⚡ OBSTETRICS MCQ BUZZWORDS MASTER TABLE ⚡

🎯 High-Yield Scenarios | Diagnosis | Next Steps | Management | Investigations

CLINICAL BUZZWORD/SCENARIO	DIAGNOSIS	NEXT STEP/INVESTIGATION	MANAGEMENT	KEY PEARLS & TRICKY POINTS
🩸 HYPERTENSIVE DISORDERS				
"Headache, visual changes, RUQ pain" + BP ≥160/110 + proteinuria	Preeclampsia with severe features	• Labs: CBC (plt), CMP (Cr, LFTs), UA (protein) • Continuous BP monitoring	• MgSO4 seizure prophylaxis • Antihypertensive (labetalol/hydralazine) • DELIVERY = definitive Rx	Severe features = BP ≥160/110, Plt <100K, Cr >1.1, pulm edema, cerebral/visual sx, RUQ pain Trick: Delivery timing based on severity + GA
"RUQ pain + N/V + malaise" In 3rd trimester with HTN	HELLP Syndrome	• CBC (schistocytes, ↓plt) • LFTs (AST/ALT >70) • LDH, bilirubin	• MgSO4 • Stabilize + DELIVER • Platelet transfusion if <20K or bleeding	HELLP = Hemolysis, Elevated Liver enzymes, Low Platelets Trick: Can occur WITHOUT severe HTN! May present postpartum
"Seizure in pregnant woman" With known preeclampsia	Eclampsia	• ABCs first! • Left lateral position • Protect airway	• MgSO4 4-6g IV load, then 2g/hr • Control BP • Deliver after stabilization	MgSO4 = 1st line for seizures (NOT phenytoin) Trick: Can occur before diagnosis of preeclampsia Antidote = Calcium gluconate
"BP 150/95 at 35 weeks" No proteinuria, no symptoms Normal labs	Gestational HTN	• Repeat BP in 4h • UA for proteinuria • Labs (plt, Cr, LFTs)	• Monitor closely (weekly visits) • NST 2x/week • Consider delivery at 37 weeks	HTN ≥20 weeks WITHOUT proteinuria/organ damage Trick: 50% develop preeclampsia - watch closely!
🔴 ANTEPARTUM HEMORRHAGE				
"Painless vaginal bleeding" + Soft, non-tender uterus 3rd trimester	Placenta Previa	🚫 NO DIGITAL EXAM! • TVUS to locate placenta	• Pelvic rest • If <34wks: Tocolytics + steroids • If ≥36wks or unstable: C-section	CRITICAL: NEVER do digital vaginal exam - can cause catastrophic bleeding! Complete previa = covers os
"Painful vaginal bleeding" + Firm, tender uterus + Fetal distress	Placental Abruption	• Clinical diagnosis! • Monitor: Continuous FHR, Coags (DIC risk)	• 2 large-bore IVs • Type & cross • If stable + preterm: Expectant • If unstable/fetal distress: DELIVER	Risk factors: HTN, cocaine, trauma, PROM Trick: US often NORMAL! (blood behind placenta) DIC in 10%
"Painless bleeding at ROM" + Fetal bradycardia Velamentous cord insertion on prior US	Vasa Previa	• EMERGENCY! • Call for help	• STAT C-section • Fetal mortality 60% if vaginal delivery	Fetal vessels cross membranes over cervical os Trick: ROM → vessel rupture → fetal exsanguination Apt test = fetal blood
"Bleeding after 20 weeks" With cervical dilation + Contractions	Preterm Labor	• Cervical exam • FFN test • TVUS for cervical length	• If 24-34wks: - Betamethasone (steroids) - Tocolytics (nifedipine)	Trick: Steroids benefit 24-34 wks ONLY MgSO4 for

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			- MgSO4 (neuroprotection <32wks) - GBS prophylaxis	neuroprotection <32wks
EARLY PREGNANCY COMPLICATIONS				
"Amenorrhea + pelvic pain + vaginal bleeding" β-hCG = 2000, no IUP on US	Ectopic Pregnancy	• Repeat β-hCG in 48h (should double) • TVUS • Check for hemoperitoneum	• Stable + small + β-hCG <5000: Methotrexate • Unstable/ruptured: Laparoscopy/laparotomy	Trick: β-hCG >1500 should see sac on TVUS If not → ectopic until proven otherwise Most common site = ampulla of tube
"β-hCG 50,000 at 8 weeks" "Snowstorm" on US + Hyperemesis + early preeclampsia	Molar Pregnancy (Hydatidiform Mole)	• β-hCG (very high) • US (no fetal parts) • CXR (r/o mets)	• Suction D&C • Follow β-hCG to zero • Contraception x 6-12 months • Monitor for choriocarcinoma	Complete mole: 46XX (all paternal) Partial: 69XXY (triploid) Trick: Risk of malignant transformation!
"Vaginal bleeding + cramping at 8 weeks" Closed cervix, visible gestational sac	Threatened Abortion	• US for fetal cardiac activity • Serial β-hCG	• Expectant management • Pelvic rest • Follow-up US in 1 week	50% continue to term pregnancy Next step: Reassure + close follow-up
"Heavy bleeding + open cervix" + Passing tissue at 10 weeks	Inevitable/Incomplete Abortion	• Confirm with US (retained POC)	• If stable: Expectant, medical (misoprostol), or surgical (D&C) • If unstable: D&C	Trick: Open cervix = inevitable Incomplete = some POC retained
DIABETES IN PREGNANCY				
"50g GCT = 165 mg/dL at 26 weeks"	Screen positive for GDM	• 100g 3-hour OGTT (Fasting, 1h, 2h, 3h glucose)	• If 2+ values abnormal = GDM • Start diet/exercise • If fails: INSULIN (NOT oral agents)	OGTT cutoffs: Fasting ≥95, 1h ≥180, 2h ≥155, 3h ≥140 Trick: Glyburide/metformin NOT standard in US
"Macrosomic baby at delivery" + Shoulder dystocia Mother had GDM	Fetal Macrosomia (complication of GDM)	• HELPERR maneuvers • Call for help	• McRoberts maneuver • Suprapubic pressure • Deliver posterior arm • Consider C-section for EFW >4500g	Neonatal complications: Hypoglycemia, hypocalcemia, polycythemia, hyperbilirubinemia Trick: Check baby's glucose after delivery!
"Polyhydramnios on US" + Poor glucose control AFI = 28 cm	Polyhydramnios (2° to GDM)	• Check maternal glucose • Fetal anatomy US (r/o anomalies)	• Optimize glucose control • Monitor for preterm labor • Amniocentesis if symptomatic	Other causes: GI atresia, anencephaly, twin-twin transfusion Trick: Fetal polyuria from hyperglycemia
INFECTIONS				
"Fever + uterine tenderness + foul discharge" During labor/postpartum	Chorioamnionitis	• Clinical diagnosis • CBC (leukocytosis) • Amniocentesis if uncertain	• Ampicillin + gentamicin • Deliver if in labor • Add clindamycin after delivery (anaerobes)	Triad: Fever + uterine tenderness + fetal tachycardia Trick: Don't delay delivery for antibiotics!
"Dysuria + fever + CVA tenderness" In 2nd trimester pregnancy	Pyelonephritis	• UA + UCx • CBC • Blood cultures	• Hospitalize • IV ceftriaxone • Hydration • Monitor for sepsis/preterm labor	Most common cause of sepsis in pregnancy Trick: ALWAYS hospitalize pregnant pts with pyelo

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"Asymptomatic bacteriuria 100,000 CFU" At first prenatal visit	Asymptomatic Bacteriuria	• Treat with antibiotics • Repeat UCx after Rx	• Nitrofurantoin or cephalexin x 3-7 days • Follow-up culture	Trick: ALWAYS treat ASB in pregnancy! Prevents pyelonephritis (30% risk if untreated)
"GBS positive at 36 weeks"	GBS Colonization	• Plan intrapartum prophylaxis	• PCN G in labor (4h before delivery ideal) • Alt: Ampicillin • PCN allergy: Cefazolin or vancomycin	Always treat if: GBS bacteriuria, previous GBS-infected infant, unknown status + risk factors Prevents neonatal sepsis
"Pruritic vesicles on vulva" Primary outbreak in 3rd trimester	Primary Genital HSV	• PCR/culture of lesions • Check for lesions at delivery	• Acyclovir suppression from 36 wks • C-section if active lesions at delivery • Vaginal OK if no lesions	Primary > recurrent for transmission Trick: C-section ONLY if active lesions! Neonatal HSV = devastating
"Positive RPR at first visit"	Syphilis in Pregnancy	• Confirm with FTA-ABS or TP-PA • Stage the disease	• Benzathine PCN G (ONLY effective Rx in pregnancy) • Dose based on stage • Treat partner • Follow titers	Congenital syphilis: Hutchinson teeth, saddle nose, saber shins Trick: PCN only drug that crosses placenta Jarisch-Herxheimer after 1st dose
RH ISOIMMUNIZATION				
"Rh negative mother, first pregnancy" No antibodies detected	Rh Negative Unsensitized	• Give RhoGAM at 28 weeks • Check baby's blood type at delivery	• RhoGAM 300µg at 28 weeks • RhoGAM within 72h postpartum if baby Rh+ • Also after: abortion, ectopic, bleeding, trauma, amnio	Trick: 300µg covers 30mL fetal blood Kleihauer-Betke if large fetomaternal hemorrhage Prevents HDN in future pregnancies
"Rh negative with anti-D antibodies" Rising titers in current pregnancy	Rh Isoimmunization (Sensitized)	• Serial anti-D titers • MCA Doppler (peak systolic velocity) • Amniocentesis if severe	• Monitor closely • Intrauterine transfusion if severe anemia • Early delivery if needed • RhoGAM won't help (already sensitized)	Fetal complications: Hemolytic anemia, hydrops fetalis, kernicterus Trick: RhoGAM useless once sensitized!
PRENATAL SCREENING & DIAGNOSIS				
"Quad screen: ↓AFP, ↑hCG, ↓Estriol, ↑Inhibin A" At 17 weeks	Screen positive for Trisomy 21 (Down Syndrome)	• Offer diagnostic testing • Amniocentesis (gold standard) • cfDNA/NIPT	• Counsel on options • Amniocentesis for karyotype • Fetal echo (cardiac defects) • Genetic counseling	Mnemonic: Down = hCG ↑, Inhibin ↑, rest ↓ NT thickness >3mm at 11-14wks also suggestive
"Quad screen: All values LOW" (↓AFP, ↓hCG, ↓Estriol, ↓Inhibin)	Screen positive for Trisomy 18 (Edwards Syndrome)	• Amniocentesis for karyotype • Detailed anatomy US	• Genetic counseling • Discuss prognosis (often lethal) • Offer termination vs expectant	T18: Clenched fists, rocker-bottom feet, cardiac defects Trick: ALL quad markers LOW
"Elevated AFP on quad screen" Normal anatomy US	Elevated AFP (need further workup)	• Repeat AFP • Detailed anatomy US • If still ↑: Amniocentesis for AFP + AChE	• If open NTD: ↑AFP + ↑AChE → Counsel/terminate/prepare • If abd wall defect: ↑AFP, normal AChE • If normal workup: Close monitoring (risk IUGR, abruption)	Causes of ↑AFP: NTD, abd wall defect, multiple gestation, wrong dates, fetal demise Trick: AChE = specific for open NTD
"35-year-old requests screening"	Advanced Maternal Age (AMA)	• Offer cfDNA/NIPT (non-invasive)	• Screen with NIPT first • If positive: Confirm	Trick: AMA = ≥35 at delivery

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		OR • Offer amniocentesis (diagnostic)	with amnio • If high risk: Direct amnio • Genetic counseling	Risk T21: 35yo = 1/350, 40yo = 1/100 Amnio risk = 0.5% miscarriage
📉 IUGR & FETAL ASSESSMENT				
"Fundal height 4cm less than expected" At 32 weeks	Suspected IUGR	• US for EFW + AFI • Umbilical artery Doppler • Consider etiologies	• Serial US q2-4 weeks • Antenatal testing (NST, BPP) • If severe: Consider delivery • Reversed diastolic flow → DELIVER	Symmetric = early insult (chromosomal, infection) Asymmetric = placental insufficiency Trick: Umbilical artery Doppler = best predictor
"Recurrent late decelerations" + Minimal variability Category III tracing	Non-Reassuring Fetal Status	• Intrauterine resuscitation: - L lateral position - O2 - IVF - Stop oxytocin - Tocolysis if tachysystole	• If no improvement: URGENT DELIVERY • C-section if remote from delivery • Operative vaginal if ready	Late decels = uteroplacental insufficiency Trick: Try resuscitation FIRST before rushing to OR Category III = immediate delivery
"Variable decelerations with rapid return to baseline" Good variability otherwise	Cord Compression (Category II)	• Maternal repositioning • Amnioinfusion if recurrent	• Continue monitoring • Position changes • Deliver if worsening/prolonged	Variable = cord compression (most common) Trick: Benign if brief + rapid return to baseline
⚡ LABOR & DELIVERY COMPLICATIONS				
"Gush of fluid, baby's head not engaged" + Fetal bradycardia immediately after	Umbilical Cord Prolapse	• EMERGENCY! • Elevate presenting part • Knee-chest position	• Manual elevation of presenting part • Trendelenburg/knee-chest • STAT C-section • Keep cord moist, no repositioning	CRITICAL: Minutes matter! Risk: ROM with unengaged head, polyhydramnios, malpresentation
"Turtle sign after head delivery" Difficulty delivering anterior shoulder	Shoulder Dystocia	• Call for HELP • HELPERR maneuvers	• McRoberts (flex thighs) • Suprapubic pressure • Deliver posterior arm • Woods screw/Rubin • Gaskin (all-fours) 🚫 NO fundal pressure!	Risk: Macrosomia, GDM, maternal obesity Complications: Erb palsy (C5-C6), clavicle fracture Trick: Document EVERYTHING!
"Sudden severe abdominal pain + regression of fetus" After difficult labor	Uterine Rupture	• EMERGENCY! • Call for help • Check vitals/ABC	• 2 large-bore IVs • Type & cross • STAT laparotomy • Hysterectomy often needed	Risk: Prior C-section (TOLAC), trauma, high-dose oxytocin, obstructed labor Classic triad: Pain, bleeding, fetal distress
"Uterus soft and boggy after delivery" + Continued bleeding despite massage	Postpartum Hemorrhage (Uterine Atony)	• Bimanual massage • Ensure bladder empty	1. Massage + oxytocin 2. Methylergonovine (avoid if HTN) 3. Carboprost (avoid if asthma) 4. Misoprostol 5. Bakri balloon/B-lynch 6. UAE or hysterectomy	4 T's: Tone (atony-80%), Tissue (retained), Trauma (laceration), Thrombin (coagulopathy) Trick: Most common cause = atony
"Sudden dyspnea + hypotension + DIC" During labor or immediately postpartum	Amniotic Fluid Embolism	• ABC/CPR if arrested • Call for help	• Supportive care • Intubation/ventilation • Pressors • Treat DIC (blood products) • DELIVER if undelivered	Classic triad: Hypoxia, hypotension, DIC Mortality 20-60% Diagnosis of exclusion
💧 PROM & PRETERM LABOR				

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"Gush of fluid at 32 weeks" Pooling, + Nitrazine, + Ferning	Preterm Premature Rupture of Membranes (PPROM)	• Sterile speculum exam • Nitrazine + ferning test • GBS culture • Monitor for infection	• If 24-34wks: - Betamethasone - Abx (ampicillin + erythro) - Expectant management • If ≥34wks: DELIVER • GBS prophylaxis	Trick: NO digital exam! (↑infection risk) Abx = prolongs latency + prevents infection MgSO4 if <32wks (neuroprotection)
"Regular contractions at 30 weeks" Cervix 3cm dilated	Preterm Labor	• Cervical exam • FFN if uncertain • TVUS cervical length	• If 24-34wks: - Betamethasone (2 doses 24h apart) - Tocolytics (nifedipine/indomethacin) - MgSO4 <32wks - GBS prophylaxis	Steroids benefit: 24-34 weeks ONLY MgSO4 = neuroprotection <32wks Tocolytics = delay 48h for steroids
👯 MULTIPLE GESTATION				
"Twins with one large, one small" Polyhydramnios in one, oligohydramnios in other	Twin-Twin Transfusion Syndrome (TTTS)	• US: Discordant growth, fluid • Confirm monochorionic-diamniotic • Stage severity	• Mild: Expectant + close monitoring • Severe: Laser ablation of communicating vessels • Serial amniocentesis (temporizing)	Only in monochorionic twins Recipient = polyhydramnios, polycythemia Donor = oligohydramnios, anemia Can lead to heart failure in recipient
🕯️ POSTPARTUM COMPLICATIONS				
"Fever + unilateral breast pain + erythema" Postpartum day 10, breastfeeding	Mastitis	• Clinical diagnosis	• Continue breastfeeding! • Dicloxacillin or cephalexin • Warm compresses • NSAIDs • If abscess: I&D	Usually S. aureus Trick: CONTINUE breastfeeding to prevent abscess!
"Fever + foul lochia at postpartum day 3" + Uterine tenderness	Endometritis	• Clinical diagnosis • CBC, blood cultures	• Gentamicin + clindamycin • Ampicillin if no improvement in 48h • Continue until afebrile x 24-48h	Risk: C-section (10-20x risk vs vaginal) Trick: Polymicrobial infection
"Unilateral leg swelling + pain" Postpartum day 5 Positive Homan's sign	Deep Vein Thrombosis (DVT)	• Doppler US of leg • D-dimer (often elevated in pregnancy)	• Therapeutic LMWH or heparin • Continue 3-6 months • Transition to warfarin postpartum OK 🚫 NO warfarin if breastfeeding concerns	Pregnancy = hypercoagulable state Trick: Warfarin OK postpartum (NOT in pregnancy!) LMWH safe in breastfeeding
🎯 MISCELLANEOUS HIGH-YIELD				
"Intense pruritus of palms/soles" In 3rd trimester No rash, worsens at night	Intrahepatic Cholestasis of Pregnancy	• LFTs (mild ↑) • Bile acids (↑↑ = diagnostic)	• Ursodeoxycholic acid • Antihistamines for symptoms • Deliver at 36-37 weeks • Antenatal testing 2x/week	Risk: Sudden stillbirth! Resolves postpartum Recurs in 60-70% of future pregnancies
"N/V + RUQ pain + hypoglycemia" + Jaundice in late 3rd trimester	Acute Fatty Liver of Pregnancy (AFLP)	• LFTs (↑↑) • Coags (↑PT/PTT) • Glucose (↓) • Ammonia (↑) • Creatinine (↑)	• DELIVER immediately! • ICU monitoring • Correct coagulopathy • Glucose infusion • Often need hysterectomy	Rare but life-threatening Microvesicular fat in hepatocytes Trick: Look for hypoglycemia (key differentiator)
"First trimester, severe N/V" Unable to keep down food/fluids Weight loss, ketonuria	Hyperemesis Gravidarum	• r/o other causes (molar, hyperthyroid) • BMP (electrolytes) • UA (ketones)	• IV fluids + electrolytes • Pyridoxine (B6) + doxylamine • Ondansetron • Methylprednisolone if severe	Trick: Check TSH - transient hyperthyroidism common Associated with molar pregnancy

🎯 **EXAM STRATEGY TIPS:**

DX = Look for buzzword combinations (symptom + timing + risk factor)

NEXT STEP = Stabilize first! ABC > Diagnosis > Definitive treatment

INVESTIGATION = Least invasive → Most invasive. Clinical diagnosis when possible

MANAGEMENT = Conservative → Medical → Surgical. Always consider GA & severity

CRITICAL RULE: If question says "most appropriate next step" and pt is unstable → STABILIZE FIRST!