OBSTETRIC CONDITION	CONTROL STATUS (MCQ)	TIMING OF DELIVERY	BEST MODE	MCQ PEARLS / EXAM TRAPS
Chronic Hypertension	Controlled BP No end-organ damage Normal fetal growth	38–39 weeks	Vaginal	• Do NOT induce <38 w if controlled • ACEi / ARBs contraindicated • Labetalol, nifedipine preferred
Chronic Hypertension	Uncontrolled BP End-organ damage ± IUGR	36–37 weeks	Induction / CS	• Early delivery saves mother • ↑ abruption & stroke risk • Target BP <140/90
Gestational Hypertension	No severe features Normal labs	37 weeks (exact)	Vaginal	• 37 weeks = MOST common MCQ • Delivery = definitive treatment
Preeclampsia (Severe)	BP ≥160/110 Headache, epigastric pain Platelets <100k	≥34 weeks OR earlier if unstable	CS if cervix unfavorable	• MgSO■ mandatory (before delivery) • Only cure = delivery • Steroids only if time allows
Eclampsia	Generalized seizures controlled on MgSO■	Immediate after stabilization	CS unless imminent vaginal delivery	• Control fits FIRST, then deliver • Do NOT delay delivery for steroids
Gestational Diabetes (GDM)	Diet controlled Good sugars	39–40 weeks	Vaginal	• No early induction if diet-controlled • Fasting target <95 mg/dL
Gestational Diabetes (GDM)	Insulin / poor control Macrosomia	38–39 weeks	Vaginal / CS	• Shoulder dystocia risk • EFW >4.5 kg → CS
Placenta Previa (Type III–IV)	Any bleeding status	36–37 weeks	Elective CS	• Absolute CS indication • NO vaginal examination • Placenta covers os
Placenta Accreta Spectrum	Diagnosed on US/MRI	34–35+6 weeks	CS + hysterectomy	• Do NOT remove placenta • MDT & massive transfusion protocol
Abruptio Placentae	Mild Fetus alive Mother stable	Immediate	Vaginal	• Vaginal = fastest route • Avoid unnecessary CS
Abruptio Placentae	Severe Fetal distress / DIC	Immediate	CS	• Fibrinogen falls first • High maternal mortality
Oligohydramnios	AFI <5 cm Isolated	37 weeks	Induction	• Cord compression risk • Continuous CTG
Polyhydramnios	Severe / symptomatic	38 weeks	Vaginal (slow ARM)	• Sudden ARM → cord prolapse • PPH due to atony
Breech (Primigravida)	Any type	39 weeks	Elective CS	• Planned CS ↓ perinatal mortality • Term breech trial discouraged
Breech (Multigravida)	Frank/complete breech Adequate pelvis	Term	Vaginal	• Pinard (legs) • Lovset (arms) • MSV (head)
Transverse Lie	In labour	Immediate	CS	• Absolute CS indication • Exception: second twin
Previous 1 LSCS	Eligible for VBAC Lower segment scar	Spontaneous labour	TOLAC	• Rupture risk <1% • Classical CS = absolute contraindication