OBSTETRIC CONDITION / COMPLICATION	DIAGNOSTIC TESTS + ABNORMAL VALUES / FINDINGS	MCQ TRAPS, EXAM HINTS & PEARLS
Preeclampsia	• BP ≥140/90 after 20 w (2 readings) • Proteinuria: PCR ≥0.3 or ≥300 mg/24 h • Platelets <100,000 (severe) • AST/ALT ≥2× normal • Creatinine >1.1 mg/dL	• Edema is NOT diagnostic • Proteinuria may be absent in severe disease • Severe features → deliver ≥34 w
Eclampsia	• Clinical diagnosis: tonic–clonic seizures • Labs: thrombocytopenia, ↑AST/ALT, ↑uric acid	• Diagnosis is CLINICAL • MgSO■ = DOC (not diazepam) • CT/MRI only if focal deficit
Gestational Hypertension	• BP ≥140/90 after 20 w • Normal platelets, LFTs, creatinine • No proteinuria	• Absence of proteinuria is key • Delivery at 37 w = MCQ favorite
Chronic Hypertension	• BP before 20 w or known pre-pregnancy • Baseline proteinuria may exist	• HTN before 20 w = chronic until proven otherwise
HELLP Syndrome	• Hemolysis: LDH >600 IU/L, schistocytes • AST/ALT >70 IU/L • Platelets <100,000	• Can occur without HTN or proteinuria • RUQ pain = hepatic involvement
Gestational Diabetes Mellitus	• 75 g OGTT (24–28 w) • Fasting ≥92 mg/dL • 1 h ≥180 mg/dL • 2 h ≥153 mg/dL	• HbA1c NOT diagnostic • Single abnormal value = diagnosis
Placenta Previa	• Transvaginal US = gold standard • Placenta covering internal os	• Digital PV exam contraindicated • Painless bleeding
Placenta Accreta Spectrum	• US: placental lacunae, loss of clear zone • MRI: posterior placenta / invasion depth	• Do NOT attempt placental removal • Antenatal diagnosis reduces mortality
Abruptio Placentae	• Clinical diagnosis • US sensitivity low • ↓ fibrinogen (<200 mg/dL) • Prolonged PT/APTT	• Painful bleeding + tense uterus • Concealed hemorrhage possible
Postpartum Hemorrhage	• Blood loss >500 mL (VD) or >1000 mL (CS) • Uterine atony: boggy uterus	• Atony most common cause (4 Ts) • Visual estimation underestimates loss
Shoulder Dystocia	• Clinical diagnosis: turtle sign, failure of shoulder delivery	• Fundal pressure CONTRAINDICATED • McRoberts = first maneuver
Uterine Rupture	• Sudden pain, cessation of contractions • CTG: fetal bradycardia	• Classical CS highest risk • Scar tenderness is late sign
Vasa Previa	• TVS + color Doppler • Fetal vessels over os	• Painless bleeding with fetal distress • Fetal blood loss
Ectopic Pregnancy	• β-hCG above discriminatory zone (~1500 IU/L) with empty uterus • TVS: adnexal mass	• Pain + bleeding + amenorrhea triad • Culdocentesis obsolete
PROM / PPROM	• Speculum exam: pooling • Nitrazine (alkaline) • Fern test positive	• Digital exam contraindicated • AFI may be reduced
IUGR	• US EFW <10th percentile • Doppler: absent/reversed EDF in UA	• Reversed EDF = deliver immediately • MCA Doppler reflects brain sparing

OBSTETRIC CONDITION / COMPLICATION	DIAGNOSTIC TESTS + ABNORMAL VALUES / FINDINGS	MCQ TRAPS, EXAM HINTS & PEARLS
Polyhydramnios	• AFI >25 cm or SDP >8 cm	• Sudden ROM → cord prolapse • PPH due to atony
Oligohydramnios	• AFI <5 cm or SDP <2 cm	• Cord compression → variable decelerations
CTG Abnormality	• Late decelerations • Reduced variability (<5 bpm)	• Late decels = uteroplacental insufficiency
Obstetric Cholestasis	• Serum bile acids >10 µmol/L • LFTs may be normal initially	• Bile acids correlate with stillbirth risk • Itching precedes jaundice