
Authors' Introduction

Dear Colleagues

We, the editor and authors, trust that you will find this book a valuable tool to help you prepare and pass the Part 2 of the Membership examination.

This book is a follow-up from the principal author's previous very successful short answer question book *Mastering Short Answer Questions for the Part 2 MRCOG Examination with Evidence-Based Answers*. It was extremely helpful to use Dr Elkady's experience of writing books for the Part 2 examination. The RCOG has now replaced the short answer questions with the new single best answer (SBA) questions, so it was felt that another well-referenced, evidence-based question book was required to fill the gap.

Becoming a member of the RCOG is an important step in the career progress of an obstetrician and gynaecologist. Passing the Part 2 MRCOG examination entitles you to attempt the Part 3 clinical assessment, which is the last leg of this long process to achieve membership.

In order to pass Part 2, you need clinical experience, extensive up-to-date evidence-based knowledge, familiarity with UK practices and a good examination technique to achieve a satisfactory score. We trust that our book adequately covers these essentials.

This book comprises 26 chapters covering the RCOG syllabus and is divided into chapters to help you with your reading and preparation in a systematic fashion.

The questions for each chapter are collated, followed by the correct answer. The answers are well referenced, evidence based and with detailed explanations, which will also help you as a revision exercise, particularly on some topics where you may have some difficulty finding up-to-date sources; for example, Chapter 4, Labour Ward Management, and Chapter 12, Paediatric and Adolescent Medicine.

To achieve the maximum benefit from this book, supposing you have already done your revision, you should try to answer the questions before looking at the answers. After you have written down your answers on a separate sheet, cross check against the correct answer and read the explanation. You may still have to review other sources (recent textbooks, Green Top guidelines, *The Obstetrician and Gynaecologist* journal or the NICE guidelines) so that you eventually have full knowledge of the topic and are ready to answer any questions across the syllabus.

After your first review as suggested here, keep reviewing and answering the questions until you achieve at least an 80%–90% correct answer response.

To assist your revision further, we have included a mock examination that is as close as possible to the real examination. You should only attempt this after having done all your homework to avoid disappointment if you do so before you are fully prepared. The mock examination papers, answer sheets and correct answers can be found at www.cambridge.org/9781316621561.

Sometimes there is no absolute right or wrong answer, therefore you may find the occasional discrepancy in an answer that may not match with other sources or references.

You will find out all you need to know about the Part 2 written examination at the college website, using the link [<https://www.rcog.org.uk/en/careers-training/mrcog-exams/part-2-mrcog/>]

The editor and the authors are senior Members/Fellows of the RCOG and are experienced examiners, or very successful organizers of the written and OSCE courses. The contributors, most of them being sub-specialists, have been carefully chosen to offer you the best and most useful questions, answers and explanations. In addition, some of the contributors are new members of the RCOG and can offer you the added advantage of the perspective of fresh graduates who have been through the process just before you, having done their revision adequately and passed the examination.

The authors would like to acknowledge the help and support offered by Paul Fogarty and thank him for suggesting Alexandra Rees as an editor.

We would also like to acknowledge the support of Dr Mohamed Hamed, an MRCOG trainee, on whom we tested a random sample of the questions to get feedback from the perspective of a trainee.

Medical knowledge is constantly changing and newer evidence is always emerging. While we have taken due care that the medical information given is both accurate and up to date according to the best available evidence, readers are strongly advised to confirm for themselves that the information given complies with standard practices.

Last but not least, we wish you good luck with your endeavours to become a member of this internationally accredited elite club, the RCOG.

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Chapter 1

Early Pregnancy

QUESTIONS

1.

A woman who is nine weeks pregnant comes to the early pregnancy assessment unit complaining of severe nausea and occasional vomiting. She is not keen on drug therapy.

What is your advice?

- A. Drink decaffeinated coffee.
- B. Drink ginger syrup.
- C. Drink herbal tea.
- D. Take a long break from work.
- E. Take up yoga.

2.

A 33-year-old woman, gravida 3, para 2, comes to the emergency department complaining of excessive vomiting for the last three days. She is otherwise asymptomatic with a normal past medical history. She is admitted and her thyroid function tests showed a low thyroid stimulating hormone (TSH) level with raised free thyroxine (T4).

What is the most important feature to differentiate transient hyperthyroidism of hyperemesis gravidarum (THHG) from hyperthyroidism?

- A. Absence of current clinical signs and symptoms of hyperthyroidism.
- B. Absence of a history of hyperthyroidism.
- C. Absent enlarged thyroid gland.
- D. Negative thyroid receptor antibodies titre.
- E. Normal TSH and T4 in a repeat thyroid function test.

3.

A primigravida who is 10 weeks pregnant is complaining of slight vaginal bleeding and the occasional abdominal colic. Ultrasound showed a live singleton pregnancy

corresponding to her last menstrual period. She is worried about losing this pregnancy and asks for any medication to help keep the pregnancy. She has read something about progesterone treatment.

How will you counsel her?

- A. She can start oral progesterone therapy.
- B. She can start a combination of oral and vaginal progesterone, as it is more effective than single therapy.
- C. She should start a combination therapy if she gets severe colic.
- D. There is no strong evidence to recommend the use of any progesterone therapy.
- E. Vaginal progesterone is more effective to treat threatened miscarriage.

4.

A 20-year-old woman who was nine weeks into her first pregnancy has just had a complete miscarriage. She is distressed and very tearful. You have explained that miscarriage does not affect her future fertility. Her partner is worried her anxiety may persist and be a possible cause of a delayed pregnancy.

What else will you tell them?

- A. Her anxiety will go away when she misses her next period.
- B. Her anxiety will persist until she achieves another pregnancy.
- C. Her anxiety will continue until she has a healthy baby.
- D. Her anxiety will most likely disappear in around four months when she gets over it.
- E. She should be referred to a psychiatrist.

5.

A woman who is 11⁺³ weeks pregnant complained of abdominal colic and an attack of brisk vaginal bleeding. A repeat ultrasound confirmed fetal demise. You diagnosed inevitable miscarriage. She is considering expectant management.

How will you counsel her?

- A. Arrange for expectant management in a hospital setting as she is under a higher risk of bleeding.
- B. Agree that expectant management is her best option.
- C. Explain that she is at a higher risk of bleeding.
- D. Recommend surgical management as she is at a higher risk of bleeding.
- E. Wait for 14 days before you recommend other options.

6.

A woman who is 11 weeks pregnant with confirmed miscarriage was very hesitant in deciding on medical or surgical management. She was still keen on avoiding the anaesthetic and surgical risks, if possible.

What will you tell her about her chances of not having surgery if she opts for medical management?

- A. It avoids the need for surgery in over 30% of women.
- B. It avoids the need for surgery in over 40% of women.
- C. It avoids the need for surgery in over 50% of women.
- D. It avoids the need for surgery in over 60% of women.
- E. It avoids the need for surgery in over 70% of women.

7.

A 20-year-old woman comes to the early pregnancy assessment unit with 7⁺⁶ weeks amenorrhea and mild to moderate vaginal bleeding with the occasional abdominal pain. She has a positive pregnancy test but refuses a transvaginal ultrasound scan.

How will you handle the situation?

- A. Ask the consultant to talk to her.
- B. Ask her to sign a form that she refused medical advice.
- C. Refer her to the radiology departmental for a scan in the earliest available appointment.
- D. Respect her wishes but explain the limitations of a transabdominal (TAS) versus a transvaginal scan (TVS).
- E. Send her back to her general practitioner.

8.

A woman who is eight weeks pregnant complains of vaginal bleeding. An ultrasound scan showed a crown rump length of 7 mm but no visible fetal heart. You advised her to come for a follow-up scan after seven days. She expressed her concern that waiting that long may harm the pregnancy or her health.

How will you counter her concern?

- A. Assure her that waiting for a repeat scan will have no detrimental effect on the outcome of the pregnancy or her health.
- B. Ask the midwife to talk to her and explain the unit's regulations.
- C. Explain that a serum human chorionic gonadotropin (beta-hCG/BhCG) measurement will confirm the diagnosis of fetal demise.
- D. Give her a leaflet explaining the unit's procedures.
- E. Offer her termination of the pregnancy as this is most likely an unviable pregnancy.

9.

The community midwife calls you about an eight-week pregnant woman who is complaining of vaginal bleeding and abdominal colic. A repeat scan confirmed fetal demise. She opted for expectant management. Her bleeding and abdominal pains have resolved. The woman wants to know how to confirm that miscarriage is complete.

What is your advice?

- A. No need for any further follow-up as she is no longer symptomatic.
- B. Return for advice if the bleeding starts again.
- C. Repeat a pregnancy test after one week.
- D. Repeat a pregnancy test after two weeks.
- E. Repeat a pregnancy test after three weeks.

10.

A woman who is 11 weeks pregnant is diagnosed with incomplete miscarriage. She opts for medical management.

What will you offer her?

- A. Oral mifepristone and 800 mcg misoprostol in one setting.
- B. Oral mifepristone and then 800 mcg misoprostol when she starts having contractions.

- C. Oral 800 mcg misoprostol.
- D. Vaginal 600 mcg misoprostol.
- E. Vaginal 800 mcg misoprostol.

11.

A pregnant woman is diagnosed with miscarriage based on absent cardiac pulsation in repeat scans. She opted for surgical management as her work commitments would not allow for a long wait and she feels she may not be able to cope with bleeding and pain if she opts for medical management. She was undecided, however, about an outpatient setting manual vacuum aspirating (MVA) under a local anaesthetic or a hospital evacuation curettage (EVA) under a general anaesthetic.

How will you counsel her?

- A. Arrange for a meeting with an experienced counsellor.
- B. Ask the consultant to come and talk to her.
- C. Explain that the median waiting time, the number of women requiring a blood transfusion, and the mean blood loss were all lower in an outpatient setting.
- D. Strongly recommend MVA because she will not be exposed to the risks of general anaesthesia.
- E. Strongly recommend EVA because it is more effective.

12.

A 23-year-old woman in her second pregnancy presents to you requesting surgical termination of the pregnancy. She is 11 weeks pregnant, verified by ultrasound scan.

What is the risk of uterine perforation in this case?

- A. 1–4/1000.
- B. 5–9/1000.
- C. 10–14/1000.
- D. 15–19/1000.
- E. 20–24/1000.

13.

A 31-year-old woman is booked for surgical termination of pregnancy at nine weeks' gestation.

Which of the following options is correct regarding prevention of infective complications?

- A. Augmentin 625 mg within two hours before the procedure.
- B. Ceftriaxone 500 mg within two hours before the procedure.
- C. Doxycycline 200 mg within two hours before the procedure.
- D. Metronidazole 500 mg within two hours before the procedure.
- E. No antibiotics are needed.

14.

The general practitioner calls you out of hours to ask what to do because she has an eight-week pregnant woman who is complaining of moderate right abdominal pain and slight vaginal bleeding.

What is your advice?

- A. Book the woman to the earliest antenatal clinic appointment.
- B. Book the woman for the earliest possible ultrasound scan.
- C. Immediate referral to the emergency gynaecology unit.

- D. Offer the woman an analgesic.
- E. Refer the patient to the next day early pregnancy assessment unit.

15.

The midwife in the early pregnancy assessment unit asks you to review a woman who has seven weeks of amenorrhoea but the previous and current ultrasound could not locate the pregnancy. The human chorionic gonadotropin (hCG) increased from 800 IU/L to 1600 IU/L after 48 hours. The woman is fit and well with no signs or symptoms.

What is your next plan?

- A. Ultrasound scan within four to seven days.
- B. Ultrasound scan after 14 days.
- C. Ultrasound scan after nine days.
- D. Request an inhibin blood test.
- E. Request a serum progesterone blood test.

16.

The serum hCG of a symptomless woman with a pregnancy of unknown location (PUL) has dropped by more than 50% after 48 hours.

What is the next step you advise?

- A. Ask her to submit a urine pregnancy test after 14 days if she stays asymptomatic.
- B. Discharge her home.
- C. Repeat the hCG after another 48 hours.
- D. Request a cancer antigen (CA-125) blood test.
- E. Request a Doppler ultrasound scan.

17.

A woman who is eight weeks pregnant is offered laparoscopic surgical management of an ectopic pregnancy. She had a previous normal pregnancy and vaginal delivery.

How will you justify laparoscopic salpingectomy as opposed to salpingostomy?

- A. Removing the diseased tube is easier and quicker to perform.
- B. Removal of the diseased tube will not affect her future fertility.
- C. Removing the ectopic pregnancy and keeping the tube will have a significantly higher incidence of a recurrent ectopic pregnancy requiring repeat surgery.
- D. Removing the ectopic pregnancy and keeping the tube will require more follow-up visits and tests, currently.
- E. There are no differences in the management options for the current or future pregnancies.

18.

A 15-year-old single teenage girl comes to see you because she had an unplanned pregnancy. She is nine weeks pregnant after failure of an emergency post-coital contraception. She explains her great inability to handle either the pregnancy care or the child, if born, for personal and social reasons.

How will you handle the situation?

- A. Ask her to bring her parents to discuss the situation.
- B. Ask her to bring her boyfriend to discuss the situation.

- C. Advise her to involve her parents but endorse her request if two doctors agree that she has sufficient maturity and understanding to appreciate what is involved.
- D. Refer her to a psychiatrist to assess her ability to understand what is involved.
- E. She cannot have an abortion without her parents' consent because she is under age (16 years).

19.

The general practitioner calls to ask about the immediate follow-up of a woman who had a suction evacuation of a complete molar pregnancy.

What is your advice?

- A. Do a urine or blood test for human chorionic gonadotropins (hCG) every two weeks for eight weeks.
- B. Do a urine pregnancy test every two weeks for 24 weeks.
- C. Do a urine check test every week until it is negative for four successive tests.
- D. Do a urine or blood test for hCG every week until it normalizes.
- E. No need for any follow-up if the urine pregnancy test is negative after one month.

20.

A woman has an evacuation of a partial molar pregnancy. She was 11 weeks pregnant.

What is your follow-up plan?

- A. Chorionic gonadotropin (hCG) assessment until she starts a hormonal contraception after the tests have normalized.
- B. Serum and urine hCG every two weeks until the levels are normal followed by one confirmatory normal urine sample after four weeks.
- C. Serum hCG after four weeks.
- D. Urine pregnancy test every two weeks.
- E. Urine pregnancy test every four weeks.

21.

Following appropriate treatment of complete and partial molar pregnancies, what percentage of women need additional chemotherapy in each case, respectively?

- A. 10% and 0.3%.
- B. 15% and 0.5%.
- C. 20% and 1.0%.
- D. 25% and 2.0%.
- F. 33% and 3.0%.

22.

A 36-year-old woman has had a suction evacuation because of a complete molar pregnancy. Her chorionic gonadotropin (hCG) levels started to rise six months after treatment. Her FIGO 2000 score was assessed as 6.

What is your management?

- A. Intravenous multi-agent chemotherapy.
- B. Needs treatment only if her score goes up to 7.
- C. Single-agent intramuscular methotrexate.
- D. Subtotal hysterectomy.
- E. Total hysterectomy and bilateral salpingo-oophorectomy.

23.

A 28-year-old woman who has received single-agent chemotherapy because of a persistent rise in her chorionic gonadotropin levels after evacuation of a complete molar pregnancy asks about her future fertility options.

What will you tell her?

- A. She cannot conceive because of the chemotherapy.
- B. She can conceive but after one year of completion of her treatment and follow-up.
- C. She can conceive after two years of undetectable gonadotropin levels (hCG) levels.
- D. She can conceive after two years of a contraceptive.
- E. She can conceive but only with oocyte donation.

24.

To improve the results of treatment of gestational trophoblastic disease (GTD), what audit topic would you recommend?

- A. The proportion of women with GTD registered with the relevant screening centre.
- B. The proportion of women with a histological diagnosis of molar pregnancy who were diagnosed by ultrasound before evacuation of the molar pregnancy.
- C. The proportion of women who receive medical management for the evacuation of a molar pregnancy.
- D. The proportion of women who had histological examination of the products of conception after an induced abortion.
- E. The proportion of women who did not use contraception during the follow-up period.

25.

You are counselling a couple who have had two consecutive miscarriages. She is 22 years old and wants to know if there are any age-related risks of miscarriage.

Which of the following age groups is associated with the smallest risk of miscarriage?

- A. 12–19 years.
- B. 20–24 years.
- C. 25–29 years.
- D. 30–34 years.
- E. 35–40 years.

26.

There are cases of women who have recurrent miscarriages.

What percentage of these women have antiphospholipid antibodies?

- A. 5%.
- B. 10%.
- C. 15%.
- D. 25%.
- E. 40%.

27.

Your foundation year 2 trainee enquires about the different types of thrombophilia.

Which of the following is an acquired thrombophilia?

- A. Antiphospholipid syndrome.
- B. Activated protein C resistance.
- C. Factor V Leiden.
- D. Prothrombin gene mutation.
- E. Protein S deficiency.

28.

A couple who have had three consecutive miscarriages have come to see you for advice after having a thrombophilia screen. The result showed that she was positive to one of the antiphospholipid antibodies.

Which of the following is an antiphospholipid antibody?

- A. Anti-B2-glycoprotein-1 antibody.
- B. Anti-B1-glycoprotein-1 antibody.
- C. Anti-B2-glycoprotein-2 antibody.
- D. Anti-B2-glycoprotein-3 antibody.
- E. Anti-B3-glycoprotein-1 antibody.

29.

A couple who have had three consecutive miscarriages have come to see you for counselling. Genetic screening showed a paternal balanced translocation.

What is their chance of having a healthy baby?

- A. 0%.
- B. 10%–20%.
- C. 20%–30%.
- D. 40%–50%.
- E. More than 80%.

30.

A 20-year-old woman presents to the family planning clinic. She is requesting termination of a 10-week pregnancy. She had a surgical termination of a 14-week pregnancy six months previously. She had problems attending and complying with the different family planning options offered to her after completion of the termination of her previous pregnancy.

What is your advice for an effective contraception in her situation?

- A. Change to surgical termination so she can have a copper intrauterine device inserted at the end of the procedure.
- B. Change to surgical termination so she can have a Mirena coil inserted at the end of the procedure.
- C. Carry on with the medical termination but have the etonogestrel implant inserted at the time of mifepristone administration.
- D. Carry on with any method of termination and resort to tubal ligation at the end of the procedure.
- E. She should be able to revisit the family planning clinic after she gets her first period.

31.

A 25-year-old woman is referred to the clinic. She has a pituitary macroprolactinoma and has been treated with bromocriptine for a year. Her prolactin levels have been normal for the past six months. She is now 11 weeks pregnant and was advised to