

**Ministry of Science and Higher Education of the Russian Federation Ministry of Education
and Science of the Kyrgyz Republic**

**Interstate Educational Organization of Higher Education Kyrgyz-Russian Slavic
University named after the first President of the Russian Federation B.N. Yeltsin.**

Fund of Assessment Tools

on industrial practice "Assistant to the Hospital Doctor"

Level of higher education

SPECIALIST

Field of study

560001 – KR General Medicine (for international students)

(code and name of the field of study)

Qualification Medical Doctor

1. LIST OF COMPETENCIES WITH AN INDICATION OF THE STAGES OF THEIR FORMATION IN THE PROCESS OF MASTERING THE DISCIPLINE

Emerging competencies	Planned learning outcomes in the discipline, characterizing the stages of competence formation	Types of assessment tools/section code in this document
<p>PC-6: the ability to determine the patient's main pathological conditions, symptoms, disease syndromes, nosological forms in accordance with the International Statistical Classification of Diseases and Health-Related Problems, X revision</p>	<p>Know: methods of conducting research to identify the main pathological conditions, symptoms of disease syndromes, nosological forms</p>	<p>Block A Questions for midterm control. Questions for intermediate certification Test tasks Oral questioning</p>
	<p>Be able to: comprehend the results of the study of the main nosological forms of diseases</p>	<p>Block C Practical Skills (Bedside / Simulation) Clinical Case Study (Physical Examination, Interpretation of Tests)</p>
	<p>Possess: skills in identifying the main pathological conditions, symptoms, disease syndromes.</p>	<p>Block D Analytical Work / Written Analysis (Clinical Case Review) Preparation and protection Clinical Case Presentations</p>
<p>PC-11: readiness to participate in the provision of emergency medical care for conditions requiring urgent medical intervention</p>	<p>Know: diagnostic methods, diagnostic capabilities of methods of direct examination of the patient of therapeutic, surgical and infectious profile, modern methods of clinical, laboratory instrumental examination of patients (including endoscopic, X-ray methods, ultrasound diagnostics);</p>	<p>Block A Practical Skills (Bedside / Simulation) Clinical Case Review (Physical Examination, Interpretation of Tests) Block D Analytical work / written analysis (Clinical case review) Preparation and defense of the presentation of a clinical case</p>
	<p>Be able to: select an individual type of care for the treatment of the patient in accordance with the situation: primary care, hospitalization;</p>	<p>Block B Situational tasks (cases) Written analysis of the clinical situation (Preparation of maps, case histories, appointments)</p>
	<p>Possess: the skills to formulate indications for the chosen method of treatment, taking into account etiologic and pathogenetic agents, to substantiate pharmacotherapy in a particular patient for the main pathological syndromes and emergency conditions, to determine the route of administration, regimen and dose of drugs, to assess the effectiveness and safety of the treatment;</p>	<p>Block D Analytical work / written analysis (Clinical case review) Preparation and defense of the presentation of a clinical case</p>

2. TECHNOLOGICAL MAP OF THE DISCIPLINE/PRACTICE

Technological map of industrial practice "assistant to a hospital doctor"

Course/semester: 4/7(8) Number of credits (ZE): 3 Reporting: credit with grade

Name of the modules of the discipline according to the RPD	Control	Form of control	Credit minimum	Classification maximum	Control schedule
Module 1					
Physiological obstetrics	Current	Patient supervision (analysis of laboratory tests, participation in treatment and diagnostic procedures); Filling out a daily diary;	17	30	20/43 weeks
	Rubizhny	Theoretical survey; Presentation of the internship diary with a completed report table.	3	5	
Module 2					
Pathological obstetrics	Current	Patient supervision (analysis of laboratory tests, participation in treatment and diagnostic procedures); Filling out a daily diary;	17	30	21/44 weeks
	Rubizhny	Theoretical survey; Presentation of the internship diary with a completed report table.	3	5	
Total per semester			40	70	
Intermediate control (Credit with grade)	Theoretical survey; Final check of the practice diary.		20	30	
Semester Ranking by Discipline			60	100	

Midterm control : checking the completeness of knowledge and skills (achievement of educational results) on the material of the module as a whole.

Intermediate control is a completed documented part of an academic discipline – a set of closely related modules of the discipline.

3. STANDARD CONTROL TASKS AND OTHER MATERIALS NECESSARY TO ASSESS THE PLANNED LEARNING OUTCOMES IN THE DISCIPLINE / PRACTICE (ASSESSMENT TOOLS)

Block A

A.0 Fund of test tasks in the discipline.

A.1 Questions for the survey:

Midwifery Test Assignments for Students Studying in English

1. Obstetric perineum is a region:

- between posterior commissure and coccyx;
- between posterior commissure 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.

2. What hormone is used as a marker for normal progressing pregnancy?

estradiol;
hypophyseal gonadotropin;
progesterone;
prolactin;
chorionic gonadotropin.

3. Name the process which helps the embryo to create a contact with the body of mother (uterus).

gastrulation;
location;
histogenesis;
fertilization;
placentation.

4. When does the embryonic period end and begin the fetal period of the intrauterine development?

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.

5. The first trimester of pregnancy is named as a period of:

organogenesis;
placentation;
implantation;
fertilization;
location.

6. The positive sign of pregnancy is:

absence of menses;
increased size of uterus;
dyspeptic disturbances;
presence of fetus in uterus;
abdominal enlargement.

7. In normal position of fetal parts, the head is located at the position of:

maximum flexion;
moderate flexion;

moderate extension;
maximum extension.

8. Fetal position is:

relation of the fetal back to the sagittal plane;
relation of the fetal back to the frontal plane;
relation of the fetal back to the transversal plane;
relation of the fetal axis to the length of uterus;
interrelation of various parts of fetus.

9. Position is called as longitudinal, when the fetal axis is:

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;
interrelation of various parts of fetus;
located under obtuse (broad) angle to the axis of uterus.

10. Fetal presentation is the relation of:

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;
most higher part of fetus to the entry in pelvis;
head of fetus to the fundus of uterus.

11. Head presentation of fetus in physiological labour is:

anterior head presentation;
occipital presentation;
frontal presentation;
facial presentation;
brow presentation.

12. The most common presentation of fetus is:

complete breech presentation;
breech with flexed legs;
footling presentation;
cephalic presentation;
transverse presentation.

13.

Fetal position means:

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;
relation of the fetal axis to the fundus of uterus;
interrelation of various parts of uterus.

14. At the first position, the back of fetus is turned:

- to the right parts of uterus;
- to the fundus of the uterus;
- to the left parts of uterus;
- to the entry in the big pelvis;
- to the entry in the small pelvis.

15. At the second position, the back of fetus is turned:

- to the right parts of uterus;
- to the fundus of uterus;
- to the left parts of uterus;
- to the entry in the big pelvis;
- to the entry in the small pelvis.

16. When fetus is lying transversely, the position of fetus can be determined by the position of:

- fetal back;
- fetal head;
- small fetal parts;
- pelvic end of the fetus;
- cannot be determined.

17. Objective examination of the pregnant woman or woman in labor starts with:

- palpation of the abdomen;
- auscultation of the abdomen;
- measurement of the pelvis;
- objective examination by systems;
- measurement of the uterus.

18. By the first method of the external obstetric examination may be defined:

- position of the fetus;
- occipito-anterior position
- occipito-posterior position;
- height of the uterine fundus;
- prelying part of the fetus.

19. By the second method of the external obstetric examination may be defined:

- prelying part of the fetus;
- disposition of the fetal parts;
- height of the uterine fundus;
- position of fetus;
- head of fetus.

20. By third method of the external obstetric examination may be defined:

- prelying part of the fetus;
- disposition of the fetal parts;

height of the uterine fundus;
position of fetus;
type of position.

21. By the fourth method of the external obstetric examination may be defined:

type of prelying part of the fetus;
type of position of the fetal parts;
type of height of the uterine fundus;
type of position of fetus;
relation to the entry in the pelvis.

22. At a women of normal constitution, the lumbar rhombus has the following form:

triangular;
geometrically correct rhombus;
correct quadrangular;
triangular, stretched in vertical direction;
quadrate (square form).

23. The method of instrumental examination used during pregnancy and at delivery is:

probing of the uterus;
examination by speculum;
biopsy;
histerography;
hysteroscopy.

24. Vaginal examination is not used for:

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.

25. Diagonal conjugate can be defined:

on the external conjugate;
on the height of pubis symphysis;
on the lateral conjugate;
examination by speculum;
on vaginal examination.

26. Diagonal conjugate is equal to:

31-32 cm;
12-13 cm;
12-15 cm;
28-29 cm;
9-12 cm.

27. True conjugate is equal to:

- 13 cm;
- 11 cm;
- 10 cm;
- 20 cm;
- 9 cm.

28. The normal fetal heart rate per minute is:

- 80-90 beats;
- 100-110 beats;
- 120-140 beats;
- 100-200 beats;
- 170-180 beats.

29.

Where the fetal heart beats are the best heard in the 1st position of anterior type of occipital presentation?

- 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.

30. The average duration of the first stage of labour in primigravidae is:

- 3-5 hrs;
- 6-9 a.m.;
- 10-2 p.m.;
- 3-6 p.m.;
- 7-12 p.m.

31. What method should be used in anaesthesia for amniocentesis:

- the general anaesthesia;
- local anaesthesia;
- sacral blockade;
- without anaesthesia and analgesic;
- light analgesia.

32. The indication for the appointment of anesthetics at the first stage of labour is:

- passability of the cervical channel for 1-1,5 fingers;
- opening of cervix to 4 cm;
- weak contraction of uterus during labour ;
- discoordination of patrimonial activity;
- absence of the fetal sac.

33. At the end of pregnancy of a primigravida women, cervix of uterus is normally:

extended;
truncated (shortened);
smoothed partially;
smoothed completely;
kept.

34. Name signs of the beginning of the first stage of labour:

efflux of amniotic fluid;
opening of cervix to 4 cm;
presence of "mature" uterine neck;
occurrence of regular birth pangs ;
head insertion into the entrance of the minor pelvis.

35. The first stage of labour comes to an end always:

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;
opening of cervix to 4 cm.

36. In labour, at head prelying of a fetus, the following basal frequency of heart beats is considered to be normal:

140-160 per minute;
120-160 beats per minute;
110-150 per minute;
100-180 per minute;
more than 200 per minute.

37. Name signs of the beginning of the second period of labour:

opening of cervix to 10 cm
presence of attempts;
efflux of amniotic fluid;
full opening of the uterine os;
insertion of the fetus head.

38. In what situation it is possible to speak about engagement of the fetus head into the entrance of the pelvic:

the head is in the pelvic cavity;
biparietal size of the head is in an entrance plane of small pelvis;
the prelying 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.

39. In what plane of the minor pelvis the internal rotation of the head takes place?

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.

40. The major movements of a fetus during labour occur in certain sequence. What of the following sequences is correct?

descent, internal rotation, flexion;
engagement, flexion, descent;
engagement, internal rotation, descent;
flexion, internal rotation, extension;
descent, flexion, engagement.

41. In the 2nd period of labour the heart beats are supervised:

after each attempt;
every 5 minutes;
every 10 minutes;
every 15 minutes;
every 20 minutes.

42. Episiotomy is for the prevention of:

bad healing of perineum;
rupture of muscles of perineum;
severe fetal hypoxia;
development of rectocele and cystocele;
contraction of musculus levator ani.

43. Volume of physiological blood loss in labour:

100 - 150 ml;
200 - 300 ml;
300 - 400 ml;
400 - 500 ml;
less than 100 ml.

44. Tactics of conducting the third stage of labour depends on:

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.

45. What is indicative during jointing of placenta?

manual afterbirth detachment;
introduction of contraction drugs;
curettage of cavity of uterus;
to put cold on the abdomen;
extirpation or amputation of uterus.

46. To diagnose the prolonged pregnancy, it is necessary:

- 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.

47. What is necessary to undertake first of all in the starting blood loss in post-partum period:

- manual detachment of placenta;
- introduction of uterus contraction preparations;
- examine of patrimonial ways;
- define signs of the placenta detachment;
- ice on the lower abdomen.

48. The major reason of the premature detachment of the normally located placenta is:

- trauma of the abdomen;
- gestosis;
- prolonged pregnancy;
- hydramnion, multi pregnancy;
- short umbilical cord.

49. For the clinical picture of premature detachment of the normally located placenta is not characteristic:

- abdominal pain;
- absent abdominal pain;
- hemorrhagic shock;
- change in the heart beat of fetus;
- change in shape of uterus.

50. For the prelying of placenta the following positions are characteristic:

- 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.

51. The prelying of placents is the pathology at which placenta is located:

- at the body of uterus;
- at the medium segment of uterus;
- at the lower segment of uterus;
- on the posterior wall of uterus;
- on the bottom of uterus.

52. In the prelying of placenta, bleeding is usually appeared at the term of pregnancy of:

8-12 weeks;
16- 20 weeks;
22- 24 weeks;
28 – 32 weeks;
36 – 40 weeks.

53. In what cases the vaginal investigation is indicative in suspicion of the prelying placenta

each visit at practitioner or gynecologist;
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.

54. Clinical symptom of the prelying placenta:

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.

55. The most characteristic features of preeclampsia include:

shin edema;
albuminuria;
subjective complaints;
pale skin;

56. The manifestations of the late gestosis include:

edema;
proteinuria;
hyperglycemia;
hyperinsulinemia;
vomiting.

57. The possible cause of death in eclampsia is:

cardiac arrest during convulsions;
pulmonary oedema;
stroke, coma;
vomiting

58. The most typical cause of maternal death in eclampsia is:

headache;
stroke;
lung oedema;
infection;
vomiting.

59. The optimal variant for delivery in severe form of gestosis is:

- application of obstetrical forceps;
- self supporting delivery;
- cesarean section;
- vacuum-extraction of fetus;
- fetus destructing operation.

60. Anatomically narrow pelvis is considered to be any pelvis which in comparison with normal:

- all the sizes are reduced by 0,5-1 cm;
- at least one size is reduced by 0,5-1 cm;
- at least one size is reduced by 1,5-2 cm;
- all the sizes are reduced by 1,5-2 cm;
- at least one size is reduced by 1,5-2 cm.

61. Generally and equally narrowed (justo minor) pelvis is characterized by:

- shortening only of the direct size of entry to the small pelvis;
- equal decrease of all sizes of the small pelvis;
- at least one size is reduced by 0,5-1 cm;
- at least one size is reduced by 1,5-2 cm;
- lengthening of the sacrum.

62.

Characteristic for the biomechanism of labour in generally and equally narrowed (justo minor) pelvis is:

- acynclitic insertion of the fetal head;
- placing of the sagittal suture at the transverse size;
- extension of the head is in the entry to the small pelvis;
- maximum extension of the fetal head;
- maximum flexion of the fetal head.

63. Simple flat pelvis is characterised by:

- the decrease of all direct sizes of the cavity of the small pelvis;
- increase in height of the cavity of the small pelvis;
- the decrease of the transverse size of the sacrolumbal rhombus;
- at least one size is reduced by 0,5-1 cm;
- at least one size is reduced by 1,5-2 cm.

64. For the course of rapid labour the most typical is:

- raised body temperature;
- nausea, vomiting;
- dry tongue, tachycardia;
- renal-hepatic insufficiency;
- fast delivery

65. The most important consequences of wide application of cesarean sections:

decrease risk of fetal hypoxia;
decrease in maternal death rate;
decrease in maternal pathologies;
decrease in perinatal death rates;
decreased blood loss.

66. The cesarean section is the relative indication in all cases, except:

one cesarean section in the anamnesis;
fetal hypoxia;
umbilical cord prolapse;
premature detachment of placenta;
presence of a dead fetus.

67. The most frequent technique of cesarean sections is:

corporal cesarean section;
extraperitoneal cesarean section;
isthmic-corporal cesarean section;
a cesarean section in the lower segment;
vaginal cesarean section.

68. In modern obstetrics the following technique of cesarean sections is not used:

classical (corporal) caesarean section;
a cesarean section in the lower segment of a uterus;
extraperitoneal caesarean section;
intraligamental cesarean section;
vaginal cesarean section.

69. Choose the basic complication of a classical cut of the uterus in cesarean section:

rupture of scar tissue in the following pregnancies and deliveries;
formation of postoperative commissure;
poor healing of wounds on the uterus;
a cesarean section in the lower segment of a uterus;
more extended damage of vessels of the uterus.

70. While applying the exit obstetrical forceps, spoons should lie on the fetal head:

in the right slanting size;
in the transverse size;
in the direct size;
at pelvic inlet;
at pelvic midcavity.

71. Formation of feto-placental system, as a rule ends at:

16 weeks of pregnancy;
20 weeks of pregnancy;
24 weeks of pregnancy;
28 weeks of pregnancy;
32 weeks of pregnancy.

72. Name the correct characteristics of the umbilical cord:

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.

73. Name the correct characteristics of the placenta:

normal weight of placenta is 1200g;
main mass of placenta consists of vessels;
in placenta chorionic gonadotropin is formed;
normally placenta is attached to the internal fauces of the uterine cervix;
in placenta erythrocytes are formed.

74. Which objective investigations are compulsory for pregnant women?

measurement of blood pressure;
determination of particularity of body constitution;
measurement of thorax circumference;
condition of mammary glands;
examination of fundus of eye.

75. Which information helps to determine intrauterine fetal position?

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.

76. Indications for vaginal examinations in women in labor are:

life-threatening asphyxia of the fetus;
nephropathy of pregnant woman;
bloody discharges from genitalia;
albuminuria;
starting of post-natal period.

77. Which changes are characteristics for normal pregnancy?

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.

78. Which changes can occur during normal pregnancy?

unstable arterial pressure and hypertension;

total or partial leucopenia;
increase in ESR till 20-25 mm an hour;
decrease of erythrocytes count;
thrombocytopenia;

79. Changes in cardiovascular system, which are characteristics for normal pregnancy:

decrease in circulating blood volume;
total or partial leucopenia;
edema of lower extremities;
increase in vascularisation of uterus;
increase in quantity of fibrinogen;

80. Which changes in a woman, caused by pregnancy, are nonreversible

choriogonin hormone;
striae gravidum;
lactation;
acromegaly;
pigmentation.

81. What signs are characteristic for 40-week pregnancy?

striae gravidum;
urine analysis showed albuminuria;
height of uterus above pubis is 36 cm;
umbilical extrusion;
bloody discharges from genitalia.

82. Indicate the characteristics for the 1st type of occipito-anterial position:

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.

83. Importance of sutures and fontanel on the head of fetus during labor:

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 type of synclitism insertion of fetal head.

84. Name the main point and the point of fixation during labour in occipito-anterial position:

chin;
the middle of frontal suture;
minor fontanel;
major fontanel;
upper jaw.

85. Clinical signs of severe acute hypoxia of fetus do not include:

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;
fetal heart rate - arrhythmia.

86. Green color of amniotic fluid indicates:

chronic hypoxia of fetus;
acute hypoxia of fetus;
antenatal death of fetus;
hemolytic disease of fetus;
metabolism of amniotic fluid.

87. Brown color of amniotic fluid indicates:

chronic hypoxia of fetus;
acute hypoxia of fetus;
antenatal death of fetus;
hemolytic disease of fetus;
metabolism of amniotic fluid.

88. Minimal height of a viable fetus is:

25cm;
32cm;
35cm;
40 cm;
45cm.

89. Minimal weight of a viable fetus is:

400g;
500g;
600g;
800g;
1000g.

90. Criterion for a viable fetus (newborn) is a term of pregnancy:

18 weeks;
20 weeks;
22 weeks;
26 weeks;
28 weeks.

91. At what time after physiological delivery is it most advisable to attach the baby to the breast?

Immediately after delivery;

In the first 2 hours after giving birth;
12 hours after delivery;
30 minutes after giving birth;
Immediately after the start of lactation.

92. Premature detachment of a normally located placenta is possible:

In the pre-term period;
In the first period of labor;
In the second period of labor;
In the third period of labor;
Regardless of the stage of labor

93. The condition of fetal intrauterine hypoxia in case of premature detachment of a normally located placenta depends on:

The area of the detached part of the placenta;
Rates of placental abruption;
Morphofunctional state of the placenta;
Gestation period, fetal "full term";
The total amount of blood loss.

94. The Solovyov index is:

10-14cm.
12-16cm.
14-17cm.
15-17cm.
16-18cm.

95. An eclampsia attack may develop:

Only during childbirth;
Only during pregnancy;
Only in the early postpartum period;
Only in the late postpartum period;
Regardless of pregnancy and childbirth.

96. At what severity of early toxicosis of pregnant women is outpatient treatment possible:

At light stage;
At average stage;
At sever stagee;
In any case;
Risk of miscarriage.

97. For the diagnosis of multiple pregnancies, the most commonly used

Ultrasound examination;
X-ray examination;
Radioisotope scintigraphy;
Computed tomography;

Magnetic resonance imaging.

98. Causes of uterine rupture during pregnancy:

An untenable scar on the uterus
Clinically narrow pelvis
Anatomically narrow pelvis
Big size of the fetus
Abnormality of the uterine structure

99. A generally constricted pelvis is characterized by:

The same reduction in all sizes of the small pelvis
Reducing only the direct size of the entrance to the pelvis
Reduction of all direct dimensions of the small pelvis
Reducing only the transverse size of the entrance to the pelvis
Reduction of all transverse dimensions of the small pelvis

100. Duration of perinatal period is:

since the 20nd week of intra-uterine development including 7 days after birth;
since the 20nd week of intra-uterine development including 10 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.

101.

Most often causes of death of premature newborns are:

developmental anomalies;
hemolytic disease of newborns;
respiratory distress syndrome;
jaundice of newborns;
intrauterine infections.

102. On the Apgar scale, mild degree of asphyxia is:

8 points;
7 points;
6 points;
5 points;
4 and less points.

103. 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:

prematurity;
detachment of placenta;
extremely intensive labor;
infections in fetus;
arterial hypertension in mother.

104. What corresponds to the first stage of infection at postnatal purrulo-septic infections?

lactation mastitis at postpartum period;
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 at postpartum period.

105. What corresponds to the second stage of infection at postnatal purrulo-septic infections?

infection in the area of postnatal wound;
infection is outside wound's area, but within the small pelvis;
infection is outside wound's area, but within the big pelvis;
infection is outside the small pelvis, near generalization;
generalised infection at postpartum period.

106. What corresponds to the third stage of infection at postnatal purrulo-septic infections?

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 at postpartum period.

107. What corresponds to the fourth stage of infection at postnatal purrulo-septic infections?

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 at postpartum period.

108. Perineal rupture of the second degree is not accompanied by the rupture of:

muscles of the perineum;
perineal skin;
levator ani muscle;
uterine cervix;
vaginal walls.

109. The main criterion for viviparity are:

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.

110. Which signs are not characteristics of early gestosis?

sialorrhea;
loss of body weight;

latent edema;
dehydration;
skin dryness.

111. If the fetus is lying across the uterus, with the head in the flank

transverse lie
cephalic lie
breech lie
frank lie
oblique lie

112. Engaging diameter, in fully extended head :

Occipital mentum
occipital submentum
submentobregmatic
biparietal
mentovertica

113. During the active phase of labour, the effective cervical dilatation in primigravida should be at the rate of

1 cm per hour
0.5 cm per hour
2.5 cm per hour
1.5 cm per hour
2 cm per hour

114. Commonest type of uniovular twins is

diamniotic monochorionic
diamniotic dichorionic
triamniotic monochorionic
monoamniotic dichorionic
monoamniotic monochorionic

115. The best way to tackle the blood coagulation disorders in abruption placenta

massive fresh blood transfusion
to administer fibrinogen rich substances
use of antifibrinolytic substances
use of medicine with heparin
use of medicine with aspirine

116. Organogenesis is complete at:

2 weeks after ovulation.
6 weeks after ovulation.
8 weeks after ovulation.
18 weeks after ovulation.
20 weeks after ovulation.

117. Diabetic control is important before conception to reduce the incidence of:

maternal nephropathy.
diabetic ketoacidosis.
congenital anomalies.
maternal retinopathy.
C-section.

118. The most common cause of heart disease in pregnant woman is:

Congenital heart disease.
Cardiomyopathy.
Myocardial infarction.
Cardiomegaly.
Rheumatic heart disease.

119. The common possible cause of oligohydramnions is:

Oesophageal atresia.
Placental haemangioma.
Renal agenesis.
Diabetes mellitus.
Rh incompatibility.

120. Of the following methods, the safest, most precise and simplest for placental localization is:

auscultation.
ultrasonography.
radioisotope study.
abdominal palpation.
soft tissue radiography.

121. Pregnancy induced hypertension is diagnosed when:

hypertension is encountered after 20 weeks of gestation.
hypertension gets worse in first week of pregnancy.
hypertension is not controlled with aldomet.
hypertension gives rise to left ventricular failure.
blood urea & creatine levels in blood are abnormal.

122. Shoulder dystocia occurs during:

stage 1 latent phase of labor
stage 1 active phase of labor
stage 2 of labor
stage 3 of labor
can occur at any stage

123. Most important cause of immediate post partum hemorrhage:

laceration of cervix

laceration of vagina
uterine atony
uterine hypertony
placental fragment retention

124. Leopold maneuvers refers to:

delivery of head
external version
internal version
breech extraction
examination of abdomen

125. Refers to the part of the fetus that occupies the lower segment of the uterus or pelvis

the show
the version
the engagement
the lie
the presentation

126. Which is the least frequent site of an ectopic pregnancy?

fallopian tube
cervix
ovary
abdominal cavity
broad ligament

127. Woman with a complete mole is most likely to present with which of the symptoms?

vaginal bleeding
excessive uterine size
hyperemesis
prominent theca lutein cysts
pre-eclampsia

128. The gold standard in diagnosing ectopic pregnancy

laparoscopy
culdocentesis
beta HCG
ultrasonography
progesterone

129. The most common side effect of tocolytics agent is:

vaginal bleeding.
abdominal pain.
nausea, vomiting.
palpitations.
oliguria.

130. What is the diameter of fetal skull that presents at vulva during normal labour:

suboccipitofrontal.
mentovertical.
suboccipitobregmatic.
occipitofrontal.
metoposterior.

A.2 Questions for mid-term control (colloquium)

1. Obstetric perineum is a region:

between posterior commissure and coccyx;
between posterior commissure 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.

2. What hormone is used as a marker for normal progressing pregnancy?

estradiol;
hypophyseal gonadotropin;
progesterone;
prolactin;
chorionic gonadotropin.

3. Name the process which helps the embryo to create a contact with the body of mother (uterus).

gastrulation;
location;
histogenesis;
fertilization;
placentation.

4. When does the embryonic period end and begin the fetal period of the intrauterine development?

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.

5. The first trimester of pregnancy is named as a period of:

organogenesis;
placentation;
implantation;
fertilization;

location.

6. The positive sign of pregnancy is:

absence of menses;
increased size of uterus;
dyspeptic disturbances;
presence of fetus in uterus;
abdominal enlargement.

7. In normal position of fetal parts, the head is located at the position of:

maximum flexion;
moderate flexion;
moderate extension;
maximum extension.

8. Fetal position is:

relation of the fetal back to the sagittal plane;
relation of the fetal back to the frontal plane;
relation of the fetal back to the transversal plane;
relation of the fetal axis to the length of uterus;
interrelation of various parts of fetus.

9. Position is called as longitudinal, when the fetal axis is:

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;
interrelation of various parts of fetus;
located under obtuse (broad) angle to the axis of uterus.

10. Fetal presentation is the relation of:

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;
most higher part of fetus to the entry in pelvis;
head of fetus to the fundus of uterus.

11. Head presentation of fetus in physiological labour is:

anterior head presentation;
occipital presentation;
frontal presentation;
facial presentation;
brow presentation.

12. The most common presentation of fetus is:

complete breech presentation;
breech with flexed legs;
footling presentation;
cephalic presentation;
transverse presentation.

13.

Fetal position means:

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;
relation of the fetal axis to the fundus of uterus;
interrelation of various parts of uterus.

14. At the first position, the back of fetus is turned:

to the right parts of uterus;
to the fundus of the uterus;
to the left parts of uterus;
to the entry in the big pelvis;
to the entry in the small pelvis.

15. At the second position, the back of fetus is turned:

to the right parts of uterus;
to the fundus of uterus;
to the left parts of uterus;
to the entry in the big pelvis;
to the entry in the small pelvis.

16. When fetus is lying transversely, the position of fetus can be determined by the position of:

fetal back;
fetal head;
small fetal parts;
pelvic end of the fetus;
cannot be determined.

17. Objective examination of the pregnant woman or woman in labor starts with:

palpation of the abdomen;
auscultation of the abdomen;
measurement of the pelvis;
objective examination by systems;
measurement of the uterus.

18. By the first method of the external obstetric examination may be defined:

position of the fetus;
occipito-anterior position

occipito-posterior position;
height of the uterine fundus;
prelying part of the fetus.

19. By the second method of the external obstetric examination may be defined:

prelying part of the fetus;
disposition of the fetal parts;
height of the uterine fundus;
position of fetus;
head of fetus.

20. By third method of the external obstetric examination may be defined:

prelying part of the fetus;
disposition of the fetal parts;
height of the uterine fundus;
position of fetus;
type of position.

21. By the fourth method of the external obstetric examination may be defined:

type of prelying part of the fetus;
type of position of the fetal parts;
type of height of the uterine fundus;
type of position of fetus;
relation to the entry in the pelvis.

22. At a women of normal constitution, the lumbar rhombus has the following form:

triangular;
geometrically correct rhombus;
correct quadrangular;
triangular, stretched in vertical direction;
quadrate (square form).

23. The method of instrumental examination used during pregnancy and at delivery is:

probing of the uterus;
examination by speculum;
biopsy;
histerography;
hysteroscopy.

24. Vaginal examination is not used for:

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.

25. Diagonal conjugate can be defined:

on the external conjugate;
on the height of pubis symphysis;
on the lateral conjugate;
examination by speculum;
on vaginal examination.

26. Diagonal conjugate is equal to:

31-32 cm;
12-13 cm;
12-15 cm;
28-29 cm;
9-12 cm.

27. True conjugate is equal to:

13 cm;
11 cm;
10 cm;
20 cm;
9 cm.

28. The normal fetal heart rate per minute is:

80-90 beats;
100-110 beats;
120-140 beats;
100-200 beats;
170-180 beats.

29.

Where the fetal heart beats are the best heard in the 1st position of anterior type of occipital presentation?

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.

30. The average duration of the first stage of labour in primigravidae is:

3-5 hrs;
6-9 a.m.;
10-2 p.m.;
3-6 p.m.;
7-12 p.m.

31. What method should be used in anaesthesia for amniocentesis:

the general anaesthesia;
local anaesthesia;
sacral blockade;
without anaesthesia and analgesic;
light analgesia.

32. The indication for the appointment of anesthetics at the first stage of labour is:

passability of the cervical channel for 1-1,5 fingers;
opening of cervix to 4 cm;
weak contraction of uterus during labour ;
discoordination of patrimonial activity;
absence of the fetal sac.

33. At the end of pregnancy of a primigravida women, cervix of uterus is normally:

extended;
truncated (shortened);
smoothed partially;
smoothed completely;
kept.

34. Name signs of the beginning of the first stage of labour:

efflux of amniotic fluid;
opening of cervix to 4 cm;
presence of "mature" uterine neck;
occurrence of regular birth pangs ;
head insertion into the entrance of the minor pelvis.

35. The first stage of labour comes to an end always:

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;
opening of cervix to 4 cm.

36. In labour, at head prelying of a fetus, the following basal frequency of heart beats is considered to be normal:

140-160 per minute;
120-160 beats per minute;
110-150 per minute;
100-180 per minute;
more than 200 per minute.

37. Name signs of the beginning of the second period of labour:

opening of cervix to 10 cm
presence of attempts;
efflux of amniotic fluid;

full opening of the uterine os;
insertion of the fetus head.

38. In what situation it is possible to speak about engagement of the fetus head into the entrance of the pelvic:

the head is in the pelvic cavity;
biparietal 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.

39. In what plane of the minor pelvis the internal rotation of the head takes place?

over an entrance to the pelvis;
in an entrance plane of the minor pelvis;
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.

40. The major movements of a fetus during labour occur in certain sequence. What of the following sequences is correct?

descent, internal rotation, flexion;
engagement, flexion, descent;
engagement, internal rotation, descent;
flexion, internal rotation, extension;
descent, flexion, engagement.

41. In the 2nd period of labour the heart beats are supervised:

after each attempt;
every 5 minutes;
every 10 minutes;
every 15 minutes;
every 20 minutes.

42. Episiotomy is for the prevention of:

bad healing of perineum;
rupture of muscles of perineum;
severe fetal hypoxia;
development of rectocele and cystocele;
contraction of musculus levator ani.

43. Volume of physiological blood loss in labour:

100 - 150 ml;
200 - 300 ml;
300 - 400 ml;
400 - 500 ml;
less than 100 ml.

44. Tactics of conducting the third stage of labour depends on:

- 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.

45. What is indicative during jointing of placenta?

- manual afterbirth detachment;
- introduction of contraction drugs;
- curettage of cavity of uterus;
- to put cold on the abdomen;
- extirpation or amputation of uterus.

46. To diagnose the prolonged pregnancy, it is necessary:

- 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.

47. What is necessary to undertake first of all in the starting blood loss in post-partum period:

- manual detachment of placenta;
- introduction of uterus contraction preparations;
- examine of patrimonial ways;
- define signs of the placenta detachment;
- ice on the lower abdomen.

48. The major reason of the premature detachment of the normally located placenta is:

- trauma of the abdomen;
- gestosis;
- prolonged pregnancy;
- hydramnion, multi pregnancy;
- short umbilical cord.

49. For the clinical picture of premature detachment of the normally located placenta is not characteristic:

- abdominal pain;
- absent abdominal pain;
- hemorrhagic shock;
- change in the heart beat of fetus;
- change in shape of uterus.

50. For the prelying of placenta the following positions are characteristic:

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.

51. The prelying of placent is the pathology at which placenta is located:

at the body of uterus;
at the medium segment of uterus;
at the lower segment of uterus;
on the posterior wall of uterus;
on the bottom of uterus.

52. In the prelying of placenta, bleeding is usually appeared at the term of pregnancy of:

8-12 weeks;
16- 20 weeks;
22- 24 weeks;
28 – 32 weeks;
36 – 40 weeks.

53. In what cases the vaginal investigation is indicative in suspicion of the prelying placenta

each visit at practitioner or gynecologist;
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.

54. Clinical symptom of the prelying placenta:

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.

55. The most characteristic features of preeclampsia include:

shin edema;
albuminuria;
subjective complaints;
pale skin;

56. The manifestations of the late gestosis include:

edema;
proteinuria;
hyperglycemia;
hyperinsulinemia;
vomiting.

57. The possible cause of death in eclampsia is:

- cardiac arrest during convulsions;
- pulmonary oedema;
- stroke, coma;
- vomiting

58. The most typical cause of maternal death in eclampsia is:

- headache;
- stroke;
- lung oedema;
- infection;
- vomiting.

59. The optimal variant for delivery in severe form of gestosis is:

- application of obstetrical forceps;
- self supporting delivery;
- cesarean section;
- vacuum-extraction of fetus;
- fetus destructing operation.

60. Anatomically narrow pelvis is considered to be any pelvis which in comparison with normal:

- all the sizes are reduced by 0,5-1 cm;
- at least one size is reduced by 0,5-1 cm;
- at least one size is reduced by 1,5-2 cm;
- all the sizes are reduced by 1,5-2 cm;
- at least one size is reduced by 1,5-2 cm.

61. Generally and equally narrowed (justo minor) pelvis is characterized by:

- shortening only of the direct size of entry to the small pelvis;
- equal decrease of all sizes of the small pelvis;
- at least one size is reduced by 0,5-1 cm;
- at least one size is reduced by 1,5-2 cm;
- lengthening of the sacrum.

62.

Characteristic for the biomechanism of labour in generally and equally narrowed (justo minor) pelvis is:

- acynclitic insertion of the fetal head;
- placing of the sagittal suture at the transverse size;
- extension of the head is in the entry to the small pelvis;
- maximum extension of the fetal head;
- maximum flexion of the fetal head.

63. Simple flat pelvis is characterised by:

the decrease of all direct sizes of the cavity of the small pelvis;
increase in height of the cavity of the small pelvis;
the decrease of the transverse size of the sacrolumbal rhombus;
at least one size is reduced by 0,5-1 cm;
at least one size is reduced by 1,5-2 cm.

64. For the course of rapid labour the most typical is:

raised body temperature;
nausea, vomiting;
dry tongue, tachycardia;
renal-hepatic insufficiency;
fast delivery

65. The most important consequences of wide application of cesarean sections:

decrease risk of fetal hypoxia;
decrease in maternal death rate;
decrease in maternal pathologies;
decrease in perinatal death rates;
decreased blood loss.

66. The cesarean section is the relative indication in all cases, except:

one cesarean section in the anamnesis;
fetal hypoxia;
umbilical cord prolapse;
premature detachment of placenta;
presence of a dead fetus.

67. The most frequent technique of cesarean sections is:

corporal cesarean section;
extraperitoneal cesarean section;
isthmic-corporal cesarean section;
a cesarean section in the lower segment;
vaginal cesarean section.

68. In modern obstetrics the following technique of cesarean sections is not used:

classical (corporal) caesarean section;
a cesarean section in the lower segment of a uterus;
extraperitoneal caesarean section;
intraligamental cesarean section;
vaginal cesarean section.

69. Choose the basic complication of a classical cut of the uterus in cesarean section:

rupture of scar tissue in the following pregnancies and deliveries;
formation of postoperative commissure;
poor healing of wounds on the uterus;
a cesarean section in the lower segment of a uterus;

more extended damage of vessels of the uterus.

70. While applying the exit obstetrical forceps, spoons should lie on the fetal head:
in the right slanting size;
in the transverse size;
in the direct size;
at pelvic inlet;
at pelvic midcavity.

71. Formation of feto-placental system, as a rule ends at:

16 weeks of pregnancy;
20 weeks of pregnancy;
24 weeks of pregnancy;
28 weeks of pregnancy;
32 weeks of pregnancy.

72. Name the correct characteristics of the umbilical cord:

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.

73. Name the correct characteristics of the placenta:

normal weight of placenta is 1200g;
main mass of placenta consists of vessels;
in placenta chorionic gonadotropin is formed;
normally placenta is attached to the internal fauces of the uterine cervix;
in placenta erythrocytes are formed.

74. Which objective investigations are compulsory for pregnant women?

measurement of blood pressure;
determination of particularity of body constitution;
measurement of thorax circumference;
condition of mammary glands;
examination of fundus of eye.

75. Which information helps to determine intrauterine fetal position?

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.

76. Indications for vaginal examinations in women in labor are:

life-threatening asphyxia of the fetus;

nephropathy of pregnant woman;
bloody discharges from genitalia;
albuminuria;
starting of post-natal period.

77. Which changes are characteristics for normal pregnancy?

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.

78. Which changes can occur during normal pregnancy?

unstable arterial pressure and hypertension;
total or partial leucopenia;
increase in ESR till 20-25 mm an hour;
decrease of erythrocytes count;
thrombocytopenia;

79. Changes in cardiovascular system, which are characteristics for normal pregnancy:

decrease in circulating blood volume;
total or partial leucopenia;
edema of lower extremities;
increase in vascularisation of uterus;
increase in quantity of fibrinogen;

80. Which changes in a woman, caused by pregnancy, are nonreversible

choriogonin hormone;
striae gravidum;
lactation;
acromegaly;
pigmentation.

81. What signs are characteristic for 40-week pregnancy?

striae gravidum;
urine analysis showed albuminuria;
height of uterus above pubis is 36 cm;
umbilical extrusion;
bloody discharges from genitalia.

82. Indicate the characteristics for the 1st type of occipito-anterial position:

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.

83. Importance of sutures and fontanelles on the head of fetus during labor:

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 type of synclitism insertion of fetal head.

84. Name the main point and the point of fixation during labour in occipito-anterial position:

chin;
the middle of frontal suture;
minor fontanel;
major fontanel;
upper jaw.

85. Clinical signs of severe acute hypoxia of fetus do not include:

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;
fetal heart rate - arrhythmia.

86. Green color of amniotic fluid indicates:

chronic hypoxia of fetus;
acute hypoxia of fetus;
antenatal death of fetus;
hemolytic disease of fetus;
metabolism of amniotic fluid.

87. Brown color of amniotic fluid indicates:

chronic hypoxia of fetus;
acute hypoxia of fetus;
antenatal death of fetus;
hemolytic disease of fetus;
metabolism of amniotic fluid.

88. Minimal height of a viable fetus is:

25cm;
32cm;
35cm;
40 cm;
45cm.

89. Minimal weight of a viable fetus is:

400g;

500g;
600g;
800g;
1000g.

90. Criterion for a viable fetus (newborn) is a term of pregnancy:

18 weeks;
20 weeks;
22 weeks;
26 weeks;
28 weeks.

91. At what time after physiological delivery is it most advisable to attach the baby to the breast?

Immediately after delivery;
In the first 2 hours after giving birth;
12 hours after delivery;
30 minutes after giving birth;
Immediately after the start of lactation.

92. Premature detachment of a normally located placenta is possible:

In the pre-term period;
In the first period of labor;
In the second period of labor;
In the third period of labor;
Regardless of the stage of labor

93. The condition of fetal intrauterine hypoxia in case of premature detachment of a normally located placenta depends on:

The area of the detached part of the placenta;
Rates of placental abruption;
Morphofunctional state of the placenta;
Gestation period, fetal "full term";
The total amount of blood loss.

94. The Solovyov index is:

10-14cm.
12-16cm.
14-17cm.
15-17cm.
16-18cm.

95. An eclampsia attack may develop:

Only during childbirth;
Only during pregnancy;
Only in the early postpartum period;
Only in the late postpartum period;

Regardless of pregnancy and childbirth.

96. At what severity of early toxicosis of pregnant women is outpatient treatment possible:

At light stage;
At average stage;
At sever stagee;
In any case;
Risk of miscarriage.

97. For the diagnosis of multiple pregnancies, the most commonly used

Ultrasound examination;
X-ray examination;
Radioisotope scintigraphy;
Computed tomography;
Magnetic resonance imaging.

98. Causes of uterine rupture during pregnancy:

An untenable scar on the uterus
Clinically narrow pelvis
Anatomically narrow pelvis
Big size of the fetus
Abnormality of the uterine structure

99. A generally constricted pelvis is characterized by:

The same reduction in all sizes of the small pelvis
Reducing only the direct size of the entrance to the pelvis
Reduction of all direct dimensions of the small pelvis
Reducing only the transverse size of the entrance to the pelvis
Reduction of all transverse dimensions of the small pelvis

100. Duration of perinatal period is:

since the 20nd week of intra-uterine development including 7 days after birth;
since the 20nd week of intra-uterine development including 10 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.

101.

Most often causes of death of premature newborns are:

developmental anomalies;
hemolytic disease of newborns;
respiratory distress syndrome;
jaundice of newborns;
intrauterine infections.

102. On the Apgar scale, mild degree of asphyxia is:

8 points;
7 points;
6 points;
5 points;
4 and less points.

103. 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:

prematurity;
detachment of placenta;
extremely intensive labor;
infections in fetus;
arterial hypertension in mother.

104. What corresponds to the first stage of infection at postnatal purrulo-septic infections?

lactation mastitis at postpartum period;
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 at postpartum period.

105. What corresponds to the second stage of infection at postnatal purrulo-septic infections?

infection in the area of postnatal wound;
infection is outside wound's area, but within the small pelvis;
infection is outside wound's area, but within the big pelvis;
infection is outside the small pelvis, near generalization;
generalised infection at postpartum period.

106. What corresponds to the third stage of infection at postnatal purrulo-septic infections?

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 at postpartum period.

107. What corresponds to the fourth stage of infection at postnatal purrulo-septic infections?

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 at postpartum period.

108. Perineal rupture of the second degree is not accompanied by the rupture of:

muscles of the perineum;
perineal skin;

levator ani muscle;
uterine cervix;
vaginal walls.

109. The main criterion for viviparity are:

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.

110. Which signs are not characteristics of early gestosis?

sialorrhea;
loss of body weight;
latent edema;
dehydration;
skin dryness.

111. If the fetus is lying across the uterus, with the head in the flank

transverse lie
cephalic lie
breech lie
frank lie
oblique lie

112. Engaging diameter, in fully extended head :

Occipital mentum
occipital submentum
submentobregmatic
biparietal
mentovertica

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1 cm per hour
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- massive fresh blood transfusion
- to administer fibrinogen rich substances
- use of antifibrinolytic substances
- use of medicine with heparin
- use of medicine with aspirine

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- 6 weeks after ovulation.
- 8 weeks after ovulation.
- 18 weeks after ovulation.
- 20 weeks after ovulation.

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- maternal nephropathy.
- diabetic ketoacidosis.
- congenital anomalies.
- maternal retinopathy.
- C-section.

118. The most common cause of heart disease in pregnant woman is:

- Congenital heart disease.
- Cardiomyopathy.
- Myocardial infarction.
- Cardiomegaly.
- Rheumatic heart disease.

119. The common possible cause of oligohydramnions is:

- Oesophageal atresia.
- Placental haemangioma.
- Renal agenesis.
- Diabetes mellitus.
- Rh incompatibility.

120. Of the following methods, the safest, most precise and simplest for placental localization is:

- auscultation.
- ultrasonography.
- radioisotope study.
- abdominal palpation.
- soft tissue radiography.

121. Pregnancy induced hypertension is diagnosed when:

hypertension is encountered after 20 weeks of gestation.

hypertension gets worse in first week of pregnancy.
hypertension is not controlled with aldomet.
hypertension gives rise to left ventricular failure.
blood urea & creatine levels in blood are abnormal.

122. Shoulder dystocia occurs during:

stage 1 latent phase of labor
stage 1 active phase of labor
stage 2 of labor
stage 3 of labor
can occur at any stage

123. Most important cause of immediate post partum hemorrhage:

laceration of cervix
laceration of vagina
uterine atony
uterine hypertony
placental fragment retention

124. Leopold maneuvers refers to:

delivery of head
external version
internal version
breech extraction
examination of abdomen

125. Refers to the part of the fetus that occupies the lower segment of the uterus or pelvis

the show
the version
the engagement
the lie
the presentation

126. Which is the least frequent site of an ectopic pregnancy?

fallopian tube
cervix
ovary
abdominal cavity
broad ligament

127. Woman with a complete mole is most likely to present with which of the symptoms?

vaginal bleeding
excessive uterine size
hypermesis
prominent theca lutein cysts
pre-eclampsia

128. The gold standard in diagnosing ectopic pregnancy

laparoscopy
culdocentesis
beta HCG
ultrasonography
progesterone

129. The most common side effect of tocolytics agent is:

vaginal bleeding.
abdominal pain.
nausea, vomiting.
palpitations.
oliguria.

130. What is the diameter of fetal skull that presents at vulva during normal labour:

suboccipitofrontal.
mentovertical.
suboccipitobregmatic.
occipitofrontal.
metoposterior.

Block B

B.0 Options for the tasks for the implementation of the LWG, RPR are given: a link to the sources indicated in the lists of basic and additional literature in the work program

B.1 Typical tasks:

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.

Block C

C.0 Variants of tasks for the implementation of course projects/works are given: a link to the sources indicated in the lists of basic and additional literature in the work program

C.2 Individual creative tasks

1. Levels of regulation of menstrual and reproductive function.
2. Endoscopic methods of inspection in gynecology.
3. Congenital dysfunction of bark of adrenal glands.
4. Steroidogenesis in ovaries.
5. Hyper menstrual syndrome.
6. Syndrome of polycystous ovaries.
7. Hyperprolactinemia.

8. Metabolic syndrome.
9. Premenstrual syndrome.
10. Climacteric syndrome.
11. Hypomenstrual syndrome.
12. Sexual transmitted infections

Block D

• Questions to check the level of learning to know

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2. Methods of artificial interruption of pregnancy in early and late terms – indications (basis), conditions, contraindications, choice of a method and technology of performance.
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49. Anesthesia in obstetrics and gynecology. Labor pain relief. Anesthesia at obstetric and gynecologic operations. Types of anesthesia. Application of analgesic preparations at intravenous administration.
50. Preoperative inspection, preparation and postoperative maintaining patients taking into account features and volume of gynecologic operations.

51. Anatomic-topographical relationship of internal genitals and bodies of the urinary systems of the woman. The techniques during performance of gynecologic operations excluding damages ureter and bladder. Diagnostics of complications.
52. Operation. A separate medical and diagnostic scraping of walls of the cervical channel and a cavity of a uterus – indications, conditions, tools. Technology of performance and protocol of operation.
53. Operation of puncture of an abdominal cavity through the back arch of a vagina - indications, conditions, tools. Equipment performance and protocol of operation.
54. Perforation of a wall of a uterus during abortion operation – the reasons, diagnostics, surgical tactics. Volume and technology of performance of operation, rehabilitation postoperative.
55. Surgical anatomy, volume and technology of performance of operation at overwind legs of a cyst (cistoma) ovary. Prevention of possible complications.
56. Methods of female surgical sterilization by tube occlusion. Opportunities laparoscopic technology of voluntary sterilization. Technology of performance of operation on Mandler's method.
57. Normal position of a uterus in a small basin. The Anatomic-physiological factors defining this situation. Medical terminology, norms and options of anomalies of position of a uterus. Surgical methods of their correction.

METHODICAL INSTRUCTIONS FOR THE ORGANIZATION OF THE STUDY OF THE DISCIPLINE:

- Conducting practical classes, monitoring SRS, checking lecture notes, essays, medical history - in the traditional mode.

Training consists of classroom classes, including a lecture course and practical classes, and independent work. The main study time is allocated for practical work on certain diseases. Patient supervision, clinical reviews and the development of practical skills of working with women in labor are widely used.

Practical classes are conducted in the form of bedside work, demonstration of thematic video material and other visual aids, solving situational problems, test tasks, analysis of clinical examples. The student's work in a group forms a sense of teamwork, personal responsibility and sociability. It is necessary to pay attention to the formation of communication skills with the patient.

Working with patients contributes to the formation of deontological behavior, accuracy, and discipline.

When analyzing nosological forms for certain diseases, it is recommended to adhere to the following sequence:

- definition;
- the relevance of the studied nosological form and the history of the issue under study;
- etiology;
- pathogenesis, including genetic factors in the development of the disease, the presence of concomitant pathology, pathomorphology;
- clinical picture;
- criteria for assessing the severity of the course in different periods of the disease;
- complications;
- possible outcomes, criteria for recovery, development of a chronic course, causes of death;
- laboratory and instrumental diagnostics;
- Criteria for diagnosis in different periods of the disease;
- differential diagnosis;
- treatment: etiological, pathogenetic, symptomatic, taking into account the age and severity of the disease, emergency medical care in emergency conditions, treatment of severe forms of diseases,

treatment and prevention of possible complications, treatment in hospital and on an outpatient basis;

- medical examination, rehabilitation;
- prevention.

In accordance with the requirements of the Federal State Educational Standards of Higher Education, it is necessary to widely use active and interactive forms of conducting classes in the educational process (business role-playing games, analysis of specific clinical situations, performing tasks of a search and research nature using Internet resources, etc.). The share of classes conducted in interactive forms should be at least 10% of classroom classes.

MODULAR CONTROL IN THE DISCIPLINE INCLUDES:

1. Current control: assimilation of educational material in classroom classes (lectures, practical, including attendance and activity) and the performance of mandatory tasks for independent work.
2. Midterm control: checking the completeness of knowledge and skills on the material of the module as a whole. The implementation of modular control tasks is carried out in writing and is a mandatory component of modular control.
3. Intermediate control is a completed documented part of an academic discipline, a set of closely related test modules.

BASIC REQUIREMENTS FOR CURRENT CONTROL:

When building a practical lesson, teachers adhere to the following general indicative plan:

1. Organizational stage of the lesson (time - up to 2%);
 - 1) roll call;
 - 2) homework on the following topic;
 - 3) motivation of the topic of this practical lesson;
 - 4) familiarization of students with the goals and plan of the lesson;
2. Control and correction of the initial level of knowledge (time - up to 20%):
 - 1) theoretical survey on the current topic;
 - 2) correction of students' theoretical knowledge by the teacher;
 - 3) the stage of demonstration of practical skills by the teacher (time - up to 15%)
 - 4) the stage of demonstration of students' independent work (defense of the report with presentation) (time - up to 45%)
- 5) the final stage of the lesson (time - up to 18%):
 - a) final final control of the formed theoretical knowledge and skills by solving situational problems;
 - b) summing up the results of the practical lesson (the teacher's characterization of the students' fulfillment of all the goals of the lesson and individual assessment of knowledge and skills).

INDEPENDENT WORK OF STUDENTS

implies preparation for practical classes and includes the study of special literature on the topic (recommended textbooks, manuals, familiarization with materials published in monographs, specialized journals, on recommended medical sites); performing tasks of a search and research nature using Internet resources; preparation of notes, speeches at the seminar, essays, multimedia presentations; conducting business games. Independent work is considered as a type of educational work in the discipline and is carried out within the hours allotted for the SRS. Each student is provided with access to the educational and methodological office of the department and the library funds of the university.

For each section, the department has developed methodological recommendations for students, as well as methodological instructions for teachers.

Recommendations for planning and organizing the time necessary to study the discipline.

1. It is recommended to organize the time necessary for studying the discipline in the following way: Study of the lecture notes on the same day, after the lecture - 10-15 minutes.

Studying the lecture notes the day before the next lecture – 10-15 minutes. Study of theoretical material from the textbook and synopsis – 1 hour per week. Preparation for the practical lesson – 2 hours.

Total per week – 3 hours 30 minutes.

2. Description of the sequence of actions of the student:

To understand the material and assimilate it qualitatively, the following sequence of actions is recommended:

After listening to the lecture and finishing the training sessions, in preparation for the next day's classes, you should first review and think about the text of the lecture you listened to today (10-15 minutes).

When preparing for the next day's lecture, you need to review the text of the previous lecture, think about what the topic of the next lecture may be (10-15 minutes).

During the week, choose a time (1-hour) to work with the recommended literature in the library.

When preparing for the next day's practical classes, you must first read the basic concepts and approaches to the topic of homework. When performing an exercise or task, you must first understand what is required in the problem, what theoretical material should be used, and outline a plan for solving the problem.

3. Recommendations for the use of materials of the educational and methodological complex. It is recommended to use the methodological instructions for the course and the text of the teacher's lectures.

4. Recommendations for working with literature:

The theoretical material of the course becomes more understandable when, in addition to listening to the lecture and studying the notes, books are also studied. It is easier to master the course by sticking to one textbook and notes. It is recommended, in addition to "memorizing" the material, to achieve a state of understanding of the topic of the discipline being studied. For this purpose, it is recommended to perform a few simple exercises on this topic after studying the next paragraph. In addition, it is very useful to mentally ask yourself the following questions (and try to answer them): what is this paragraph about?, what new concepts have been introduced, what is their meaning?, what will it give in practice?.

5. Tips for preparing for midterm and intermediate control:

In addition to studying the lecture notes, it is necessary to use a textbook. In addition to "memorizing" the material, it is very important to achieve a state of understanding of the topics studied in the discipline. For this purpose, it is recommended to perform several exercises on this topic after studying the next paragraph. In addition, it is very useful to mentally ask yourself the following questions (and try to answer them): what is this paragraph about?, what new concepts have been introduced, what is their meaning?, what will it give in practice?.

In preparation for the intermediate control, you need to study the theory: definitions of all concepts and approaches to assessment to the state of understanding the material and independently solve several typical problems from each topic. When solving problems, it is always necessary to be able to interpret the result of the solution qualitatively.

6. Instructions for the organization of work on homework. When doing homework, you must first read the basic concepts and approaches to the topic of the task. When performing an exercise or task, you must first understand what is required in the problem, what theoretical material should be used, outline a plan for solving the problem, and then proceed to calculations and make a high-quality conclusion.

7. In preparation for intermediate and midterm control, you need to study the theory: definitions of all concepts and approaches to assessment to the state of understanding the material and independently complete several typical tasks.

8. Practicing missed classes:

Control over the assimilation of the material of the curriculum of the discipline by students is carried out systematically by the teacher of the department and is reflected in the teacher's journal

and in points. A student who has received an unsatisfactory grade in the current material is obliged to prepare this section and answer it to the teacher at an individual interview.

A lecture missed without valid reasons must be worked out by the method of oral questioning by the lecturer or preparation of an essay on the materials of the missed lecture within a month from the date of absence. Other methods of working out missed lectures are also possible (questioning at practical sessions, test control, etc.). Practicing practical exercises.

- Each lesson missed by a student without a valid reason is worked out without a mandatory basis. Work is carried out according to the schedule of the department, agreed with the dean's office.

- Missed classes must be worked out within 10 days from the date of absence. Seminar classes missed by a student without a valid reason are worked out no more than one lesson per day. Missed classes for a good reason (illness, absences with the permission of the dean's office) are worked out according to the thematic material without taking into account the hours.

- A student who has not completed the pass within the established time frame is allowed to attend regular classes only with the permission of the dean or his deputy in writing. It is not allowed to exclude students who are poorly prepared for these classes from the next seminar class.

- For students who missed seminar classes due to a long illness, the work should be carried out after the permission of the dean's office according to an individual schedule agreed with the department.

- In exceptional cases (participation in inter-university conferences, competitions, Olympiads, duty, etc.), the dean and his deputy, in agreement with the department, can exempt students from working off some missed classes.

PROCEDURE FOR PATIENT SUPERVISION.

1. Theoretical preparation for the patient's supervision (familiarization with the patient's topics).
2. Distribution of patients among students.
3. Establishing a trusting contact with the patient.
5. Collection of complaints and anamnesis of the patient's disease and life.
6. Examination and examination of the systems of internal organs.
7. Examination and description of clinical status.
8. Making a preliminary diagnosis.
9. Collection of laboratory research data.
10. Differential diagnosis.
11. Clinical diagnosis.
12. Determination of the tactics of the proposed management of the patient.
13. Writing diaries, stage or discharge epicrisis in the patient's educational history.
14. A brief summary of etiology, pathogenesis, clinical presentation and treatment according to modern data from literary sources.
15. Discussion of the educational medical history in a group among students and with the teacher of the department.

MEDICAL HISTORY.

The student fills out the medical history according to the specified scheme:

1. General information about the patient;
2. Complaints.
3. Medical history (anamnesis morbi).
4. Life history (anamnesis vitae).
5. Objective research.
6. Traumatological (orthopedic) status.
7. Preliminary diagnosis with justification.
8. Laboratory, instrumental and additional research methods.
9. Clinical diagnosis.
10. Substantiation of clinical diagnosis.
11. Treatment.
12. Diary.

13. Epicrisis.

14. References.

REPORT WITH PRESENTATION. Rules of preparation and writing:

Oral presentation - the report should not be a retelling of other people's thoughts, but an attempt to independently problematize and conceptualize a certain, rather narrow and specific topic. All footnotes available in the work are carefully checked and provided with "addresses". It is unacceptable to include excerpts from the works of other authors in your work without indicating this, to retell someone else's work close to the text without reference to it, to use someone else's ideas without indicating the original source. This also applies to sources found on the Internet. You must specify the full address of the site.

All cases of plagiarism should be excluded. At the end of the work, an exhaustive list of all sources used is given.

Preparation of a report for the lesson.

The main stages of the preparation of the report:

- choosing a topic;
- teacher's consultation;
- preparing a report outline;
- work with sources and literature, collection of material;
- writing the text of the report;
- preparation of the manuscript and its submission to the teacher before the start of the report, which determines the student's readiness for the presentation;
- Presentation of a report, answers to questions.

The topic of the report is proposed by the teacher at the WCF.

Multimedia presentations are a type of independent work of students to create visual information aids made with the help of a multimedia computer program PowerPoint. This type of work requires the coordination of the student's skills in collecting, systematizing, processing information, designing it in the form of a selection of materials that briefly reflect the main issues of the topic under study, in electronic form. That is, the creation of presentation materials expands the methods and means of processing and presenting educational information, forms students' computer skills. Presentation materials are prepared by the student in the form of slides using Microsoft PowerPoint.

Requirement for students to prepare a presentation and defend it in the classroom in the form of a report.

1. The topic of the presentation is chosen by the student from the proposed list of FOS and must be agreed with the teacher and correspond to the topic of the lesson.

2. Stages of preparing a presentation

Drawing up a presentation plan (setting a task; goals of this work)

Thinking through each slide (at first, this can be done manually on paper), while it is important to answer the questions:

- How does the idea of this slide reveal the main idea of the entire presentation?
- What will be on the slide?
- What will be said?
- How will the transition to the next slide be made?

3. Making a presentation using MS PowerPoint:

- It makes sense to be careful. Sloppily made slides (discrepancies in fonts and indentations, typographical errors) arouse suspicion that the student-speaker approached the substantive issues half-heartedly.
- The title page is necessary to introduce you and the topic of your report to the audience.
- The number of slides is no more than 30.
- The optimal number of lines on a slide is from 6 to 11.

- A common mistake is to read the slide verbatim. It is best if detailed information is written on the slide, and the words tell their meaningful meaning. The information on the slide can be more formal and strictly stated than in the speech.
- Optimal switching speed – one slide in 1-2 minutes.
- It is encouraged to use more drawings, pictures, formulas, graphs, tables in the presentation. You can use animation effects.
- When explaining tables, you need to say what the rows correspond to and what the columns correspond to.
- Introduce only those notations and concepts without which it is impossible to understand the main ideas of the report.
- In a short speech, you cannot repeat the same idea, even in other words - time is precious.
- The last slide with conclusions in short presentations should not be pronounced.
- It is recommended to change the main font in the text and formulas to Arial or similar; the Times font looks bad from afar. Be sure to set the MathType to the basic font size equal to the basic font size in the text.

4. A student is obliged to prepare and make a report at a strictly allotted time by the teacher, and on time.

5. Instructions to speakers.

- communicate new information;
- use technical means;
- know and navigate well in the topic of the entire presentation;
- be able to discuss and quickly answer questions;
- strictly follow the established time limit: speaker - 10 minutes; discussion - 5 min.;

It should be remembered that the speech consists of three parts: introduction, main part and conclusion.

The introduction helps to ensure the success of the speech on any topic. The introduction should contain:

- the title of the presentation;
- communication of the main idea;
- modern assessment of the subject of presentation;
- a brief list of issues under consideration;
- a lively interesting form of presentation;

The main part, in which the speaker must deeply reveal the essence of the topic raised, is usually built on the principle of a report. The task of the main part is to provide enough data for listeners and

were interested in the topic and wanted to get acquainted with the materials. At the same time, the logical structure of the theoretical block should not be given without visual aids, audio-visual and visual materials. A conclusion is a clear and concise summary that listeners are always waiting for.

BASIC REQUIREMENTS FOR WRITING TESTS:

1. There are 100 closed-ended questions in one test task.
2. Ready-made answers are given to the questions, one of which is correct and the rest are incorrect.
3. For each correct answer – 1 point.
4. The total score is defined as the sum of the interest earned.
5. The number of percentages collected is converted into points.

REFERENCE VERSION OF THE TEST:

To normalize metabolic processes in the fetus and stimulate oxidative reactions of the Krebs cycle, the following is used:

1. glucose (5-10%) solution with insulin
2. Tocolytics
3. Antispasmodics
4. Sedatives

5. All of the above.

SITUATIONAL TASK IN OBSTETRICS. REFERENCE ANSWER OPTION.

CONDITION: A primiparous woman of 24 years old was admitted to the maternity hospital. For several days - headache, feeling unwell. Before the onset of complaints, I felt healthy. On examination: edema of the lower extremities and anterior abdominal wall. When boiling urine, there is a large flaky sediment. Blood pressure is 180/100 mm Hg. External examination: breech presentation, contractions in 4-5 minutes, s/b of the fetus on the left, above the navel, 140 beats per minute. Pelvic dimensions: 25-28-31-20cm. Vaginal examination: the opening is complete, the amniotic sac is intact, the left leg is palpable on the left and front. The posterior surface of the womb and the sacral cavity are free. During the vaginal examination, convulsions appeared, lasting 3-4 minutes, with loss of consciousness.

- 1) Assess the condition of the woman in labor upon admission.
- 2) Determine the period of labor.
- 3) What does the presence of the amniotic membrane at the moment of labor indicate?
- 4) The cause that provoked the cramps?
- 5) What are the doctor's tactics?

ANSWERS:

- 1) Eclampsia.
- 2) Stage II of labor.
- 3) On the physiological course of the first stage of labor.
- 4) Vaginal examination without inhalation anesthesia.
- 5) Caesarean section.

The initial level of students' knowledge is determined by testing and a mandatory oral interview, the current control of the mastery of the subject is determined by an oral survey in the course of practical classes during clinical reviews, when solving typical situational tasks and modules.

At the end of the cycle, it is planned to conduct a test control on all topics covered in combination with an oral interview. The final control includes:

- Interview on theoretical issues;
- control of practical skills and abilities;
- solving situational problems.

BASIC REQUIREMENTS FOR INTERMEDIATE CONTROL

When appearing for a differentiated test or examination, students are required to have their record books, which they present to the examiner at the beginning of the exam.

At the intermediate control, the student must correctly answer the theoretical questions of the ticket and complete the situational tasks.

Students can use technical means, reference and regulatory literature, visual aids, educational programs.

Assessment of intermediate control:

- min 20 points - Questions to check the level of learning to know (if the student correctly formulates the basic concepts when answering the questions asked)
- 20-25 points – Tasks to check the level of learning to BE ABLE and POSSESS (if the student correctly formulates the essence of the problem set in the ticket and gives recommendations for its solution)
- 25-30 points - Tasks to check the level of learning to BE ABLE and POSSESS (in case of complete completion of the control task).

Questions on obstetrics are included in the Final State Certification of Graduates.