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

in the discipline "Obstetrics"

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**
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	**Know**: methods of conducting research to identify the main pathological conditions, symptoms of disease syndromes, nosological forms	**Block A** Questions for midterm control. Questions for intermediate certification Test tasks Oral questioning
	Be able to: comprehend the results of the study of the main nosological forms of diseases	**Block C** Practical Skills (Bedside / Simulation) Clinical Case Study (Physical Examination, Interpretation of Tests)
	Possess: skills in identifying the main pathological conditions, symptoms, disease syndromes.	**Block D** Analytical Work / Written Analysis (Clinical Case Review) Preparation and protection Clinical Case Presentations
PC-11: readiness to participate in the provision of emergency medical care for conditions requiring urgent medical intervention	**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);	**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
	Be able to: select an individual type of care for the treatment of the patient in accordance with the situation: primary care, hospitalization;	**Block B** Situational tasks (cases) Written analysis of the clinical situation (Preparation of maps, case histories, appointments)
	Possess: the skills to formulate indications for the chosen method of treatment, taking into account etiotropic 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;	**Block D** Analytical work / written analysis (Clinical case review) Preparation and defense of the presentation of a clinical case

2. TECHNOLOGICAL MAP OF THE DISCIPLINE/PRACTICE

Technological map of the discipline "obstetrics"

Course/Semester: 3/5(6) Number of credits (ZE): 5 Reporting: Exam

Name of the modules of the discipline according to the RPD	Control	Form of control	Credit minimum	Classification maximum	Control schedule
Module 1					
	Current	Theoretical survey; Patient supervision (anamnesis, gynecological examination, analysis of laboratory tests) Verification of SRS.	17	30	20/43 weeks
	Rubizhny	Oral questioning Solving situational problems	3	5	
Module 2					
	Current	Theoretical survey; Patient supervision (anamnesis, gynecological examination, analysis of laboratory tests) Verification of SRS.	17	30	21/44
	Rubizhny	Oral questioning Solving situational problems	3	5	
Total per semester			40	70	
Intermediate control (Credit with grade)	Oral questioning Solving situational problems		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:
1.
At pregnancy, the following physiological changes occur in the external genital organs:

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:

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:

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:

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:

labia major;
labia minor;
major glands of vestibulum;
clitoris;
all are incorrect.
#
6.
The internal genital organs include:

uterus;
fallopian tubes;
ovaries;
vagina;
all are incorrect.
#
7.
The primary direction of the muscular fibres in the body of uterus is:

oblique;

circular;
obliquo-longitudinal;
longitudinal;
none of the above.
#
8.
The main direction of the muscular fibres in cervix is:

oblique;
circular;
obliquo-longitudinal;
longitudinal;
none of the above.
#
9.
Ovary is supported in the abdominal cavity by, exept:

ligamentum ovary propria;
ligamentum latum of uteri;
infundibulopelvic ligamentum;
Ligamentum sacro-uterina;
#
10.
What hormone is used as a marker for normal progressing pregnancy?

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).

gastrulation;
location;
histogenesis;
fertilization;
placentation.
#
12.
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.
#
13.
The first trimester of pregnancy is named as a period of:

organogenesis;
placentation;
fetal;
fertilization;
location.
#
14.
The probable sign for diagnosis of pregnancy is:

change of mood;
change of smell;
auscultation of fetal heart beats;
enlarged uterus.
#
15.
The positive sign of pregnancy is:

absence of menses;
increased size of uterus;
dyspeptic disturbances;
presence of fetus in uterus;
abdominal enlargement.
#
16.
Early diagnosis of pregnancy is made by.

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:

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:

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?

threatened abortion (miscarriage);
early gestosis;
anaemia;
hypotonia;
nephropathy.
#
20.
During pregnancy, the predisposition to edema of the lower extremities is caused by:

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?

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:

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:

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?

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:

rhesus conflict;
gestosis (toxicosis);
multiple pregnancy;
gestational pyelonephritis;
all of the above.
#
26.
In obstetrics, USG helps to determine:

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:

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:

maximum flexion;
moderate flexion;
moderate extension;
maximum extension.
#
29.
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 axis to the length of uterus;
interrelation of various parts of fetus.
#
30.
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;
located under obtuse (broad) angle to the axis of uterus.

#
31.
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;
head of fetus to the fundus of uterus.
#
32.
Head presentation of fetus in physiological labour is:

anterior head (cephalic) presentation;
occipital presentation;
frontal presentation;
facial presentation.
#
33.
The most common presentation of fetus is:

complete breech presentation;
breech with flexed legs (frank breech);
footling presentation;
cephalic presentation;
transverse presentation.
#
34.
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;
interrelation of various parts of uterus.
#
35.
Kind of the fetal position is the relation between:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

probing of the uterus;
examination of the uterine cervix by speculum;
biopsy;
histerography;
hysteroscopy.
#
48.
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.
#

49.
Diagonal conjugate can be defined:

on the external conjugate;
on the height of pubis symphysis;
on the lateral conjugate;
on vaginal examination.
#
50.
Diagonal conjugate is the distance between:

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:

31-32 cm;
12-13 cm;
12-15 cm;
28-29 cm;
9-12 cm.
#
52.
True conjugate is the distance between:

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:

13 cm;
11 cm;
10 cm;
20 cm;
9 cm.
#
54.
The normal fetal heart rate per minute is:

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?

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?

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:

3-5 hrs;
6-9 a.m.;
10-2 p.m.;
3-6 p.m.;
7-12 p.m.
#
58.
Unlike nephropathy, in arterial hypertensia the presence of the following symptoms is characteristic:

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:

large fetus;
toxicosis (preeclampsia);
increased volume of amniotic fluid;
multi pregnancy;
all listed.
#
60.
In diagnostics of prolonged pregnancy the following methods are helpful:

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:

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:

the general anaesthesia;
local anaesthesia;
sacral blockade;
without anaesthesia and analgesic;
light analgesia.
#
63.
The labour pain arises owing to:

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:

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:

inhalation anasthetics;
the narcotics;
oxitotics;
analgesics.
#
66.
The indication for the appointment of anesthetics at the first stage of labour is:

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:

extended;
truncated (shortened);
smoothed partially;
smoothed completely;
kept.
#
68.
For a mature cervix of uterus it is characteristic:

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:

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:

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:

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:

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:

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:

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?

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?

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:

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:

after each attempt;
every 5 mines;
every 10 mines;
every 15 mines;
every 20 minute.
#
80.
Vaginal examination in labour is made:

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:

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:

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:

bad healing of perineum;
rupture of muscles of perineum;
development of rectocele and cystocele;
contraction of musclus levator ani.
#
84.

Indications to perineotomia:

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:

promedol;
methylergometrine;
pregnantol;
mammophizin;
quinine.
#
86.
Volume of physiological blood loss in labour:

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:

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:

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:

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:

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:

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:

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?

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?

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:

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:

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:

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:

first 2 months after labour;
period of the breast feeding of a newborn;
period of afterbirth amenorrhea;
all above.
#
99.
The term “lochi” means:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:
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:

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:

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

intrauterine fetal death;
pallor of skin;
anemia;
Rh-sensibilization.
#
113.

Premature detachment of the normally located placenta is complicated by:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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

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:

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:

shin edema;
albuminuria;
subjective complaints: headache, eye sight disturbances;
all of the above.
#
126.
Eclampsia can be differentiated with:

epilepsy;
hypertension;
brain tumours;
stroke;
all above listed.
#
127.
The manifestations of the late gestosis include:

oedema;
proteinuria;
hyperglycemia;
hyperinsulinemia;
all answers are wrong.
#
128.
Complications of eclampsia:

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:

cardiac arrest during convulsions;
pulmonary oedema;
stroke, coma;
all listed above.
#
130.
The most typical cause of maternal death in eclampsia is:

renal-hepatic insufficiency;
stroke;
lung oedema;

infection.
#
131.
The optimal variant for delivery in severe form of gestosis is:

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:

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:

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:

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:

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:

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:

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:

promedol;
morphine;
tocolytics;
spasmolytics;
all listed above.
#
139.
Discoordinated labour activity is characterised by:

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:

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:

decrease in maternal death rate;
decrease in maternal pathologies;
decrease in perinatal death rates;
decreased blood loss.
#
142.
The cesarean section is indicated:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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?

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

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:

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:

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:

respiratory;
alimentary;
excretory;
hormonal;
all listed above.
#
158.
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.
#
159.
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.
#

160.
Name the correct characteristics of the amniotic fluid:

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:

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?

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?

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:

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?

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?

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:

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

presence of choriogonin hormone;
striae gravidum;
lactation;
acromegaly;
pigmentation.
#
169.
What signs are characteristic for 40-week pregnancy?

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:

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:

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:

chin;
the middle of frontal suture;
minor fontanel;
major fontanel;
upper jaw.
#
173.
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;
arrhythmia.
#
174.
Green color of amniotic fluid indicates:

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:

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:

alcohol;
morphine;
penicillin, Streptomycin;
ether;
all listed above.
#
177.
Velocity of penetration of medicines through placenta depends on all listed, except:

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:

30cm;
32cm;
35cm;
50cm.
#
179.
Minimal weight of a viable fetus is:

500g;
600g;
800g;
1000g.
#
180.
Criterion for a viable fetus (newborn) is a term of pregnancy:

20 weeks;
22 weeks;
26 weeks;
28 weeks.
#
181.
Signs of maturity of a newborn are:

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:

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:

developmental anomalies;
hemolytic disease of newborns;
respiratory distress syndrome;
jaundice of newborns;
infections.
#
184.
On the Apgar scale, mild degree of asphyxia is:

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:

prematurity;
detachment of placenta;
extremely intensive labor;
infections in fetus;
arterial hypertension in mother.
#
186.
Causes of fetal respiratory distress syndrome are:

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:

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?

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?

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?

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?

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:

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:

superficial muscles of the perineum;
perineal skin;
levator ani muscle;
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?

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:

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:

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:

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?

shock;
blood loss;
abdominal pain;
stop of labour activity;
all of the above.
#
199.
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.
#

200.
Which signs are not characteristics of early gestosis?

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

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

1.
At pregnancy, the following physiological changes occur in the external genital organs:

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:

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:

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:

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:

labia major;
labia minor;
major glands of vestibulum;

clitoris;
all are incorrect.
#
6.
The internal genital organs include:

uterus;
fallopian tubes;
ovaries;
vagina;
all are incorrect.
#
7.
The primary direction of the muscular fibres in the body of uterus is:

oblique;
circular;
obliquo-longitudinal;
longitudinal;
none of the above.
#
8.
The main direction of the muscular fibres in cervix is:

oblique;
circular;
obliquo-longitudinal;
longitudinal;
none of the above.
#
9.
Ovary is supported in the abdominal cavity by, exept:

ligamentum ovary propria;
ligamentum latum of uteri;
infundibulopelvic ligamentum;
Ligamentum sacro-uterina;
#
10.
What hormone is used as a marker for normal progressing pregnancy?

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).

gastrulation;
location;

histogenesis;
fertilization;
placentation.
#
12.
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.
#
13.
The first trimester of pregnancy is named as a period of:

organogenesis;
placentation;
fetal;
fertilization;
location.
#
14.
The probable sign for diagnosis of pregnancy is:

change of mood;
change of smell;
auscultation of fetal heart beats;
enlarged uterus.
#
15.
The positive sign of pregnancy is:

absence of menses;
increased size of uterus;
dyspeptic disturbances;
presence of fetus in uterus;
abdominal enlargement.
#
16.
Early diagnosis of pregnancy is made by.

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:

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:

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?

threatened abortion (miscarriage);
early gestosis;
anaemia;
hypotonia;
nephropathy.
#
20.
During pregnancy, the predisposition to edema of the lower extremities is caused by:

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?

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:

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:

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?

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:

rhesus conflict;
gestosis (toxicosis);
multiple pregnancy;
gestational pyelonephritis;
all of the above.
#
26.
In obstetrics, USG helps to determine:

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:

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:

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

#
29.
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 axis to the length of uterus;
interrelation of various parts of fetus.
#
30.
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;
located under obtuse (broad) angle to the axis of uterus.
#
31.
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;
head of fetus to the fundus of uterus.
#
32.
Head presentation of fetus in physiological labour is:

anterior head (cephalic) presentation;
occipital presentation;
frontal presentation;
facial presentation.
#
33.
The most common presentation of fetus is:

complete breech presentation;
breech with flexed legs (frank breech);
footling presentation;
cephalic presentation;
transverse presentation.
#
34.
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;
interrelation of various parts of uterus.
#
35.
Kind of the fetal position is the relation between:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

probing of the uterus;
examination of the uterine cervix by speculum;
biopsy;
histerography;
hysteroscopy.
#
48.
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.
#
49.
Diagonal conjugate can be defined:

on the external conjugate;
on the height of pubis symphysis;
on the lateral conjugate;
on vaginal examination.
#
50.
Diagonal conjugate is the distance between:

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:

31-32 cm;
12-13 cm;
12-15 cm;
28-29 cm;
9-12 cm.
#
52.
True conjugate is the distance between:

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:

13 cm;
11 cm;
10 cm;
20 cm;
9 cm.
#
54.
The normal fetal heart rate per minute is:

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?

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?

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:

3-5 hrs;
6-9 a.m.;
10-2 p.m.;
3-6 p.m.;
7-12 p.m.
#
58.
Unlike nephropathy, in arterial hypertensia the presence of the following symptoms is characteristic:

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:

large fetus;
toxicosis (preeclampsia);
increased volume of amniotic fluid;
multi pregnancy;
all listed.
#
60.
In diagnostics of prolonged pregnancy the following methods are helpful:

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:

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:

the general anaesthesia;
local anaesthesia;
sacral blockade;
without anaesthesia and analgesic;
light analgesia.
#
63.
The labour pain arises owing to:

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:

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:

inhalation anasthetics;
the narcotics;
oxitotics;
analgesics.
#
66.
The indication for the appointment of anesthetics at the first stage of labour is:

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:

extended;
truncated (shortened);
smoothed partially;
smoothed completely;
kept.
#
68.
For a mature cervix of uterus it is characteristic:

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:

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:

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:

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:

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:

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:

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?

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?

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:

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:

after each attempt;
every 5 mines;
every 10 mines;
every 15 mines;
every 20 minute.
#
80.
Vaginal examination in labour is made:

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:

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:

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:

bad healing of perineum;
rupture of muscles of perineum;
development of rectocele and cystocele;
contraction of musclus levator ani.
#
84.
Indications to perineotomia:

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:

promedol;
methylergometrine;
pregnantol;
mammophizin;
quinine.
#
86.
Volume of physiological blood loss in labour:

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:

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:

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:

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:

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:

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:

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?

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?

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:

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:

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:

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:

first 2 months after labour;
period of the breast feeding of a newborn;
period of afterbirth amenorrhea;
all above.
#
99.
The term “lochi” means:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:
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:

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:

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

intrauterine fetal death;
pallor of skin;
anemia;
Rh-sensibilization.
#
113.
Premature detachment of the normally located placenta is complicated by:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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

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:

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:

shin edema;
albuminuria;
subjective complaints: headache, eye sight disturbances;
all of the above.
#
126.
Eclampsia can be differentiated with:

epilepsy;
hypertension;
brain tumours;
stroke;
all above listed.
#
127.
The manifestations of the late gestosis include:

oedema;
proteinuria;
hyperglycemia;
hyperinsulinemia;
all answers are wrong.
#
128.
Complications of eclampsia:

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:

cardiac arrest during convulsions;
pulmonary oedema;
stroke, coma;
all listed above.
#
130.
The most typical cause of maternal death in eclampsia is:

renal-hepatic insufficiency;
stroke;
lung oedema;
infection.
#
131.
The optimal variant for delivery in severe form of gestosis is:

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:

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:

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:

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:

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:

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:

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:

promedol;
morphine;
tocolytics;
spasmolytics;
all listed above.
#
139.
Discoordinated labour activity is characterised by:

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:

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:

decrease in maternal death rate;
decrease in maternal pathologies;
decrease in perinatal death rates;
decreased blood loss.
#
142.
The cesarean section is indicated:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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?

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

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:

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:

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:

respiratory;
alimentary;
excretory;
hormonal;
all listed above.
#
158.
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.
#
159.
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.
#
160.
Name the correct characteristics of the amniotic fluid:

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:

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?

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?

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:

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?

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?

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:

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

presence of choriogonin hormone;
striae gravidum;
lactation;
acromegaly;
pigmentation.
#
169.
What signs are characteristic for 40-week pregnancy?

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:

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:

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:

chin;
the middle of frontal suture;
minor fontanel;
major fontanel;
upper jaw.
#
173.
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;
arrhythmia.
#
174.
Green color of amniotic fluid indicates:

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:

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:

alcohol;
morphine;
penicillin, Streptomycin;
ether;
all listed above.
#
177.
Velocity of penetration of medicines through placenta depends on all listed, except:

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:

30cm;
32cm;
35cm;
50cm.
#
179.
Minimal weight of a viable fetus is:

500g;
600g;
800g;
1000g.
#
180.
Criterion for a viable fetus (newborn) is a term of pregnancy:

20 weeks;
22 weeks;
26 weeks;
28 weeks.
#
181.
Signs of maturity of a newborn are:

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:

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:

developmental anomalies;
hemolytic disease of newborns;
respiratory distress syndrome;
jaundice of newborns;
infections.
#
184.
On the Apgar scale, mild degree of asphyxia is:

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:

prematurity;
detachment of placenta;
extremely intensive labor;
infections in fetus;
arterial hypertension in mother.
#
186.
Causes of fetal respiratory distress syndrome are:

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:

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?

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?

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?

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?

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:

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:

superficial muscles of the perineum;
perineal skin;
levator ani muscle;
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?

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:

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:

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:

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?

shock;
blood loss;
abdominal pain;
stop of labour activity;
all of the above.
#
199.
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.
#
200.
Which signs are not characteristics of early gestosis?

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

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:

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.

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.

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.

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.

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.

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.

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).

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.

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.

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.

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.

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.

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.

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.

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.

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.

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%).

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.

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.

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.

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.

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. The influence of female sex hormones on the development of the fetus and the health of the child.
3. Multiple pregnancy.
4. Changes in systems and organs during pregnancy.
5. Hypertensive disorders during pregnancy. Their influence on the "Mother-placenta-fetus" system
6. Pregnancy dominant. Dominant of childbirth. Mechanisms of unleashing tribal forces.
7. Anomalies of labor.
8. Causes of obstetric bleeding during pregnancy, childbirth and the postpartum period.
9. Recurrent pregnancy loss.
10. Postterm pregnancy.

Block D

• Questions to check the level of learning to know

1. Basic methods of examination in obstetrics and gynecology. Clinical and laboratory research methods. Electrophysiological, enodoscopic, morphological research methods in obstetrics. Ultrasound diagnostics in obstetrics: fetometry, Dopplerography, assessment of the biophysical profile of the fetus.
2. Course and management of pregnancy by trimesters of its development. Prevention of complications.
3. Pregnancy dominant. Dominant of childbirth. Degree of maturity of the neck. The essence of reciprocal relations. Factors of unleashing labor.
4. Harbingers of childbirth. Physiological preliminary period. Phases, dynamics of the first stage of labor. Duration of labor depending on parity.
5. Methods for assessing the intensity and effectiveness of labor forces. Hysterography. Tocography. Partogram.
6. Biomechanism of childbirth in the anterior and posterior view of the occipital presentation. Structure and size of the pelvis. Fetus as an object of childbirth.
7. Clinical course and management of labor by periods. Prevention of bleeding in the third stage of labor. Management of the early postpartum period.
8. Breech presentations of the fetus. Features of the course of pregnancy and childbirth. Biomechanism of childbirth. Childbirth management. Methods of delivery. Manuals and operations for breech presentations of the fetus.
9. Multiple pregnancy. Features of the course, management of pregnancy and childbirth. Indications for cesarean section.

10. Childbirth with a large fetus. Features of the course and management. Maternal and fetal outcomes.
11. Physiology and pathology of the postpartum period: changes in hormonal levels, involution of the organs of the reproductive system. Lactation.
12. Recurrent pregnancy loss. Etiopathogenesis. Classification. Tactics of management and treatment of pregnant women with miscarriage. Prevention in risk groups. Course and management of preterm labor.
13. Post-term pregnancy. Effect on the fetus. Etiopathogenesis. Tactics of management and treatment of pregnant women with overcarriage. Prevention in risk groups. Tactics and management of late childbirth.
14. Isoserological incompatibility of maternal and fetal blood. Etiology, pathogenesis, management of pregnancy. Diagnosis of hemolytic disease. Delivery. Prevention and treatment of immunological conflict.
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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 mobi).

4. Life history (namnesis 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.