Q1. G₃ P₂ A₀ presents at 34 weeks of gestation with the history of heavy vaginal bleeding, abdominal pain and decreased fetal movements and O/E uterus is tense and tender.

a) What is the most likely diagnosis?
b) Give steps of management.

Key:

Diagnosis-abruptio placenta.
Management:
1. Access general condition.
2. Stabilize the patient.
3. Fetal well being (cTG Biophysical Profile).
4. Decision about mode of delivery depending upon type and severity of haemorrhage
   -Maternal condition.
   -Gestational age.
   -Fetal condition.
   -Bishop’s scoring.
   -Previous mode of delivery.
Q2. \( P_1 A_0 \) presents two weeks after delivery with fever, rigors, chills, red hot and tender left breast.

a) What is the most likely diagnosis?

b) Briefly outline your management?

**Key:**

Diagnosis-Breast abscess.

Management:

History examination.

Investigation.

Treatment:

- Antibiotics.
- Analgesics.
- Incision and drainage.
- Post operative advice regarding continuation of breast feeding.
- Follow up.
Q3. G₃ P₂ A₀ presents at 36 weeks of gestation. She has breech presentation.
Enumerate five complications of external cephalic version? (ECV)

**Key:**

Complications of ECV:
1. Preterm labour.
2. Preterm premature rupture of membranes (PPROM).
3. Placental abruption.
4. Rh sensitization.
5. Evulsion of cord.
6. Fetal distress/death.
Q4. A 24 years old primigravida presents in emergency at 12 weeks of gestation with history of increased frequency of vomiting for the last two days O/E her pulse is 100/minute & blood pressure 90/60 mm Hg.
   a) What is your the most likely diagnosis?
   b) Give steps of your management in this case?

Key:

Diagnosis-Hyperemesis gravidarum.
Management:
- History (rule out gastroenteritis).
- Examination-General, physical and obstetrical.
- Investigations-Baseline, serum electrolytes LFT’s, RFt’s, USG to rule out twin gestation and trophoblastic disease.
Treatment:
- Change of environment.
- Rehydration.
- Antiemetics.
- Vitamins.
- Treatment of cause.
- Prevent complications.
Q5. Primigravida at 10 weeks of gestation is presented at antenatal clinic. Enumerate routine investigations you advice?

**Key:**

- Blood Grouping and Rh factor.
- Hb.
- TLC, DLC, ESR. \(\text{CBC}\)
- Platelet count.
- Urine complete examination.
- Blood sugar.
- Dating Scan.
- Hepatitis screening.
- Rubella antibodies.
Q6. Primigravida at 38 weeks presents in emergency with tonic, clonic fits. O/E B.P. is 180/120 mmHg with generalized edema. Outline plan of emergency management?

Key:

Diagnosis-Eclampsia.
-Senior obstetrician, anaesthetist nursing staff should be available.
-I/V line./Catheter./O2.
-Arrangements for airway maintenance.
-Blood for investigation.
-Hb, Platelet count, LFT’s.
-Coagulation profile.
-Renal functions, uric acid.
-C/E urine.
Ultrasound scan for fetal well being.

Treatment:
-Aims-Stabilization of patient.
-Control of B.P., Hydralazine, Isokit, Nifedapine.
-Control of fits, MgSO₄.
-Prevention of recurrence of fits. – MgSO₄, sedation.
-Delivery C-section.
-Look for complications.
-Follow up.
Q7. Gravida 2 is going to have outlet forceps delivery because of poor maternal effort.
Enumerate prerequisites of forceps delivery?

**Key:**

1) Presentation should be suitable, cephalic or mentoanterior.
2) Full dilatation of cervix.
3) Empty bladder.
4) Good contractions.
5) Analgesia-Epidural, Pudendal block + Local, perineal infiltration.
6) There should be no cephaolpelvic disproportion.