Obs/gyne OSCE

018/019/020

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لا تنسوا أهلنا في غزة من دعائكم

Obstetrics and gynaecology OSCE
Batch 20’

1st rotation:

Group 1:
Section 1: APH (placenta previa),

- Differentials: **placenta previa, vasa previa, abruptio placenta, uterine rupture, + mention local causes**
- Types of placenta previa & there definition +placenta accreta
- Risk factors of placenta previa **(mention 8-9)**
- Is it painless or painful? Management?

Section 2: Abdominal pain (ovarian torsion),

- Differentials **(must mention Mittelschmerz)**
- Investigations
- Management → **(it was detorsion cystectomy)**

Section 3: urinary incontinence

- Types
- How to differentiate stress from urge
- Risk factors (mention around 11)
- Diagnosis
- Management

Section 4: Molar pregnancy & miscarriages

- First trimester bleeding differentials:
  miscarriages, molar, ectopic pregnancy
- Mention types of miscarriages & how you differentiate them on US and on physical?
  US: Products of conception, physical: cervix closed or open
- Molar: risk factors, US findings, management of resection and evacuation. Investigations and how to follow the HCG. **(hyperemesis gravidarum, TSH are important to mention)**

Group 2: Antenatal Booking, PPH, fibroid, pelvic prolapse (almost the same as in checklists)

Insaf Iyad
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2nd Rotation
Group 1:

Station 1: A case of PPH

- Mention risk factors
- Management (especially drugs)

Station 2: A case of miscarriage

- Types of miscarriage [*incomplete,complete,missed,septic,threatened*]
- Investigations [*hx,pex,US,B-HCG,CBC,blood group*]
- Management [*expectant,surgical,interventional*]
- Complications [*bleeding,perforation,incomplete evacuation, injury to bowel or bladder,embolism*]
- Findings in a missed miscarriage [*closed OS, thin endometrium*]

Station 3: A case of a 36 + week pregnant eclamptic patient having convulsions

- Management [*starting from admission &ABCs until delivery*]
- 4 things to monitor after administrating MgSO4 [*deep tendon reflexes,respiratory rate, urine output, serum level of Mg]*
- Mode of delivery

Station 4: Prolapse

- Risk factors
- Symptoms
- Types
- Complications Of Surgery

Group 2:

Section 1: 28 year old G3 P1+1 presents to the emergency department complaining of right iliac fossa pain. Her LMP was 7 weeks ago. She looks in pain with stable vital signs, abdominally she is tender over the right iliac fossa.

- **Differentials:**

Ectopic pregnancy, abortion, salpingitis, PID, ruptured ovarian cyst, adenexal or ovarian torsion, UTI, urertic stone, appendicitis, gastroenteritis

- **Investigations:**

B-HCG, urine test, HB/PCV, WBCs,CRP, stool analysis, U/S, CT scan

- **What are ultrasound findings in ectopic pregnancy?**

Empty uterus, adenexal mass, fluid in POD

- **3 prerequisties for medical treatment**

Gestational sac <4cm, no hemoperitoneum, no fetal heart, stable pt, B-HCG <10000 IU/L

Section 2: 41 weeks pregnant, fully dilated, CTG showed decelerations and bradycardia

- **What is your next step? And why?**

Instrumental delivery (assisted delivery), because of fetal distress

- **What are the available options?**

Vacuum or Forceps

- **What would you choose?**

Depending on which instrument I have more experience to use

- **What are the prerequisites of assisted vaginal delivery?**

Expert doctor, Empty bladder, Fully dilated cervix, head engaged, Vertex presentation, Adequate contractions, Station more than 1, no susception of fetal bleeding, adequate pelvic dimentions, gestational age >34 wks

- **Indications?**

Exhausted mother, Maternal morbidity mainly cardiac, Prolonged 2nd stage of labor, non-reassuring fetal heart rate, breech presentation

- **Complications of assisted vaginal delivery?**

Maternal hematoma, Genital tract lacerations, Fetal scalp hematoma, Fetal facial palsy, Fetal Skull trauma

Section 3: a lady 3 years post menopausal presented with vaginal spotting

- **Differentials:**

Endometrial / vaginal atrophy, exogenous estrogen, endometrial CA, endometrial or cervical polyps, endometrial hyperplasia

- **Investigations:**

U/S (endometrial thickness must be <5 mm), endometrial sampling (pippell), hysterectomy and D&C

- **Biopsy came back positive for endometrial cancer with endometrial thickness of 10 mm, what are the risk factors?**

Early menarche, late menopause, low parity, obesity, high socioeconomics, history of breast or cervical cancer, family history of endometrial cancer

- **Management**

TAH + BSO

Section 4: 24 wks pregnant lady with abdominal and back pain

- **Take history:**

Pain analysis, other symptoms like bleeding or discharge, gi symptoms, urinary symptoms, OBS/GYN history, LMP, fetal movements, exacerbating and relieving factors, ROM, history of HTN, epigastric pain, blurring vision, headache, trauma

- **Investigations**

CBC, blood group, detailed anomaly scan (rule out congenital anomalies), GTT, viral screening if infection is suspected, U/S

- **Pt was found to have polyhydramnios, what are the causes of polyhydramnios?**

Maternal causes: Idiopathic, GDM, CVS disease, TORCH infections, placental chorioangioma
Fetal causes: anemia, anomalies and malformations like intestinal obstruction, anencephaly, hydrops fetalis, twin to twin transfusion syndrome, trisomy

- **Physical exam findings:**

Distended abdomen, shiny skin, varicose veins, stria, itching, difficult to feel fetal parts or hear fetal heart, lower limb edema, hemorrhoids, abnormal lie and presentation

Obstetrics and Gynaecology OSCE
Batch 19'

1st rotation:

Section 1: Antenatal Booking

- List five key pieces of information you would want to obtain in the history during an antenatal booking appointment

ANS: **LMP, PMHx, PObsHx, FHx, Social Hx**

- What are the main laboratory investigations typically performed during antenatal booking?

CBC, Blood type, Rubella and varicella Ab titers., Urine dipstick, Urine culture and screening for STIs and blood borne pathogenesis.

- What specific test is used to screen for gestational diabetes mellitus (GDM)?

ANS: **50-gram glucose challenge test (O'Sullivan test)**

- At what gestational age is screening for GDM typically performed?

ANS: **24-28w**

- At what gestational ages are anomaly scans usually performed? (Provide two ranges)

ANS: **First trimester 10-14w, 2nd trimester 18-22w**

Section 2: Pelvic Organ Prolapse (POP)

- List five important elements you would include in a history for a patient presenting with symptoms of pelvic organ prolapse

ANS: **Nature of symptoms, 'can you describe the feeling of discomfort' 'where do you feel it?' 'Is there a sensation of pressure, fullness or something falling out' 'Where do you feel it?'/ Ask for symptoms severity and impact. / Onset and progression / Exacerbating and reliving factors / Bowel and bladder function**

- What are the risk factors of such condition?

ANS: **Parity (Vaginal delivery >), Age and menopause, Heavy lifting, obesity, Chronic cough, Hysterectomy, CTDs, Family history.**

- What are the main types of pelvic organ prolapse?

ANS: Cystocele, Rectocele, Uterine prolapse, Enterocele, Vaginal vault prolapse

Section 3: Postpartum Hemorrhage (PPH)

- A patient has a vaginal delivery and is transferred to the recovery room. Two hours later, she experiences heavy vaginal bleeding. What is the most likely diagnosis? **ANS: Primary PPH**

- List four possible causes of primary postpartum hemorrhage?

ANS: Uterine atony, Retained placental tissue, Genital tract trauma, coagulopathy.

- Name three drugs commonly used in the management of postpartum hemorrhage?

ANS: Oxytocin, Ergometrine, Misoprostol.

- What important step should be performed before initiating uterine massage in a patient with postpartum hemorrhage?

ANS: Empty the bladder

Section 4: Abdominal Pain in Pregnancy

- A pregnant woman at 20 weeks' gestation presents with right-sided abdominal pain. List three possible differential diagnoses:

ANS: Ectopic pregnancy, ovarian cyst (rupture or torsion) and appendicitis.

- What laboratory tests would you order for this patient?

ANS: Beta-hCG, CBC (Anemia, Infection), Progesterone levels

- What imaging modality is most appropriate for evaluating abdominal pain in a pregnant patient?

ANS: TVUS (BETTER visualisation of the pelvic organs, identify IUP, ectopic pregnancy or other causes of abdominal pain)

- If ectopic pregnancy is diagnosed, what are the classic findings on ultrasound?

ANS: Absence of IU gestational sac, presence of an adnexal mass, free fluid in pelvis (sug of rupture)

- List two main lines of management for ectopic pregnancy.

ANS: Medical Mx with MTX injection and Surgical Tx via laparoscopic or laparotomy

- What are the indications for methotrexate therapy in ectopic pregnancy?

ANS: Hemodynamically stable, unruptured, small ectopic mass size <3.5 cm, low b-hCG levels, no fetal cardiac activity, patient willing and able to comply with follow up.

Section 5: Cardiotocography (CTG)

- What abnormal feature in this CTG?

ANS: Fetal bradycardia FHR > 110 FOR > 3min sug of fetal distress

- List six important points to consider when interpreting a CTG.

ANS: 1. Patient ID, Paper speed, data and time 2. **Baselines FHR 3. Variability 4. Accelerations 5. Decelerations 6. Contractions,.**

- Name three reassuring features of a CTG.

ANS: Normal baseline FHR of 110-160. Moderate variability from the baseline of 6-25 bpm. Presence of accelerations.

- In the case of fetal distress detected on CTG, list four initial management steps before considering delivery.

ANS: Change the mother's position to left lateral position, O2 admin, Fluid bolus and stop oxytocin and vaginal examination. If these failed => Immediate delivery.

Section 6: Urge Incontinence

- Take a detailed history from such patient.

ANS: Fever, Dysuria, Hematuria, Low back pain, Vaginal bleeding, Vaginal heaviness, Frequency(How often of you urinate during the day and night?), Urgency(Do you experience a sudden, compelling urge to urinate that is difficult to avoid?), Nocturia, Hesitancy, stress recurrent UTI, Difficulty in initiation of urination, Family Hx of prolapse, pelvic surgery and heavy lifting.

- What are main laboratory or diagnostic investigations you would consider for a patient with urge incontinence?

ANS: Urinalysis (R/O UTI), Urodynamic studies, CBC, CRP, Urine culture, speculum, bimanual examination and US.

- If a patient reports feeling a lump in the vagina, what condition might this suggest?

ANS: Pelvic Organ Prolapse

- Types of prolapse:

ANS: Uterine prolapse cystocele, rectocele.

Section 7: Antepartum Hemorrhage (APH)

- THE case ethology was trauma but Other than trauma, list four risk factors for placental abruption?

ANS: Prior Abruption, PROM, Low BMI, Polyhydraminos, Premature rupture of membranes, IU infections, PET, Smoking, substance misuse (Amphetamines, Cocaines), Multiparty, IFGR, Non-vertex presentation, IVF, First trimester bleeding with hematoma on US, Folate deficiency.

- In a case of placental abruption where the patient is stable with a 5 cm cervical dilation, what is the most appropriate next step in management?

ANS: Elective vaginal delivery but if unstable = CS.

- What is the appropriate management if the patient with placental abruption is unstable?

ANS: Admission to labor room, Check insure vitals for stabilisation, IV cannula for fluids, CBC, Blood group, KFT and coagulation factors, cross match, do proper physical and obs examination and US to check for viability, placental localisation and amount of liquor., Immediate delivery via CS.

Section 8: Early Pregnancy Complications

- A patient presents at 7 weeks gestation with vaginal bleeding and mild abdominal pain. List four possible differential diagnoses.

ANS: Ectopic pregnancy, Threatened miscarriage, molar pregnancy or trauma.

- **Hx, PEx ? Similar to checklists.**

- In an ultrasound examination, the presence of an intrauterine pregnancy with a crown-rump length (CRL) > 7mm and no fetal heart activity is most consistent with which diagnosis? **ANS: Missed miscarriage**

2nd rotation:

Section 9: Fibroids in Pregnancy

- List four differential diagnoses for abdominal pain in a pregnant woman with fibroids

ANS: Red degeneration of a fibroid, Appendicitis, Placental abruption and preterm -labor.

- What investigations would you consider for a pregnant woman with fibroids presenting with abdominal pain?

ANS: Abdominal and pelvic saline infusion US (Size, location of fibroid)(R/O other causes of pain), CBC, Urinalysis. MRI, D&C

- Name three potential complications that fibroids can cause for the fetus during pregnancy:

ANS: Fetal malpresentation, Labor dystocia, Preterm labor, IUGR.

- What is the approximate risk of malignancy in uterine fibroids? **ANS: 0.25%**

Section 10: CTG (Brady cardia)

Section 11: PROM

Section 12: Urine incontinence

Section 13: Urge incontinence

Section 14: Torsion of ovarian cyst (The case: Patient came with sudden severe abdominal pain)

- Give DDx:

ANS: Gynecologic: PID, Ectopic pregnancy, Endometriosis with acute haemorrhage or rupture, Ovarian hyper stimulation syndrome. Non-Gynecologic: Appendicitis, Diverticulitis, Enterocolitis, Bowel ischemia, IBD)

- Investigations?

ANS: CBC, CRP, Urinalysis,TVUS (Look for ovarian enlargement, abnormal ovarian position, free fluid in pelvic, decreased blood flow on Doppler) CT or MRI

- Management of 5*6 mass with absent flow?

ANS: Laparoscopy, if the ovary is viable = Ovarian cystectomy. If necrotic = Oophorectomy.

Section 15: Preterm labor.

- What are the risk factors?

ANS: Age <15yr, first time mothers, >35y, lowest risk between 25-29yr. Black women, Low weight, Smoking, Alcohol, Prior preterm, 2nd trimester abortions, uterine abnormalities, prior pregnancy bleeding. Uterine over distension, APH, IUD, PPPRO, multi-gestations, shortened cervix <3cm.

- Character of pain and symptoms?

ANS: Symptoms are regular uterine contractions occurring with cervical changes; Dilatation of 2cm or more, effacement over 80% + Increased vaginal discharge, diarrhea.

- What tocolytics to use?

ANS: Terbutaline B-agonist, Indomethacin, Magnesium sulfate, CCBs Nifedipine, Oxytocin antagonists Atosiban.

- When to not prevent labor?

ANS: ABSOLUTE: Fetal death, fetal anomalies incompatible with life, Chorio-amnionitis, fetal or maternal condition requiring delivery. RELATIVE: IUGR, PET, Cervical dilation >4cm and vaginal bleeding.

3rd Rotation

Section 16: Abdominal pain in pregnant woman ==> Fibroids

Section 17: A woman wants to insert IUD, take Hx , Intrauterine Devices (IUD)

- List five important points to include in the history when a woman requests IUD insertion.

ANS: Menstrual Hx? (Regularity, Heaviness of flow, any pain) Sexual Hx (# of partners, history of STIs and current contraceptive use = STI screening before insertion), Pregnancy Hx (Past pregnancies and if there is any ectopics, miscarriages, deliveries), Medical Hx (DM, bleeding disorders, allergy to copper) , Gyne Hx (Previous IUD use, PID or abnormality in uterus.)

- What are three potential complications of IUD use?

ANS: Menorrhagia and dysmenorrhea (Especially with copper IUDs), Expulsion, Uterine perforation.

- For a patient with heavy menstrual bleeding, which type of IUD would you recommend? **ANS: Mirena (Levonorgestrel-releasing IUS)**

- If you perform a speculum exam and cannot visualize the IUD strings, what are the next two steps in priority?

ANS: TVUS (To confirm IUD's location within uterus and r/o displacement and perforation) = Further imaging if IUD no found on TVUS = Abdominal XR or pelvic MRI.

- If imaging reveals that the IUD has perforated the uterus and is in the abdominal cavity, what is the appropriate management?

ANS: Laparoscopic or open surgery

Section 18: Pre-eclampsia

- List five physical signs or symptoms that may be present in a patient with pre-eclampsia **ANS: HTN, Proteinuria, Edema, Headache, Visual disturbances.**

- Name four risk factors for developing pre-eclampsia

ANS: Primigravida, age>40yr, BMI>35, first degree relative with PET

- What are three potential fetal complications associated with pre-eclampsia?

ANS: IUGR, Preterm birth and fetal distress

Section 19: Right Iliac Fossa (RIF) Pain - Ruptured Ectopic Pregnancy

- In a patient presenting with right iliac fossa pain suspected of having a ruptured ectopic pregnancy, list four key elements of the physical examination

ANS: Abdominal tenderness, adnexal tenderness or mass, hypotension or signs of shock, referred shoulder pain due to diaphragmatic irritation from intra-abdominal bleeding.

- Provide three differential diagnoses for right iliac fossa pain in a woman of reproductive age

ANS: Appendicitis, Ovarian torsion, Ruptured corpus luteum cyst.

- Outline the initial management steps for a patient with a suspected ruptured ectopic pregnancy

ANS: Admit the patient, immediate stabilisation (2 large IV cannulas, Blood typing and urgent blood transfusion and IV fluids), urgent surgical consultation and confirm diagnosis with US and beta-hCG testing.

- What type of surgery is typically performed for a ruptured ectopic pregnancy?

ANS: Emergency laparotomy with salpingectomy.

4th Rotation

Section 20: APH

- DDx, risk factors for placental abruption, investigation and Management.

Section 21: Vaginal discharge (Candida vaginitis)

- Take detailed Hx:

ANS: Onset and duration, character of discharge (Colour, Thick, watery or clumpy and is there an odor?) Itching, burning or irritation? Pain during intercourse or painful urination? Recent Antibiotic use? Contraceptive? Compromised immune system? Prior episodes? How often were they? How were they treated? Any allergies to medications, especially antifungals.

- Examination:

ANS: General, Assess for signs of systemic illness like fever and Vulva: Erythema, edema, Excoriations and any lesions. Vagina: Speculum, erythema, (colour and consistency and adherence) discharge and any lesion. Bimanual exam: Tenderness may be present in complicated cases

- Diagnosis:

ANS: Vaginal pH (In candiasis < 4.5), Wet mount: 10% KOH preparation of vaginal discharge examined under microscope look for fungal elements: Budding yeast, pseudo-hyphae or hyphae. Whiff test is negative in candiasis (No fishy odor with addition of KOH) and fungal culture.

- Tx:

ANS: Topical anti-fungals: Imidazole or triazole. Recurrent vulvovaginal candiasis: Longer duration of initial therapy, maintenance therapy, consider alternative antifungal agents for non-albican species and address potential predisposing factors like DM.

Section 22: PROM

- DDx, Hx, PEx, Investigation, Management

- DDx: **ANS: Urinary incontinence, Vaginal discharge from vaginitis, Semen, Water from recent bathing.**

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- Similar to Checklist

Section 23: APH

- DDx, investigations, Pic and findings on US for ectopic, methotrexate criteria.

5th Rotation

Section 24: CTG

Section 25: Multiple pregnancy

Section 26: Bivalve speculum

Section 27: IUD

5th Year OSCE (018 Batch)

•1st OBGYN Rotation:

Section 1: 26YO lady, primigravida, has 2*4 fibroid detected through Ultrasound during clinic visits, she is worried about the effect of fibroid on her pregnancy, answer the examiner questions

- how does it complicate her pregnancy?

ANS: preterm labor, PROM, IUGR, pain due to red degeneration ...

- if she presented later with pain, how will you manage it?

ANS: Admit, IV fluids, analgesics and send home

- ultrasound findings you'll pay attention to?

ANS: fetal viability, liquor amount, placental site, location of fibroid & size

- If she will deliver through C/S , will you remove the fibroid?

ANS: No, due to the risk of bleeding

not sure about the exact answers required or if anything is missing

Section 2. 32 YO lady, G3P2, IUCD since x years, presented with lower abdominal pain and vaginal bleeding, has a history of pelvic inflammatory disease, history of 2 assisted pregnancies " IVF", smoker

- Most likely diagnosis:

ANS: ectopic pregnancy

- Risk factors mentioned in the question?

ANS: IUCD, PID, ART and smoking

- DDX?

ANS: Salpingitis / ectopic pregnancy / abortion / ovarian torsion / cyst/ appendicitis

- Tx?

ANS: expectant, medical "methotrexate"

Section 3. 33 weeks pregnant lady, mention what you'll do in a physical exam.

- Introduce and take permission
- Exposure
- Inspection: mention everything u can see.

also mention the position of the lady , in inspection mention from foot of the bed and from right side of the bed and mention divarication of recti and cough for hernias

- Next palpation: mention superficial, deep, organ palpation
- Obstetrics: Fundal height, grips, auscultate baby's heart

Section 4. 3rd trimester pregnant lady with watery discharge (rupture of membranes):

- Differential diagnosis?
- How to confirm?
- Management?

•2nd OBGYN Rotation:

Section 1. Booking

- What are the estimated time of delivery ?
- What are the important points in the history you want to ask?
- What are the investigations you must do. If the mom is O negative what's the next step ?

ANS:Indirect Coombs test

Section 2. Abdominal pain in pregnancy in third trimester

- Dxx?

ANS: Obstetric causes: preterm labor, PET, placental abruption
Gyne causes: ovarian torsion, red degeneration of fibroid
Non gyne causes: appendicitis, intestinal obstruction, cholecystitis

- Analyze the complaint

ANS: Socrates

- What are the examination you should do

ANS:General
Vital signs
Abdominal examination
Obstetric examination
Gynecological examination

- Management

ANS: Admission, steroids, tocolysis, analgesia

Section 3. Speculum examination Steps:

1. **Introduce your self ، permission, privacy, light, chaperone**
2. **Position exposure**
3. **Gloves, lubricating gel**
4. **Brush and container for Pap smear**

-What are the indications for speculum exam?

1. **Looking for masses, ulcers**
2. **Post coital bleeding**
3. **Antepartum hemorrhage**
4. **IUCD insertion**
5. **Hysterosalpingogram**
6. **Vaginal discharge**

Section 4. Pelvic organ prolapse:

- DDX

ANS: Rectocele ،uterine prolapse, cystocele, enterocele، tumors

- What are the questions you ask in the history

ANS: -Size, consistency, vaginal itching irritation
-Urinary symptoms urgency frequency, stress incontinence
-Bowel symptoms obstructed defecation constipation ، fecal incontinence
-Sexual symptoms

- Steps of assessment

ANS: -History
-General examination
-Vital signs
-Abdominal exam
-Gynecological examination
-Ultrasound

- Management

ANS: -Observation and conservative
-Surgical
-Vaginal ring

• 3rd OBGYN Rotation:

Section 1: PET, 39 weeks gestation presents with headache, BP of 160/110, proteinuria (/20 marks)

- Diagnosis
- 5 symptoms you want to ask about
- Physical exam
- Investigations
- Management:

ANS: IV antihypertensives, MgSO4, deliver immediately)

Section 2: PROM, 33 weeks gestation, comes to ED complaining of clear watery fluid discharge (/20 marks)

- Possible causes:

ANS: PROM, discharge from infection, urinary incontinence, bloody show, semen

- Investigations

- Evaluation?
- Management (indications for delivery vs how long we can wait)

Section 3: Ectopic Pregnancy, amenorrhea from 7 weeks, bleeding, dizzy, b-hcg<1000 (/15 marks)

- Differential diagnosis:

ANS: Ectopic pregnancy, intrauterine pregnancy

- U/S findings show empty uterus and adnexal mass. What is your ddx now:

ANS: ectopic pregnancy, complete abortion, complicated cyst/ovarian torsion

- Her BP is low, other info, what's you're management in the ER
- Treatment of ectopic pregnancy in this case:

ANS: laparotomy or laparoscopy for salpingectomy or salpingotomy

Section 4: 26 year old, 2 years with no pregnancy occurring at all.

- Diagnosis:

ANS: Primary Infertility

- What would you like to ask in your history:

ANS: Details like how often is her husband home/marital problems, do either of them smoke, their occupations, use of contraception, regularity of menstrual cycle

- Investigations for husband and her:

If SFA of the husband showed (I think 20k?) sperm count, abnormal motility, and abnormal morphology, what would you do to help this couple?

ANS: IVF

• 4th OBGYN Rotation:

Section 1: CTG same as in checklists

- What are the features important in interpreting the CTG? **he also asked about normal fetal heart rate (110-160) and normal fetal variability (5-25)**
- What is the type of deceleration in this CTG?

ANS: late deceleration

- What is the likely cause?

ANS: Placental insufficiency

- he asked about other types of deceleration and the cause for each (variable: umbilical cord compression, early: fetal head compression)
- What will be your next step in the management of this patient?

ANS: Regarding the position, it should be in left lateral

Section 2: Pelvic organ prolapse

- What are types of prolapse (differential diagnosis)?
- What are urinary tract symptoms?
- What are the bowel symptoms?
- What are the sexual symptoms?
- What are the risk factors?

Section 3: The emergency department calls you to assess a 32 year old woman who presents with left lower quadrant pain, some vaginal spotting and a positive pregnancy test.

- What relevant questions you want to ask in the focused history?
- What relevant physical examinations you want to perform?
- What you will do next?

ANS: B-hCG

- Then the examiner tells you it was 800 and Transvaginal ultrasound shows empty uterus, what are your differential diagnosis?

ANS: Ectopic pregnancy or abortion

- If you do B-hCG after 48 hours and it was 1000, what is the diagnosis

ANS: Ectopic pregnancy

- What are the management options for ectopic pregnancy?

Section 4. 32 yo Primigravida in 31 weeks gestation, presented with increased fundal height

- Take focused history and physical examination?
- Differential diagnosis?
- What are the maternal complications of multiple gestation?

- **5th OBGYN Rotation:**

Section 1. Menopause and postmenopausal bleeding

Section 2. PET

Section 3. Booking (Hx, invx, obstetric exam for 32 weeks pregnant)

Section 4. Infertility

6th Year OSCE (018 Batch)

- **1st OBGYN Rotation:**

(group1)

Section 1. Typical case of PCOS with an U/S picture of polycystic ovary

- What's the most likely diagnosis?
- What are the differential diagnoses?
- How can you confirm diagnosis? (Rotterdam criteria)
- What are the risk factors?
- What investigations you want to order for this patient?
- What are the treatment options?

Section 2. Case of 35 weeks gestation with vaginal bleeding of 2 hours duration

- What are the differential diagnoses?
- What are the risk factors for placenta previa?
- What are the risk factors for abruption?
- How would you manage this patient?

Section 3. Case of patient 38 weeks, in labor

- **What are the steps for abdominal obstetric examination? (IN DETAIL)** هون بدهم ماكلويد

Section 4. Case of endometrial hyperplasia

- What is the most likely diagnosis?
- What are the risk factors?
- How to confirm the diagnosis?
- What are the histological types of endometrial hyperplasia?
- What are the treatment options?
- What are the types of progesterone can you give this lady?

(group2)

Section 1. Polyhydramnios:

- DDx
- What is the best next step to differentiate between them?
- What do you see on U/S?
- What is the most important laboratory test to do?
- What are the physical findings you will see when you examine the abdomen?
- What is the surgical management? :)

Section 2. A 32 years old pregnant lady coming for antenatal care visit

- Routine tests?
- Bp =160/100, +2 proteinuria, what is the dx?
- Investigations?
- Management plan?
- Changes on Maternal Abdomen, fetal heart and U/S?
- What are the possible complications?

Section 3.U/S:

- What is the position of the uterus? (Anteverted or retroverted?)
- What do you see inside the uterus?
- What are the types of IUDs?
- What is the mechanism of action for IUDs?
- What are the contraindications?
- What are the complications? (Early and late)

Section 4. Infertility

- Clinical examination for both female and male
- What are the investigations (for males and females)?
- How do you test tubal factors?
- How can you confirm ovulation?
- Management?

•2nd OBGYN Rotation:

(group1)

Section 1: picture of forceps

- What is this instrument?

ANS: Obstetric forceps

- What are the indications?

ANS: maternal exhaustion, shorten second stage of labor, fetal distress

•What are the prerequisites of using this instrument?

ANS: ROM, full dilation, know the position of the head

- What are the complications of using this instrument?

ANS: Fetal fracture, shoulder dystopia, maternal tear, injury to rectum and anal sphincter, bleeding, infection

Section 2: Case in which patient comes at 7 weeks gestation, told in outside clinic she's had a miscarriage.

- What are the possible types of miscarriage in this patient?

ANS: Inevitable, incomplete, complete, septic

- What should you do?

ANS: History +physical, U/S, beta HCG, CBC, blood group, cross match

- What are the modes of treatment?

ANS: Expectant, medical, surgical

- What are the complications of surgical treatment?

ANS: Bleeding, incomplete evacuation, infection, perforation, injury to bower or bladder

- If this patient has septic abortion, what are the complications?

ANS: PID, peritonitis, thrombosis, septic shock, DIC, death

Section 3: patient comes at 33 weeks with vaginal bleeding. Some risk factors stated in prompt.

- What are the possible causes of this presentation?

ANS: Placenta Abruptio, placenta previa, vasa previa, uterine rupture, trauma, local causes, coagulopathy

- If this is placental abruption, what are the risk factors?
- What are the signs and symptoms of placental abruption?
- What are some CTG changes you could see in this fetus
- What is your immediate management?

ANS: Call for help, ABCs, two large bore cannulas, fluid resuscitation, delivery if unstable, or attempt to wait until at least 34 weeks

Section 4: Early cervical cancer screening (questions brought from Dr kamil's seminar)

- What are the modes of prevention?

ANS: Vaccine and screening

- What are the modes of screening?

ANS: Pap smear, liquid cytology, HPV DNA, speculum exam and colposcopy

- What are the modes of transmission of HPV?

- When and for who vaccination should occur? How many doses is the vaccine?

ANS: Students was in the checklist apparently. 3 doses

- What are the conditions of a screening test?

(group2)

Section 1. Vaginal Bleeding after Delivery (14 hours)

- Diagnosis:

ANS: Primary postpartum hemorrhage.

- Risk factors in this patient:

ANS: Previous PPH, increased fetal weight, multiparity, prolonged labor, oxytocin augmentation.

- Management:

ANS: ABC approach, call for help, 2 large IV cannulas for fluids, CBC, blood group and cross-match, coagulation profile, monitor urine output.

- Management:

ANS: uterine massage, drugs: oxytocin, tranexamic acid, methergine,carboprost.

- Surgical management:

ANS: balloon tamponade, uterine packing, B-Lynch suturing, uterine or ovarian or internal iliac artery embolization, hysterectomy.

Section 2. Vaginal Discharge

- History:

ANS: Duration, color, amount, smell, consistency, itching, dyspareunia, sexual activity, burning pain, medical history (DM, antibiotic use, topical contraceptives), immunosuppression, hygiene.

- Differential

ANS: Candida, trichomoniasis, bacterial vaginosis, physiological discharge.

- Most likely cause:

ANS: Candida. Features: thick whitish cheesy discharge, itching, burning. Confirm by wet mount microscopy + normal vaginal pH.

Section 3. Vacuum

- **Types, prerequisites, indications, complications**.

Section 4. Gross Picture of Fibroid

- Diagnosis:

ANS: Fibroid.

- How fibroid causes bleeding:

ANS: It disrupts blood vessels, making them more fragile and affects contractility.

- Types:

ANS: Submucosal, subserosal, intramural, cervical, pedunculated or parasitic.

- Differential Diagnosis:

ANS: Adenomyosis, pregnancy, uterine malignancy, cervical polyp, hematometra, bleeding disorder, or anticoagulants.

- Management:

ANS: CBC, TVUS, MRI, hysteroscopy, laparoscopy. Medical Rx: OCP, progestin-only pill, Mirena, GnRH agonist, tranexamic acid. Uterine artery embolization, radiofrequency ablation. Surgical: Myomectomy, hysterectomy

- **3rd OBGYN Rotation:**

Section 1. PET (symptoms, risk factors, oral drugs, emergency drugs)

Section 2. Abdominal pain for pregnant lady 39w (history and examination)

Section 3. OHS (risk factors, symptoms, signs, management)

Section 4. Menopause (symptoms, causes of early menopause, indication for HRT, complications)

- **4th OBGYN Rotation:**

Section 1:PET

Section 2: PPH

Section 3: Menorrhagia

Section 4:Adenomyosis

- **5th OBGYN Rotation:**

(group1)

Section 1: Amenorrhea in a married lady

Important points in Hx, DDx, Labs

Section 2:Vaginal discharge

Physiological vs Pathological discharge, most common causative agents, tests, Treatment

Section 3: Labor

Frequency and indications for PV exam, Cardinal movements, movements done in the 3rd stage

Section 4: PROM (very similar to checklists)

﴿وَاللَّهُ أَخْرَجَكُم مِّن بُطُونِ أُمَّهَاتِكُمْ لَا تَعْلَمُونَ شَيْئًا وَجَعَلَ لَكُمُ السَّمْعَ وَالْأَبْصَارَ وَالْأَفْئِدَةَ ۙ لَعَلَّكُمْ تَشْكُرُونَ﴾

سورة النحل 87

بالتوفيق في الامتحان

اذكرونا بدعوة