Introduction: How to answer EMQs for the MRCOG Part 2 and general revision hints and tips

Know your stuff!: read all relevant guidelines and *The Obstetrician and Gynaecologist*

Many of the EMQs are based upon up-to-date guidelines used by the Royal College of Obstetricians and Gynaecologists, or those used by obstetricians and gynaecologists in the UK such as NICE (National Institute for Health and Care Excellence) and the FSRH (Faculty of Sexual and Reproductive Healthcare). You will find references to these guidelines in the answers for each question in this book.

Answer each question just as the guideline suggests or states. It may be that there is more than one good answer to a question, but the most appropriate will usually be the one that relates to a guideline.

Cover over the options list to avoid getting distracted

If your knowledge is up-to-date and accurate, then you will most likely know the answer to a question once you have read it. Therefore, looking at the option list first will only distract you and may lead you to doubt yourself.

A better strategy is to read the question (more than once) with the list of options covered up and then look for your answer within the list. If your answer is not there (!), then re-read the question to see what subtlety you may have missed.

Don't rush in with your first answer: there may be a better one!

Sometimes, there may be two similar answers – only one of which is the correct and most appropriate answer. Therefore,

ensure that you have read the full list of options before answering the question.

Use your clinical time wisely

Every patient you see in clinic or whilst on call you can treat as a potential EMQ or other style of exam question. For example, if you see a patient with polycystic ovarian syndrome in clinic, ask yourself, 'What does it state in the guideline about this condition?' Then, read the guideline either before or after you have seen the patient to cement the information in your head.

Practice, practice, practice!

Practice makes perfect, and this is certainly true with EMQs. Make use of the various books available (including this one!). Some may not necessarily be in the exact style of the exam, but will allow you to test your revision and acquired knowledge!

Ask others to test you, including at work when you have a spare minute; perhaps on nights, so that every part of your day can be used for revision.

Work in revision groups

Revision for an exam can be a lonely process. Working in groups for at least part of your revision time can make it more enjoyable (if there can be such a thing!) and allow you to gain knowledge from each other which may just stick.

OBSTETRICS

RHESUS D PROPHYLAXIS

Options

A 500 IU anti-D
B Kleihauer and 500 IU anti-D
C 250 IU anti-D
D Kleihauer and 250 IU anti-D
E No anti-D required
F Anti-D at 6-weekly intervals
G Large dose (2500 or 5000 IU) anti-D required
H Give RAADP (routine antenatal Anti-D prophylaxis)
I Check antibody screen and give RAADP
J Check antibody screen at booking and at 28 weeks

What would be the most appropriate management in each scenario?

1 A 28-year-old RhD-negative woman in her first pregnancy undergoes a fetal loss at 21 weeks of gestation.
2 A 30-year-old RhD-negative woman has a threatened miscarriage at 14 weeks of gestation in her first pregnancy and anti-D prophylaxis is administered. Bleeding continues three days later but then stops, and once again one week later.
3 A 39-year-old RhD-negative woman in her third pregnancy (non-sensitised) wishes to be sterilised after birth and declines RAADP.
4 A RhD-negative woman receives 30 mls of a blood transfusion, before discovering that she has been given RhD-positive blood.

CHICKENPOX IN PREGNANCY

Options

A Test for VZV (varicella zoster virus) immunity
B Administer VZIG (varicella zoster immunoglobulin) as soon as possible
C No risk, therefore nil required
D Refer to Fetal Medicine Unit for fetal testing
E Administer VZIG in the next 48 hours
F Administer VZIG and manage as potentially infectious from 8–28 days after administration
G Administer VZIG and manage as potentially infectious from 8–21 days after administration
H Administer VZIG and monitor for 28 days after administration
I Oral acyclovir
J Intravenous acyclovir

What would be the most appropriate management in each scenario?

5 A pregnant woman at 22 weeks of gestation is admitted to the antenatal ward with an antepartum haemorrhage. Whilst an inpatient on a ward, she has contact with a child who has a chickenpox rash all over her body and the vesicles have not crusted over. Testing of the woman reveals she is non-immune to VZV.
6 A pregnant woman at 39 weeks of gestation develops shingles following contact with a child with chickenpox. She has a normal delivery three days later of a baby boy weighing 3695 g. What is the most appropriate management for the neonate?
7 A woman delivers a baby girl at 40 weeks and develops a chickenpox rash three days post delivery. What is the most appropriate management for the neonate?

REDUCING THE RISK OF THROMBOEMBOLISM

Options

A Antenatal high-dose, low-molecular-weight heparin (LMWH)
B Antenatal LMWH and six weeks postnatal LMWH
C Antenatal high-dose LMWH and six weeks postnatal LMWH; involve expert haematologist in care
D Antenatal high-dose LMWH and six weeks postnatal LMWH
E Unfractionated heparin
F Warfarin
G Six weeks postnatal LMWH
H Seven days postnatal LMWH
I Antenatal high-dose LMWH and seven days postnatal LMWH

What would be the most appropriate management in each scenario?

8 A 32-year-old woman is seen for booking in early pregnancy. She has a family history of thrombophilia and testing reveals anti-thrombin 3 deficiency.
9 A 33-year-old woman is seen for booking in her second pregnancy with a history of a DVT at 20 weeks in her first pregnancy. Previous screening has indicated no known inherited thrombophilia.
10 A 28-year-old woman with a BMI of 40 presents at 12 weeks of gestation for booking in her first pregnancy. She smokes 20 cigarettes per day.

THE ACUTE MANAGEMENT OF THROMBOSIS AND EMBOLISM

Options

A Chest X-ray
B Full blood count
C D-dimer
D Renal and hepatic function test
E CTPA (computed tomography pulmonary angiogram)
F V-Q scan (ventilation-perfusion lung scan)
G Bilateral lower-limb Doppler
H Anti-Xa level
I Spirometry
J Lower-limb Doppler on the suspected side

What would be the most appropriate investigation in each scenario?

11 A 25-year-old woman who is 30 weeks pregnant presents with shortness of breath, chest pain and reduced oxygen saturations. You suspect a pulmonary embolism, but the chest X-ray is normal. What would be your next line investigation?

12 A 25-year-old woman who is 28 weeks pregnant is being treated for a confirmed deep vein thrombosis and weighs 95 kg. This is her second deep vein thrombosis in the last five years. The haematologist requests an investigation on this patient.

HYPERTENSION IN PREGNANCY

Options

A Do not admit patient to hospital or treat hypertension; no indication for blood tests, but monitor blood pressure weekly.
B Do not admit patient to hospital or treat hypertension, but take blood tests and monitor blood pressure twice per week.
C Admit patient to hospital, treat hypertension with oral anti-hypertensives, consider steroids and early delivery.
D Admit patient to hospital, treat hypertension with IV anti-hypertensives, take blood pressure at least four times per day and take a quantificative protein test.
E Admit patient to hospital, treat hypertension with oral anti-hypertensives, take blood pressure at least four times per day and take a quantificative protein test.
F Admit patient to hospital, treat hypertension with alternate including IV anti-hypertensives, take blood pressure at least four times per day and take a quantificative protein test. Consider the administration of steroids, discuss with consultant obstetrician, neonatal and anaesthetic staff with regards to delivery.
G Do not admit patient to hospital, treat hypertension with oral anti-hypertensives, take blood pressure at least twice per week, take blood tests.
H Do not admit patient to hospital, treat hypertension with oral anti-hypertensives, take blood pressure at least twice per week, no need for blood tests.

What would be the most appropriate management in each scenario?

13 A 40-year-old woman presents at 32 weeks of gestation in her first pregnancy with a blood pressure of 143/90 mmHg. Blood pressure at the beginning of her pregnancy was 100/60 mmHg. Quantitative testing

indicated no proteinuria. She feels well, with no headaches or visual disturbance.

14 A 30-year-old woman presents at 34 weeks of gestation in her first pregnancy with a blood pressure of 152/103 (blood pressure at the beginning of pregnancy – 130/60) with significant proteinuria on urinalysis.

15 A 27-year-old woman presents at 28 weeks of gestation in her second pregnancy with a blood pressure of 152/105 (blood pressure at the beginning of pregnancy – 132/58), but with no evidence of proteinuria on urinalysis. She is commenced on oral labetalol and is sent home from the triage department to return in a week for a repeat blood pressure monitoring. At this time, she returns and her blood pressure has increased to 167/115 mmHg, with significant proteinuria on urinalysis. She has a frontal headache and describes spots in front of her eyes.