;
external genitals are loosened;
all of the above.
#
2.
Obstetric perineum is a region:
2
between posterior commisure and coccyx;
between posterior commisure and anus;
between anus and coccyx;
from the lower edge of pubis (loin) up to anus;
from the lower edge of coccyx up to anus.
#
3.
The major features of the structure of vagina are:
1
the wall is covered by multilayered squamous epithelium;
glands and submucous layer are absent in the mucous membrane;
contents of vagina is just the result of contraction of cervical glands, fallopian tubes, desquamated epithelial cells of vagina;
all are incorrect;
all are correct.
#
4.
At pregnancy, the following physiological changes occur in vagina, exept:
4
the blood supply of the vaginal walls increases sharply;
loosening of the vaginal walls;
hyperplasia and a hypertrophy of muscular elements of vagina;
the pH in vagina is alkaline.
#
5.
External genital organs include:
5
labia major;
labia minor;
major glands of vestibulum;
clitoris;
all are incorrect.
#
6.
The internal genital organs include:
5
uterus;
fallopian tubes;

ovaries;
vagina;
all are incorrect.
#
7.
The primary direction of the muscular fibres in the body of uterus is:
4
oblique;
circular;
obliquo-longitudinal;
longitudinal;
none of the above.
#
8.
The main direction of the muscular fibres in cervix is:
2
oblique;
circular;
obliquo-longitudinal;
longitudinal;
none of the above.
#
9.
Ovary is supported in the abdominal cavity by, exept:
4
ligamentum ovary propria;
ligamentum latum of uteri;
infundibulopelvic ligamentum;
ligamentum sacro-uterina;
#
10.
What hormone is used as a marker for normal progressing pregnancy?
5
estradiol;
hypophyseal gonadotropin;
progesterone;
prolactin;
chorionic gonadotropin.
#
11.
Name the process which helps the embryon to create a contact with the body of mother (uterus).
5
gastrulation;
implantation;
histogenesis;
fertilization;
placentation.
#
12.
When does the embryonic period end and begin the fetal period of the intrauterine development?
3
at the end of the first month;

at the end of the second month;
at the beginning of the third month;
at the end of the third month;
at the beginning of the fourth month.
#
13.
The first trimester of pregnancy is named as a period of:
1
organogenesis;
placentation;
fetal;
fertilization;
implantation.
#
14.
The probable sign for diagnosis of pregnancy is:
4
change of mood;
change of smell;
auscultation of fetal heart beats;
enlarged uterus.
#
15.
The positive sign of pregnancy is:
4
absence of menses;
increased size of uterus;
dyspeptic disturbances;
presence of fetus in uterus;
abdominal enlargement.
#
16.
Early diagnosis of pregnancy is made by.
4
change in basal temperature;
detection of HCG (human chorionic gonadotropin) in urine;
USG;
all of the above.
#
17.
Assumed date of labour can be known in all the given statements, except:
4
regular menstrual cycle;
continuation of pregnancy for 280 days;
ovulation occurs around the 14th day of cycle;
use of oral contraceptives before pregnancy;
conception occurred in the middle of cycle.
#
18.
Most often a pregnant woman complains on:
3
gastrointestinal disorders;

pain in the lower abdomen;
stop of menses;
bloody discharges from vagina;
all of the above.
#
19.
Which among the following is not the common complication occurring in the first trimester of pregnancy?
5
threatened abortion (miscarriage);
early gestosis;
anaemia;
hypotonia;
nephropathy.
#
20.
During pregnancy, the predisposition to edema of the lower extremities is caused by:
5
decreased osmotic pressure in the blood plasma;
compression of the inferior vena cava by the pregnant uterus and the increase of the venous pressure in the lower extremities;
retension of sodium in the body;
increased secretion of aldosterone;
all of the above.
#
21.
Frequency of what pathology increases in the aged primapara?
2
breech presentation;
weakness of labor strength;
detachment of normally placed placenta;
placenta prelying;
transverse position of fetus.
#
22.
Most favourable sign for the prognosis of present pregnancy is the completion of the previous pregnancy by:
4
pathological labor with surgical delivery;
artificial abortion;
habitual miscarriage;
normal labor;
all of the above.
#
23.
Term of pregnancy and the date of labour cannot be defined by:
3
last menstruation;
first fetal movement;
size of fetus;
USG data;
data obtained during the first attendance of the female consultation on the proposed pregnancy.

#
24.
What is the estimated date of labour if the first day of the last menstruation is the 1st of May?
4
the 6th of February;
the 8th of August;
the 24th of April;
the 8th of February;
the 3rd of October.
#
25.
The reason of the premature labour may be:
5
rhesus conflict;
gestosis (toxicosis);
multiple pregnancy;
gestational pyelonephritis;
all of the above.
#
26.
In obstetrics, USG helps to determine:
5
position of placenta and its pathology;
condition of the fetus;
non progressive pregnancy;
anomaly of the development of the fetus;
all are correct.
#
27.
Amnioscopy helps to estimate:
4
quantity of amniotic fluid;
staining of amniotic fluid;
presence of flakes of vernix caseosa;
all are correct;
all are incorrect.
#
28.
In normal position of fetal parts, the head is located at the position of:
2
maximum flexion;
moderate flexion;
moderate extension;
maximum extension.
#
29.
Fetal position is:
3
relation of the fetal back to the sagittal plane;
relation of the fetal back to the frontal plane;
relation of the fetal axis to the length of uterus;
interrelation of various parts of fetus.

#
30.
Position is called as longitudinal, when the fetal axis is:
3
 located under the right angle to the longitudinal axis of uterus;
 located under the acute angle to the axis of uterus;
 coincides with the length of uterus;
 located under obtuse (broad) angle to the axis of uterus.
#
31.
Fetal presentation is the relation of:
3
 head of fetus to its entry in the pelvis;
 pelvic end to the entry in pelvis;
 most lower part of fetus to the entry in pelvis;
 head of fetus to the fundus of uterus.
#
32.
Head presentation of fetus in physiological labour is:
2
 anterior head (cephalic) presentation;
 occipital presentation;
 frontal presentation;
 facial presentation.
#
33.
The most common presentation of fetus is:
4
 complete breech presentation;
 breech with flexed legs (frank breech);
 footling presentation;
 cephalic presentation;
 transverse presentation.
#
34.
Fetal position means:
1
 relation of the fetal back to the lateral walls of uterus;
 relation of the fetal head to the entry in pelvis;
 relation of the fetal axis to the length of uterus;
 interrelation of various parts of uterus.
#
35.
Kind of the fetal position is the relation between:
3
 fetal back to the sagittal plane;
 fetal head to the plane of entry in the small pelvis;
 fetal back to the anterior and posterior walls of uterus;
 fetal axis to the length of uterus.
#
36.
At the first position, the back of fetus is turned:

3
 to the right;
 to the fundus of the uterus;
 to the left;
 to the entry in the small pelvis.
#
37.
At the second position, the back of fetus is turned:
1
 to the right;
 to the fundus of uterus;
 to the left;
 to the entry in the small pelvis.
#
38.
When fetus is lying transversely, the position of fetus can be determined by the position of:
2
 fetal back;
 fetal head;
 small fetal parts;
 pelvic end of the fetus;
 cannot be determined.
#
39.
Objective examination of the pregnant woman or woman in labor starts with:
4
 palpation of the abdomen;
 auscultation of the abdomen;
 measurement of the pelvis;
 objective examination by systems;
 all of the above.
#
40.
By the first method of the external obstetric examination may be defined:
3
 position of the fetus;
 occipito-anterior or occipito-posterior vertex position;
 height of the uterine fundus;
 prelying part of the fetus.
#
41.
By the second method of the external obstetric examination may be defined:
4
 prelying part of the fetus;
 disposition of the fetal parts;
 height of the uterine fundus;
 position of fetus;
 head of fetus.
#
42.
By third method of the external obstetric examination may be defined:
1

prelying part of the fetus;
disposition of the fetal parts;
height of the uterine fundus;
position of fetus;
type of position.
#
43.
By the fourth method of the external obstetric examination may be defined:
5
prelying part of the fetus;
position of the fetal parts;
height of the uterine fundus;
position of fetus;
relation of the prelying part to the entry in the pelvis.
#
44.
External obstetric examination at the second half of pregnancyincludes all the following, except:
4
determination of location, position and size of fetus;
anatomic estimation of pelvis;
determination of the term of pregnancy;
functional estimation of pelvis;
estimation of frequency and rhythm of the fetal heart beats.
#
45.
Circumference of abdomen can be measured:
2
on the middle of the distance between umbilicus and xiphoid process;
on the level of umbilicus;
randomly;
on two transverse fingers above umbilicus;
on three transverse fingers above umbilicus.
#
46.
At a women of normal constitution, the lumbar rhombus has the following form:
2
triangular;
geometrically correct rhombus;
correct quadrangular;
triangular, stretched in vertical direction;
quadrate (square form).
#
47.
The method of instrumental examination used during pregnancy and at delivery is:
2
probing of the uterus;
examination of the uterine cervix by speculum;
biopsy;
histerography;
hysteroscopy.
#
48.

Vaginal examination is not used for:
3
determination of stage of opening of the uterine cervix;
estimation of integrity of the amniotic sac;
estimation of condition of fetus;
determination of features of insertion of the fetal head;
estimation of the size of pelvis.
#
49.
Diagonal conjugate can be defined:
4
on the external conjugate;
on the height of pubis symphysis;
on the lateral conjugate;
on vaginal examination.
#
50.
Diagonal conjugate is the distance between:
3
ischium tubercles;
iliac crests;
lower edge of symphysis and promentorium;
major trochanters of femur bone;
umbilicus and xiphoid process.
#
51.
Diagonal conjugate is equal to:
2
31-32 cm;
12-13 cm;
12-15 cm;
28-29 cm;
9-12 cm.
#
52.
True conjugate is the distance between:
2
the middle of the upper edge of pubis and promentorium;
the maximum protruding point of symphysis and promentorium;
the lower edge of symphysis and protruding point of promentorium;
iliac crests;
umbilicus and xiphoid process.
#
53.
True conjugate is equal to:
2
13 cm;
11 cm;
10 cm;
20 cm;
9 cm.
#

54.
The normal fetal heart rate per minute is:
3
80-90 beats;
100-110 beats;
120-140 beats;
100-200 beats;
170-180 beats.
#
55.
Where the fetal heart beats are the best heard in the 1st position of anterior type of occipital presentation?
2
on the right below umbilicus;
on the left below umbilicus;
on the left above umbilicus;
on the left at the level of umbilicus;
in any point.
#
56.
Which of the reasons can conduct to the decrease in amniotic fluid in pregnant women?
2
microcephalia;
abnormalities of urinogenital tract of the fetus;
teratoma of sacrococcygeal region;
virus and bacterial infection.
#
57.
The average duration of the first stage of labour in primigravidae is:
3
3-5 h;
6-9 h;
10-14 h;
15-18 h;
19-24 h.
#
58.
Unlike nephropathy, in arterial hypertensia the presence of the following symptoms is characteristic:
5
edema;
proteinuria;
oliguria;
all listed;
none of the above.
#
59.
The excessive increase in body weight at a woman of second half of pregnancy, most likely it should be suspected:
5
large fetus;
toxicosis (preeclampsia);

increased volume of amniotic fluid;
multi pregnancy;
all listed.
#
60.
In diagnostics of prolonged pregnancy the following methods are helpful:
5
amnioscopy;
electrocardiogram and FCG of a fetus;
dynamics of measurement of an abdomen circle and height of the bottom of uterus;
colpocytology;
all listed above.
#
61.
Amniscopy allows, generally, to estimate:
4
quantity of amniotic fluid;
colour of amniotic fluid;
presence of flakes of vernix caseosa;
all listed;
nothing from the listed.
#
62.
What method should be used in anaesthesia for amniocenthesis:
3
the general anaesthesia;
local anaesthesia;
sacral blockade;
without anaesthesia and analgesic;
light analgesia.
#
63.
The labour pain arises owing to:
4
irritation of the nervous terminations of uterus and patrimonial ways;
decrease of a threshold of pain sensitivity of the brain;
decreased production of endorphines;
all listed;
nothing from the listed.
#
64.
Pudendal anaesthesia is most often applied:
1
at the second stage of premature labour;
at distructive operations of fetus;
at the extraction of fetus for the pelvic end;
at all listed;
nothing from the listed.
#
65.
At the first stage of labour, all the listed preparations are applied for anaesthesia, except:
3

inhalation anasthetics;
the narcotics;
oxitotics;
analgesics.
#
66.
The indication for the appointment of anesthetics at the first stage of labour is:
3
opening of cervix to 4 cm;
weak contraction of uterus during labour ;
discoordination of patrimonial activity;
absence of the fetal sac.
#
67.
At the end of pregnancy of a primigravida women, cervix of uterus is normally:
2
extended;
truncated (shortened);
smoothed partially;
smoothed completely;
kept.
#
68.
For a mature cervix of uterus it is characteristic:
5
its disposition along the conductive axis of pelvis;
softening on all its length;
passability of the cervical channel for 1-1,5 fingers;
shortening of cervix to 1-1,5 cm;
all the listed.
#
69.
Name signs of the beginning of the first stage of labour:
3
efflux of amniotic fluid;
presence of "mature" uterine neck;
occurrence of regular birth pangs ;
head insertion into the entrance of the minor pelvis.
#
70.
The first stage of labour comes to an end always:
1
by the full disclosure of the uterine cervix;
by occurrence of attempts;
by efflux of amniotic fluid;
in 6-8 hours from the beginning of regular birth pangs;
all listed.
#
71.
In labour, at head prelying of a fetus, the following basal frequency of heart beats is considered to be normal:
1

120-160 beats per minute;
110-150 per minute;
100-180 per minute;
more than 200 per minute.
#
72.
Name signs of the beginning of the second period of labour:
3
presence of attempts;
efflux of amniotic fluid;
full opening of the uterine os;
insertion of the fetus head.
#
73.
Vaginal examination in labour is carried on purpose:
5
detection of the integrity of the uterine sac;
assessment of the degree of disclosure of the uterine cervix;
estimation of features of insertion of fetus head;
estimation of the sizes and condition of osteal pelvis;
all listed above.
#
74.
In what situation it is possible to speak about engagement of the fetus head into the entrance of the pelvic:
2
the head is in the pelvic cavity;
bisparietal size of the head is in an entrance plane of small pelvis;
the prelaying part is at the level of sciatic axis;
arrow-like suture is in the cross-section size of the pelvis;
the fetus head is bent.
#
75.
In what plane of the minor pelvis the internal rotation of the head takes place?
3
over an entrance to the pelvis;
in an entrance plane of the minor pelvic;
in a plane of the wider part of the pelvic cavity;
in a plane of a narrow part of the pelvic cavity;
in a plane of the exit of the pelvis.
#
76.
The major movements of a fetus during labour occur in certain sequence. What of the following sequences is correct?
42
descent, internal rotation, flexion;
engagement, flexion, descent;
engagement, internal rotation, descent;
engagement, flexion, internal rotation, extension;
descent, flexion, engagement.
#
77.

A leading point at the occipital prelying of a fetus is:

big fontanel;
small fontanel;
the middle of the frontal suture;
the middle of the distance between big and small fontanel.
#
78.
An indicator for the beginning of the second stage of labour is:
4
descending of a prelaying part into the minor pelvis;
attempts;
internal turn of a head;
full disclosure of the uterine cervix;
baby birth.
#
79.
In the 2nd period of labour the heart beats are supervised:
1
after each attempt;
every 5 mines;
every 10 mines;
every 15 mines;
every 20 minute.
#
80.
Vaginal examination in labour is made:
5
before labour stimulation;
at admission in a hospital;
at occurrence of bleeding discharges;
at efflux of amniotic fluid;
all listed is true.
#
81.
Conduction of labour in the second period of labour includes, mainly, the control, except:
4
for the condition of woman and fetus;
for the engagement and crowning of the prelaying part of the fetus;
for the condition of fetoplacental circulation;
for the pressure in the antervillum space;
#
82.
The indication to the section perineum in labour is:
5
rupture threat of perineum;
a large fetus;
premature labour (a small fetus);
pelvic fetus prelying;
all answers are correct.
#
83.

Episiotomy is for the prevention of:
2
bad healing of perineum;
rupture of muscles of perineum;
development of rectocele and cystocele;
contraction of musclus levator ani.
#
84.
Indications to perineotomia:
5
high rigid perineum;
rupture threat of perineum;
premature labour;
acute hypoxia of a fetus;
all listed is true.
#
85.
For the prevention of bleeding in labour at a moment of crowning of the head, it is often applied:
2
promedol;
methylergometrin;
pregnantol;
mammophizin;
quinine.
#
86.
Volume of physiological blood loss in labour:
2
100 - 150 ml;
200 - 300 ml;
300 - 400 ml;
400 - 500 ml;
less than 100 ml.
#
87.
Tactics of conducting the third stage of labour depends on:
1
degree of the blood loss;
duration of labour;
presence of signs of the afterbirth detachment;
conditions of the newborn;
duration of labour without amniotic fluid.
#
88.
The major mechanisms of the afterbirth detachment and the afterbirth discharging are:
4
the increase of the intrautrine pressure;
the decrease of the size of a uterus and the sizes of placentary platform;
retraction and contraction of myometrium;
all listed above;
nothing from the listed.
#

89.
Ways of removal of non-detached afterbirth from the uterus:
4
Abuladze's method;
pull for an umbilical cord;
method of Krede-Lazarevich;
manual afterbirth detachment andafterbirth discharging.
#
90.
Characteristic signs of the total tight attachment of placenta are:
4
pain in the abdomen;
bleeding;
height of standing of the uterine bottom above the navel after a child birth;
absence of signs of afterbirth detachment.
#
91.
The bleeding at the postpartum period is possible in all cases, except:
4
at thrombocytopenia;
at long (prolonged) labour;
at muli fetus and hydramnion;
at labour in the back type of facial prelying.
#
92.
Indications for the manual inspection of the uterus:
4
application of prostaglandins in labour;
long labour;
labour at pelvic prelying;
labour in the presence of a scar on uterus after cesarean sections;
none of the above.
#
93.
What is indicative during jointing of placenta?
5
manual afterbirth detachment;
introduction of contraction drugs;
curettage of cavity of uterus;
to put cold on the abdomen;
extirpation or amputation of uterus.
#
94.
The prolonged pregnancy is characterized?
5
oligoamnios;
increased basal tonus of uterus;
decreased excitement of myometrium;
decreased circumference of the abdomen;
all the above are right.
#
95.

To diagnose the prolonged pregnancy, it is necessary:
2
 to do USG to confirm the position of fetus;
 to determine exact duration of pregnancy;
 to measure the heart rate of fetus;
 to determine the volume of amniotic fluid;
 to carry out the stress contraction test.
#
96.
Major symptoms of the overmaturity of fetus are:
5
 dry skin;
 absent of vernix caseosa;
 narrow sutures and fontanels;
 dense bones of scull;
 all is true;
 all is false.
#
97.
Indications for cesarean section during the prolonged pregnancy are:
6
 pelvic prelying;
 big size of fetus;
 old age of women;
 narrow pelvis;
 all is false;
 all is true.
#
98.
The term “afterbirth period” usually means:
1
 first 2 months after labour;
 period of the breast feeding of a newborn;
 period of afterbirth amenorrhea;
 all above.
#
99.
The term “lochi” means:
4
 the afterbirth secretion from uterus;
 the wound secretion from the afterbirth uterus;
 detachment of the decidual membrane;
 all of the above;
 none of the above.
#
100.
Management and care of women in the early afterbirth period implies the control of, except:
4
 arterial blood pressure, pulse, respiration;
 contraction of uterus;
 blood loss;
 colpocytological examination;

#
101.
In the early afterbirth period, the following changes occur in the genital system of women:
5
involution of uterus;
formation of the cervical canal of the uterine cervix;
regeneration of muscular tonus of the pelvic bottom;
retraction, contraction of uterus and thrombus formation of vessels of placental site;
all is true;
all is false.
#
102.
Healing of the placental site takes place due to:
5
destruction and rejection of fragments of the decidual membrane;
regeneration of endometrium from the fundal glands;
epithelization of endometrium;
formation of granulations from leukocytes;
all of the above.
#
103.
Joint stay of both mother and child in postpartum department furthers:
4
the decreased rate of purulent-septic diseases;
establishment of steady lactation;
formation of psychoemotional tie between mother and her child;
all the above;
none.
#
104.
What is predisposed to the blood loss in the early post-partum period:
5
weakness of labour activity;
increased volume of amniotic fluid;
multi pregnancy;
large fetus;
all the above.
#
105.
What is necessary to undertake first of all in the starting blood loss in post-partum period:
4
manual detachment of placenta;
introduction of uterus contraction preparations;
examine of patrimonial ways;
define signs of the placenta detachment;
ice on the lower abdomen.
#
106.
Pathological blood loss in the early post-partum period demands:
5
press of aorta;
injection of drugs contracting the uterus;

manual examination of uterine cavity;
examine patrimonial ways;
all the above.
#
107.
During bleeding in the 3rd period of labour and presence of symptoms of the placental detachment it is necessary to:
4
make the detachment of the afterbirth by the outer approach;
inject the contracting drugs for uterus;
put ice on the lower abdomen;
all of the above.
#
108.
Most usual cause of the late postpartum bleeding is:
1
disturbance in contraction of uterine muscles;
hemostatic disturbances;
trophoblastic diseases;
retention of fragments of placental tissue in uterus;
none;
all.
#
109.
Tactics of a doctor during hemorrhage in the 3rd period of labour in the absence of symptoms of placenta detachment:
4
to inject drugs causing the uterine contraction;
to use the Krade-Lazarevich's method;
to use Abuladze's method;
to make the manual detachment of placenta and discharge of afterbirth;
to inject spasmolytics.
#
110.
Most usual cause of bleeding in the early afterbirth period:
4
hypotonus of uterus;
retention of fragments of the afterbirth tissue in uterus;
disturbance of blood coagulation system;
long period without amniotic fluid.
#
111.
In diagnosis of the premature detachment of the normally located placenta, the most informative methods include:
3
external obstetrics examination;
vaginal examination;
USG;
estimation of heart activity;
#
112.

Complicated form of the detachment of the normally located placenta can cause everything except
4
intrauterine fetal death;
pallor of skin;
anemia;
Rh-sensibilization.
#
113.
Premature detachment of the normally located placenta is complicated by:
5
appearance of Couvelaire uterus;
intranatal fetal death;
development of DIC (disseminated intravascular coagulation) syndrome;
hemmorhagic shock;
all of the above.
#
114.
The major reason of the premature detachment of the normally located placenta is:
2
trauma of the abdomen;
gestosis;
prolonged pregnancy;
hydramnion, multi pregnancy;
short umbilical cord.
#
115.
For the clinical picture of premature detachment of the normally located placenta is not characteristic:
2
abdominal pain;
absent abdominal pain;
hemorrhagic shock;
change in the heart beat of fetus;
change in shape of uterus.
#
116.
Most usual cause of the detachment of the normally located placenta is:
3
powerful hit on abdomen;
powerful birth pangs;
late gestation;
short umbilical cord;
early efflux of the amniotic fluid.) investigation of blood coagulation system.
#
117.
For the prelying of placenta the following positions are characteristic:
4
on the anterior wall at the bottom;
on the bottom of uterus;
on the posterior wall of uterus;
partial or total covering of the internal os;

at the lower segment of uterus.
#
118.
The prelying of placents is the pathology at which placenta is located:
3
at the body of uterus;
at the lower segmentl;
at the lower segment of uterus, partial or total covering of the internal os;
on the posterior wall of uterus;
on the bottom of uterus.
#
119.
In the prelying of placenta, bleeding is usually appeared at the term of pregnancy of:
4
8-12 weeks;
16- 20 weeks;
22- 24 weeks;
28 – 32 weeks;
36 – 40 weeks.
#
120.
The most characteristic clinical sign of the prelying of placental is:
4
chronic intrauterine hypoxia of fetus;
decreased Hb levels and RBCs in the blood;
repeted bloody discharges from genital organs;
arterial hypotension;
threat of abortion.
#
121.
The prelying of placenta should be differentiated with:
5
torsion of the pedicle of cystoma ovari;
rupture of uterus;
necrosis of myomatous nodule;
strangulation of myomatous uterus in the small pelvis;
none of above.
#
122.
Characteristic features of bleedings in the prelying of placenta include:
5
sudden occurrence of bleeding;
their repeatability;
anemization of a pregnant woman;
all are wrong;
all are right.
#
123.
In what cases the vaginal investigation is indicative in suspicion of the placenta prelying
4
at the term of 27 weeks on admission in the hospital;
after admission in hospital and stop of bleeding;

before the localizing of placenta with USG;
only for selection of the method of delivery.
#
124.
Clinical symptom of the placenta prelying:
4
pains in the lower abdomen;
changes in the heart beat of fetus;
changes in the form of uterus;
bleeding of different intensity;
efflux of amniotic fluid.
#
125.
The most characteristic features of preeclampsia include:
3
shin edema;
albuminuria;
subjective complaints: headache, eye sight disturbances;
all of the above.
#
126.
Eclampsia can be differentiated with:
5
epilepsy;
hypertension;
brain tumours;
stroke;
all above listed.
#
127.
The manifestations of the late gestosis include:
2
oedema;
proteinuria;
hyperglycemia;
hyperinsulinemia;
all answers are wrong.
#
128.
Complications of eclampsia:
5
neurologic complications;
fetal death;
pulmonary oedema;
premature detachment of the normally located placenta;
all listed above.
#
129.
The possible cause of death in eclampsia is:
4
cardiac arrest during convulsions;
pulmonary oedema;

stroke, coma;
all listed above.
#
130.
The most typical cause of maternal death in eclampsia is:
2
renal-hepatic insufficiency;
stroke;
lung oedema;
infection.
#
131.
The optimal variant for delivery in severe form of gestosis is:
3
application of obstetrical forcepses;
self supporting delivery;
cesarean section;
vacuum-extraction of fetus;
fetus destructing operation.
#
132.
Anatomically narrow pelvis is considered to be any pelvis which in comparison with normal:
4
all the sizes are reduced by 0,5-1 cm;
at least one size is reduced by 0,5-1 cm;
all the sizes are reduced by 1,5-2 cm;
at least one size is reduced by 1,5-2 cm;
all answers are not true.
#
133.
Generally and equally narrowed (justo minor) pelvis is characterized by:
2
shortening only of the direct size of entry to the small pelvis;
equal decrease of all sizes of the small pelvis;
lengthening of the sacrum;
all listed are correct.
#
134.
Characteristic for the biomechanism of labour in generally and equally narrowed (justo minor) pelvis is:
4
acynclytic insertion;
placing of the sagittal suture at the transverse size;
extension of the head is in the entry to the small pelvis;
maximum flexion of the head.
#
135.
Simple flat pelvis is characterised by:
1
the decrease of all direct sizes of the cavity of the small pelvis;
increase in height of the pelvis;
the decrease of the transverse size of the sacrolumbal rhombus;

all listed is true;
nothing from the listed.
#
136.
Clinically narrow pelvis is:
5
one of the forms of anatomically narrow pelvis;
absence of ascending of the head of the fetus due to weakness of labour activity;
non-compliance of the head of the fetus and pelvis of the mother, revealed during pregnancy;
all listed above;
nothing from the above listed.
#
137.
For evenly narrowed pelvis is characteristic:
5
the normal form;
thin bones;
uniform reduction of all sizes;
sharp subpubical corner;
all listed is true.
#
138.
For the treatment of discoordination of the labour activity, as a rule, are used:
5
promedol;
morphine;
tocolytics;
spasmolytics;
all listed above.
#
139.
Discoordinated labour activity is characterised by:
5
irregularbirth pangs;
various intensity ofbirth pangs;
painful birth pangs;
poor dynamics of the opening of the uterine cervix;
all listed above.
#
140.
For the course of rapid labour the most typical is:
5
raised body temperature;
nausea, vomiting;
dry tongue, tachycardia;
all listed above;
nothing from the above listed.
#
141.
The most important consequences of wide application of cesarean sections:
3
decrease in maternal death rate;

decrease in maternal pathologies;
decrease in perinatal death rates;
decreased blood loss.
#
142.
The cesarean section is indicated:
4
in insufficiency of blood circulation II B - III stages;
in septic endocarditis;
in acute heart failure at labour;
in all listed;
nothing from the listed.
#
143.
The cesarean section should be performed in a planned manner (absolute indication) if the following takes place:
6
infertility in the anamnesis;
birth of injured children or stillborn in the anamnesis;
chronic fetal hypoxia;
multiple myoma of the uterus;
scar on the uterus;
all answers are wrong.
#
144.
The cesarean section is the relative indication in all cases, except:
3
one cesarean section in the anamnesis;
fetal hypoxia;
umbilical cord prolapse;
premature detachment of placenta;
presence of a dead fetus.
#
145.
Indications to cesarean sections, as a rule, are taken into account with the following factors:
5
age of the woman;
pregnancy term;
the anatomic sizes of the pelvis;
the obstetrical-gynecologic anamnesis;
all answers are correct.
#
146.
Advantages of cesarean sections at the lower segment of a uterus do not include:
3
a cut in the functional less active and less vascularized zone;
conformity of direction of the cut on a uterus to a direction of the basic layers of the myometrium;
wound healing on the uterus by full regeneration.
#
147.
The most frequent technique of cesarean sections is:

4
corporal cesarean section;
extraperitoneal cesarean section;
isthmic-corporal cesarean section;
a cesarean section in the lower segment (cross-section);
vaginal cesarean section.
#
148.
In modern obstetrics the following technique of cesarean sections is not used:
4
classical (corporal) caesarean section;
a cesarean section in the lower segment of a uterus;
extraperitoneal caesarean section;
intraligamental cesarean section;
vaginal cesarean section.
#
149.
Choose the basic complication of a classical cut of the uterus in cesarean section:
1
rupture of scar tissue in the following pregnancies and deliveries;
formation of postoperative commissure;
poor healing of wounds on the uterus;
more extended damage of vessels of the uterus.
#
150.
A risk factor of inconsistency of a scar on the uterus after cesarean sections is:
5
performance of cesarean sections at premature labour;
the complicated course of the postoperative period;
corporal cesarean section;
an interval between cesarean sections less than 2 years;
all listed above.
#
151.
Quality of a postoperative scar on the uterus after cesarean sections basically depends on:
5
the choice of technique of operation;
technics of suturing of a section on the uterus;
the cleanliness degree of vaginal dab before operation;
the conduction and course of the postoperative period;
all answers are correct.
#
152.
Rules of introduction of spoons of obstetrical forceps are the following:
4
the left spoon held by the right hand and enter into the right half of pelvis of mother;
the right spoon held by the left hand and enter into the left half
of pelvis of mother;
all listed are true;
all listed are wrong.
#
153.

What condition does not allow perform operation using obstetrical forceps?
2
alive fetus;
opening of the uterine cervix by 4 cm;
absence of amnion;
head in large part of the pelvic cavity.
#
154.
While applying the exit obstetrical forceps, spoons should lie on
2
the fetal head:
in the right slanting size;
in the transverse size;
in the direct size;
all listed above.
#
155.
In case of head inclination, obstetrical forceps traction should be:
5
periodically rotational;
periodically rocking;
periodically in the form of jerks;
all listed above;
nothing from the listed.
#
156.
Placing obstetrical forceps is contraindicated in case of:
5
dead fetus;
anatomically and clinically narrow pelvis;
incomplete opening of uterine cervix;
threaten uterine rupture;
all listed above.
#
157.
The main functions of placenta are:
5
respiratory;
alimentary;
excretory;
hormonal;
all listed above.
#
158.
Formation of feto-placental system, as a rule ends at:
1
16 weeks of pregnancy;
20 weeks of pregnancy;
24 weeks of pregnancy;
28 weeks of pregnancy;
32 weeks of pregnancy.
#

159.
Name the correct characteristics of the umbilical cord:
2
the umbilical cord is formed from the villus;
there are 2 arteries in the umbilical cord;
there are 2 veins in the umbilical cord;
lymphatic vessels go through the umbilical cord;
diameter of the umbilical cord is 12 cm.
#
160.
Name the correct characteristics of the amniotic fluid:
3
normal quantity is 4 liters;
amniotic fluid is pink in color;
by its composition, amniotic fluid may be used for estimation of the condition of the fetus;
amniotic fluid exerts high pressure on the fetus;
by the end of pregnancy, there is relative increase of the quantity of amniotic fluid.
#
161.
Name the correct characteristics of the placenta:
3
normal weight of placenta is 1200g;
main mass of placenta consists of vesels;
in placenta chorionic gonadotropin is formed;
normally placenta is attached to the internal fauces of the uterine cervix;
in placenta erythrocytes are formed.
#
162.
Which objective investigations are compulsory for pregnant women?
1
measurement of blood pressure;
determination of particularity of body constitution;
measurement of thorax circumference;
condition of mammary glands;
examination of fundus of eye;
urinary Zimnitski's test.
#
163.
Which information helps to determine intrauterine fetal position?
1
determination of ratio of fetal back to longitudinal axis of uterus;
place of the attachment of placenta;
fundal height of uterus;
place in which the fetal heart sounds are heard;
disposition of small parts of fetus.
#
164.
Indications for vaginal examinations in women in labor are:
3
life-threatening asphyxia of the fetus;
nephropathy of pregnant woman;
bloody discharges from genitalia;

albuminuria;
starting of post-natal period.
#
165.
Which changes are characteristics for normal pregnancy?
2
thickening of sacro-iliac joints;
increase of body mass by 300g a week in the second half of pregnancy;
expressed edema in lower extremities;
divergence of the pubic rami to the sides by 0,3-0,5cm;
depigmentation of linea alba of the abdomen.
#
166.
Which changes can occur during normal pregnancy?
3
unstable arterial pressure and hypertension;
leucopenia;
increase in ESR (erythrocyte sedimentation rate) till 20-25 mm an hour;
decrease of erythrocytes count;
thrombocytopenia;
#
167.
Changes in cardiovascular system, which are characteristics for normal pregnancy:
3
decrease in circulating blood volume;
leucopenia;
edema of lower extremities;
increase in vascularisation of uterus;
increase in quantity of fibrinogen;
#
168.
Which changes in a woman, caused by pregnancy, are nonreversible
2
presence of choriogonin hormone;
striae gravidum;
lactation;
acromegaly;
pigmentation.
#
169.
What signs are characteristic for 40-week pregnancy?
3
striae gravidum;
albuminuria;
height of standing of uterus above pubis is 36 cm;
umbilical extrusion;
bloody discharges from genitalia.
#
170.
Indicate the characteristics for the 1st type of occipito-anterial position:
4
fetal heart beats are heard on the right;

major fontanel is determined from the left and the front;
minor fontanel is determined from the left and the back;
back of the fetus is turned to the front and the left;
back of the fetus is turned to the uterine fundus.
#
171.
Importance of sutures and fontanels on the head of fetus during labor:
5
determination of size of head of fetus;
determination of configuration of head of fetus;
determination of type of occipital position;
determination of occipito-frontal size of fetus;
determination of synclitism and asynclitism insertion of fetal head.
#
172.
Name the main point and the point of fixation during labour in occipito-anterial position:
3
chin;
the middle of frontal suture;
minor fontanel;
major fontanel;
upper jaw.
#
173.
Clinical signs of severe acute hypoxia of fetus do not include:
2
fetal heart rate of 90-100 beats per minute;
fetal heart rate of 120-140 beats per minute;
muffled fetal heart beats;
fetal heart rate of 160-190 beats per minute;
arrhythmia.
#
174.
Green color of amniotic fluid indicates:
1
chronic hypoxia of fetus;
acute hypoxia of fetus;
antenatal death of fetus;
hemolytic disease of fetus;
disturbance of metabolism of amniotic fluid.
#
175.
Brown color of amniotic fluid indicates:
3
chronic hypoxia of fetus;
acute hypoxia of fetus;
antenatal death of fetus;
hemolytic disease of fetus;
disturbance of metabolism of amniotic fluid.
#
176.
Placenta is permeable to:

5
alcohol;
morphine;
penicillin, Streptomycin;
ether;
all listed above.
#
177.
Velocity of penetration of medicines through placenta depends on all listed, except:
5
molecular mass of preparation;
solubility of medicine in lipids;
degree of binding of medical substance with blood proteins;
size of molecule of preparation;
mass of fetus.
#
178.
Minimal height of a viable fetus is:
2
30cm;
32cm;
35cm;
50cm.
#
179.
Minimal weight of a viable fetus is:
1
500g;
600g;
800g;
1000g.
#
180.
In Republic of Belarus, criterion for a viable fetus (newborn) is a term of pregnancy:
2
20 weeks;
22 weeks;
26 weeks;
28 weeks.
#
181.
Signs of maturity of a newborn are:
5
mass/ height coefficient;
disposition of umbilical ring;
condition of external genitalia;
quantity of vernix caseosa;
all listed are correct.
#
182.
Duration of perinatal period is:
3

from conception till delivery;
the first 7 days after birth;
since the 22nd week of intra-uterine development including 7days after birth;
since the 22nd week of intra-uterine development including 10 days after birth;
since the 24th week of pregnancy till the 7th day after birth.
#
183.
Most often causes of death of premature newborns are:
3
developmental anomalies;
hemolytic disease of newborns;
respiratory distress syndrome;
jaundice of newborns;
infections.
#
184.
On the Apgar scale, mild degree of asphyxia is:
2
8 points;
7 points;
6-5 points;
4 and less points.
#
185.
Low marks on Apgar scale (3 and 5 points on the 1st and the 5th minute respectively) can be in all listed clinical situations except:
5
prematurity;
detachment of placenta;
extremely intensive labor;
infections in fetus;
arterial hypertension in mother.
#
186.
Causes of fetal respiratory distress syndrome are:
5
CNS trauma due to labor;
developmental defects of heart;
developmental defects of diaphragm;
intra-uterine infections;
all listed above;
none from the listed.
#
187.
Characteristics of recent course of postnatal infection are:
5
polyethiological;
often caused by pathogenic flora;
light clinical features;
high resistance to antibacterial therapy;
all listed above.
#

188.
What corresponds to the first stage of infection according to the Sazonov-Bartels' classification of postnatal purrulo-septic infections?
2
lactation mastitis;
infection in the area of the postnatal wound;
infection is outside the wound's area, but within the small pelvis;
infection is outside the small pelvis, near generalization;
generalised infection.
#
189.
What corresponds to the second stage of infection according to the Sazonov-Bartels' classification of postnatal purrulo-septic infections?
2
infection in the area of postnatal wound;
infection is outside wound's area, but within the small pelvis;
infection is outside the small pelvis, near generalization;
generalised infection.
#
190.
What corresponds to the third stage of infection according to the Sazonov-Bartels' classification of postnatal purrulo-septic infections?
4
infection in the area of postnatal wound;
infection is outside wound's area, but within the small pelvis;
associated with the lactation mastitis;
infection is outside the small pelvis, near generalization;
generalised infection.
#
191.
What corresponds to the fourth stage of infection according to the Sazonov-Bartels' classification of postnatal purrulo-septic infections?
5
infection in the area of postnatal wound;
infection is outside wound's area, but within the small pelvis;
infection is outside the small pelvis;
infection outside the small pelvis, near generalization;
generalised infection.
#
192.
Causes of the rupture of vagina during labor include:
5
infantilism;
prompt duration of labor;
large fetal head;
incorrect presentations of the fetal head;
all of the above.
#
193.
Perineal rupture of the second degree is not accompanied by the rupture of:
4

superficial muscles of the perineum;
perineal skin;
musculus levator ani;
uterine cervix;
vaginal walls.
#
194.
Which of the following are used for the prophylaxis of suppuration and distension of perineal sutures during rupture of the first and the second degrees?
5
potassium permanganate [local];
laser rays on the area of sutures;
measures on prevention of defecation during 4-5 days;
ultraviolet rays on the area of sutures;
all of the above.
#
195.
The most informative for the diagnosis of the beginning of uterus rupture during labor is:
5
pain in the area of the lower segment of uterus;
bloody vaginal discharges;
rough labor activity;
high standing of the contraction ring;
all of the above.
#
196.
Causes of the rupture of uterus during labor can be:
5
large fetus;
narrow pelvis;
incorrect insertion of the head;
overdose of oxytocin;
all of the above.
#
197.
Methods for the treatment of complete rupture of uterus:
5
adequate anesthesiological manipulation;
operation;
infusion-transfusion therapy adequate to the blood loss;
correction of disturbance of hemocoagulation;
all answers are right.
#
198.
Which of the following are the main clinical features of complete rupture of uterus?
5
shock;
blood loss;
abdominal pain;
stop of labour activity;
all of the above.
#

199.
The main criterion for viviparity are:
4
fetal mass of 1000 g and more;
length of fetus of 35 cm and more;
presence of heartbeats;
presence of unaided breathing;
pregnancy duration of 28 weeks and more.
#
200.
Which signs are not characteristics of early gestosis?
3
sialorrhea;
loss of body weight;
latent edema;
dehydration;
skin dryness.

Задачи акушерство Obstetrics' cases

Нормальные роды

A 26-year-old G1P0 woman at 39 weeks' gestation is admitted to the hospital in labor. She is noted to have uterine contractions every 2 to 3 minutes. Her antepartum history is significant for a nonimmune rubella status. On examination, her blood pressure (BP) is 110/70 mm Hg and heart rate (HR) is 80 beats per minute (bpm). The estimated fetal weight is 3000 gr. On pelvic examination, she has been noted to have a change in cervical examinations from 4-cm dilation to 5-cm over the last 2 hours. The pelvis is assessed to be adequate on digital examination.

Послеродовое кровотечение

A 26-year-old G2-P1 woman underwent a normal vaginal delivery. A viable 3800 gr male infant was delivered. The placenta delivered spontaneously. The obstetrician noted significant blood loss from the vagina, totaling approximately 700 mL. The uterine fundus appeared to be well contracted.

Послеродовое кровотечение

A 29-year-old G5-P4 woman at 39 weeks' gestation with preeclampsia delivers vaginally. Her prenatal course has been uncomplicated except for asymptomatic bacteriuria caused by Escherichia coli in the first trimester treated with oral cephalexin. She denies a family history of bleeding diathesis. After the placenta is delivered, there is appreciable vaginal bleeding estimated at 1000 cc.

Острая гипоксия плода

A 22-year-old G3P2 woman at 40 weeks' gestation complains of strong uterine contractions. She denies leakage of fluid per vagina. She denies medical illnesses. Her antenatal history is unremarkable. On examination, the blood pressure (BP) is 120/80 mm Hg, heart rate (HR) is 85 beats per minute (bpm), and temperature is 98°F (36.6°C). The fetal heart rate is in the 140 to 150 bpm range. The cervix is dilated at 5 cm and the vertex is at –3 station. Upon artificial rupture of membranes, fetal bradycardia to the 70 to 80 bpm range is noted for 3 minutes without recovery.

Преждевременная отслойка плаценты

A 30-year-old G5-P4 woman at 32 weeks' gestation complains of significant bright red vaginal bleeding. She denies uterine contractions, leakage of fluid, or trauma. The patient states that 4 weeks previously, after she had engaged in sexual intercourse, she experienced some vaginal spotting. On examination, her blood pressure is 110/60 mm Hg, heart rate (HR) is 80 beats per minute (bpm), and temperature is 37.2°C. The heart and lung examinations are normal. The abdomen is soft and uterus nontender. Fetal heart tones are in the range of 140 to 150 bpm.

Преждевременная отслойка плаценты

A woman presents at 20 weeks' gestation reporting vaginal bleeding. The bleeding occurred2 h ago and was bright red. She reported no abdominal pain with the bleeding and she had not had any previous episodes. She had had intercourse the previous evening. Her last cervical smear was normal 2 years ago. This is her first pregnancy and her current obstetric history is unremarkable with normal first-trimester scan and Down's syndrome screening. She reports that her booking blood tests had been normal. She is extremely anxious when seen, concerned that she is going to have a miscarriage. Examination: The blood pressure is 105/65 mmHg and pulse 86/min. Abdominal examination confirms that the uterus reaches to 1 cm below the umbilicus. The uterus is soft and non-tender. The fetal heart is heard with the hand-held fetal Doppler ultrasound probe. Speculum examin ation reveals a reddened area around the external cervical os, with an inflammatory appearance and a small amount of contact bleeding. The os itself is closed.

Преждевременная отслойка плаценты Гипертензия

A 22-year-old G2-P1 woman at 35 weeks' gestation complains of abdominal pain. She states that she has been experiencing moderate vaginal bleeding, no leakage of fluid per vagina, and has no history of trauma. On examination, her blood pressure is 150/90 mm Hg, and heart rate (HR) is 110 beats per minute (bpm). The fundus reveals tenderness, and a moderate amount of dark vaginal blood is noted in the vaginal vault. The ultrasound examination shows no placental abnormalities. The cervix is 1 cm dilated. The fetal heart tones are in the range of 160 to 170 bpm. The urine protein to creatinine ratio is 0.1 (normal < 0.3).

Гипертензия

A woman was admitted from the antenatal clinic two days ago at 38 weeks' gestation. She is 42 years old and this is her second pregnancy. Her first child was born by spontaneous vaginal delivery 13 years ago. She has subsequently remarried. Her booking blood pressure was 138/70 mmHg at 13 weeks. Her booking blood tests were unremarkable. At her 36 week midwife appointment 2 weeks ago, her blood pressure was 140/85 mmHg and the urinalysis was normal. The blood pressure was repeated 2 days later and was 140/82mmHg. Two days ago she saw her midwife for a further appointment and her blood pressure was 148/101 mmHg. Urinalysis showed protein. She feels well in herself except for swollen legs. She denies any headache or blurring of vision.
Examination: She has oedema to the mid calves and her fingers are swollen such that she cannot remove her rings. Abdominal palpation is non-tender and the symphysiofundal height is 39 cm. Reflexes are normal.

Гипертензия

A 19-year-old G1P0 woman at 29 weeks' gestation arrives to the hospital because of severe dyspnea of 6 hours' duration. Her prenatal course has been unremarkable, and she denies any medical problems. Her blood pressure (BP) is 160/114 mm Hg, heart rate (HR) is 105 beats per minute (bpm), respiratory rate (RR) is 40 breaths per minute and labored, and oxygen saturation is 90%. The fetal heart tones are in the range of 140 bpm. A urine protein to creatinine ratio is 0.6. The serum alanine transaminase (ALT) is 84 IU/L (normal < 35) and aspartate transaminase (AST) is 90 IU/L (normal < 35). The prenatal records show the following:
Gestational Age - BP (mm Hg) - Urine Protein - FHT (bpm) - Fundal Height (cm)
8 weeks - 100/60 - 0 – 140 -*;
12 weeks - 110/70 – 0 – 148 -*;
16 weeks - 100/76 – 0 – 150 -*;
20 weeks - 105/58 – 0 – 138 - 20;
26 weeks - 130/89 - 1+ - 142 – 25.

Гипертнезия (Преэклампсия)

A 17-year-old girl is admitted to the labour ward by ambulance because of a severe headache and reduced fetal movements. This is her first pregnancy. She did not discover she was pregnant until very late and was uncertain of her last menstrual period date so was dated by ultrasound scan at 23 weeks. According to that scan she is now 37 weeks. When she was first booked in the antenatal clinic her blood pressure was 120/68mmHg and urinalysis negative. The blood pressure was last checked 1 week ago and was 132/74 mmHg and urine was negative again. Booking blood tests were all normal. This morning she woke with a frontal headache which has persisted despite paracetamol. She says that her vision is a bit blurred but she cannot be more specific about this. She also reports nausea and epigastric discomfort, but has not vomited. She denies leg or finger swelling.
Examination: The blood pressure is 164/106 mmHg. This is repeated twice at 15 min intervals and is found to be 160/110 mmHg and 164/112 mmHg. She is apyrexial and her heart rate is 83/min. Her face is minimally swollen and fundoscopy is normal. Cardiac and respiratory examinations are normal. Abdominally she is tender in the epigastrium and beneath the right costal margin, but the uterus is soft and non-tender. The fetus is cephalic and 3/5 palpable.
The legs and fingers are mildly oedematous and lower limb reflexes are very brisk, with clonus.
Investigations: Haemoglobin 116 g/L, White cell count 5 x 10^{9}/L, Platelets 126 x 10^{9}/L ; Sodium - 141 mmol/L, Potassium - 4.0 mmol/L, Alanine transaminase - 189 IU/L, Alkaline

phosphatase - 74 IU/L, Gamma glutamyl transaminase - 34 IU/L, Bilirubin - 12 .mol/L, Albumin - 24 g/L, Urea – 3.8 mmol/L, Creatinine - 92 μmol/L, Urinalysis: ++++ protein. Cardiotocograph (CTG): baseline 140/min, reduced variability (5–10/min). Variable decelerations, occasional accelerations.

Гипертензия (преэклампсия)

A woman was admitted from the antenatal clinic two days ago at 38 weeks' gestation. She is 42 years old and this is her second pregnancy. Her first child was born by spontaneous vaginal delivery 13 years ago. She has subsequently remarried. Her booking blood pressure was 138/70 mmHg at 13 weeks. Her booking blood tests were unremarkable. At her 36 week midwife appointment 2 weeks ago, her blood pressure was 140/85 mmHg and the urinalysis was normal. The blood pressure was repeated 2 days later and was 140/82mmHg. Two days ago she saw her midwife for a further appointment and her blood pressure was 148/101 mmHg. Urinalysis showed protein. She feels well in herself except for swollen legs. She denies any headache or blurring of vision.
Examination:She has oedema to the mid calves and her fingers are swollen such that she cannot remove her rings. Abdominal palpation is non-tender and the symphysiofundal height is 39 cm. Reflexes are normal.
Investigations: Haemoglobin 124 g/L, White cell count 8 x 10^{9}/L, Platelets 210 x 10^{9}/L ; Sodium - 137 mmol/L, Potassium – 3,9 mmol/L, Alanine transaminase - 37 IU/L, Alkaline phosphatase - 98 IU/L, Gamma glutamyl transaminase - 32 IU/L, Bilirubin – 10 μmol/L, Urea – 2.5 mmol/L, Creatinine – 80 μmol/L, Gamma glutamyl transaminase - 32 IU/L, Urate - 43 mmol/L. Urinalysis: ++++ protein. 24-h urinary protein collection: volume 1.8 L; total protein 2.16 g; protein per litre 1.2 g.

Приступ эклампсии

An obviously pregnant woman is brought to the emergency department having suffered a seizure in the park 20 min ago. She had been alone at the time but the seizure was witnessed by another woman who said that she had stood up from a bench and then suddenly dropped to the ground. She thought she may have hit her head on the side of the bench with the fall. Her arms and legs had been shaking and then were 'stiff and trembling' for about 40 s. The woman's face had gone dusky and there was some frothing at the mouth. She noticed that the woman's trousers were wet afterwards. When the fit stopped the woman had appeared unconscious for a few minutes and then showed some response to being talked to but seemed confused and drowsy.
Examination: She appears to be about 30 years old and in the third trimester of pregnancy. She is now conscious but still drowsy and her Glasgow Coma Scale is 9/15. Her blood pressure is 140/98 mmHg and heart rate 104/min. Examination shows no obvious cardiac or chest abnormality, and on abdominal palpation there is no apparent ten derness. The uterus feels approximately 30-week size (midway between umbilicus and xiphisternum), and a fetus can be palpated, cephalic with 4/5 palpable. Reflexes are brisk and plantar reflexes are upgoing.

Преждевременные роды

A healthy 19-year-old G1-P0 woman at 29 weeks' gestation presents to the labor and delivery area complaining of intermittent abdominal pain. She denies leakage of fluid or bleeding per vagina. Her antenatal history has been unremarkable. She has been eating and drinking normally. On examination, her blood pressure (BP) is 110/70 mm Hg, heart rate (HR) is 90 beats per

minute (bpm), and temperature is 37.2°C. The fetal heart rate tracing reveals a baseline heart rate of 120 bpm and a reactive pattern. Uterine contractions are occurring every 3 to 5 minutes. On pelvic examination, her cervix is 3 cm dilated, 90% effaced, and the fetal vertex is presenting at (–1) station.

Преждевременные роды

A 28-year-old woman nulliparous woman is admitted to the labour ward at 31 weeks and 6 days' gestation, with abdominal pain. In this pregnancy she has had chronic low back pain for which she has been under the physiotherapist. She has also been treated for confirmed urinary tract infections on two occasions. She underwent two large-loop excisions of the transformation zone (LLETZ) procedures some years ago. Since then her smears have been normal, the most recent being 10 months ago. Yesterday she noticed an increase in her discharge with some dark vaginal bleeding and abdominal discomfort. She thought the symptoms may have related to something she had eaten but she now feels intermittent abdominal pain every few minutes, with no pain in between episodes. Fetal movements are normal. There is no history of leaking of liquor. She has urinary frequency, though this has not worsened recently. She is always constipated.
Examination: The woman is apyrexial with blood pressure 109/60 mmHg and heart rate 96/min. Symphysiofundal height is 30 cm and moderate contractions are palpated lasting approximately 35 s. The fetus is breech on palpation and the presenting part feels engaged. No liquor is visible on speculum examination. On vaginal examination the cervix is effaced and 3 cm dilated, with the breech felt –2 cm above the ischial spines and membranes intact.

Пиелонефрит

A 40-year-old woman presents with a fever and abdominal pain. She is 18 weeks pregnant in her third pregnancy. The pregnancy has been unremarkable so far and she has no significant gynaecological or medical history. She has felt unwell for 10 days but has become worse in the last 48 h. She is nauseated and has vomited several times. She is intermittently hot and cold. Her abdominal pain is generalized and constant with some right-sided loin pain. She denies any dysuria and says that she has frequency which has been present through Out the pregnancy. She has had no recent change in bowel habit. There has been no vaginal bleeding and she has a mild thin vaginal discharge.
Examination: She appears flushed and unwell. Her temperature is 38.2°C, blood pressure 115/68mmHg and pulse 112/min. Cardiac and chest examination is normal. The fundal height is approximately 2 cm below the umbilicus, and the uterus is soft and non-tender. The rest of the abdomen is tender on deep palpation, maximally in the right lower quadrant. There is right renal angle tenderness. The fetal heart is heard at 160/min with hand-held Doppler.
Haemoglobin 111 g/L, White cell count 18.9 x 10^9/L, Neutrophils 16.2 x 10^9/L, Platelets 346 x 10^9/L ; Sodium - 139 mmol/L, Potassium - 4.2 mmol/L, Urea - 8.1 mmol/L, Creatinine - 68 μmol/L, C-reactive protein - 127 mg/L ; Urinalysis: + protein; + blood; ++ leucocytes; + nitrites.

Пиелонефрит

A 20-year-old G1P0 woman at 29 weeks' gestation is hospitalized with back pain and high temperature. She has been receiving intravenous (IV) ampicillin and gentamicin for 48 hours.

She complains of acute shortness of breath. On examination, her temperature is 99°F, heart rate is 100 beats per minute (bpm), respiratory rate (RR) is 24 bpm and labored, and blood pressure (BP) is 120/70 mmHg. Right costovertebral angle tenderness is elicited. The fetal heart tones are in the range of 140 to 150 bpm. The urine culture reveals Escherichia coli sensitive to ampicillin.

Анемия у беременной

A 29-year-old G2P1 woman at 20 weeks' gestation is seen for her second prenatal visit. Her antenatal history is unremarkable except for a urinary tract infection treated with an antibiotic 2 weeks ago. The patient was noted to be anemic on her prenatal screen with a hemoglobin level of 95 g/L and a mean corpuscular volume (MCV) of 70 fL. On examination, her blood pressure (BP) is 100/60 mm Hg, heart rate (HR) 80 beats per minute (bpm), and she is afebrile. The thyroid gland appears normal on palpation. The heart and lung examinations are unremarkable. The fundus is at the umbilicus. The fetal heart tones are in the 140- to 150-bpm range. The evaluation of the anemia includes: ferritin level: 90 mcg/L (normal 30-100); serum iron: 140 mcg/dL (normal 50-150); hemoglobin electrophoresis: Hb A1 of 95% and Hb A2 of 5.5% (normal 2.2%-3.5%).

Предлежание плаценты

A 30-year-old G5P4 woman at 32 weeks' gestation complains of significant bright red vaginal bleeding. She denies uterine contractions, leakage of fluid, or trauma. The patient states that 4 weeks previously, after she had engaged in sexual intercourse, she experienced some vaginal spotting. On examination, her blood pressure is 110/60 mm Hg, heart rate (HR) is 80 beats per minute (bpm), and temperature is 99°F (37.2°C). The heart and lung examinations are normal. The abdomen is soft and uterus nontender. Fetal heart tones are in the range of 140 to 150 bpm.

Несостоявшийся выкидыш

A 30-year-old woman is referred from her general practitioner. She is 11 weeks and 2 days gestation and has noticed dark spotting and mild period-like pains for the last 4 days. Her last period was 4 months ago but she has a history of polycystic ovarian syndrome and has an irregular cycle bleeding for 4–7 days every 5–6 weeks. She had a positive home pregnancy test because she noticed breast tenderness, and came for a dating ultrasound scan 4 weeks ago that confirmed a viable single intrauterine pregnancy. Since then she has had a booking visit with the midwife and all routine blood tests are normal. She is gravida 2 para 0. Her last pregnancy 9 months ago ended in a complete miscarriage at 7 weeks. There is no other medical or gynaecological history of significance.
Examination: She is apyrexial with normal heart rate and blood pressure. The abdomen is soft and non tender. Speculum examination shows a small cervical ectropion but this is not bleeding. The cervix is closed and no blood or abnormal discharge is seen. Bimanual examination reveals an 8–10-week-sized anteverted mobile uterus with no cervical excitation, adnexal masses or tenderness.

Transvaginal ultrasound scan report: the uterus contains a gestational sac measuring 36 mm. A single fetus of crown–rump length 47 mm is visible. Fetal heart beat is absent. The uterus is anteverted. Both ovaries appear normal with no adnexal masses visible.

Полный выкидыш

A 41-year-old woman is seen in the early pregnancy unit because of vaginal bleeding. She is gravida 4 para 2 having had two previous normal vaginal deliveries followed by a miscarriage. She has a regular 28-day menstrual cycle and her last period started 9 weeks ago. She had slight vaginal bleeding two weeks ago and on ultrasound scan an early intrauterine pregnancy had been visualized with gestational sac of 22mm diameter and a yolk sac visualized of 5 mm. No fetus was visualized. She was given an appointment for a repeat ultrasound. Four days ago her bleeding became very heavy and she passed large clots which she described as 'like liver'. She developed severe abdominal pain which lasted for about 4 h, and since then the bleeding has become very light and she is now pain free. She has normal appetite and no nausea or vomiting. She has no urinary or bowel symptoms.
Examination: She appears well and is apyrexial. There are no signs of anaemia. The heart rate is 82/min and blood pressure is 132/78 mmHg. The abdomen is soft and mildly tender suprapubically. Speculum shows the cervix is closed with a small amount of old blood in the vagina. There is slight uterine tenderness on bimanual palpation and the uterus feels normal size, anteverted and mobile, with no adnexal tenderness or cervical excitation.
A transvaginal ultrasound scan is shown longitudinal view of the uterus with a thin homogenous endometrium and no evidence of a gestation sac or retained products of conception.

Начавшийся выкидыш

A 23-year-old woman is referred by her general practitioner with vaginal bleeding. She noticed that there was blood on the toilet paper 2 days ago, and following this she has had bright red spotting intermittently. She has no pain and there are no urinary or bowel symptoms. Her last menstrual period started 9 weeks and 6 days ago and she has a regular 31-day cycle. She had a positive home urine pregnancy test 3 weeks ago after she realized she had missed a period and was feeling very tired. This is her first pregnancy. She had been using condoms but with poor compliance, so the pregnancy was unplanned but she is now happy about it. She is generally well, only having been admitted to hospital once in the past for an appendectomy at the age of 17 years. She takes no medication, does not smoke and drinks minimal alcohol. She denies any use of recreational drugs.
Examination: The woman is apyrexial. The blood pressure is 120/65 mmHg and heart rate 78/min. The abdomen is soft and non-tender with no palpable uterus or other masses. Transvaginal ultrasound is shown: The crown–rump length is 25mm (equivalent to around 9 weeks' gestation) and the fetal heart beat is seen.

Тестовые задания по гинекологии для студентов, обучающихся на английском языке

MCQ Gynecology

1.
Which one of the following are external genital organ:
5
major labia;
minior labia;
bartholin glands;
clitoris;
all answers are correct.
#
2. Bartholin gland of vagina are located:
4
in the basis of minor labia;
in thickness of mid- layers of major labia;
in a groove between the bottom thirds of minor and major labia;
in thick back parts of major labia.
#
3. The upper border of the frontal vaginal wall contacts with:
2
urethra;
urenary bladder;
ureter;
all are wrong.
#
4. The lower border of the frontal vaginal wall contacts with:
3
urethra;
urenary bladder;
ureter;
all are wrong.
#
5. The upper border of back wall of vagina consists of:
2
rectum;
douglus pouch;
cervix of the urinary bladder;
urethra;
all are wrong.
#
6.
The normal border of the outer and inner sex organs (genitals) usually is:
3
outer uterine os;
inner uterine os;

hymen;
minor labia;
no answer is correct.
#
7.
Length of fallopian tube during reproductive age of woman is:
3
7-8 cm;
9-10 cm;
10-12 cm;
15-18 cm;
19-20 cm.
#
8.
Length of non fertile uterus is:
2
4-6 cm;
6-7 cm;
8-9 cm;
9-10 cm;
11-12 cm.
#
9.
The internal genital organs are represented by the following organs except for:
4
uterus;
fallopian tube;
ovary;
bartholin gland;
vagina.
#
10.
Which are the ligaments of paramount no importance to support the uterus in normal position:
1
ovarian ligament;
wide ligament;
round ligament;
creasta-uterine ligament;
#
11.
What is the position of the uterus in small pelvis:
1
body and cervix of the uterus making angle with each other;
body of the uterus is situated in the narrow part of the small pelvis;
vaginal part of the cervic uteri and external uterine os are located below ischial spines;
all answers are correct.

#
12.
Ovary is supported in the abdominal cavity by the help of:
3
round ligament;
cardinal ligament;
pelvico-infundibulum ligament;
cresto-uterine ligament.
#
13.
Which are the actual position of the ovary:
4
size of the ovary is 4.5 cm-4cm-3cm;
ovaries are covered with perithoneum;
ovaries are located on a forward leaf of wide ligament;
ovaries are located on backward leaf of wide ligament;
#
14.
Parametrium:
5
situated between the leaves of wide uterine ligament;
situated at the uterine cervix;
situated generally in the ground of wide uterine ligament;
provides mild connection between perithoneum and uterus;
all answers are correct.
#
15.
Ovaries are vasculated by:
4
uterine artery;
ovarian artery;
illolumbar artery;
both uterine and ovarian artery;
both internal genital and ovarian artery.
#
16.
Oligomenorrhoea is:
3
rare and poor menstruation;
rare and painfull menstruation;
decreased amount of the blood loss during menstruation;
intermenstrual bloody allocation;
short menstruation cycle.
#
17.
Menorrhagia is:

2
acyclic uterine bleeding;
cyclic uterine bleeding in connection with menstruation cycle;
painfull and abundant menstruation;
pre- & post menstruation bloody allocation;
short period of menstruation cycle.
#
18.
Metrorrhagia:
4
changes in menstruation rhythm;
increased amount of the blood loss during menstruation cycle;
increased duration of menstruation cycle;
acyclic uterine bleeding.
#
19.
Follicular phase of menstruation cycle is characterised by:
3
desquamation of functional layer of endometrium;
proliferation of endometrial functional layer;
the increase of endrogen in blood circulation;
atrophy of ovarian follicle;
development of yellow body in ovary.
#
20.
For the luteinising phase of the menstruation cycle is not characteristic:
3
secretory transformation of the endometrium;
continues about 13 days;
the level of estrogen in blood is increasing;
corpus leuteum is present in ovarium.
#
21.
Desquamation of functional layer of endometrium occurs owing to:
2
peak output of luteotropine;
decreased amount of estrogen and progesterone in the blood;
decreased amount of prolactin in the blood;
increased amount of estradiol in the blood;
peak output of follitropine.
#
22.
Hypothalamus secretes the following hormones:
4
gonadotropine;
estrogen;

gestagen;
releasing-hormone.
#
23.
Hypothalamus secretes the following hormones excluding:
1
gonadotropine;
releasing factor FSH;
releasing factor LH;
no one is correct;
all are correct.
#
24.
Action of estrogen on the organism:
5
blocks receptor of uterus;
weaken proliferative process of endrometrium;
causes secretory transformation of endometrium;
all answers are correct;
all are wrong.
#
25.
Which hormone provides lactation process:
4
estrogen;
cortizol;
insulin;
prolactin;
all are correct.
#
26.
Estrogen possess the following action:
4
promotes peristalsis in uterus and tube;
promotes processes of ossification;
stimulates activity of cellular immunity;
all answers are correct;
all are wrong.
#
27.
Gestagens possess the following action:
5
decrease amount of cholesterole in the blood;
determine development of primary and secondary sex characters;
increase uterine contractility;
all answers are correct;

all are wrong.
#
28.
Androgen is secreted:
3
in ovary (intersticial cell, stroma, internal theca);
reticular zone of adrenal cortex;
both are true;
both are incorrect.
#
29.
Tests of functional diagnostics allow to detect:
5
two-phase nature of menstrual cycle;
level of estrogen saturation of an organism;
presence of ovulation;
full value of luteinising cycle;
all are correct.
#
30.
Tests of functional diagnostics include:
4
investigation of cervical mucous layer;
changes of basal temperature;
colpocytology;
all answers are correct;
all are incorrect.
#
31.
Tests of functional diagnostics allow to detect the following except:
4
cario-picnotic index;
symtom “pupillus”;
measurement of basal temperature;
gestagen testing;
fern symptom.
#
32.
The test for measurement of basal temperature is based on hyperthermal effect of:
3
estradiol;
prostaglandin;
progesterone;
LTH;
FH.
#

33.
The most exact method for the diagnosis of the reason of the uterine bleeding:
4
colposcopy
laparoscopy
USG
hysteroscopy
cystoscopy
#
34.
The indication for hysterosalpingography is:
5
suspicion on fallopian tube sterility;
suspicion on internal endometriosis;
presence of intrauterine pathology;
suspicion on fallopian tube pregnancy;
all answers are correct.
#
35.
Which method of diagnosis is not obligatory for confirmation myoma of the uterus:
2
USG of the organs of lower pelvis;
pelviography;
separate diagnostic currettage of the mucous membrane from the uterus & its cervix;
hysteroscopy;
laparoscopy.
#
36.
At appearance of acyclic hemorrhagic discharges, the following is conducted:
4
hysterosalphyngography;
determination of LH;
USG;
diagnostic currettage;
all of the above.
#
37.
Choose the most exact method for determination of pathological reason for uterine bleeding in women
2
from 30-40 years:
measurement of the basal temperature of the body;
diagnostic currettage of the mucous membrane of the uterus;
hysteroscopy;
measurement of the concentration of estrogens and progesterone in the blood serum.
#

38.
The most exact method for the diagnosis of pathology in uterine bleeding:
4
colposcopy;
laparoscopy;
USG;
hysteroscopy.
#
39.
The women with dysfunctional uterine bleeding form the risk group:
5
on spontaneous abortion or preterm delivery;
on development of birth abnormalities;
on development of the genital tumors;
on development of the tumors of the mammary glands;
all answers are correct.
#
40.
Diagnostic value of laparoscopy in gynecology is particularly high under all enumerated conditions, except:
2
ectopic pregnancy;
uterine pregnancy;
tumors of the ovaries;
myoma of the uterus;
all of the above.
#
41.
Which of the following is not used for the diagnosis of reasons of uterine bleeding:
2
colposcopy;
laparoscopy;
USG;
separate currettage of the mucous membrane of the uterus & its cervix;
hysteroscopy.
#
42.
Methods of the diagnostics of the endometrial cancer are the following, except:
1
laparoscopy;
separate diagnostic currettage of the mucous membrane from the uterine cervix & its body;
USG;
Hysteroscopy.
#
43.
The main method for the diagnosis of the cancer of the uterine body:

1
 hystologic study of the endometrium;
 cytological study of the aspirate from the uterine cavity;
 transvaginal echography;
 hysteroscopy;
 radiologically monitored hysterosalphingography.
#
44.
At suspicion on endometrial cancer, hysteroscopy allows to diagnose (define) all enumerated, except:
3
 presence of any pathological process;
 superficial spreading of process;
 the depth of invasion;
 result of biopsy.
#
45.
For anovulatory menstrual cycle are characteristic the following features:
2
 cyclic changes in organism;
 elongated follicular persistancy;
 prevalence of gestogens in the second phase of the cycle;
 prevalence of gestogens in the first phase of the cycle.
#
46.
Which of the following enumerated reasons are the most probable for dysfunctional uterine bleeding?
1
 anovulation;
 organic diseases;
 chronic endometritis;
 malignant diseases of the uterine cervix.
#
47.
Amenorrhoea is the absence of menstruations during:
3
 4 months;
 5 months;
 6 months;
 1 year;
 none of the above.
#
48.
Physiological amenorrhoea is the absence of menstruations:
5
 in girls of 10-12 years;

during pregnancy;
during period of lactation;
at senile age;
all of the above.
#
49.
Which amenorrhoea is regarded to be not physiological?
4
before menarchy;
after menopause;
during pregnancy;
at reproductive age;
during lactation.
#
50.
Amenorrhoea in girls of 16 years can be result of all enumerated conditions, except:
4
closure (atresia) of hymen;
syndrome of insensitivity to androgens;
polycystosis of ovaries;
granulosocellular tumor.
#
51.
False amenorrhoea can be caused by:
3
atresia of the uterine tubes;
atresia of the body of the uterus;
atresia of the vagina;
dysgenesis of gonads;
all of the above.
#
52.
True (pathological) amenorrhoea can result from all specified below diseases, except:
4
hypothyroidism;
neurogenic anorexia;
syndrome of testicular feminisation;
atresia of hymen;
micro- and makroadenoma of the hypophysis.
#
53.
Physiological amenorrhoea is typical for:
5
childhood period;
postmenopause;
period of lactation;

to pregnancy;
all answers are correct.
#
54.
Secondary amenorrhoea can result from:
5
psychic stress;
massive blood loss during labour;
expressed deficiency of the body mass;
genital tuberculosis;
all of the above.
#
55.
During treatment of the patient with any form of dysgenesis of gonads, as a rule, what is not recovered:
3
menstrual function;
sexual functions;
reproductive function;
all of the above;
none of the above.
#
56.
Associated syndromes with hypergonadotropic amenoroea are:
4
ovary depletion syndrome;
resistant ovary syndrome;
Shereshevski-Turner syndrome;
all of the above.
#
57.
Long and severe uterine bleeding in assosiation with regular cycle is named:
4
metrorrhagia;
oligomenorrhoea;
polymenorrhoea;
hyperpolymenorrhoea;
menorrhagia.
#
58.
Causes of primary algomenorrhoea:
4
infantilism;
retrodeviation of uterus;
high production of prostaglandins;
all the above factors.

#
59.
Which of the following does not belong to clinics of premenstrual syndrome:
4
heaviness of lactate glands;
increase in body weight;
migraine;
amenorrhoea;
depression.
#
60.
Which of these is not common for ovarian polycystic syndrome:
3
amenorrhoea;
hirsutism;
ovulatory menstrual cycles;
obesity;
infertility.
#
61.
Characteristic changes in menstrual cycle during lactation after labour:
2
hyperpolymenorrhoea;
amenorrhoea due to high prolactin levels;
amenorrhoea due to decreased estrogens;
metrorrhagia;
none of the above.
#
62.
Which is not characteristic for climacteric syndrome:
3
neurovegetative disturbances;
metabolic-endocrinic disturbances;
ovarian hyperstimulation syndrome;
psycho-emotional disturbances;
extragenital diseases.
#
63.
In climacteric syndrome in women during premenopause the symptoms noticed are:
4
vegetative-vascular;
metabolic-endocrinic;
neuro-psychological;
all the above.
none of the above.
#

64.
Physiological course of climacteric period is usually characterized by:
2
absence of involution of genitals;
stopping of mentrual function;
presence of reproductive function;
peservation of menstrual function.
#
65.
Which pathological changes of the endometrium can occur in patients with recurrent anovulatory ovarian bleeding:
5
glandular-cystic hyperplasy;
atypical hyperplasy;
endometrial polyps;
adenocarcinoma;
all are correct.
#
66.
Causative agents of nonspecific inflammatory diseases of the female genital organs are:
1
staphylococcus;
chlamydiae;
gonococcus;
gardenella;
all the above.
#
67.
All the below factors increase risk of inflammatory diseases of genitals except:
3
beginning of sexual activities at the age of 15;
medical abortion;
taking oral contraceptives;
hysterosalpingography;
use of IUD.
#
68.
Which of the following factors does not increase risk of inflammatory diseases of genitals:
3
beginning of sexual activities at the age of 15;
medical abortion;
taking oral contraceptives;
hysterosalpingography;
use of IUD.
#
69.

What among the following may be the reason of inflammatory process of the internal genitals:
5
medical abortion;
dilation of the cervical canal and currettage;
implantation of IUD;
hysterosalpingography;
all the above;
none of the above.
#
70.
Complaints characteristic for inflammatory diseases of genitals are the following except:
4
pain in the lower part of the abdomen;
fever;
stinking-odour secretions from the vagina;
increased concentration of bilirubin in the blood;
increased erythrocyte sedimentation rate and increased leucocytosis.
#
71.
Infection with which microorganisms causing colpitis demands the treatment of both partners:
1
trichomonads;
candidas;
streptococci;
staphylococci;
enterococci;
#
72.
Which of the following methods is better for diagnosis of inflammatory fallopian tubes:
4
increased count of leucocytes;
gram stain smear of mucous from the cervix;
colpocentesis;
laparoscopy;
USG of small pelvis.
#
73.
All the below methods may help in diagnosis inflammatory diseases of lower pelvis except:
4
laproscopy;
USG;
colpocentesis;
urine analysis by Zimnitski;
rectal examination.
#
74.

Main complications of inflammatory diseases in the organs of the lower pelvis are all expect:
1
endometriosis;
ectopic pregnancy;
scars in the region of the lower pelvis;
disparaeunia;
hydrosalphinx.
#
75.
Which factors further candidosis vulvovaginitis:
1
obesity;
syringing with soda solution;
diabetes mellitus;
rare sexual intercourse;
frequent use of antibacterial drugs;
all the above are false.
#
76.
The factors which do not predispose to candida vaginosis are:
4
oral contraceptives;
pregnancy and diabetes mellitus;
antidepressants;
hypotensive drugs.
#
77.
Which disease should be kept in mind if vaginal candida infection frequently arises:
2
anemia;
diabetes mellitus;
systemic lupus;
endometriosis of the genitals;
congenital hyperplasy of adrenal glands.
#
78.
Factors for the resistance of mucous membrane of vagina to infections:
3
high levels of progesterone;
low levels of estrogens;
acidic medium;
absence of “Doderlein’s” bacilli;
high levels of progesterone.
#
79.
For bacterial vaginosis are characteristic all except:

2
 increase in pH of vaginal secretion;
 low pH of vaginal secretion;
 presence of leucorrhea in pungent smell;
 presence of “key” cells in smears;
 finding vaginal cocci.
#
80.
Bacterial vaginosis is characterized by all the following except:
3
 pH 5.0;
 “key” cells;
 increased inflammatory process;
 positive test with caustic potassium (KOH);
 good effect with metronidazole treatment.
#
81.
Name the main clinical symptom of bacterial vaginosis:
3
 itching of external genital;
 dyspareunia;
 great amount of white secretion with unpleasant smell;
 dysuria;
 pelvic pain.
#
82.
In patients with Chlamydia infection (not in pregnancy) better to use the following except:
4
 doxycycline;
 erythromycin;
 “Sumamed”
 ampicilline;
 tetracycline;
#
83.
In the development of gardnerellosis the most important is:
5
 hypoestrogenia;
 pH of vaginal secretion shifts to basic;
 death of lactobacilli;
 growth of anaerobs;
 all of the above.
#
84.
Etiology of gonorrhea in the inflammatory process at the region of fallopian tubes may be suggested:

4
 in the presence of bilateral salpingoophoritis at a primarily infertile woman;
 in combination of bilateral salpingoophoritis with endocervititis (at a woman who did not have partus or abortions);
 in combination bilateral salpingoophoritis with urethritis, bartolinitis;
 all the above.
#
85.
What is involved into the process in the ascending gonorrhea:
2
 canal of the cervix of uterus;
 fallopian tubes;
 paraurethral glands;
 urethra.
#
86.
Main way of dissemination (generalization) of gonorrhea infection is:
5
 lymphogenic;
 hematogenic;
 perineural;
 contact;
 intracanalicular.
#
87.
Endometritis is:
5
 inflammation of fallopian tube;
 inflammation of muscles of uterus;
 inflammation of peritoneum;
 inflammation of parametrium;
 inflammation of mucous layer of uterus.
#
88.
Parametritis is :
4
 inflammation of ovaries;
 inflammation of caecum;
 inflammation of fallopian tube;
 inflammation of surrounding structure of uterus;
 inflammation of omentum.
#
89.
The composition of the solution for hydrotubation usually no includes:
4
 antibiotic;

lidase;
hydrocortisone;
vitamins of group B;
#
90.
In tuberculosis of genital tract, which of the following organ is affected in 90-100 %?
1
ovaries;
uterus;
fallopian tube;
cervix uteri;
vagina.
#
91.
In tuberculosis of genital tract, primary lesion is generally localized in:
1
lungs;
bones;
urinary system;
lymphatic nodes;
on peritoneum.
#
92.
Which parts of genital system in a women are generally affected in tuberculosis?
1
fallopian tube;
ovaries;
uterus;
external genital organs;
vagina.
#
93.
Which of the following are not the causes of tuboovarian abscess:
1
hepatitis;
endometritis;
salpingitis;
cervicitis;
#
94.
Step of pathogenesis of tuboovarian abscess may be:
3
perihepatitis;
endometritis;
endosalpingitis;
cervicitis;

myometritis.
#
95.
Pleuroperitonitis is:
1
inflammation of peritoneum of small pelvis;
inflammation of adipose tissue of small pelvis;
inflammation of serous membrane of uterus;
all of the above;
none of the above.
#
96.
The most typical clinical symptoms of peritonitis:
5
vomiting, dry tongue;
constipation & meteorism;
abdominal distension & bloating;
symptom of irritation of peritoneum;
all of the above;
none of the above.
#
97.
To a group at high risk to get AIDS pertain:
5
homosexual individuals;
narcomaniac;
hemophiliacs;
people having haotic sexual life;
all the above;
none of the above.
#
98.
Which of the following is not related to HIV-infection?
2
HIV-infection increases risk of developing cancer of uterine cervix;
sexual intercourse is the only way of infection;
this virus causes condyloma;
often combines with hepatitis B.
#
99.
The complex preoperative preparation to cavitary gynaecological operation as a rule includes:
3
siphon enema for 3-4 day every night till operation;
vegetable oil 1 tablespoon 3 times a day before food for 10 days till operation;
cleansing [purgetive] enema the night before operation ;

all the above.
#
100.
Radical operative intervention of hysteromyoma is:
2
Supravaginal amputation of tumor;
hysterectomy (complete hysterectomy);
myomectomy;
all the above.
#
101.
Composition of surgical pedicle of ovary is:
5
ligamentum ovarii proprium;
ligamentm infundibulopelvic;
mesosalpinx;
fallopian tube;
all the above;
all are incorrect.
#
102.
In composition of surgical pedicle of ovary is not included:
5
ligamentm infundibulopelvic;
ligamentum ovarii proprium;
mesovarium;
tube;
round ligament.
#
103.
For torsion of pedicle of ovarian tumor is characteristic:
4
severe pain underneath the stomach, arising after physical exertion;
determination of immovable, severely painful tumors on bimanual investigation of small pelvis;
positive symptom of irritative peritoneum on the side of tumor;
all the above.
#
104.
Torsion of pedicle of ovarian tumor may be:
1
complete;
full;
repeated;
all the above;
none of the above.
#

105.
Anatomical pedicle of ovarian tumor consists of:
3
ligamentum ovarii suspensoria;
loop of intestine and omentum;
ligamentm infundibulopelvic;
fallopian tube;
none of the above.
#
106.
What should be done during the operation on the torsion of pedicle of dermoid ovarian cyst:
4
overwound pedicle of ovarian tumor should be unwound to clear up
the anatomy; make hysterectomy with appendages;
removal of both ovaries;
none of the above.
#
107.
Clinical symptoms of torsion of pedicle of ovarian cystoma:
2
sharp pain in upper region of abdomen;
positive Blumberg's symptom;
anemia;
temperature rise;
enlargement of uterus.
#
108.
Operation of hysterectomy (total hysterectomy) differs from supravaginal amputation of uterus (subtotal hysterectomy) by removing:
2
upper third of vagina;
cervix uteri;
parametral tissues;
iliac lymphatic nodes;
greater omentum.
#
109.
Complications of medical abortion is not:
2
infertility;
disturbance of ovarian function;
endometritis;
uterine perforation;
cystitis.
#
110.

Risk factors for ectopic pregnancy:
3
uterine hypoplasia;
oral contraception
deferred inflammatory diseases of the genitals;
history of Caesarean section;
#
111.
Which method of diagnosing ectopic pregnancy is most accurate?
3
culpocentesis;
endometrial biopsy;
laparoscopy;
serial determination of CHG;
USG of pelvic organs.
#
112.
The main clinical manifestations of progressive ectopic pregnancy:
5
paroxysmal pain at the lower regions of abdomen;
smearing discharges of blood from the vagina;
weakly positive symptoms of irritation of peritoneum;
all of the above;
none of the above symptoms.
#
113.
In progressive tubular pregnancy is indicated to do:
2
currettage of the uterus;
emergency surgery;
conservative treatment;
hysteroscopy;
all listed above.
#
114.
Not informative features for the differentiation of uterine pregnancy and tube pregnancy are:
4
USG of pelvic organs;
the level of chorionic gonadotropin in the blood;
bimanual examination of small pelvis organs;
smears for colpocytology;
uterine currettage.
#
115.
Ectopic pregnancy can be located in all the following organs except:
5

cervix;
rudimentary horn of uterus;
ovary;
abdominal cavity;
vagina.
#
116.
What is the most frequent place of implantation of fetal egg in ectopic pregnancy?
2
on the peritoneum;
in ampullary part of fallopian tube;
the ovary;
in isthmus part of fallopian tube;
in interstitial part of fallopian tube.
#
117.
In damaged ectopic pregnancy with marked anemia the patient is done the section:
3
transverse suprapubic anchor;
according to Pfannenshtil;
vertical incision from loin to navel;
all listed above.
#
118.
These symptoms are associated with disturbance of tubal pregnancy except:
3
unilateral pain in lower abdomen;
vaginal bleeding or smearing discharge;
rectal bleeding;
pain in the subscapular area.
#
119.
With progressive ectopic pregnancy is used:
2
conservative anti-inflammatory treatment;
operation;
hemotransfusion;
all of the above;
none of the above.
#
120.
In the tube abortion it is possible to observe:
5
the formation of retrouterinal hematoma;
the formation of peritubar hematoma;
the formation of hematosalpynx;

massive hemorrhage into the abdominal cavity;
all mentioned above;
none of the above mentioned.
#
121.
The operations predominantly performed in the tube ectopic pregnancy:
1
salpingectomy
salpingoovarioectomy;
longitudinal salpingostomy;
the resection of the segment of fallopian tube which contains fertile egg, plastics.
#
122.
The operation recommended in ectopic pregnancy, besides:
2
salpingoectomy;
salpingoovariectomy;
longitudinal salpingostomy;
the resection of the segment of tube, which contains fertile egg, plastic.
#
123.
Apoplexy of ovary more frequently begins:
1
in the period of ovulation;
in the stage of the vascularization of the corpus luteum;
in the period of maturation of Graafian follicle;
in the period of atresia of follicles.
#
124.
For apoplexy of ovary is characteristic everything, except:
4
pain below abdomen;
internal hemorrhage;
negative biological reactions to the pregnancy;
increased leukocytosis;
the symptoms of the irritation of peritoneum.
#
125.
In case of the significant hemorrhage into the abdominal cavity in patient with apoplexy of ovary, it is indicated;
1
abdominal incision, the resection of ovary;
abdominal incision, the removal of ovary;
the observation of on-duty doctor for the dynamics of symptoms, by indication - blood transfusion;
the conservative therapy: rest, cold to the bottom of abdomen, fortifying therapy.

#
126.
Basic clinical symptoms of the hemorrhagic shock:
5
arterial pressure; (high or low?)
oliguria and anuria;
frequent thready pulse;
acrocyanosis;
all symptoms mentioned above.
#
127.
Predisposing factors for development of endometriosis of genitalia, except:
4
multiply labours and abortions
scar on the uterus after cesarean section or myomectomy;
retrodeviation of uterus
contraception by progestins;
frequent catarrhal diseases.
#
128.
“Infertility marriage” means:
2
absence of capability for bearing in the woman ;
absence of capability for conception during 1 year in the husbands;
the absence of the pregnancy of 0,5 years;
none of the above mentioned.
#
129.
Marriage is infertile if pregnancy does not begin even with the sexual life without the application of contraceptives for:
2
0,5 years;
1 year;
2,5 years;
3 years;
5 years.
#
130.
Marriage is considered to be infertile if pregnancy does not begin even with the presence of regular sexual life without the application of contraceptives during:
2
0,5 years;
1 year;
2,5 years;
5 years.
#

131.
Reasons of the infertility of married women are:
5
the inflammatory diseases of sex organs;
infantilism and the hypoplasia of sex organs;
the general wasting diseases and intoxications;
all reasons are false;
all reasons are true.
#
132.
The most frequent reasons for tubal infertility are:
1
the unspecific recurrent inflammatory diseases of the appendages of womb;
the specific inflammatory diseases of the appendages of womb;
the endometriosis of uterine tubes;
anomalies of the development of uterine tubes;
all mentioned reasons.
#
133.
The most frequent reason of female infertility:
3
ovarian cyst;
uterus myoma;
fallopian tube obstruction;
anovulatory cycles.
#
134.
What is the most authentic for specification of the reason of culpocentesis;
3
colposcopy;
hysterosalpingography;
hysteroscopy;
USG.
#
135.
Oral contraceptives can be applied to the cancer prophylaxis of:
3
vagina;
fallopian tube;
endometrium;
uterine cervix;
colon.
#
136.
Juvinile uteral bleedings are caused more often:
1

impairment of rhythmic production of hormones from the ovaries;
organic diseases of the reproductive system;
disease of various systems of an organism;
all listed;
none of the listed.
#
137.
Treatment of dysfunctional uterine bleedings at youthful age includes:
5
physiotherapeutic treatment;
vitamins;
contractive preparations;
hemostatics;
all listed.
#
138.
Characteristic features of the development of the secondary sex signs at girls in comparison with boys is all listed, except:
2
development of subcutaneous fat;
changes between pelvic and humeral belts towards relative increase in a circle of the last.
#
139.
The sign of Shereshevsky-Terner's syndrome is:
5
female phenotype;
primary amenorrhea;
underdevelopment of uterus;
aplasia or hypoplasia of gonads;
all listed is true.
#
140.
Atresia is:
4
secondarily occurred underdevelopment of organs, caused by prenatal or postnatal inflammatory process;
absence of a part of organ;
absence of organ;
obliteration in places of anatomic narrowing of a sexual tract.
#
141.
Agnesia is:
3
secondarily occurred underdevelopment of organs, caused by prenatal or postnatal inflammatory process;
absence of a part of organ;

absence of organ;
obliteration in places of anatomic narrowing of a sexual tract.
#
142.
Aplasia is:
2
secondarily occurred underdevelopment of organs, caused by prenatal or postnatal inflammatory process;
absence of a part of organ;
absence of organ;
obliteration in places of anatomic narrowing of a sexual tract.
#
143.
Atresia of hymen is:
1
continuous hymen, not having an orifice;
continuous hymen with a small orifice;
entirely absence of hymen.
#
144.
Agnesia of vagina is:
3
primary absence of a part of vagina;
full or partial obliteration of vagina due to inflammatory process at ante- and postnatal period;
primary full absence of vagina;
full septum in vagina.
#
145.
Aplasia of vagina is:
1
primary absence of a part of vagina;
full or partial obliteration of vagina due to inflammatory process at ante- and postnatal period;
primary full absence of vagina;
full septum in vagina.
#
146.
Atresia of vagina is:
2
primary absence of a part of vagina;
full or partial obliteration of vagina due to inflammatory process at ante- and postnatal period;
primary full absence of vagina;
full septum in vagina.
#
147.
Deficiency of body weight is one of the reson for:

4
delay in menarche;
long formation of menstrual functions;
development or aggravation of impairment of menstrual functions;
all listed;
none.
#
148.
Name the most frequent sign characteristic for uterus myoma:
1
hyperpolymenorrhea;
infertility;
impairment of function of a bladder and rectum;
pain in the lower part of the abdomen.
#
149.
Which symptom is typical for myoma of the uterus, corresponding to the size of the uterus at a term of pregnancy 6-7 weeks:
5
acute spastic pain;
frequent micturation;
constipation;
arrest in micturation;
all the above.
#
150.
Submucous myomas can be accompanied by all listed symptoms, except:
4
pathological bleedings;
anemia;
infertility;
impairment in micturation;
spasmatic pains in the bottom of the abdomen.
#
151.
Uterine bleedings caused by myoma, are characterised by:
5
gradual strengthening of bleedings;
considerable lengthening of menstrual bleedings;
profound bleeding at normal duration of menstruation;
development of anemia;
irregularity of menstrual cycle with hypermenorrhea.
#
152.
Myoma of the uterus is accompanied by clinical conditions mentioned below except:
4

anemia;
polyuria;
impairment of defication;
amenorrhea;
pains at the lower part of abdomen.
#
153.
The presence of submucous uterine mioma may be proved by the examinations enumerated below except:
5
transvaginal echography;
X-ray hysterosaphingography;
hysteroscopy;
probing (sondage) of the uterine cavity;
laparoscopy.
#
154.
Which of the following is not used for diagnostics of uterine myoma?
3
abdominal palpation;
bimanual investigation;
X-ray investigation of the thorax;
USG of organs of the lower pelvis;
laparoscopy.
#
155.
Which method of investigations is not necessary for confirmation of the diagnosis of uterine mioma?
2
USG examination of organs of the lower pelvis;
pelviography;
separate diagnostic currettage of mucous of the uretus & its cervix;
hysteroscopy;
laparoscopy.
#
156.
Most informative method for the diagnostics of the nascent myomatic node is:
2
transvaginal echography;
investigation of the uterine cervix with mirror and bimanual checkup;
X-ray hysteroscalphyngography;
hysteroscopy;
laparoscopy.
#
157.
Most informative method for the diagnosis of sumucous myomatic node is:

3
checkup of the uterine cervix with mirror and subcequent bimanual investigation;
laparoscopy;
hysteroscopy;
colposcopy;
X-ray pelviography.
#
158.
Conservative myomectomy is conducted usually:
5
at patients of young age;
in subperitoneal location of the myomatic node on the pedicle;
for preservation of the menstrual function;
for preservation of generative functions;
all of the above.
#
159.
The indication for extirpation of uterus in myoma:
2
low localizing of nodes;
precancerous diseases of the uterus;
secondary changes to submucous myomatic node;
combination of myoma with ovarian cyst.
#
160.
Displasia of vulva is characterized by all enumerated, except :
4
atypia in all layers of multilaminated flat epithelium, except the superficial layer;
impairment of layering of the epithelium;
preservation of the basal membrane;
destruction of the cells.
#
161.
Vulval cancer is mostly found in woman at:
3
reproductive age;
premenopause;
postmenopause;
regardless of age.
#
162.
Symptoms of vulval cancer:
5
presence of tumor;
bleeding of tissues;

purulent discharges from ulcerous surface;
itching;
all of the above.
#
163.
What is not a method for treatment of vulval cancer:
2
normal vulvectomia;
removal of tumor;
radilogical treatment;
chemiotherapy;
combine therapy.
#
164.
The most frequent localisation of malignant process of female genitals is:
1
cervix of uterus;
ovary;
miometrium;
vulva;
fallopian tube.
#
165.
Precancer diseases and cancer of uterine cervix mostly often develop:
4
in the cervical canal;
on the frontal labia of the uterine cervix;
on the border with vaginal arch;
on the transitive zone on the border of multilayer squamous and cylindrical epithelium.
#
166.
Severe dyplasia of cervical epithelium is:
2
beginning (initial) form of cancer;
precancer;
background process;
dyshormonal hyperplasia;
all answers are correct.
#
167.
Severe dysplasia of the uterine cervix is charactirized by morphological changes in epithelium in:
4
all layer;
only on superficial layer;
only in separate cells;

in all layers except for superficial.
#
168.
Prophylaxis of cancer of the uterine cervix consist of:
5
prophylactic medical examinations of patients with application
cytologic and colpocytological methods of diagnostics;
regular routine inspections of women with cytologic examination of smear;
improvement of work of examination rooms;
to constant study of the staff;
all answers are correct.
#
169.
Find the precancer changes on vaginal part of the uterine cervix:
3
recidivous polyps of cervical canal;
true erosion;
dysplasia;
ectropion;
endometrosis.
#
170.
The most informative screening test for the early diagnosis of cervical cancer of uterus:
3
simple colposcopy;
bimanual and rectal examination;
cytological examination of smear from the canal of uterine cervix and surface of uterine cervix;
vacuum-currettage of cervical canal.
#
171.
Diagnosis of cervical cancer is made with the help of:
5
gynecological examination;
cytological examination of scrape from the uiterine cervix and cervical canal;
colposcopy;
hystological examination of a piece of the uterine cervix;
all answers are correct.
#
172.
Risk factors of precancer of endometrium are the following, excluding:
3
anovulary menstruation cycle;
obesity;
ovular menstruation cycle;
diabetus mellitus.
#

173.
Risk factor for the appearance of hyperplastic processes and cancer of the endometrium:
4
the disorder of lipid metabolism;
stress situations;
the disorder of menstrual cycle;
all mentioned above.
#
174.
Hyperplastic processes and cancer of endometrium are developed most frequently during:
5
anovulation;
obesity;
diabetes mellitus;
arterial hypertension;
all mentioned above.
#
175.
The factors of the risk for the development of precancerous diseases and cancer of endometrium include:
5
steady anovulation;
obesity and arterial hypertensia;
prolonged use of intrauterine contraceptives;
the sterility of endocrine origin;
all mentioned above are correct.
#
176.
What states of endometrium are considered to be precancerous:
4
glandular and cystic hyperplasia;
glandular polyp of endometrium;
atrophy of endometrium;
atypical hyperplasia;
all mentioned above are true.
#
177.
Major method for diagnosis of cancer of the uterine body:
1
histological study of the scrape of endometrium;
cytological study;
trans-vaginal echography;
hysterography;
X-ray and television hysterosalpingography.
#
178.

Major clinical symptom of cancer of the uterine body:
3
chronic pelvic pain;
contact hemorrhages;
acyclic hemorrhages;
disturbance of the function of adjacent organs;
sterility.
#
179.
Major way of metastastic propagation of cancer of the endometrium:
2
hematogenic;
lymphogenic;
implantation;
contact;
all mentioned above.
#
180.
The first stage of cancer of the endometrium is divided into versions (A, B, C) depending on:
2
degree of the propagation of tumor beyond the limits of uterus;
degree of the invasion of tumor into the myometrium;
size of the lumen of uterus;
dimensions of uterus.
#
181.
Wertheim's operation differs from the simple extirpation of uterus in terms of the removal:
4
parametric adipose tissue;
iliac lymph nodes;
upper third of vagina and entire lymphatic collector, which surrounds
all mentioned above.
#
182.
Trophoblastic disease is:
4
the sarcoma of uterus;
myoma of uterus;
the cystoma of ovary;
chorionepithelioma;
cancer of the body of utreus.
#
183.
Chorio-carcinoma is most frequently developed after:
4
extra-uterine pregnancy;

labour;
the artificial termination of pregnancy;
vesicular drift;
the late induced abortion.
#
184.
Most frequently chorionepitelioma appears after:
3
abortions;
normal labour;
vesicular drift;
premature labour;
all mentioned above.
#
185.
The most often cancer of ovaries is found out at a stage of :
3
1 stage;
2 stage;
3 stage;
4 stage.
#
186.
What kind of cancer of ovaries does not occur:
1
the mixed;
the secondary;
the metastatic;
the primary.
#
187.
What percent occupies a primary cancer of ovaries among all cancer diseases of ovaries?
4
40 %;
20 %;
60 %
5 %;
80 %.
#
188.
Benign tumours of the ovaries do not concern:
3
serous cystadenoma;
mucinous cystadenoma;
light-cell tumour;
endometroid cystadenoma.

#
189.
To tumourous processes in ovaries concern:
4
follicular cyst;
cysts of corpus luteum;
endometriosis;
all listed;
none from the listed.
#
190.
What cysts are more often subject to remission without operative treatment?
3
the serous;
benign teratoma;
cysts ofcorpus luteum;
mucinous;
endometroid.
#
191.
Treatment of paraovarian cysts in young women.
1
removal of cysts;
removal of ovary with cysts;
puncture of cysts;
taking of sex hormones;
taking gestogens.
#
192.
What from listed is not a risk factor of the development of cancer of the ovaries?
4
absence of deliveries in the anamnesis;
abortions or a significant amount of pregnancies in the anamnesis;
cancer of ovaries in close relatives;
chronic pyelonephritis;
endocrine diseases in the anamnesis.
#
193.
For diagnosis of tumours of ovaries, the following diagnostic methods are used:
5
the cytologic;
the endoscopic;
the ultrasonic;
the histologic;
all listed methods.
#

194.
The age period at which it is most often found out ovarian carcinoma:
1
45 – 55 years;
7 – 17 years;
30 – 40 years;
60 – 70 years.
#
195.
What volume of operative intervention it is necessary to consider as the radical for the cancer of ovaries at 2 and 3 stages?
2
expanded extirpation of the uterus (Vertheim's operation);
extirpation of the uterus with appendages and with simultaneous resection or extirpation of the omentum major;
supravaginal amputation of the uterus and appendages;
any of the listed above volumes of operative intervention.
#
196.
Metastatic affection of the ovary is possible in:
5
mammary gland cancer;
carcinoma of the body of uterus;
malignant affection of one of the ovaries;
cancer of the GIT;
in all cases listed above.
#
197.
Krukenberg's tumour:
4
is a metastasis of a cancer of the GIT;
is a rule, affects both the ovaries;
has a solid structure;
all answers are true;
all answers are wrong.
#
198.
What of the ovarian tumours is most often exposed to malignancy?
3
fibroma;
mucinous cystadenoma;
serous cystadenoma;
tekoma;
teratoma.
#
199.

Cancer of the ovary concerns:
4
all the malignant tumours of the ovaries;
only germinogenous tumours;
only stromal tumours;
only tumours of epithelial origin.
#
200.
The basic method for the treatment of follicular cyst of ovaries:
1
surgical removal of the cysts;
hormonal therapy;
antibacterial therapy;
surgical removal of the cysts with the ovary;
chemotherapy.

Задачи по гинекологии
Gynecology's cases

An 18-year-old woman complains of heavy menstruation with blood clots for 10 days, which began after a 2-month delay. Menstruation began at the age of 16, but the rhythm has not been established until now. The girl's height is 172 cm, body weight is 50 kg. According to Tanner, mammary glands have a II degree of development, pubic hair is sparse. The external genitalia are properly developed. On examination: the uterus is small, rudimentary, the ratio of the body to the cervix is 1:1, the appendages are not palpable.

A 15-year-old woman was admitted to the gynecological department with complaints of abundant bloody discharge from the genital tract, weakness, dizziness. Menstruation from 13 year old, regular, painless. He denies sexual activity. During the last year, there have been progressive delays in menstruation with an increase in the intervals between them up to 2-4 months. She received hemostatic and antianemic therapy. She got sick 10 days ago, when, after a 2-month absence of menstruation, moderate spotting from the genital tract appeared. In the following days, the intensity of bleeding increased, weakness and dizziness appeared. He does not notice any pain in the lower abdomen.

The woman is 16 years old; menstruation is irregular, with long breaks. Last menstruation was 4 months ago. She is a pale on admission with significant blood discharge from the genital tract.

A 22-year-old woman reported bleeding during 12 days, after a 6-week delay in menstruation. The bleeding started as moderate, then periodically decreased and intensified again. Anemia, 1st degree.

A 26-year-old woman, complaining of bleeding from the genital tract during 10 days and slight aching pains in the lower abdomen, coinciding with the onset of bleeding. Menstruation from 16 year old, during 3-4 days, irregular, with delays of up to 10-20 days, not abundant, painless. She

had bleeding two years ago, and conservative treatment was carried out. Last menstruation 1.5 months ago.

A 49-year-old woman complaining of heavy menstruation with blood clots during 10 days, which began after a 2-month delay. She have progressive menstrual delays with an increase in the intervals between them to 2-4 months during the last year.

The woman is 42 years old, complaining of bloody discharge from the genital tract during 10 days. Menstruation is irregular, with long breaks; the last menstruation was 4 months ago.

A 53-year-old woman, with bloody outflow from the vagina. Menopause is 3 years old. For 3 months, he periodically notices the appearance of bloody moderate discharge.

A 28-year-old woman, complaining of prolonged bleeding after a 3-month delay in menstruation. The patient has been infertile for 2 years.

A 48-year-old woman was admitted to the gynecological department with complaints of acyclic, bloody discharge lasting 20 days and occurring after a 2-month delay in menstruation. Menstruation from 17 year old. No special features. Height 155 cm, weight 112 kg, diabetes mellitus for 7 years. Blood pressure 180/110 mm Hg. There are no deviations from the gynecological examination of the genitals.

A 60-year-old woman with complaints of bloody spotting from the vagina for a week, sleep disorders, and appetite. The patient is worried about her condition. Menopause is 10 years old. Examination of the cervix with speculum: bloody spotting from the cervix. Bimanual vaginal examination: the condition of the internal genital organs corresponds to age-related changes. The uterus has a dense consistency and limited mobility. Appendages are not defined.